DRAFT

Houston Area HIV Services Ryan White Planning Council

Quality Improvement Committee

11:00 a.m., Friday, February 22, 2019

Meeting Location: 2223 W. Loop South, Room 532; Houston, Texas 77027

Agenda

* = Handout to be distributed at the meeting

I. Call to Order — Denis Kelly and
   A. Welcoming Remarks and Moment of Reflection — Gloria Sierra, Co-Chairs
   B. Introductions
   C. Adoption of Agenda
   D. Approval of Minutes
   E. Nuts, Bolts, Petty Cash and Open Meetings Act Training — Tori Williams
   F. 2019 Meeting Day and Time – see calendar — Tori Williams

II. Public Comments and Announcements

(NOTE: If you wish to speak during the Public Comment portion of the meeting, please sign up on the clipboard at the front of the room. No one is required to give his or her name or HIV status. All meetings are audio taped by the Office of Support for use in creating the meeting minutes. The audiotape and the minutes are public record. If you state your name or HIV status it will be on public record. If you would like your health status known, but do not wish to state your name, you can simply say: "I am a person living with HIV", before stating your opinion. If you represent an organization, please state that you are representing an agency and give the name of the organization. If you work for an organization, but are representing your self, please state that you are attending as an individual and not as an agency representative. Individuals can also submit written comments to a member of the staff who would be happy to read the comments on behalf of the individual at this point in the meeting. All information from the public must be provided in this portion of the meeting.)

III. Committee Orientation
   A. Review Committee Description
   B. Conflict of Interest and Voting Policy
   C. Approve 2019 Committee Goals
   D. Review the Timeline of Critical 2019 Council Activities

IV. Training in How to Read Reports from the Administrative Agents
   A. Part A (updated documents to be provided at the meeting) — Carin Martin
      1. Service Utilization Report – Part A & MAI, dated 11/15/17
      2. Procurement Report – Part A & MAI, dated 11/15/17
   B. Part B and State Services (updated documents to be provided at the meeting) — Patrick Martin
      1. Procurement Reports Part B & SS – dated 02/06/19
      2. Service Utilization Report Part B – dated 02/05/19
      3. Health Insurance Program Reports – dated 01/08/19 & 02/04/19
   C. Criteria for FY 2019 Service Categories – March meeting — Tori Williams

V. Reports from the Administrative Agents
   A. Part A: FY 2017 Chart Reviews — Heather Keizman
      1. Primary Care
      2. Oral Health – Rural
      3. Vision
      4. Case Management — Samantha Bowen
   B. Chart Review Performance Measures — Heather Keizman
   C. Core Performance Measures by Gender
   D. Part A: Clinical Quality Management Committee Qtrly. Report

E. Part B/SS Annual Consumer Involvement Report* — Reachelian Ellison
F. Part B/SS FY16 Chart Reviews* — Tiffany Shepherd

VI. New Business
A. Elect a Committee Vice Chair

VII. Announcements

VIII. Adjourn

Optional: New members meet with committee mentor — Carol Suazo

Houston Area HIV Services Ryan White Planning Council

Quality Improvement Committee

2:00 p.m., Tuesday, November 13, 2018
Meeting location: 2223 W. Loop South, Room 416; Houston, Texas 77027

Minutes

MEMBERS PRESENT	MEMBERS ABSENT	OTHERS PRESENT
Denis Kelly, Co-Chair	Connie Barnes	Patrick Martin, TRG
Gloria Sierra, Co-Chair	David Benson, excused	Carin Martin, RWGA
Rosalind Belcher	Tom Lindstrom, excused	Heather Keizman, RWGA
Ronnie Galley	Viviana Santibanez, excused	Tori Williams, Ofc of Support
Daphne L. Jones	Carol Suazo	Amber Harbolt, Ofc of Support
John Poole	Billy Ray Grant, Jr	Diane Beck, Ofc of Support
Kevin Aloysius	Shamra Hodge	
Savi Bailey	Tracy Sandles	
Eddie Givens	Crystal Starr	
Stephen Nazarenus	David Watson	
Samantha Robinson		
Pete Rodriguez		

Call to Order: Denis Kelly, Co-Chair, called the meeting to order at 2:06 p.m. and asked for a moment of reflection.

Adoption of the Agenda: ***Motion #1****: it was moved and seconded (Jones, Galley) to adopt the agenda.* **Motion carried**.

Approval of the Minutes: ***Motion #2****: it was moved and seconded (Rodriguez, Galley) to approve the September 18, 2018 meeting minutes.* **Motion carried**. Abstentions: Jones, Poole, Robinson.

Public Comment: None.

Reports from the Administrative Agents
Ryan White Part A: C. Martin presented the following reports, see attached:

- FY18 Part A/MAI Procurement, dated 10/25/18
- FY18 Part A/MAI Service Utilization, dated 10/24/18

Ryan White Part B and State Services: P. Martin presented the following reports, see attached:

- FY18/19 Procurement Part B, dated 11/05/18
- FY18/19 Procurement DSHS SS, dated 11/05/18
- FY17/18 Procurement DSHS SS, dated 11/05/18
- FY17/18 DSHS State Services Service Utilization, dated 09/14/18
- FY18 Health Insurance Assist. Service Utilization, dated 11/01/18
- FY18 Health Insurance Assist. Service Utilization, dated 10/08/18

Standards of Care and Performance Measures
FY19/20 Standards of Care & Performance Measures, Part A/MAI: See attached. C. Martin reviewed the recommended changes. ***Motion #3****: it was moved and seconded (Bailey, Jones) to approve the recommended changes to the Standards of Care with the suggested edits.* **Motion carried**. Abstentions: Givens.

FY19/20 Standards of Care, Part B/State Services: See attached. P. Martin reviewed the recommended changes. ***Motion #4****: it was moved and seconded (Jones, Robinson) to approve the recommended changes to the Standards of Care.* **Motion carried**.

Appreciations: Williams said that this is the last meeting of the year and thanked everyone for serving on the committee. External members will need to reapply for next year while those who graduated from LEAP this year will be automatically reassigned to a committee. Kelly and Sierra also thanked everyone for serving on the committee.

Announcements: Kelly asked that everyone consider donating winter coats and blankets to the organization of your choice.

Adjourn: The meeting was adjourned at 3:50 p.m.

Submitted by: Approved by:

_____ _____

Tori Williams, Director Date Committee Chair Date

Scribe: D. Beck

ja = Just arrived at meeting
lr = Left room temporarily
lm = Left the meeting
C = Chaired the meeting
nv = non-voting member

2018 Quality Assurance Meeting Voting Record for Meeting Date 11/13/18

MEMBERS:	#1 Agenda				#2 Meeting Minutes				#3 FY 19/20 Part A/MAI Standards of Care				#4 FY 19/20 Part B/SS Standards of Care			
	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN
Denis Kelly, Co-Chair				C				C				C				C
Gloria Sierra, Co-Chair		X				X				X				X		
Rosalind Belcher		X				X				X				X		
Connie Barnes	X				X				X				X			
David Benson	X				X				X				X			
Ronnie Galley lm 3:14 pm		X				X				X			X			
Daphne L. Jones		X						X		X				X		
Tom Lindstrom	X				X				X				X			
John Poole		X						X		X				X		
Viviana Santibanez	X				X				X				X			
Carol Suazo	X				X				X				X			
Kevin Aloysius				nv				nv				nv		X		
Savi Bailey lm 3:29 pm		X				X				X			X			
Eddie Givens		X				X						X		X		
Billy Ray Grant, Jr.	X				X				X				X			
Shamra Hodge	X				X				X				X			
Stephen Nazarenus		X				X				X				X		
Samantha Robinson		X						X		X				X		
Pete Rodriguez		X				X				X				X		
Tracy Sandles	X				X				X				X			
Crystal Starr	X				X				X				X			
David Watson	X				X				X				X			

Nuts and Bolts for New Members

Staff will mail meeting packets a week in advance; if they do not arrive in a timely manner, please contact Rod in the Office of Support. In the meantime, most reminder emails will include an electronic copy of the meeting packet.

The meeting packet will have the date, time and room number of the meeting; this information is also posted on signs on the first and second floor the day of the meeting.

Sign in upon arrival and use the extra agendas on the sign in table if you didn't bring your packet.

Only Council/committee members sit at the table since they are the voting members; staff and other non-voting members sit in the audience.

The only members who can vote on the minutes are the ones who were present at the meeting. If you were absent at the meeting, please abstain from voting.

Due to County budgeting policy, there will be no petty cash reimbursements in March and possibly April so give your receipts to Rod, but be prepared to receive a reimbursement check in late April.

Be careful about stating personal health information in meetings as all meetings are tape recorded and, due to the Open Meetings Act, are considered public record. Anyone can ask to listen to the recordings, including members of the media.

Ryan White Definition of Conflict of Interest

"Conflict of Interest" (COI) is defined as an actual or perceived interest by a Ryan White Planning Council member in an action which results or has the appearance of resulting in personal, organizational, or professional gain. COI does not refer to persons living with HIV disease (PLWH) whose sole relationship to a Ryan White Part A or B or State Services funded provider is as a client receiving services. The potential for conflict of interest is present in all Ryan White processes: needs assessment, priority setting, comprehensive planning, allocation of funds and evaluation.

Houston Area HIV Services Ryan White Planning Council
Office of Support
2223 West Loop South, Suite 240, Houston, Texas 77027
832 927-7926 telephone; 713 572-3740 fax

MEMORANDUM

To: Members, Ryan White Planning Council
External Members, Ryan White Committees

Copy: Carin Martin

From: Tori Williams, Director, Office of Support

Date: January 24, 2019

Re: End of Year Petty Cash Procedures

The fiscal year for Ryan White Part A funding ends on February 28, 2019. Due to procedures in the Harris County Auditor's Office, it is important that all volunteers are aware of the following end-of-year procedures:

1.) Council and External Committee members must turn in all requests for petty cash reimbursements **at or before 2 p.m. on Friday, February 15, 2019.**

2.) Requests for petty cash reimbursements for childcare, food and/or transportation to meetings before March 1, 2019 **will not be reimbursed at all if they are turned in after March 30, 2019.**

3.) The Office of Support may not have access to petty cash funds between March 1 and May 31, 2019. This means that volunteers should give Rod the usual reimbursement request forms for transportation, food and childcare expenses incurred after March 1, 2019 but the Office may not be able to reimburse volunteers for these expenses until mid to late May 2019.

We apologize for this significant inconvenience. Please call Tori Williams at the number listed above if you have questions or concerns about how these procedures will affect you personally.

(OVER FOR TIMELINE)

March 1

2018

Beginning of fiscal year 2018

Feb 15

2019

Turn in all receipts

Feb 28

2019

End of fiscal year 2018. No money available to write checks until possibly the end of May

March 30

2019

Turn in all remaining receipts for fiscal year 2018 or you will not be reimbursed for those expenses incurred between March 1, 2018 and Feb. 28, 2019

Houston Area HIV Services Ryan White Planning Council
Office of Support
2223 West Loop South, Suite 240, Houston, Texas 77027
713 572-3724 telephone; 713 572-3740 fax
www.rwpchouston.org

Memorandum

To: Members, Houston Ryan White Planning Council
External Members, Ryan White Committees

From: Tori Williams, Director, Ryan White Office of Support

Date: February 4, 2019

Re: Open Meetings Act Training

Please note that all Council members, and External Committee members, are required to take the Open Meetings Act training at least once in their lifetime. If you have never taken the training, or if you do not have a certificate of completion on file in our office, you must take the training and submit the certificate to the Office of Support before March 31, 2018. The training takes 60 minutes and can be accessed through the following link (if you have difficulty with the link, copy and paste it into Google and it should lead you to the correct area of the Attorney General's website):

https://www.texasattorneygeneral.gov/og/oma-training

If you do not have high-speed internet access, you are welcome to view the video in the Office of Support. We will make the training available in suite 240 after the Council adjourns on Thursday, February 14th; popcorn will be provided. Or, you can contact Diane Beck and make an appointment to see it on one of the computers in our office.

Upon completion of training, you will be provided with a code that is used to print a certificate of completion. Using the code, you may obtain the certificate from the Attorney General's Office in the following ways:

Print it from the Attorney General web link at:
https://www.texasattorneygeneral.gov/forms/openrec/og_certificates.php

Or, call the Office of Support with the validation code and the staff will print it for you.

We appreciate your attention to this important requirement. Do not hesitate to call our office if you have questions.

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Office of Support
2223 West Loop South, Suite 240, Houston, Texas 77027
713 572-3724 telephone; 713 572-3740 fax
www.rwpchouston.org

Memorandum

To: Volunteers, Houston Ryan White Program

From: Tori Williams, Director, Ryan White Office of Support

Date: September 27, 2017

Re: Open Meetings Act Training

As a follow up to Orientation, please note that all Council and external committee members are required to take the Open Meetings Act training at least once in their life time. If you have never taken the training, or if you do not have a certificate of completion on file in our office, you must take the training and submit the certificate to the Office of Support before November 15, 2017. The training takes 60 minutes and can be accessed through the following link:

https://www.texasattorneygeneral.gov/og/oma-training

If you do not have high-speed internet access, you are welcome to view the video in the Office of Support. You can contact Diane Beck at the telephone number listed above and make an appointment to see it on one of the computers in our office.

Upon completion of training, you will be provided with a code that is used to print a certificate of completion. Using the code, you may obtain the certificate from the Attorney General's Office in the following ways:

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Or, call the Office of Support with the validation code and the staff will print it for you.

We appreciate your attention to this important requirement. Do not hesitate to call our office if you have questions.

2019

JANUARY

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Jan 01: New Year's Day	Jan 21: M L King Day	Feb 14: Valentine's Day	Feb 18: Presidents' Day
Apr 19: Good Friday	Apr 21: Easter	May 12: Mother's Day	May 27: Memorial Day
Jun 16: Father's Day	Jul 04: Independence Day	Sep 02: Labor Day	Oct 14: Columbus Day
Oct 31: Halloween	Nov 11: Veterans Day	Nov 28: Thanksgiving Day	Dec 25: Christmas

Houston Area HIV Services Ryan White Planning Council
Standing Committee Structure

(Reviewed 07-15-15)

1. Affected Community Committee

This committee is designed to acknowledge the collective importance of consumer participation in Planning Council (PC) strategic activities and provide consumer education on HIV-related matters. The committee will serve as a place where consumers can safely and in an environment of trust discuss PC work plans and activities. This committee will verify consumer participation on each of the standing committees of the PC, with the exception of the Steering Committee (the Chair of the Affected Community Committee will represent the committee on the Steering Committee).

When providing consumer education, the committee should not use pharmaceutical representatives to present educational information. Once a year, the committee may host a presentation where all HIV/AIDS-related drug representatives are invited.

The committee will consist of HIV+ individuals, their caregivers (friends or family members) and others. All members of the PC who self-disclose as HIV+ are requested to be a member of the Affected Community Committee; however membership on a committee for HIV+ individuals will not be restricted to the Affected Community Committee.

2. Comprehensive HIV Planning Committee

This committee is responsible for developing the Comprehensive Needs Assessment, Comprehensive Plan (including the Continuum of Care), and making recommendations regarding special topics (such as non-Ryan White Program services related to the Continuum of Care). The committee must benefit from external membership and expertise.

3. Operations Committee

This committee combines four areas where compliance with Planning Council operations is the focus. The committee develops and facilitates the management of Planning Council operating procedures, guidelines, and inquiries into members' compliance with these procedures and guidelines. It also implements the Open Nominations Process, which requires a continuous focus on recruitment and orientation. This committee is also the place where the Planning Council self-evaluations are initiated and conducted.

This committee will not benefit from external member participation except where resolve of grievances are concerned.

4. Priority and Allocations Committee

This committee gives attention to the comprehensive process of establishing priorities and allocations for each Planning Council year. Membership on this committee does include external members and must be guided by skills appropriate to priority setting and allocations, not by interests in priority setting and allocations. All Ryan White Planning Council committees, but especially this committee, regularly review and monitor member participation in upholding the Conflict of Interest standards.

5. Quality Improvement Committee

This committee will be given the responsibility of assessing and ensuring continuous quality improvement within Ryan White funded services. This committee is also the place where definitions and recommendations on "how to best meet the need" are made. Standards of Care and Performance Measures/Outcome Evaluation, which must be looked at within each year, are monitored from this committee. Whenever possible, this committee should collaborate with the other Ryan White planning groups, especially within the service categories that are also funded by the other Ryan White Parts, to create shared Standards of Care.

In addition to these responsibilities, this committee is also designed to implement the Planning Council's third legislative requirement, assessing the administrative mechanism in rapidly allocating funds to the areas of greatest need within the eligible area, or assessing how well the grantee manages to get funds to providers. This means reviewing how quickly contracts with service providers are signed and how long the grantee takes to pay these providers. It also means reviewing whether the funds are used to pay only for services that were identified as priorities by the Planning Council and whether all the funds are spent. This Committee may benefit from the utilization of external members.

HOUSTON AREA HIV HEALTH SERVICES
RYAN WHITE PLANNING COUNCIL

EST. JUL 15, 1998 **REV JANUARY 1, 2018** **POLICY No. 600.01**

QUORUM, VOTING, PROXIES, ATTENDANCE

PURPOSE

This policy establishes the guidelines as to what legally constitutes a Houston Area HIV Health Services (Ryan White) Planning Council meeting. In addition, the policy will define and establish how voting is done, what constitutes a roll call vote and who monitors that process. This policy will define attendance, and the process by which a member can be removed from the council.

AUTHORITY

The adoption of the Houston Area HIV Health Services (Ryan White) Planning Council Bylaws Rev. 01/18 Article VI; (Sections 6.01-6.04).

PROCESS

QUORUM:

A majority of the members of the Council are required to constitute a quorum. A minimum of one (1) self-identified HIV+ member must also be present to constitute a quorum. If quorum is not met, the Council Chair, in consultation with the Office of Support staff, will determine when to dismiss those present. To constitute a Standing Committee quorum, at least two (2) committee members and a Chair must be present; one of these must be a self-identified HIV positive member.

VOTING:

Each council member will have only one vote on any regular business matter coming before the Council. A simple majority of members present and voting will be required to pass any matter coming before the Council except for that of proposed Bylaws changes. Proposed changes to the Bylaws will be submitted in written form for review to the full Council at least fifteen (15) days prior to voting and will require a two-thirds (2/3) majority for passage. The Chair of the Council will not vote except in the event of a tie. The Chairs of the Standing Committees shall not vote at Committee meetings except in the event of a tie. In a case where standing committees have co-chairs, only one of them may vote at Steering. The Chair of the Council is an ex-offico member of all committees (standing, subcommittee, and work groups). Ex-offico means that he/she is welcome to attend and is allowed to be a part of committee discussion. He/she is not allowed to vote. In the absence of the Chair of the Council, the next officer may assume the ex-officio role with committees. In an effort to manage agency influence over a single committee or workgroup, only one voting member (Council or External) per agency will be permitted to vote on Ryan White Planning Council committees and workgroups. If there is an unresolved tie vote and the Chair of the Committee works for the same agency as another committee member, then the information will be forwarded to the Steering Committee for resolution.

ALTERNATE PARTICIPATION:

During committee meetings any HIV+ full council member may serve as an alternate on a committee for any absent HIV+ committee member. The Chair of the Committee will

communicate to the rest of the committee that the alternate HIV+ person is there to conduct business. Alternates have full voting privileges. This rule is not applicable in full council meetings.

CONFLICT OF INTEREST AND VOTING AMONG EXTERNAL MEMBERS:

External members must declare a conflict of interest.

The number of external members on a committee (not a subcommittee or work group) should not equal or exceed the number of council members on that committee.

ROLL CALL VOTE:

When a roll call vote is taken, the Secretary will call the roll call vote, noting voting, and will announce the results of the roll call vote. The Secretary will monitor voting for possible conflicts of interest (RWPC Policy No. 800.01). The Secretary will process inquiries into votes made in conflict of interest.

ATTENDANCE:

Council members are required to attend meetings of the Houston Area HIV Health Services (Ryan White) Planning Council. External Committee members are required to attend meetings of the committee to which they are assigned. The Secretary shall cause attendance records to be maintained and shall regularly provide such records to the Chair of the Operations Committee. The Operations Committee will review attendance records quarterly.

If a Council or external committee member has 4 absences (excused or unexcused) from Council meetings or 4 absences from committee meetings within a calendar year or fails to perform the duties of a Council member described herein without just cause, that member will be subject to removal. In order to avoid such action, the following will occur: Step 1: Office of Support staff will contact the member by telephone to check on their status. Step 2: If the member continues to miss meetings, the Chair of the Planning Council will formally notify the member in writing to remind them of Council policies regarding attendance and to give the member an opportunity to request assignment to another committee. If assignment to another committee is requested, the Chair of the newly selected committee and the Planning Council Chair must approve the change. Step 3: If the Council member continues to miss meetings, the CEO will be informed of the situation and the steps taken by the Council to address the situation. If an external committee member continues to miss meetings, the Chair of the Council will be informed of the situation and the steps taken by the Council to address the situation. Step 4: The CEO has the sole authority to terminate a Council member and will notify said member in writing, if that is their decision. The CEO or the Chair of the Planning Council has the authority to terminate an external committee member and will notify said member in writing, if that is their decision.

If for two consecutive months the Office of Support is unable to make contact with a Council or external committee member by telephone and receives returned email and/or mail sent to that member, staff will send a certified letter requesting the member to contact the Office of Support by telephone or in writing to update their contact information. If the member does not respond to the certified letter within 30 days, or if the certified letter is returned to the Office of Support, the Operations Committee will be notified at their next regularly scheduled meeting. At the request of the Operations Committee, the Chair of the Planning Council and the CEO will be informed of the situation and the steps taken by the Council to address the situation. As stated above, the CEO has the sole authority to terminate a Council member and will notify said member in writing, if that is his/her decision. The CEO or the Chair of the Planning Council has the authority to terminate an external committee member and will notify said member in writing, if that is his/her decision.

Reasons for absences that would be used to determine reassignment or dismissal include: 1) sickness; 2) work related conflicts (in or out of town and vacations), and 3) unforeseeable circumstances. Any Planning Council member who is unable to attend a Planning Council meeting or standing committee meeting must notify the Office of Support prior to such meeting. The Office of Support staff will document why a member is absent.

PROXIES:

There will be no voting by proxy.

2018 Quarterly Report
Quality Improvement Committee
(November 2018)

Status of Committee Goals and Responsibilities (*means mandated by HRSA)

1. Conduct the "How to Best Meet the Needs" (HTBMN) process, with particular attention to the continuum of care with respect to HRSA identified core services.

2. Develop a process for including consumer input that is proactive and consumer friendly for the Standards of Care and Performance Measures review process.

3. Continue to improve the information, processes and reporting (within the committee and also thru collaboration with other Planning Council committees) needed to:
   a. Identify "The Un-met Need";
   b. Determine "How to Best Meet the Needs";
   c. *Strengthen and improve the description and measurement of medical and health related outcomes.

4. *Identify and review the required information, processes and reporting needed to assess the "Efficiency of the Administrative Mechanism". Focus on the status of specific actions and related time-framed based information concerning the efficiency of the administrative mechanism operation in the areas of:
   a. Planning fund use (meeting RWPC identified needs, services and priorities);
   b. Allocating funds (reporting the existence/use of contract solicitation, contract award and contract monitoring processes including any time-frame related activity);
   c. Distributing funds (reporting contract/service/re-imbursement expenditures and status, as well as, reporting contract/service utilization information).

5. Annually, review the status of committee activities identified in the current Comprehensive Plan.

Status of Tasks on the Timeline:

_____ _____
Committee Chairperson Date

DRAFT

Houston Area HIV Services Ryan White Planning Council

Timeline of Critical 2019 Council Activities

(Revised 02-04-19)

A square around an item indicates an item of particular importance or something out of the ordinary regarding the date, time or meeting location.

The following meetings are subject to change. Please call the Office of Support to confirm a particular meeting time, date and/or location: 832 927-7926.

General Information: The following is a list of significant activities regarding the 2019 Houston Ryan White Planning Council. Consumers, providers and members of the general public are encouraged to attend and provide public comment at any of the meetings described below. For more information on Planning Council processes or to receive monthly calendars and/or review meeting agendas and support documents, please contact the Office of Support at 832 927-7926 or visit our website at: www.rwpchouston.org.

Routinely, the Steering Committee meets monthly at 12 noon on the first Thursday of the month. The Council meets monthly at 12 noon on the second Thursday of the month.

Thurs. Jan. 24	Council Orientation. 2019 Committee meeting dates will be established at this meeting.
Thurs. Feb. 7	12 noon. First Steering Committee meeting for the 2019 planning year.
Tues. Feb. 5	10:00 am. Orientation for new 2019 External Committee Members.
Thurs. Feb. 14	12 noon. First Council meeting for the 2019 planning year.
Mon. Feb. 18	5:00 pm. Deadline for submitting **Proposed Idea Forms** to the Office of Support. The Council is currently funding, or recommending funding, for 17 of the 28 allowable HRSA service categories. The Idea Form is used to ask the Council to make a change to a funded service or reconsider funding a service that is not currently being funded in the Greater Houston area with Ryan White Part A, Part B or State Services dollars. The form requires documentation for why dollars should be used to fund a particular service and why it is not a duplication of a service already being offered through another funding source. Anyone can submit a Idea Form. Please contact the Office of Support at 832 927-7926 to request a copy of the required forms
Thurs. Feb. 28	12 noon. Priority & Allocations Committee meets to approve the **policy on allocating FY 2019 unspent funds**, **FY 2020 priority setting process** and more.
March	Date and time TBD. EIIHA Workgroup meeting.
Friday, March 1	5 pm Deadline for submitting a Project LEAP application form. See April 3 for description of Project LEAP. Call 832 927-7926 for an application form.
Mon. March 25	1:30 pm. **Consumer Training** on the How to Best Meet the Need process.
March 19	2:00 pm. Joint meeting of the Quality Improvement, Priority & Allocations and Affected Community Committees to determine the criteria to be used to select the **FY 2020 service categories** for Part A, Part B and *State Services* funding.
Wed. April 3	**Project LEAP** classes begin. Project LEAP is a free 17-week training course for individuals living with and affected by HIV to gain the knowledge and skills they need to help plan HIV prevention and care services in the Houston Area. To apply, call 832 927-7926.

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Houston Area HIV Services Ryan White Planning Council

Timeline of Critical 2019 Council Activities

(Revised 02-04-19)

A square around an item indicates an item of particular importance or something out of the ordinary regarding the date, time or meeting location.

The following meetings are subject to change. Please call the Office of Support to confirm a particular meeting time, date and/or location: 832 927-7926.

Thurs. April 4	12 noon. Steering Committee meets.
Thurs. April 11	12 noon. Planning Council meets.
*	1:30 – 4:30 pm. **Council and Community Training for the How to Best Meet the Need process**. Those encouraged to attend are community members as well as individuals from the Quality Improvement, Priority & Allocations and Affected Community Committees. Call 832 927-7926 for confirmation and additional information.
* Thurs. April 18	10 am – 5 pm, Two special workgroup meetings. Topics to be announced.
* Tues. April 23	10 am – 5 pm. **How To Best Meet the Need Workgroups #1 and #2** at which the following services for FY 2020 will be reviewed: • Ambulatory/Outpatient Medical Care (including Emergency Financial Assistance, Local Pharmacy Assistance, Medical Case Management & Service Linkage – Adult, Rural and Pediatric, Outreach) • Clinical Case Management • Referral for Health Care and Support Services • Health Insurance Premium & Co-pay Assistance • Medical Nutritional Therapy (including Nutritional Supplements) • Mental Health • Substance Abuse Treatment/Counseling • Non-Medical Case Management (Service Linkage at Testing Sites) • Non-Medical Case Management (Substance Use) • Oral Health – Untargeted & Rural • Vision Care Call 832 927-7926 for meeting dates and times and to receive meeting packets.
* Wed. April 24	3:00 pm – 5:00 pm. **How To Best Meet the Need Workgroup #3** at which the following services will be reviewed: • Early Intervention Services • Home & Community-based Health Services (Adult Day Treatment) • Hospice • Linguistic Services • Transportation (van-based-Untargeted & Rural) Call 832 927-7926 for confirmation and additional information.
Thurs. April 25	12 noon. Priority & Allocations Committee meets to allocate **Part A unspent funds.**
Mon. May 6	5:00 pm. Deadline for submitting **Proposed Idea Forms** to the Office of Support. (See February 18 for a description of this process.) Please contact the Office of Support at 832 927-7926 to request a copy of the required forms.

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Houston Area HIV Services Ryan White Planning Council

Timeline of Critical 2019 Council Activities

(Revised 02-04-19)

A square around an item indicates an item of particular importance or something out of the ordinary regarding the date, time or meeting location.

The following meetings are subject to change. Please call the Office of Support to confirm a particular meeting time, date and/or location: 832 927-7926.

Tues. May 14	12 noon. **How to Best Meet the Need Workgroup** meets for recommendations on the **Blue Book**. The Operations Committee reviews the FY 2020 Council Support Budget.
Tues. May 14	2:00 pm. Quality Improvement Committee meets to approve the **FY 2020 How to Best Meet the Need results** and review **subcategory allocation requests**. Draft copies are forwarded to the Priority & Allocations Committee.
Mon. May 20	7:00 pm., Public Hearing on the **FY 2020 How To Best Meet the Need results**.
Tues. May 21	Time TBD. Special Quality Improvement Committee meeting to review public comments regarding **FY 2020 How To Best Meet the Need results**.
Thurs. May 23	12 noon. Priority & Allocations Committee meets to recommend the **FY 2020 service priorities** for Ryan White Parts A and B and *State Services* funding.
Thurs. June 6	12 noon. Steering Committee meets to approve the **FY 2020 How to Best Meet the Need results**.
Thurs. June 13	12 noon. Council approves the **FY 2020 How to Best Meet the Need results**. **Project LEAP students present the results of their special projects to the Council, hence the meeting may be at an off-site location.**
Week of June 17-21	Dates and times TBD. Special Priority & Allocations Committee meetings to draft the **FY 2020 allocations for RW Part A and B and *State Services* funding**.
Tues. June 18	2:00 pm. Quality Improvement Committee reviews the results of the Assessment of the Administrative Mechanism and hosts Standards of Care training.
Thurs. June 27	12 noon. Priority & Allocations Committee meets to approve the **FY 2020 allocations for RW Part A and B and *State Services* funding**.
Mon. July 1	7 pm. Public Hearing on the **FY 2020 service priorities and allocations**.
Tues. July 2	Time TBD. Special meeting of the Priority & Allocations Committee to review public comments regarding the **FY 2020 service priorities and allocations**.
July/Aug.	Workgroup meets to complete the proposed **FY 2020 EIIHA Plan**.
Wed. July 3	12 noon. Steering Committee approves the **FY 2020 service priorities and allocations**.
Thurs. July 11	12 noon. Council approves the **FY 2020 service priorities and allocations**.

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Houston Area HIV Services Ryan White Planning Council

Timeline of Critical 2019 Council Activities

(Revised 02-04-19)

A square around an item indicates an item of particular importance or something out of the ordinary regarding the date, time or meeting location.

The following meetings are subject to change. Please call the Office of Support to confirm a particular meeting time, date and/or location: 832 927-7926.

Thurs. July 25	12 noon. If necessary, the Priority & Allocations Committee meets to address problems Council sends back regarding the **FY 2020 priority & allocations**. They also allocate **FY 2019 carryover funds**. (**Allocate even though dollar amount will not be avail. until Aug.**)
Thurs. Aug. 1	12 noon. ALL ITEMS MUST BE REVIEWED BEFORE BEING SENT TO COUNCIL – THIS STEERING COMMITTEE MEETING IS THE **LAST CHANCE TO APPROVE ANYTHING NEEDED FOR THE FY 2020 GRANT**. (Mail out date for the August Steering Committee meeting is July 25, 2019.)
Mon. Aug. 19	1:30 pm. **Consumer Training** on Standards of Care and Performance Measures.
Mon. Sept. 9	5:00 pm. Deadline for submitting **Proposed Idea Forms** to the Office of Support. (See February 18 for a description of this process.) Please contact the Office of Support at 832 927-7926 to request a copy of the required forms.
* Tues. Sept. 17	2:00 pm. Joint meeting of the Quality Improvement, Priority & Allocations and all Committees to review data reports and make suggested changes.
Mon. Sept. 23	1:30 pm. **Consumer-Only Workgroup** meeting to review FY 2020 Standards of Care and Performance Measures.
Tues. Oct. 15	12 noon. Review and possibly update the Memorandum of Understanding between all Part A stakeholders.
* October or November	Date & time TBD. Community Workgroup meeting to review **FY 2020 Standards of Care & Performance Measures** for all service categories.
Thurs. Oct. 24	12 noon. Priority & Allocations Committee meets to allocate FY 2019 unspent funds.
November	Date & time TBD. Review the evaluation of 2019 Project LEAP. Operations Committee also hosts a How to Best Meet the Need Workgroup to make recommendations on 2020 Project LEAP.
November	The Resource Group contacts all stakeholders to see if changes need to be made to the Ryan White Part B/State Services Letter of Agreement.
Thurs. Nov. 14	12 noon. Council recognizes all external committee members.
Tues. Nov. 12	9:30 am. Commissioners Court to receive the World AIDS Day Resolution.
Sun. Dec. 1	**World AIDS Day**.
Thurs. Dec. 12	12 noon. Election of Officers for the 2020 Ryan White Planning Council.

Part A Reflects "Increase" Funding Scenario
MAI Reflects "Increase" Funding Scenario

FY 2018 Ryan White Part A and MAI Procurement Report

Priority	Service Category	Original Allocation *RWPC Approved Level Funding Scenario*	Award Reconcilation (b)	July Adjustments (carryover)	October Adjustments	Final Quarter Adjustments	Total Allocation	Percent of Grant Award	Amount Procured (a)	Procure-ment Balance	Original Date Procured	Expended YTD	Percent YTD	Percent Expected YTD
1	**Outpatient/Ambulatory Primary Care**	**9,634,415**	**391,824**	**703,670**	**180,631**	**0**	**10,910,540**	**50.99%**	**10,910,540**	**0**		**8,001,337**	**73%**	**92%**
1.a	Primary Care - Public Clinic (a)	3,520,995	70,069	378,670	0		3,969,734	18.55%	3,969,734	0	3/1/2018	$317,777	8%	75%
1.b	Primary Care - CBO Targeted to AA (a) (e) (f)	940,447	80,923	100,000	51,877		1,173,247	5.48%	1,173,247	0	3/1/2018	$991,211	84%	92%
1.c	Primary Care - CBO Targeted to Hispanic (a) (e)	786,424	80,923	100,000	51,877		1,019,224	4.76%	1,019,224	0	3/1/2018	$768,581	75%	92%
1.d	Primary Care - CBO Targeted to White/MSM (a) (e)	1,003,821	100,899	100,000	51,877		1,256,597	5.87%	1,256,597	0	3/1/2018	$546,924	44%	92%
1.e	Primary Care - CBO Targeted to Rural (a) (e)	1,127,327	22,434	0	0		1,149,761	5.37%	1,149,761	0	3/1/2018	$795,594	69%	92%
1.f	Primary Care - Women at Public Clinic (a)	1,837,964	36,576	0			1,874,540	8.76%	1,874,540	0	3/1/2018	$4,242,084	226%	75%
1.g	Primary Care - Pediatric (a.1)	15,437	0				15,437	0.07%	15,437	0	3/1/2018	$9,600	62%	92%
1.h	Vision	402,000	0	25,000	25,000		452,000	2.11%	452,000	0	3/1/2018	$329,565	73%	92%
2	**Medical Case Management**	**2,535,802**	**0**	**0**	**0**	**0**	**2,535,802**	**11.85%**	**2,535,802**	**0**		**1,649,691**	**65%**	**92%**
2.a	Clinical Case Management	488,656	0	0	0		488,656	2.28%	488,656	0	3/1/2018	$379,295	78%	92%
2.b	Med CM - Public Clinic (a)	482,722	0	0	0		482,722	2.26%	482,722	0	3/1/2018	$214,673	44%	75%
2.c	Med CM - Targeted to AA (a) (e)	321,070	0	0	0		321,070	1.50%	321,070	0	3/1/2018	$305,727	95%	92%
2.d	Med CM - Targeted to H/L (a) (e)	321,072	0	0	0		321,072	1.50%	321,072	0	3/1/2018	$159,648	50%	92%
2.e	Med CM - Targeted to W/MSM (a) (e)	107,247	0	0	0		107,247	0.50%	107,247	0	3/1/2018	$76,314	71%	92%
2.f	Med CM - Targeted to Rural (a)	348,760	0	0			348,760	1.63%	348,760	0	3/1/2018	$216,425	62%	92%
2.g	Med CM - Women at Public Clinic (a)	180,311	0	0			180,311	0.84%	180,311	0	3/1/2018	$92,558	51%	75%
2.h	Med CM - Targeted to Pedi (a.1)	160,051	0	0	0		160,051	0.75%	160,051	0	3/1/2018	$103,795	65%	92%
2.i	Med CM - Targeted to Veterans	80,025	0	0	0		80,025	0.37%	80,025	0	3/1/2018	$60,367	75%	92%
2.j	Med CM - Targeted to Youth	45,888	0	0			45,888	0.21%	45,888	0	3/1/2018	$40,890	89%	75%
3	**Local Pharmacy Assistance Program (a) (e)**	**1,934,796**	**256,674**	**0**	**69,363**	**0**	**2,260,833**	**10.57%**	**2,260,833**	**0**	3/1/2018	**$1,651,228**	**73%**	**92%**
4	**Oral Health**	**166,404**	**0**	**0**	**0**	**0**	**166,404**	**0.78%**	**166,404**	**0**	3/1/2018	**153,800**	**92%**	**92%**
4.a	Oral Health - Untargeted (c)	0					0	0.00%	0	0	N/A	$0	0%	0%
4.b	Oral Health - Targeted to Rural	166,404	0	0			166,404	0.78%	166,404	0	3/1/2018	$153,800	92%	92%
5	**Mental Health Services (c)**	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**	**NA**	**$0**	**0%**	**0%**
6	**Health Insurance (c)**	**1,244,551**	**28,519**	**0**	**0**	**0**	**1,273,070**	**5.95%**	**1,273,070**	**0**	3/1/2018	**$984,852**	**77%**	**92%**
7	**Home and Community-Based Services (c)**	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**	**NA**	**$0**	**0%**	**0%**
8	**Substance Abuse Services - Outpatient**	**45,677**	**0**	**0**	**0**	**0**	**45,677**	**0.21%**	**45,677**	**0**	3/1/2018	**$24,388**	**53%**	**92%**
9	**Early Intervention Services (c)**	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**	**NA**	**$0**	**0%**	**0%**
10	**Medical Nutritional Therapy (supplements)**	**341,395**	**0**	**0**	**0**	**0**	**341,395**	**1.60%**	**341,395**	**0**	3/1/2018	**$267,080**	**78%**	**92%**
11	**Hospice Services**	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**	**NA**	**$0**	**0%**	**0%**
12	**Outreach Services**	**420,000**	**39,927**				**459,927**	**2.15%**	**459,927**	**0**	**3/1/2018**	**$199,533**	**43%**	**92%**
13	**Non-Medical Case Management**	**1,231,002**	**0**	**0**	**0**	**0**	**1,231,002**	**5.75%**	**1,231,002**	**0**		**1,012,492**	**82%**	**92%**
13.a	Service Linkage targeted to Youth	110,793		0			110,793	0.52%	110,793	0	3/1/2018	$82,326	74%	92%
13.b	Service Linkage targeted to Newly-Diagnosed/Not-in-Care	100,000			0		100,000	0.47%	100,000	0	3/1/2018	$69,474	69%	92%
13.c	Service Linkage at Public Clinic (a)	427,000		0	0		427,000	2.00%	427,000	0	3/1/2018	$363,460	85%	75%
13.d	Service Linkage embedded in CBO Pcare (a) (e)	593,209		0	0		593,209	2.77%	593,209	0	3/1/2018	$497,233	84%	92%
14	**Medical Transportation**	**482,087**	**25,824**	**0**	**0**	**0**	**507,911**	**2.37%**	**507,911**	**0**		**286,354**	**56%**	**92%**
14.a	Medical Transportation services targeted to Urban	252,680	0	0	0		252,680	1.18%	252,680	0	3/1/2018	$214,038	85%	92%
14.b	Medical Transportation services targeted to Rural	97,185	0	0	0		97,185	0.45%	97,185	0	3/1/2018	$72,316	74%	92%
14.c	Transportation vouchering (bus passes & gas cards)	132,222	25,824	0	0		158,046	0.74%	158,046	0	3/1/2018	$0	0%	0%
15	**Linguistic Services (c)**	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**	**NA**	$0	**0%**	**0%**
16	**Emergency Financial Assistance**	**450,000**		**0**	**150,000**	**0**	**600,000**	**2.80%**	**600,000**	**0**	3/1/2018	$223,565	**37%**	**92%**
17	**Referral for Health Care and Support Services (c)**	**0**	**0**	**0**			**0**	**0.00%**	**0**	**0**	NA	$0	**0%**	**0%**
BEA27516	**Total Service Dollars**	**18,486,129**	**742,768**	**703,670**	**399,994**	**0**	**20,332,561**	**92.87%**	**20,332,561**	**0**		**14,031,221**	**69%**	**92%**
	Grant Administration	**1,675,047**	**0**	**0**	**0**	**0**	**1,675,047**	**7.83%**	**1,675,047**	**0**	**N/A**	**0**	**0%**	**92%**
BEA27517	HCPHES/RWGA Section	1,146,388	0	0		0	1,146,388	5.36%	1,146,388	0	N/A	$0	0%	92%
PC	RWPC Support*	528,659			0	0	528,659	2.47%	528,659	0	N/A	0	0%	92%

Part A Reflects "Increase" Funding Scenario
MAI Reflects "Increase" Funding Scenario

FY 2018 Ryan White Part A and MAI
Procurement Report

Priority	Service Category	Original Allocation *RWPC Approved Level Funding Scenario*	Award Reconcilation (b)	July Adjustments (carryover)	October Adjustments	Final Quarter Adjustments	Total Allocation	Percent of Grant Award	Amount Procured (a)	Procure-ment Balance	Original Date Procured	Expended YTD	Percent YTD	Percent Expected YTD
BES27521	**Quality Management**	**495,000**	**0**	**0**	**0**	**0**	**495,000**	**2.31%**	**495,000**	**0**	**N/A**	**$0**	**0%**	**92%**
		20,656,176	**742,768**	**703,670**	**399,994**	**0**	**22,502,608**	**103.01%**	**22,502,608**	**0**		**14,031,221**	**62%**	**92%**
								Unallocated	Unobligated					
	Part A Grant Award:	**21,398,944**	***Carry Over:***	**0**		***Total Part A:***	**21,398,944**	**-1,103,664**	**0**					
		Original Allocation	**Award Reconcilation (b)**	**July Adjusments (carryover)**	**October Adjustments**	**Final Quarter Adjustments**	**Total Allocation**	**Percent**	**Total Expended on Services**	**Percent**				
	Core (must not be less than 75% of total service dollars)	**15,903,040**	**677,017**	**703,670**	**249,994**	**0**	**17,533,721**	**86.40%**	**17,533,721**	**85.77%**				
	Non-Core (may not exceed 25% of total service dollars)	**2,583,089**	**25,824**	**0**	**150,000**	**0**	**2,758,913**	**13.60%**	**2,908,913**	**14.23%**				
	Total Service Dollars (does not include Admin and QM)	**18,486,129**	**702,841**	**703,670**	**399,994**	**0**	**20,292,634**		**20,442,634**					
	Total Admin (must be ≤ 10% of total Part A + MAI)	**1,675,047**	**0**	**0**	**0**	**0**	**1,675,047**	**7.83%**						
	Total QM (must be ≤ 5% of total Part A + MAI)	**495,000**	**0**	**0**	**0**	**0**	**495,000**	**2.31%**						

MAI Procurement Report

Priority	Service Category	Original Allocation *RWPC Approved Level Funding Scenario*	Award Reconcilation (b)	July Adjustments (carryover)	October Adjustments	Final Quarter Adjustments	Total Allocation	Percent of Grant Award	Amount Procured (a)	Procure-ment Balance	Date of Procure-ment	Expended YTD	Percent YTD	Percent Expected YTD
1	**Outpatient/Ambulatory Primary Care**	**1,797,785**	**49,060**	**90,830**	**0**	**0**	**1,937,675**	**84.33%**	**1,937,675**	**0**		**1,575,475**	**81%**	**92%**
1.b (MAI)	Primary Care - CBO Targeted to African American	910,163	24,530	45,415	0	0	980,108	42.65%	980,108	0	3/1/2018	$920,975	94%	92%
1.c (MAI)	Primary Care - CBO Targeted to Hispanic	887,622	24,530	45,415	0	0	957,567	41.67%	957,567	0	3/1/2018	$654,500	68%	92%
2	**Medical Case Management**	**320,100**	**0**	**40,000**	**0**	**0**	**360,100**	**15.67%**	**320,100**	**40,000**		**$126,959**	**40%**	92%
2.c (MAI)	MCM - Targeted to African American	160,050		20,000			180,050	7.84%	180,050	0	3/1/2018	$84,228	47%	92%
2.d (MAI)	MCM - Targeted to Hispanic	160,050		20,000			180,050	7.84%	160,050	20,000	3/1/2018	$42,731	27%	92%
	Total MAI Service Funds	**2,117,885**	**49,060**	**130,830**	**0**	**0**	**2,297,775**	**100.00%**	**1,937,675**	**360,100**		**1,575,475**	**81%**	**92%**
	Grant Administration	0	0	0	0	0	0	0.00%	0	0		0	0%	0%
	Quality Management	0	0	0	0	0	0	0.00%	0	0		0	0%	0%
	Total MAI Non-service Funds	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**		**0**	**0%**	**0%**
BEC27516	**Total MAI Funds**	**2,117,885**	**49,060**	**130,830**	**0**	**0**	**2,297,775**	**100.00%**	**1,937,675**	**360,100**		**1,575,475**	**81%**	**92%**
	MAI Grant Award	**2,166,944**	***Carry Over:***	**0**		***Total MAI:***	**2,166,944**							
	Combined Part A and MAI Orginial Allocation Total	**22,774,061**												

Footnotes:

All	When reviewing bundled categories expenditures must be evaluated both by individual service category and by combined categories. One category may exceed 100% of available funding so long as other category offsets this overage.
(a)	Single local service definition is four (4) HRSA service categories (Pcare, LPAP, MCM, Non Med CM). Expenditures must be evaluated both by individual service category and by combined service categories.
(a.1)	Single local service definition is three (3) HRSA service categories (does not include LPAP). Expenditures must be evaluated both by individual service category and by combined service categories.
(b)	Adjustments to reflect actual award based on Increase or Decrease funding scenario.
(c)	Funded under Part B and/or SS
(d)	Not used at this time
(e)	10% rule reallocations

Prepared by: Ryan White Grant Administration

FY 2018 Ryan White Part A and MAI Service Utilization Report

SUR - 3rd Quarter Cumulative (3/1-11/30)

Priority	Service Category	Goal	Unduplicated Clients Served YTD	Male	Female	Verify	AA (non-Hispanic)	White (non-Hispanic)	Other (non-Hispanic)	Hispanic	Verify	0-12	13-19	20-24	25-34	35-44	45-49	50-64	65 plus	Verify
1	**Outpatient/Ambulatory Primary Care (excluding Vision)**	**6,467**	**7,062**	**73%**	**27%**	**100%**	**47%**	**14%**	**2%**	**36%**	**100%**	**0%**	**1%**	**4%**	**27%**	**26%**	**13%**	**26%**	**2%**	**100%**
1.a	Primary Care - Public Clinic (a)	2,350	3,215	69%	31%	100%	50%	10%	2%	38%	100%	0%	0%	2%	18%	26%	15%	35%	4%	100%
1.b	Primary Care - CBO Targeted to AA (a)	1,060	1,543	68%	32%	100%	99%	0%	1%	0%	100%	0%	0%	8%	39%	27%	10%	15%	1%	100%
1.c	Primary Care - CBO Targeted to Hispanic (a)	960	1,218	85%	15%	100%	0%	0%	0%	100%	100%	0%	1%	5%	30%	30%	14%	19%	1%	100%
1.d	Primary Care - CBO Targeted to White and/or MSM (a)	690	653	88%	12%	100%	0%	87%	11%	1%	100%	0%	0%	4%	26%	20%	16%	30%	3%	100%
1.e	Primary Care - CBO Targeted to Rural (a)	400	590	71%	29%	100%	46%	25%	2%	28%	100%	0%	0%	7%	32%	27%	11%	21%	2%	100%
1.f	Primary Care - Women at Public Clinic (a)	1,000	998	0%	100%	100%	60%	8%	2%	30%	100%	0%	0%	1%	14%	29%	18%	33%	5%	100%
1.g	Primary Care - Pediatric (a)	7	10	80%	20%	100%	30%	10%	0%	60%	100%	10%	60%	30%	0%	0%	0%	0%	0%	100%
1.h	Vision	1,600	1,971	74%	26%	100%	50%	15%	2%	33%	100%	0%	0%	4%	24%	22%	14%	33%	2%	100%
2	**Medical Case Management (f)**	**3,075**	**4,518**																	
2.a	Clinical Case Management	600	899	73%	27%	100%	63%	18%	2%	17%	100%	0%	0%	5%	27%	25%	11%	29%	3%	100%
2.b	Med CM - Targeted to Public Clinic (a)	280	577	92%	8%	100%	60%	9%	2%	29%	100%	0%	1%	3%	28%	22%	13%	30%	3%	100%
2.c	Med CM - Targeted to AA (a)	550	1,544	69%	31%	100%	99%	0%	0%	0%	100%	0%	0%	8%	35%	25%	10%	20%	2%	100%
2.d	Med CM - Targeted to H/L(a)	550	827	86%	14%	100%	0%	0%	0%	100%	100%	0%	1%	7%	32%	30%	10%	18%	2%	100%
2.e	Med CM - Targeted to White and/or MSM (a)	260	395	87%	13%	100%	0%	89%	11%	0%	100%	0%	1%	3%	25%	21%	15%	32%	4%	100%
2.f	Med CM - Targeted to Rural (a)	150	659	70%	30%	100%	49%	28%	3%	21%	100%	0%	0%	7%	27%	22%	11%	29%	4%	100%
2.g	Med CM - Targeted to Women at Public Clinic (a)	240	231	0%	100%	100%	65%	9%	3%	23%	100%	0%	0%	1%	16%	29%	19%	30%	3%	100%
2.h	Med CM - Targeted to Pedi (a)	125	98	65%	35%	100%	72%	4%	0%	23%	100%	63%	29%	8%	0%	0%	0%	0%	0%	100%
2.i	Med CM - Targeted to Veterans	200	167	96%	4%	100%	71%	19%	1%	10%	100%	0%	0%	0%	2%	4%	8%	63%	23%	100%
2.j	Med CM - Targeted to Youth	120	20	95%	5%	100%	45%	5%	0%	50%	100%	0%	15%	85%	0%	0%	0%	0%	0%	100%
3	**Local Drug Reimbursement Program (a)**	**2,845**	**3,707**	**77%**	**23%**	**100%**	**47%**	**15%**	**2%**	**35%**	**100%**	**0%**	**0%**	**5%**	**29%**	**28%**	**14%**	**23%**	**1%**	**100%**
4	**Oral Health**	**200**	**279**	**69%**	**31%**	**100%**	**42%**	**30%**	**2%**	**27%**	**100%**	**0%**	**0%**	**5%**	**20%**	**30%**	**11%**	**30%**	**4%**	**100%**
4.a	Oral Health - Untargeted (d)	NA	NA	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
4.b	Oral Health - Rural Target	200	279	69%	31%	100%	42%	30%	2%	27%	100%	0%	0%	5%	20%	30%	11%	30%	4%	100%
5	**Mental Health Services (d)**	**NA**	**NA**																	
6	**Health Insurance**	**1,700**	**1,337**	**81%**	**19%**	**100%**	**43%**	**27%**	**3%**	**27%**	**100%**	**0%**	**0%**	**3%**	**15%**	**20%**	**15%**	**39%**	**8%**	**100%**
7	**Home and Community Based Services (d)**	**NA**	**NA**																	
8	**Substance Abuse Treatment - Outpatient**	**40**	**20**	**95%**	**5%**	**100%**	**20%**	**50%**	**5%**	**25%**	**100%**	**0%**	**0%**	**0%**	**40%**	**25%**	**15%**	**20%**	**0%**	**100%**
9	**Early Medical Intervention Services (d)**	**NA**	**NA**																	
10	**Medical Nutritional Therapy/Nutritional Supplements**	**650**	**434**	**79%**	**21%**	**100%**	**40%**	**21%**	**3%**	**36%**	**100%**	**0%**	**0%**	**2%**	**13%**	**15%**	**16%**	**46%**	**8%**	**100%**
11	**Hospice Services (d)**	**NA**	**NA**																	
12	**Outreach**	**NA**	**602**	**74%**	**26%**	**100%**	**57%**	**13%**	**1%**	**29%**	**100%**	**0%**	**0%**	**6%**	**32%**	**25%**	**13%**	**22%**	**2%**	**100%**
13	**Non-Medical Case Management**	**7,045**	**6,106**																	
13.a	Service Linkage Targeted to Youth	320	150	81%	19%	100%	59%	5%	5%	31%	100%	0%	13%	87%	0%	0%	0%	0%	0%	100%
13.b	Service Linkage at Testing Sites	260	117	68%	32%	100%	68%	6%	2%	25%	100%	0%	0%	0%	53%	21%	9%	15%	2%	100%
13.c	Service Linkage at Public Clinic Primary Care Program (a)	3,700	2,822	66%	34%	100%	61%	10%	2%	27%	100%	0%	0%	0%	18%	23%	14%	40%	6%	100%
13.d	Service Linkage at CBO Primary Care Programs (a)	2,765	3,017	78%	22%	100%	53%	13%	2%	32%	100%	0%	1%	7%	31%	23%	13%	23%	2%	100%
14	**Transportation**	**2,850**	**2,591**																	
14.a	Transportation Services - Urban	170	442	67%	33%	100%	63%	12%	3%	23%	100%	0%	0%	7%	29%	24%	14%	24%	2%	100%
14.b	Transportation Services - Rural	130	144	69%	31%	100%	43%	33%	3%	21%	100%	0%	1%	3%	19%	24%	13%	35%	5%	100%
14.c	Transportation vouchering	2,550	2,005																	
15	**Linguistic Services (d)**	**NA**	**NA**																	
16	**Emergency Financial Assistance (e)**	**NA**	**NA**																	
17	**Referral for Health Care - Non Core Service (d)**	**NA**	**NA**																	
Net unduplicated clients served - all categories*		**12,941**	**12,318**	**74%**	**26%**	**100%**	**53%**	**15%**	**2%**	**30%**	**100%**	**1%**	**1%**	**5%**	**24%**	**24%**	**13%**	**30%**	**4%**	**100%**
Living AIDS cases + estimated Living HIV non-AIDS (from FY 17 App) (b)		**NA**	**22,830**	**74%**	**26%**	**100%**	**49%**	**23%**	**3%**	**25%**	**100%**	**0%**	**6%**		**18%**	**27%**	**30%**	**18%**		**100%**

***11,657** clients to be served is based on the number of unduplicated clients served in FY 2016 (update per CPCDMS)

Available Data As Of: 12/19/2018

Prepared by: Ryan White Grant Administration

FY 2018 Ryan White Part A and MAI Service Utilization Report

RW MAI Service Utilization Report

Priority	Service Category MAI unduplicated served includes clients also served under Part A	Goal	Unduplicated MAI Clients Served YTD	Male	Female	Verify	AA (non-Hispanic)	White (non-Hispanic)	Other (non-Hispanic)	Hispanic	Verify	0-12	13-19	20-24	25-34	35-44	45-49	50-64	65 plus	Verify
	Outpatient/Ambulatory Primary Care (excluding Vision)																			
1.b	Primary Care - MAI CBO Targeted to AA (g)	1,060	1,889	73%	27%	100%	99%	0%	1%	0%	100%	0%	1%	7%	37%	25%	11%	18%	1%	100%
1.c	Primary Care - MAI CBO Targeted to Hispanic (g)	960	1,239	87%	13%	100%	0%	0%	0%	100%	100%	0%	1%	6%	31%	32%	12%	17%	1%	100%
2	**Medical Case Management (f)**																			
2.c	Med CM - Targeted to AA (a)	1,060	542	77%	23%	100%	48%	17%	3%	32%	100%	0%	1%	9%	32%	28%	12%	18%	1%	
2.d	Med CM - Targeted to H/L(a)	960	122	80%	20%	100%	59%	20%	3%	17%	100%	0%	1%	10%	40%	19%	7%	20%	3%	

RW Part A New Client Service Utilization Report

Report reflects the number & demographics of clients served during the report period who did not receive services during previous 12 months (3/1/12 - 2/28/13)

Priority	Service Category	Goal	Unduplicated New Clients Served YTD	Male	Female	Verify	AA (non-Hispanic)	White (non-Hispanic)	Other (non-Hispanic)	Hispanic	Verify	0-12	13-19	20-24	25-34	35-44	45-49	50-64	65 plus	Verify
1	**Primary Medical Care**	**2,100**	**1,477**	**76%**	**24%**	**100%**	**54%**	**13%**	**3%**	**30%**	**100%**	**0%**	**1%**	**8%**	**35%**	**24%**	**11%**	**18%**	**2%**	**100%**
2	**LPAP**	**1,200**	**542**	**77%**	**23%**	**100%**	**48%**	**17%**	**3%**	**32%**	**100%**	**0%**	**1%**	**9%**	**32%**	**28%**	**12%**	**18%**	**1%**	**100%**
3.a	Clinical Case Management	400	122	80%	20%	100%	59%	20%	3%	17%	100%	0%	1%	10%	40%	19%	7%	20%	3%	100%
3.b-3.h	Medical Case Management	1,600	1027	76%	24%	100%	57%	12%	2%	29%	100%	3%	2%	9%	35%	23%	10%	17%	1%	100%
3.i	Medical Case Manangement - Targeted to Veterans	60	32	97%	3%	100%	69%	16%	0%	16%	100%	0%	0%	0%	3%	9%	19%	44%	25%	100%
4	**Oral Health**	**40**	**41**	**80%**	**20%**	**100%**	**46%**	**27%**	**0%**	**27%**	**100%**	**0%**	**2%**	**15%**	**24%**	**27%**	**10%**	**20%**	**2%**	**100%**
12.a. 12.c. 12.d.	**Non-Medical Case Management (Service Linkage)**	**3,700**	**1,655**	**74%**	**26%**	**100%**	**58%**	**11%**	**2%**	**28%**	**100%**	**0%**	**2%**	**7%**	**29%**	**22%**	**12%**	**24%**	**4%**	**100%**
12.b	**Service Linkage at Testing Sites**	**260**	**130**	**73%**	**27%**	**100%**	**67%**	**5%**	**2%**	**26%**	**100%**	**0%**	**2%**	**22%**	**41%**	**16%**	**7%**	**11%**	**2%**	**100%**

Footnotes:

(a)	Bundled Category
(b)	Age groups 13-19 and 20-24 combined together; Age groups 55-64 and 65+ combined together.
(d)	Funded by Part B and/or State Services
(e)	Not funded in FY 2017
(f)	Total MCM served does not include Clinical Case Management

Available Data As Of: 12/19/2018

The Houston Regional HIV/AIDS Resource Group, Inc.
FY 1819 Ryan White Part B
Procurement Report
April 1, 2018 - March 31, 2019

Reflects spending through December 2018

Spending Target: 75%

Revised 2/13/2019

Priority	Service Category	Original Allocation per RWPC	% of Grant Award	Amendment*	Contractual Amount	% of Grant Award	Date of Original Procurement	Expended YTD	Percent YTD
6	Oral Health Care	$2,085,565	62%	$325,806	$2,411,371	72%	4/1/2018	$1,333,620	64%
7	Health Insurance Premiums and Cost Sharing (1)	$726,885	22%	$0	$726,885	22%	4/1/2018	$393,976	54%
9	Home and Community Based Health Services (2)	$202,315	6%	$0	$202,315	6%	4/1/2018	$103,920	51%
	Unallocated funds approved by RWPC for Health Insurance	$325,806	10%	($325,806)	$0	0%	4/1/2018	$0	0%
	Total Houston HSDA	3,340,571	100%	$0	$3,340,571	100%		1,831,516	55%

Note: Spending variances of 10% will be addressed:

1 HIP - Funded by Part A, B and State Services. Provider spends grant funds by ending dates Part A- 2/28; B-3/31; SS-8/31. Agancy usually expends all funds.

The Houston Regional HIV/AIDS Resource Group, Inc.

FY 1819 DSHS State Services

Procurement Report

September 1, 2018- August 31, 2019

Chart reflects spending through December 2018

Spending Target: 33.33%

Revised 2/13/2019

Priority	Service Category	Original Allocation per RWPC	% of Grant Award	Amendment	Contractual Amount	% of Grant Award	Date of Original Procurement	Expended YTD	Percent YTD
5	**Health Insurance Premiums and Cost Sharing (1)**	$979,694	49%	**$142,285**	$1,121,979	56%	1/0/1900	$386,062	34%
6	**Mental Health Services (2)**	$300,000	15%	**$0**	$300,000	15%	9/1/2018	$46,729	16%
7	**EIS - Incarcerated**	$166,211	8%	**$0**	$166,211	8%	9/1/2018	$57,448	35%
11	**Hospice (3)**	$359,832	18%		$359,832	18%	9/1/2018	$49,280	14%
15	**Linguistic Services (4)**	$68,000	3%		$68,000	3%	9/1/2018	$11,700	17%
	Unallocated (RWPC Approved for Health Insurance - TRG will amend contract)	$142,285	7%	**-$142,285**	$0	0%	9/1/2018	$0	0%
	Total Houston HSDA	**2,016,022**	**100%**	**$0**	$2,016,022	100%		551,219	27%

First month of expenditures. Submissions/services/data entry are slow during first few months of contract.

1 HIP - Funded by Part A, B and State Services. Provider spends grant funds by ending dates Part A- 2/28; B-3/31; SS-8/31. Agancy usually expends all funds.

2 Mental Health Services are under Utilized and under reported.

3 Hospice care has had lower than expected client turn out

4 Linguistic is one behind on reporting due to slow invoicing by provider.

2018-2019 Ryan White Part B Service Utilization Report

4/1/2018 - 3/31/2019 Houston HSDA (4816)

3rd Quarter - 4/1/2018 to 12/31/2018

Revised 2/5/2019

Funded Service	UDC		Gender				Race				Age Group							
	Goal	YTD	Male	Female	FTM	MTF	AA	White	Hisp	Other	0-12	13-19	20-24	25-34	35-44	45-49	50-64	65+
Health Insurance Premiums & Cost Sharing Assistance	*1,250*	3	100.00%	0.00%	0.00%	0.00%	75.00%	25.00%	0.00%	0.00%	0.00%	0.00%	8.82%	8.82%	23.53%	11.76%	44.12%	2.94%
Home & Community Based Health Services	*30*	34	70.59%	26.47%	0.00%	2.94%	58.82%	8.82%	32.35%	0.00%	0.00%	0.00%	0.00%	66.67%	0.00%	33.33%	0.00%	0.00%
Oral Health Care	*3,100*	856	72.90%	25.93%	0.00%	1.17%	49.65%	17.06%	31.43%	1.87%	0.00%	0.12%	1.75%	14.84%	18.69%	13.79%	43.46%	7.36%
Unduplicated Clients Served By RW Part B Funds:	*NA*	**893**	**81.16%**	**17.47%**	**0.00%**	**1.37%**	**61.16%**	**16.96%**	**21.26%**	**0.62%**	**0.00%**	**0.11%**	**2.02%**	**14.78%**	**18.81%**	**13.77%**	**43.34%**	**7.17%**

COMMENT:

The delay in Data Upload from CPCDMS into ARIES is the reason for the discrepancy in the HIP/HIA YTD Total. Please see HINS Report for review on HIP/HIA totals.

Houston Ryan White Health Insurance Assistance Service Utilization Report

Period Reported: 09/01/2018-11/30/18

Revised: 1/8/2019

	Assisted			NOT Assisted		
Request by Type	Number of Requests (UOS)		Number of Clients (UDC)	*Number of Requests (UOS)*	*Dollar Amount of Requests*	*Number of Clients (UDC)*
Medical Co-Payment	535	$50,915.73	464			*0*
Medical Deductible	26	$8,995.08	32			*0*
Medical Premium	1013	$404,708.94	625			*0*
Pharmacy Co-Payment	609	$59,462.09	583			*0*
APTC Tax Liability	0	$0.00	0			*0*
Out of Network Out of Pocket	0	$0.00	0			*0*
ACA Premium Subsidy Repayment	6	$995.00	3	*NA*	*NA*	*NA*
Totals:	2189	$523,086.84	1707	0	$0.00	

Comments: This report represents services provided under all grants.

Houston Ryan White Health Insurance Assistance Service Utilization Report

Period Reported: 09/01/2018-12/31/2018

Revised: 2/4/2019

	Assisted			NOT Assisted		
Request by Type	Number of Requests (UOS)		Number of Clients (UDC)	*Number of Requests (UOS)*	*Dollar Amount of Requests*	*Number of Clients (UDC)*
Medical Co-Payment	785	$72,937.77	509			*0*
Medical Deductible	70	$23,424.75	50			*0*
Medical Premium	2447	$984,144.70	686			*0*
Pharmacy Co-Payment	1345	$135,910.80	651			*0*
APTC Tax Liability	0	$0.00				*0*
Out of Network Out of Pocket	0	$0.00				*0*
ACA Premium Subsidy Repayment	9	$1,042.00	8	*NA*	*NA*	*NA*
Totals:	4656	$1,215,376.02	1904	0	$0.00	

Comments: This report represents services provided under all grants.

Service Category	**Is this a core service?** If no, how does the service support access to core services & support clients achieving improved outcomes?	**How does this service assist individuals *not in care** to access primary care?** **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	**Documentation of Need** (Sources of Data include: 2016 Needs Assessment, 2017-2021 Comp Plan, 2016 Outcome Measures, 2016 Chart Reviews, Special Studies and surveys, etc.)	**Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources** (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	**Justify the use of Ryan White Part A, Part B and State Services funds for this service.** **Is this a duplicative service or activity?**	**Service Efficiency** Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified?	**Recommendation(s)**
Clinical Case Management - Part A	✔ Yes ___No	☐ EIIHA ☐ Unmet Need ☐ Continuum of Care		Covered under QHP? ___Yes ✔ No			
Case Management – Non-Medical - Part A (Service Linkage at testing sites)	___Yes ✔ No	☐ EIIHA ☐ Unmet Need ☐ Continuum of Care		Covered under QHP? ___Yes ✔ No			

‡ Service Category for Part B/State Services only.

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Primary Care Chart Review Report FY 2017

Ryan White Part A Quality Management Program – Houston EMA

October 2018

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HCPH is the local public health agency for the Harris County, Texas jurisdiction. It provides a wide variety of public health activities and services aimed at improving the health and well-being of the Harris County community.

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PREFACE

EXPLANATION OF PART A QUALITY MANAGEMENT

In 2017, the Houston Eligible Metropolitan Area (EMA) awarded Part A funds for adult Outpatient Ambulatory Medical Services to five organizations. Approximately 12,000 unduplicated individuals living with HIV receive Ryan White-funded services at these organizations.

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

Introduction

On March 26, 2017, the RWGA PC/CQI commenced the evaluation of Part A funded Primary Medical Care Services funded by the Ryan White Part A grant. This grant is awarded to HCPH by the Health Resources and Services Administration (HRSA) to provide HIV-related health and social services to people living with HIV. The purpose of this evaluation project is to meet HRSA mandates for quality management, with a focus on:

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

A comprehensive review of client medical records was conducted for services provided between 3/1/17 and 2/28/18. The guidelines in effect during the year the patient sample was seen, *Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents Living with HIV* were used to determine degree of compliance. The current treatment guidelines are available for download at: http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf. The initial activity to fulfill the purpose was the development of a medical record data abstraction tool that addresses elements of the guidelines, followed by medical record review, data analysis and reporting of findings with recommendations.

Tool Development

The PC/CQI worked with the Clinical Quality Improvement (CQI) committee to develop and approve data collection elements and processes that would allow evaluation of primary care services based on the *Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents Living with HIV, 2017* that were developed by the Panel on Antiretroviral Guidelines for Adults and Adolescents convened by the DHHS. In addition, data collection elements and processes were developed to align with the Health Resources and Services Administration (HRSA), HIV/AIDS Bureau's (HAB) HIV/AIDS Clinical Performance Measures for Adults & Adolescents. These measures are designed to serve as indicators of quality care. HAB measures are available for download at: http://hab.hrsa.gov/deliverhivaidscare/habperformmeasures.html. An electronic database was designed to facilitate direct data entry from patient records. Automatic edits and validation screens were included in the design and layout of the data abstraction program to "walk" the nurse reviewer through the process and to facilitate the accurate collection, entering and validation of data. Inconsistent information, such as reporting GYN exams for men, or opportunistic infection prophylaxis for patients who do not need it, was considered when designing validation functions. The PC/CQI then used detailed data validation reports to check certain values for each patient to ensure they were consistent.

Chart Review Process

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

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

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

Tale 1. Data Collection Parameters

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

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

The Sample Selection Process

The sample population was selected from a pool of 7,423 clients (adults age 18+) who accessed Part A primary care (excluding vision care) between 3/1/17 and 2/28/18. The medical charts of 635 clients were used in this review, representing 8.6% of the pool of unduplicated clients. The number of clients selected at each site is proportional to the number of primary care clients served there. Three caveats were observed during the sampling process. In an effort to focus on women living with HIV health issues, women were over-sampled, comprising 44.6% of the sample population. Second, providers serving a relatively small number of clients were over-sampled in order to ensure sufficient sample sizes for data analysis. Finally, transgender clients were oversampled in order to collect data on this sub-population.

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

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

Characteristics of the Sample Population

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

Table 2. Demographic Characteristics of Clients During Study Period 3/1/17-2/28/18

	Sample		**Ryan White Part A Houston EMA**	
Gender	Number	Percent	Number	Percent
Male	310	48.8%	5,513	74%
Female	283	44.6%	1,821	24.5%
Transgender Male to Female	42	6.6%	112	1.5%
Transgender Female to Male	0	0%	0	0%
TOTAL	**635**		**7,446**	
Race				
Asian	8	1.3%	99	1.3%
African-Amer.	310	48.8%	3,737	50.2%
Pacific Islander	0	0%	4	.1%
Multi-Race	5	.8%	56	.7%
Native Amer.	2	.3%	30	.4%
White	310	48.8%	3,520	47.3%
TOTAL	**635**		**7,446**	
Hispanic				
Non-Hispanic	376	59.2%	4,775	64.1%
Hispanic	259	40.8%	2,671	35.9%
TOTAL	**635**		**7,446**	
Age				
<=24	23	3.6%	455	5.4%
25-34	164	25.8%	2,199	29.3%
35-44	176	27.7%	2,093	28%
45-49	97	15.3%	955	12.8%
50-64	169	26.6%	1,661	22.3%
65 and older	6	.9%	83	1.1%
Total	**635**		**7,446**	

Report Structure

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

[1] http://hab.hrsa.gov/deliverhivaidscare/habperformmeasures.html Accessed November 10, 2013

Findings

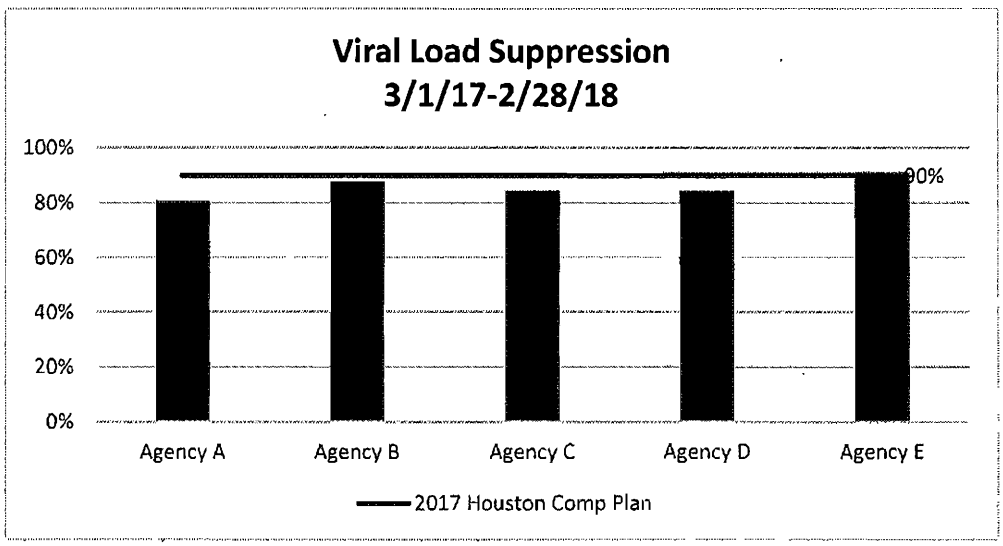
Core Performance Measures

Viral Load Suppression

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

	2015	2016	2017
Number of clients with viral load below limits of quantification at last test during the measurement year	519	544	535
Number of clients who: • had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year, and • were prescribed ART for at least 6 months	601	615	626
Rate	**86.4%**	**88.5%**	**85.5%**
	-5.6%	**2.1%**	**-3%**

2017 Viral Load Suppression by Race/Ethnicity			
	Black	Hispanic	White
Number of clients with viral load below limits of quantification at last test during the measurement year	236	225	62
Number of clients who: • had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year, and • were prescribed ART for at least 6 months	283	257	73
Rate	**83.4%**	**87.5%**	**84.9%**



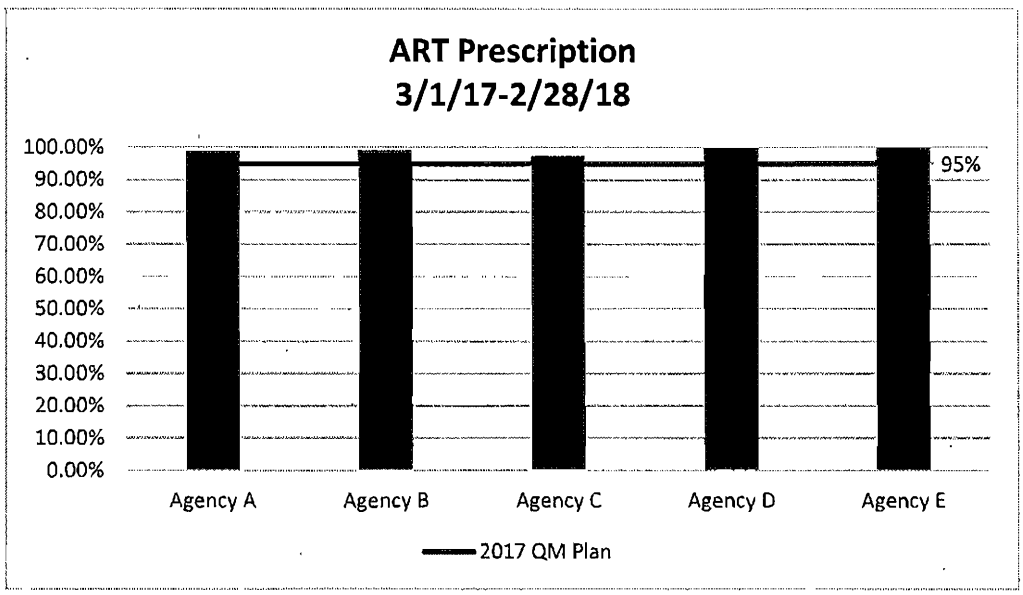
ART Prescription

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

	2015	2016	2017
Number of clients who were prescribed an ART regimen within the measurement year	613	620	627
Number of clients who: • had at least two medical visit with a provider with prescribing privileges, i.e. MD, PA, NP in the measurement year	635	635	635
Rate	**96.5%**	**97.6%**	**98.7%**
Change from Previous Years Results	**1.2%**	**1.1%**	**1.1%**

- Of the 8 clients not on ART, none had a CD4 <200, 5 were long-term non-progressors, and 3 refused

2017 ART Prescription by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who were prescribed an ART regimen within the measurement year	284	257	73
Number of clients who: • had at least two medical visit with a provider with prescribing privileges, i.e. MD, PA, NP in the measurement year	290	259	73
Rate	**97.9%**	**99.2%**	**100%**

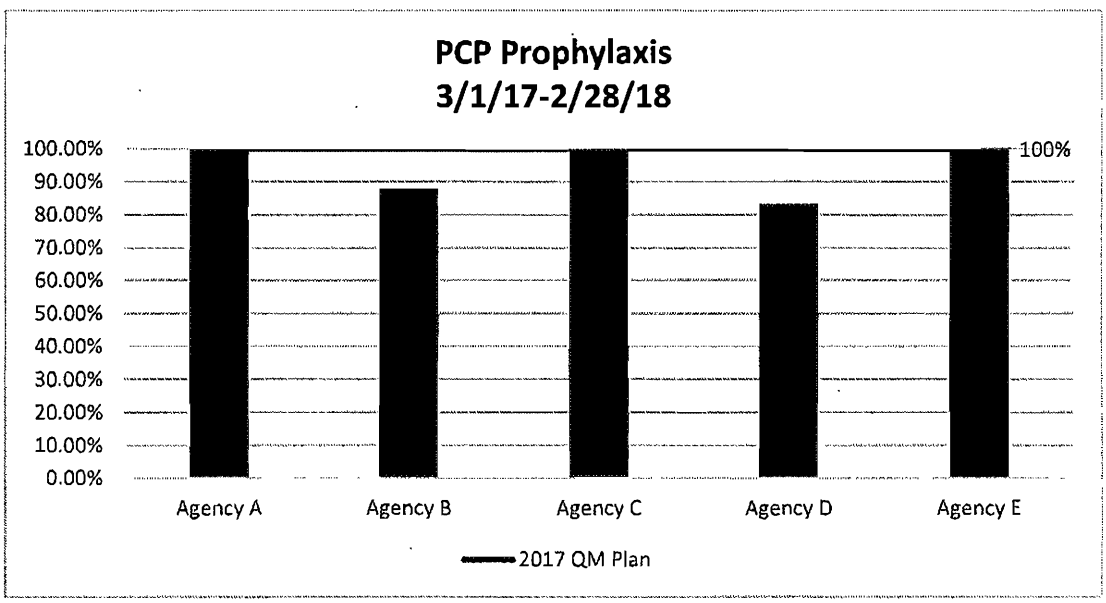


PCP Prophylaxis

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

	2015	2016	2017
Number of clients with CD4 T-cell counts below 200 cells/mm^3 who were prescribed PCP prophylaxis	53	48	53
Number of clients who: • had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year, and • had a CD4 T-cell count below 200 cells/mm^3, or any other indicating condition	57	48	57
Rate	**93%**	**100%**	**93%**
Change from Previous Years Results	**-7%**	**7%**	**-7%**

2017 PCP Prophylaxis by Race/Ethnicity			
	Black	Hispanic	White
Number of clients with CD4 T-cell counts below 200 cells/mm^3 who were prescribed PCP prophylaxis	22	25	5
Number of clients who: • had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least once in the measurement year, and • had a CD4 T-cell count below 200 cells/mm^3, or any other indicating condition	25	25	6
Rate	**88%**	**100%**	**83.3%**



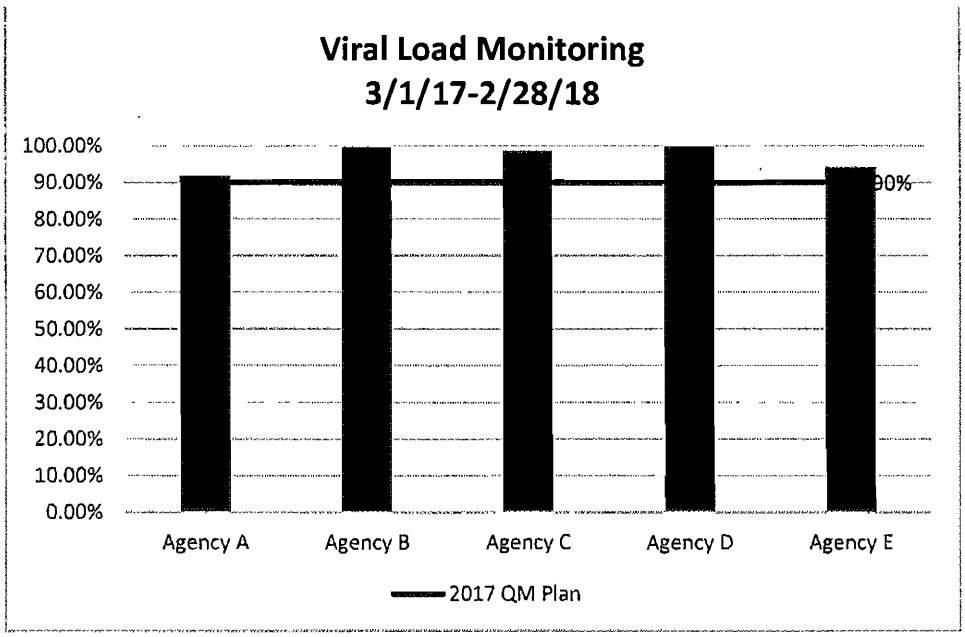
All Ages Performance Measures

Viral Load Monitoring

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

	2015	2016	2017
Number of clients who had a viral load test performed at least every six months during the measurement year	590	601	622
Number of clients who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year	635	635	635
Rate	**92.9%**	**94.6%**	**98%**
Change from Previous Years Results	**1.4%**	**1.7%**	**3.4%**

2017 Viral Load by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who had a viral load test performed at least every six months during the measurement year	285	254	70
Number of clients who had a medical visit with a provider with prescribing privileges1, i.e. MD, PA, NP at least twice in the measurement year	290	259	73
Rate	**98.3%**	**98.1%**	**95.9%**



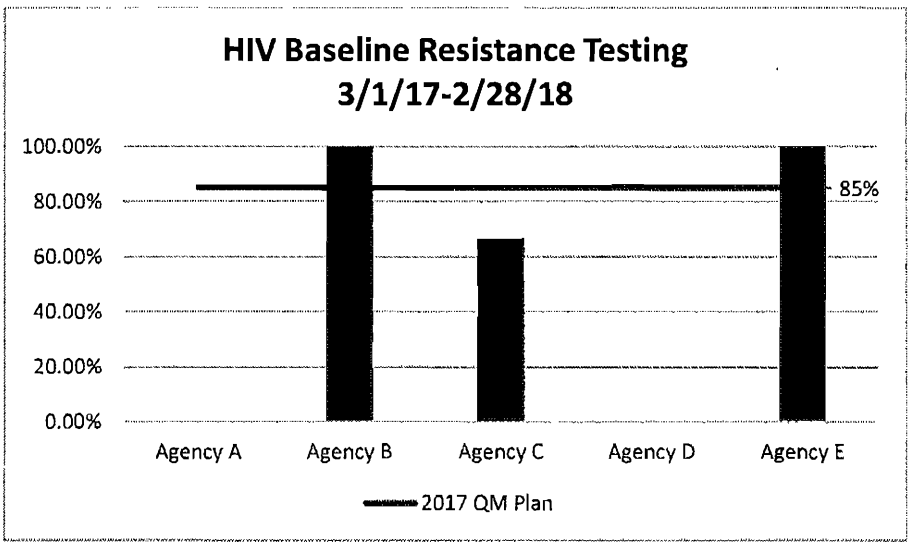
HIV Drug Resistance Testing Before Initiation of Therapy

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

	2015	2016	2017
Number of clients who had an HIV drug resistance test performed at any time before initiation of HIV ART	7	9	5
Number of clients who: • had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year, and • were prescribed ART during the measurement year for the first time	10	13	7
Rate	**70%**	**69.2%**	**71.4%**
Change from Previous Years Results	**-15%**	**-.8%**	**2.2%**

2017 Drug Resistance Testing by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who had an HIV drug resistance test performed at any time before initiation of HIV ART	1	1	2
Number of clients who: • had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year, and • were prescribed ART during the measurement year for the first time	2	2	2
Rate	**50%**	**50%**	**100%**

*Agency D did not have any clients that met the denominator



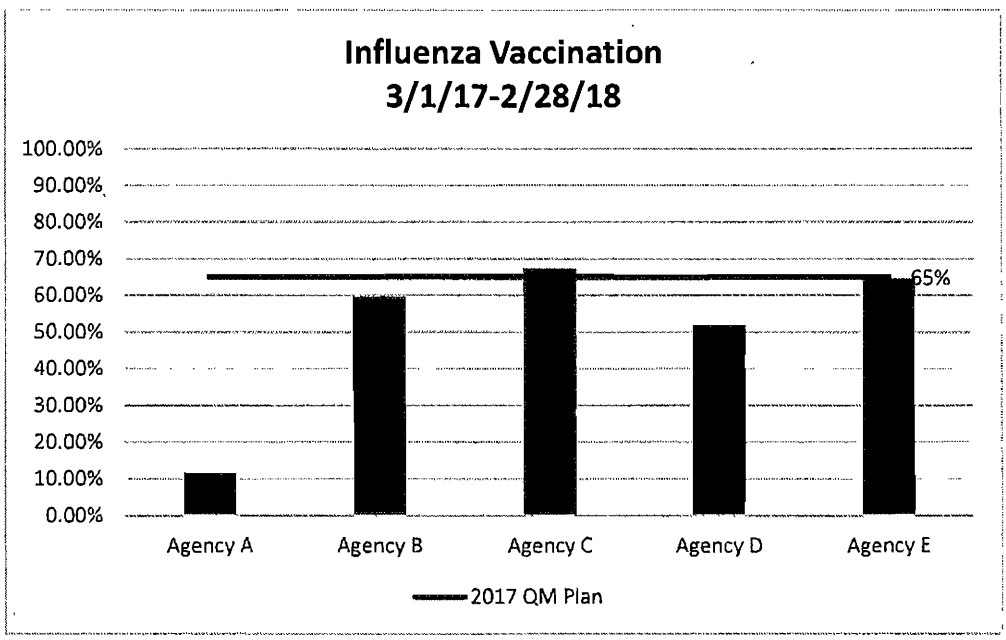
Influenza Vaccination

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

	2015	2016	2017
Number of clients who received influenza vaccination within the measurement year	326	312	310
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement period	579	588	579
Rate	**56.3%**	**53.1%**	**53.5%**
Change from Previous Years Results	**-10.3%**	**-3.2%**	**.4%**

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

2017 Influenza Screening by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who received influenza vaccination within the measurement year	129	144	30
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	257	249	62
Rate	**50.2%**	**57.8%**	**48.4%**

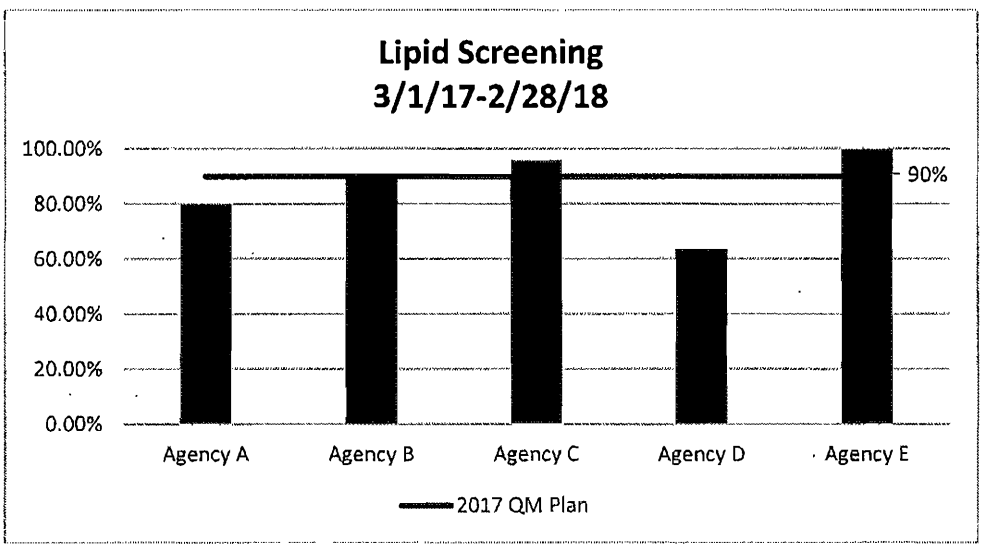


Lipid Screening

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

	2015	2016	2017
Number of clients who: • were prescribed ART, and • had a fasting lipid panel in the measurement year	542	551	557
Number of clients who are on ART and who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	613	620	627
Rate	**88.4%**	**88.9%**	**88.8%**
Change from Previous Years Results	**-4.7%**	**.5%**	**-.1%**

2017 Lipid Screening by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who: • were prescribed ART, and • had a fasting lipid panel in the measurement year	247	235	65
Number of clients who are on ART and who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	284	257	73
Rate	**87%**	**91.4%**	**89%**

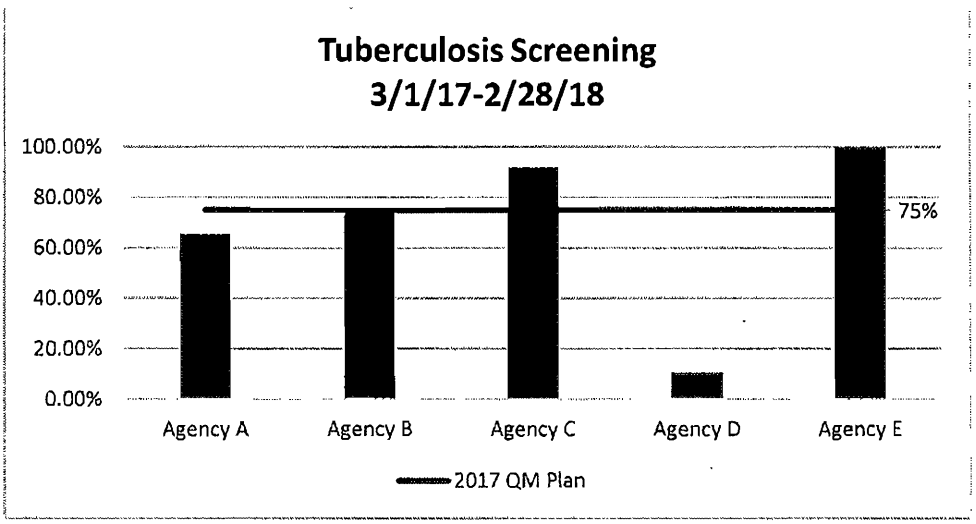


Tuberculosis Screening

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

	2015	2016	2017
Number of clients who received documented testing for LTBI with any approved test (tuberculin skin test [TST] or interferon gamma release assay [IGRA]) since HIV diagnosis	376	382	375
Number of clients who: • do not have a history of previous documented culture-positive TB disease or previous documented positive TST or IGRA; and • had a medical visit with a provider with prescribing privileges at least twice in the measurement year.	560	571	558
Rate	**67.1%**	**66.9%**	**67.2%**
Change from Previous Years Results	**-4%**	**-.2%**	**.3%**

2017 TB Screening by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who received documented testing for LTBI with any approved test (tuberculin skin test [TST] or interferon gamma release assay [IGRA]) since HIV diagnosis	165	154	50
Number of clients who: • do not have a history of previous documented culture-positive TB disease or previous documented positive TST or IGRA; and • had a medical visit with a provider with prescribing privileges at least once in the measurement year.	247	228	72
Rate	**66.8%**	**67.5%**	**69.4%**



Adolescent/Adult Performance Measures

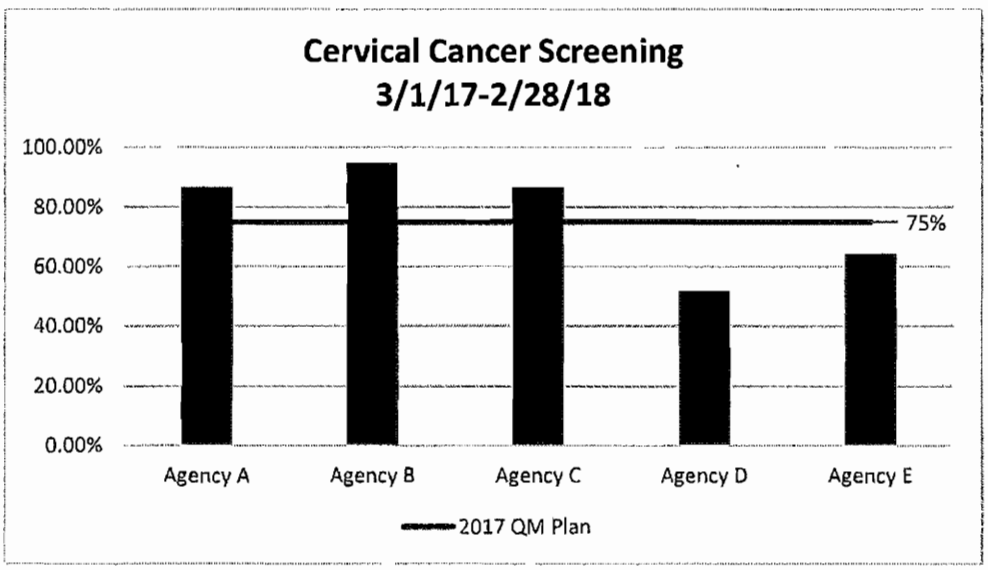
Cervical Cancer Screening

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

	2015	2016	2017
Number of female clients who had Pap screen results documented in the previous three years	197	229	226
Number of female clients: • for whom a pap smear was indicated, and • who had a medical visit with a provider with prescribing privileges at least twice in the measurement year*	289	286	274
Rate	**68.2%**	**80.1%**	**82.5%**
Change from Previous Years Results	**5.3%**	**11.9%**	**2.4%**

- 17.7% (40/226) of pap smears were abnormal

2017 Cervical Cancer Screening Data by Race/Ethnicity			
	Black	Hispanic	White
Number of female clients who had Pap screen results documented in the previous three years	103	108	13
Number of female clients: • for whom a pap smear was indicated, and • who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	127	126	18
Rate	**81.1%**	**85.7%**	**72.2%**



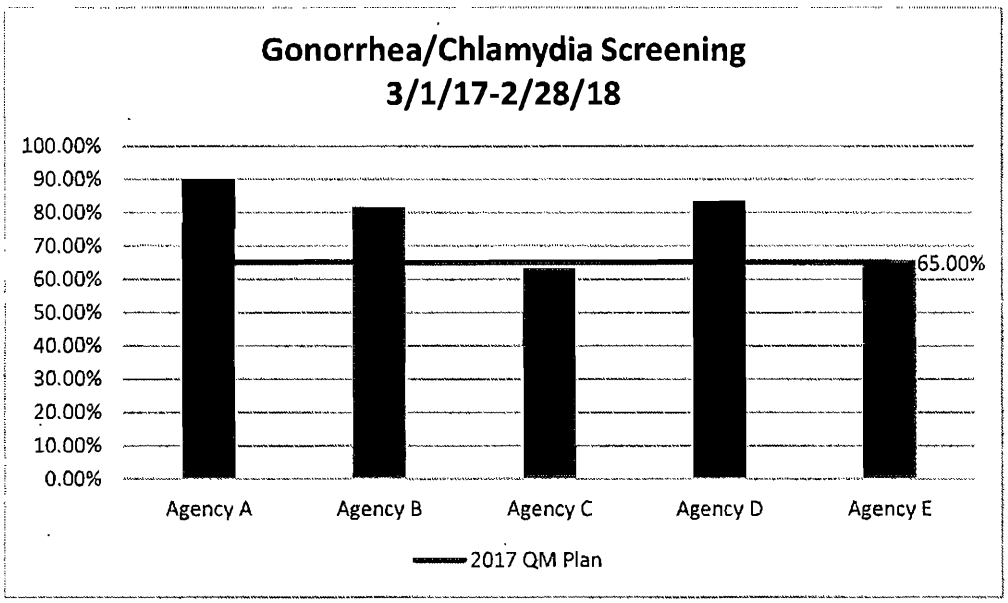
Gonorrhea/Chlamydia Screening

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

	2015	2016	2017
Number of clients who had a test for Gonorrhea/Chlamydia	442	463	493
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	635	635	635
Rate	**69.6%**	**72.9%**	**77.6%**
Change from Previous Years Results	**2.4%**	**3.3%**	**4.7%**

- 17 cases of chlamydia and 15 cases of gonorrhea were identified

2017 GC/CT by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who had a serologic test for syphilis performed at least once during the measurement year	232	200	54
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	290	259	73
Rate	**80%**	**77.2%**	**74%**



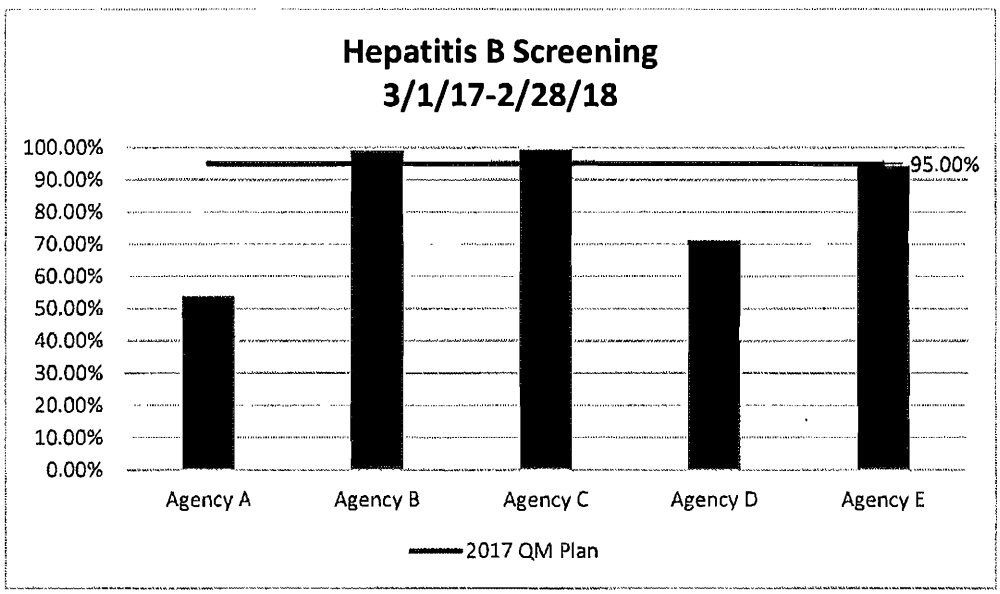
Hepatitis B Screening

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

	2015	2016	2017
Number of clients who have documented Hepatitis B infection status in the health record	634	610	553
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	635	635	635
Rate	**99.8%**	**96.1%**	**87.1%**
Change from Previous Years Results	**1.1%**	**-3.7%**	**-9%**

- 2% (13/635) were Hepatitis B positive

2017 Hepatitis B Screening by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who have documented Hepatitis B infection status in the health record	255	224	63
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	290	259	73
Rate	**87.9%**	**86.5%**	**86.3%**

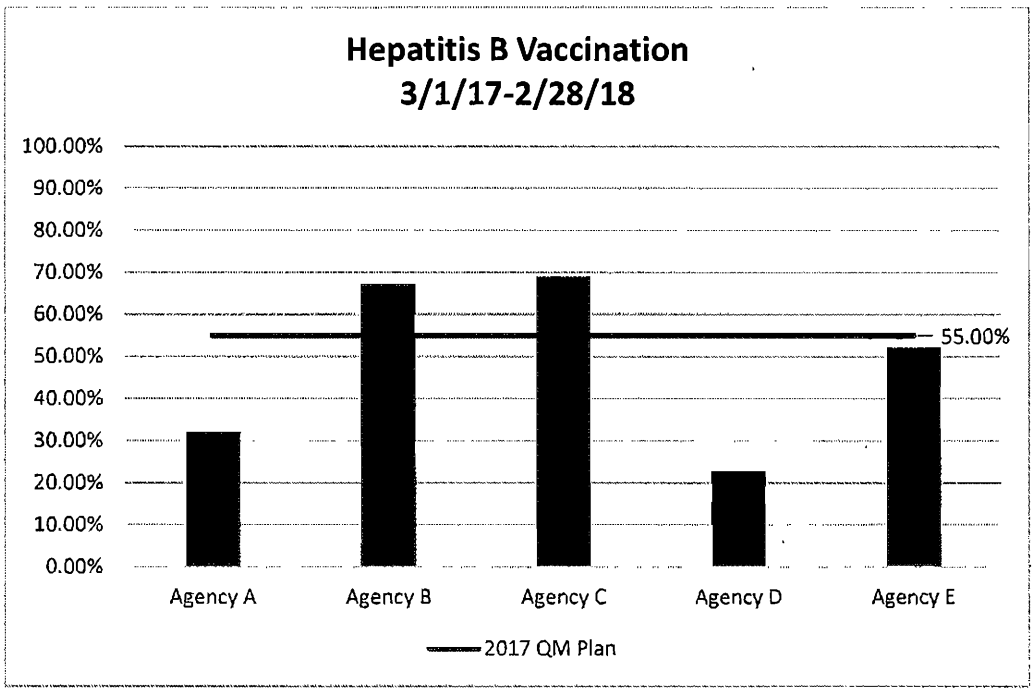


Hepatitis B Vaccination

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

	2015	2016	2017
Number of clients with documentation of having ever completed the vaccination series for Hepatitis B	184	179	196
Number of clients who are Hepatitis B Nonimmune and had a medical visit with a provider with prescribing privileges at least twice in the measurement year	307	322	381
Rate	**59.9%**	**55.6%**	**51.4%**
Change from Previous Years Results	**4.3%**	**-4.3%**	**-4.2%**

2017 Hepatitis B Vaccination by Race/Ethnicity			
	Black	Hispanic	White
Number of clients with documentation of having ever completed the vaccination series for Hepatitis B	69	107	18
Number of clients who are Hepatitis B Nonimmune and had a medical visit with a provider with prescribing privileges at least twice in the measurement year	153	184	38
Rate	**45.1%**	**58.2%**	**47.4%**



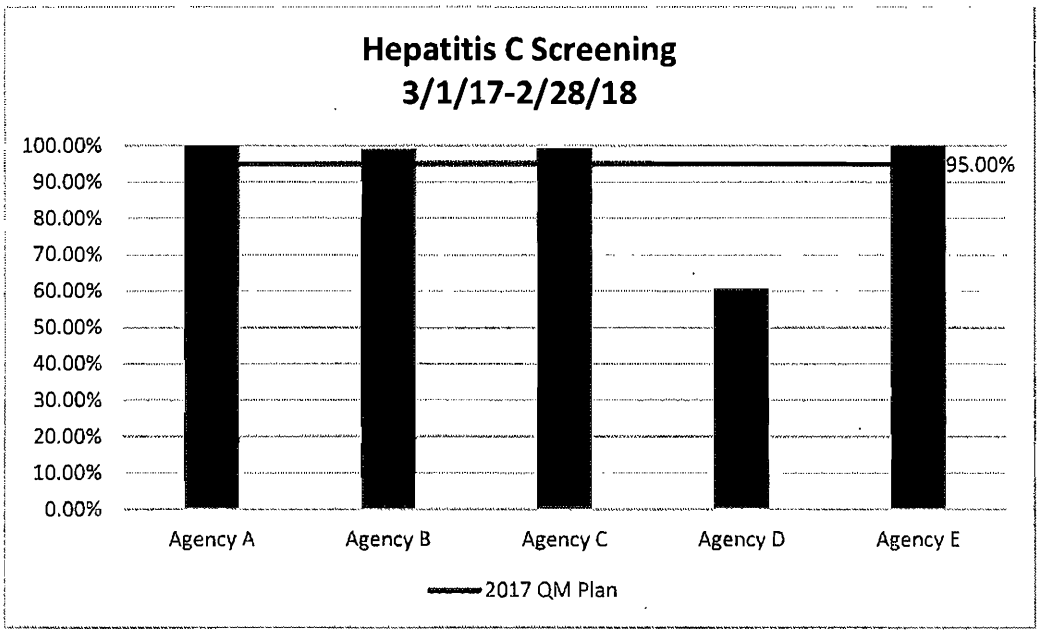
Hepatitis C Screening

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

	2015	2016	2017
Number of clients who have documented HCV status in chart	633	629	589
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	635	635	635
Rate	**99.7%**	**99.1%**	**92.8%**
Change from Previous Years Results	**1.1%**	**-.6%**	**-6.3%**

- 8% (52/635) were Hepatitis C positive, including 14 acute infections only and 21 cures

2017 Hepatitis C Screening by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who have documented HCV status in chart	266	244	69
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	290	259	73
Rate	**91.7%**	**94.2%**	**94.5%**

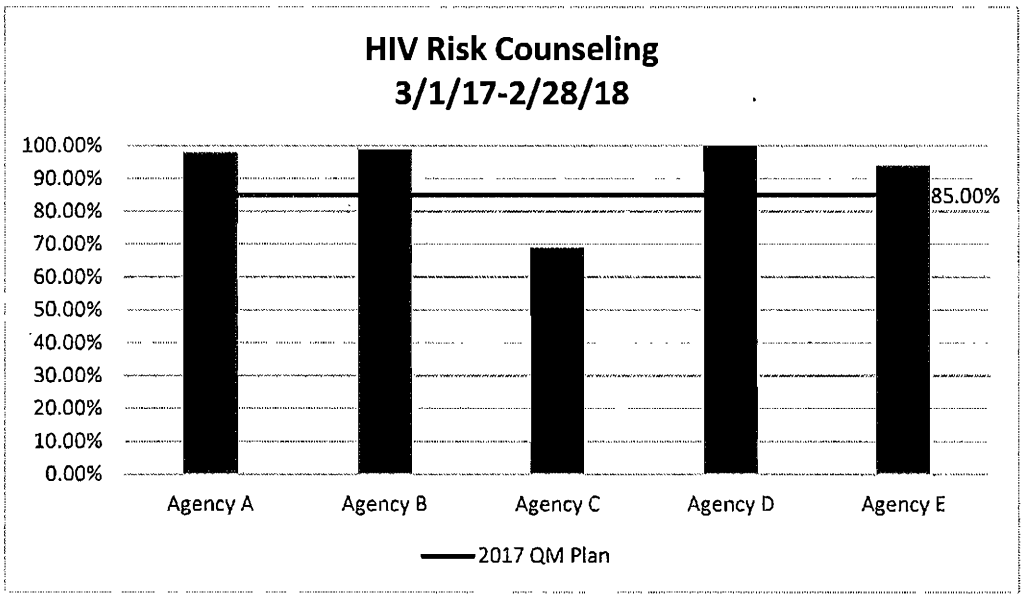


HIV Risk Counseling

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

	2015	2016	2017
Number of clients, as part of their primary care, who received HIV risk counseling	453	441	576
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	635	635	635
Rate	**71.3%**	**69.4%**	**90.7%**
Change from Previous Years Results	**-5.7%**	**-1.9%**	**21.3%**

2017 HIV Risk Counseling by Race/Ethnicity			
	Black	Hispanic	White
Number of clients, as part of their primary care, who received HIV risk counseling	265	233	67
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	290	259	73
Rate	**91.4%**	**90%**	**91.8%**

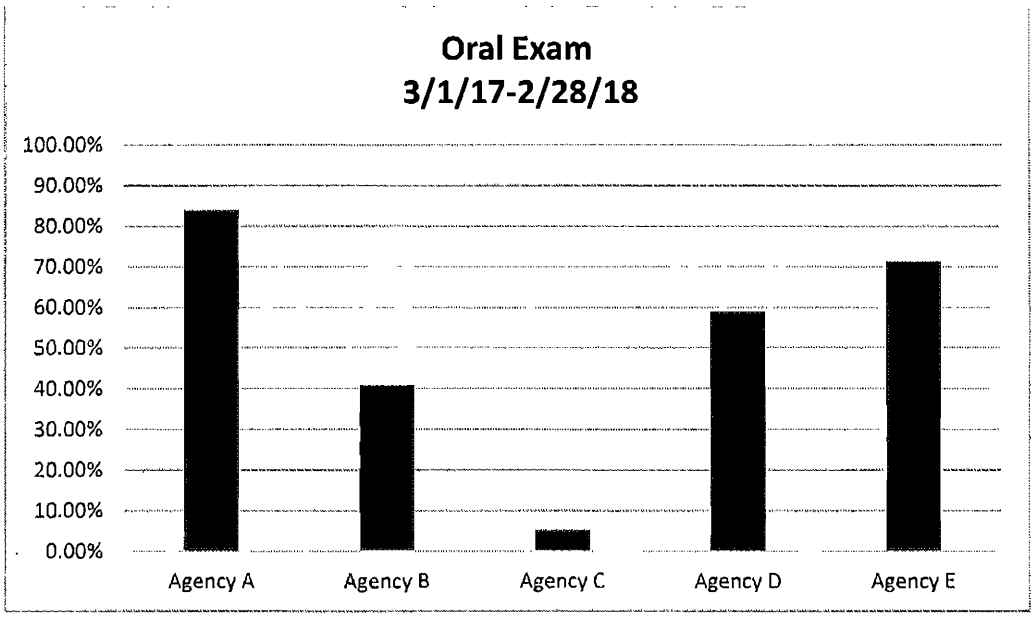


Oral Exam

- Percent of clients living with HIV who were referred to a dentist for an oral exam or self-reported receiving a dental exam at least once during the measurement year

	2015	2016	2017
Number of clients who were referred to a dentist for an oral exam or self-reported receiving a dental exam at least once during the measurement year	340	327	272
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	635	635	635
Rate	**53.5%**	**51.5%**	**42.8%**
Change from Previous Years Results	**-2.6%**	**-2%**	**-8.7%**

2017 Oral Exam by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who were referred to a dentist for an oral exam or self-reported receiving a dental exam at least once during the measurement year	113	114	39
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	290	259	73
Rate	**39%**	**44%**	**53.4%**



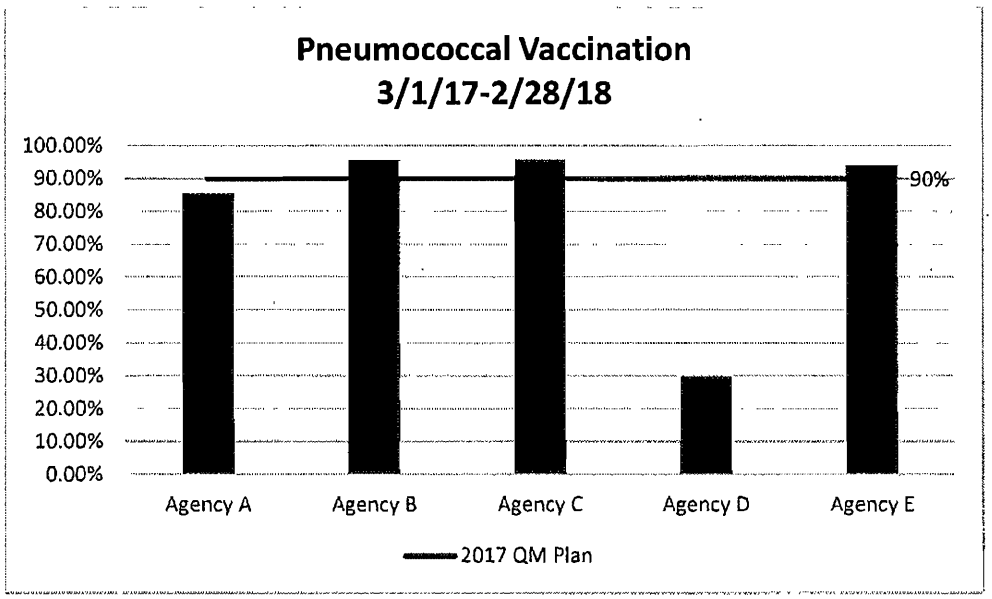
Pneumococcal Vaccination

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

	2015	2016	2017
Number of clients who received pneumococcal vaccination	546	534	514
Number of clients who: • had a CD4 count > 200 cells/mm3, and • had a medical visit with a provider with prescribing privileges at least twice in the measurement period	622	616	616
Rate	**87.8%**	**86.7%**	**83.4%**
Change from Previous Years Results	**-1.4%**	**-1.1%**	**-3.3%**

- 311 clients (60.5%) received both PPV13 and PPV23 (FY16- 49.4%,FY15- 43.3%)

2017 Pneumococcal Vaccination by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who received pneumococcal vaccination	234	219	51
Number of clients who: • had a CD4 count > 200 cells/mm3, and had a medical visit with a provider with prescribing privileges at least twice in the measurement period	281	252	70
Rate	**83.3%**	**86.9%**	**72.9%**

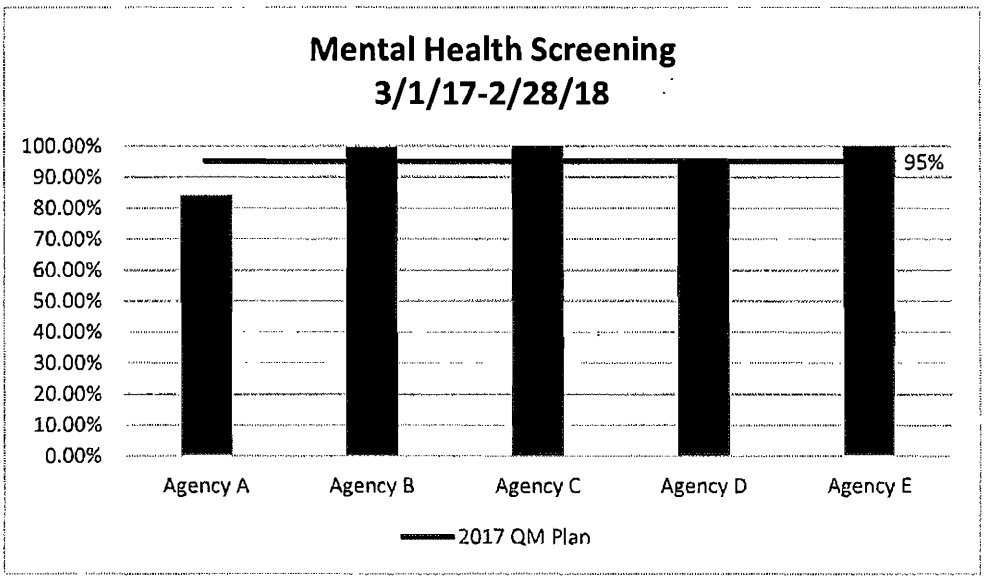


Preventative Care and Screening: Mental Health Screening

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

	2015	2016	2017
Number of clients who received a mental health screening	586	558	612
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement period	635	635	635
Rate	**92.3%**	**87.9%**	**96.4%**
Change from Previous Years Results	**3%**	**-4.4%**	**8.5%**

- 25.4% (161/635) had mental health issues. Of the 58 who needed additional care, 49 (84.5%) were either managed by the primary care provider or referred; 6 clients refused a referral.

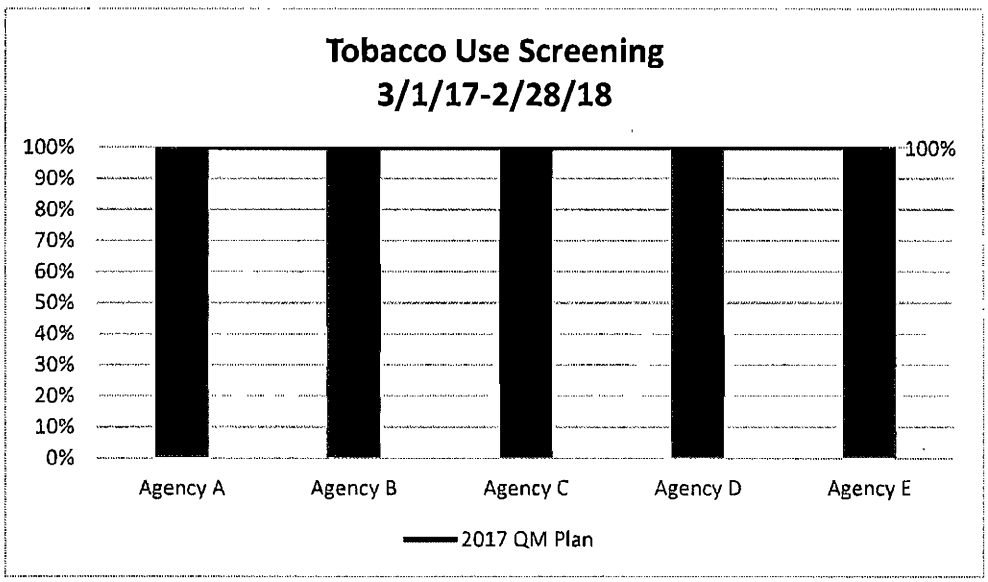


Preventative Care and Screening: Tobacco Use: screening & cessation intervention

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

	2015	2016	2017
Number of clients who were screened for tobacco use in the measurement period	635	631	635
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement period	635	635	635
Rate	**100%**	**99.4%**	**100%**
Change from Previous Years Results	**.6%**	**-.6%**	**.6%**

- Of the 635 clients screened, 174 (27.4%) were current smokers.
- Of the 174 current smokers, 97 (55.7%) received smoking cessation counseling, and 11 (6.3%) refused smoking cessation counseling



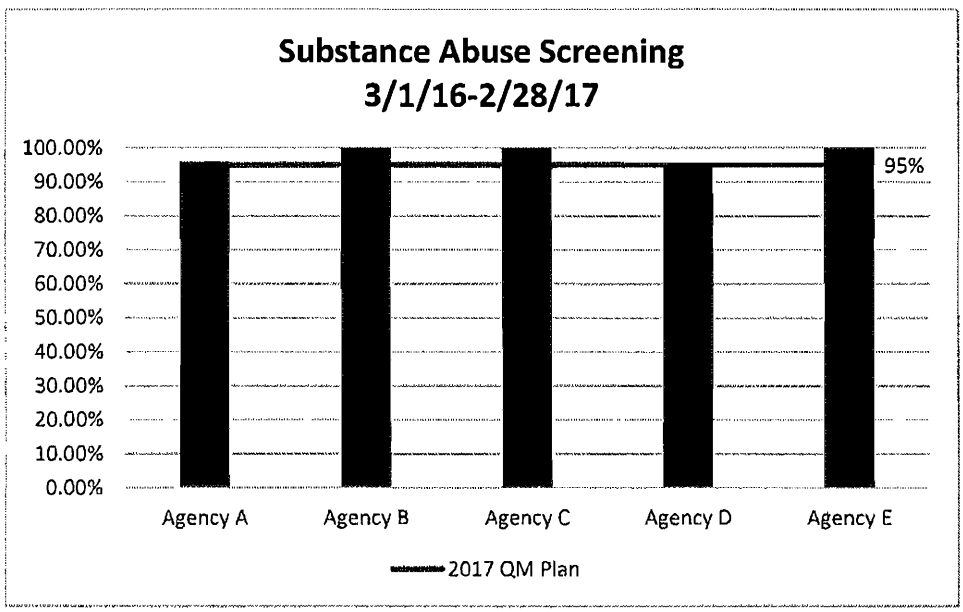
Substance Use Screening

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

	2015	2016	2017
Number of new clients who were screened for substance use within the measurement year	627	626	629
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement period	635	635	635
Rate	**98.7%**	**98.6%**	**99.1%**
Change from Previous Years Results	**.4%**	**-.1%**	**.5%**

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

- 6.9% (44/635) had a substance use disorder. Of the 44 clients who needed referral, 27 (61.4%) received one, and 11 (25%) refused.

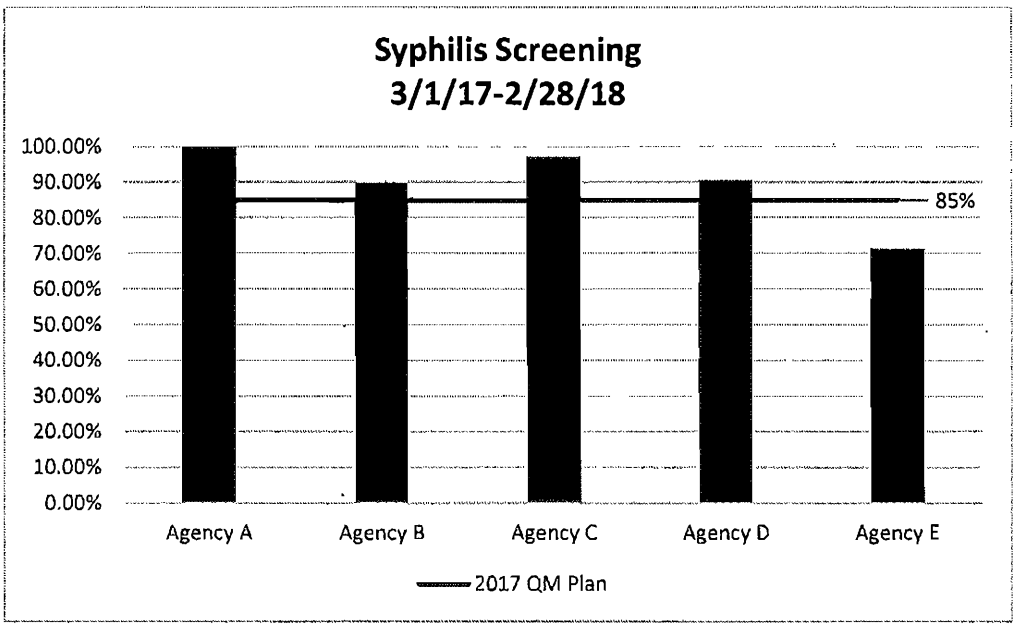


Syphilis Screening

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

	2015	2016	2017
Number of clients who had a serologic test for syphilis performed at least once during the measurement year	599	597	587
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	635	635	635
Rate	**94.3%**	**94%**	**92.4%**
Change from Previous Years Results	**.8%**	**-.3%**	**-1.6%**

- 6.6% (42/635) new cases of syphilis diagnosed

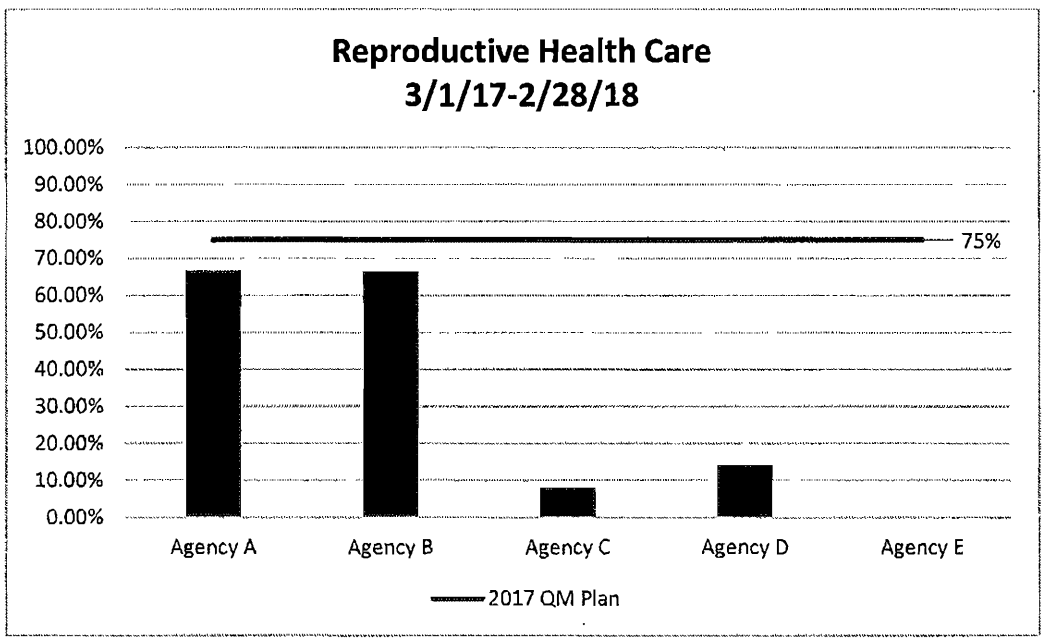


Other Measures

Reproductive Health Care

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

	2015	2016	2017
Number of reproductive-age women who received reproductive health assessment and care	34	34	22
Number of reproductive-age women who: • did not have a hysterectomy or bilateral tubal ligation, and • had a medical visit with a provider with prescribing privileges at least twice in the measurement period	69	63	63
Rate	**49.3%**	**54%**	**34.9%**
Change from Previous Years Results	**7.6%**	**4.7%**	**-19.1%**

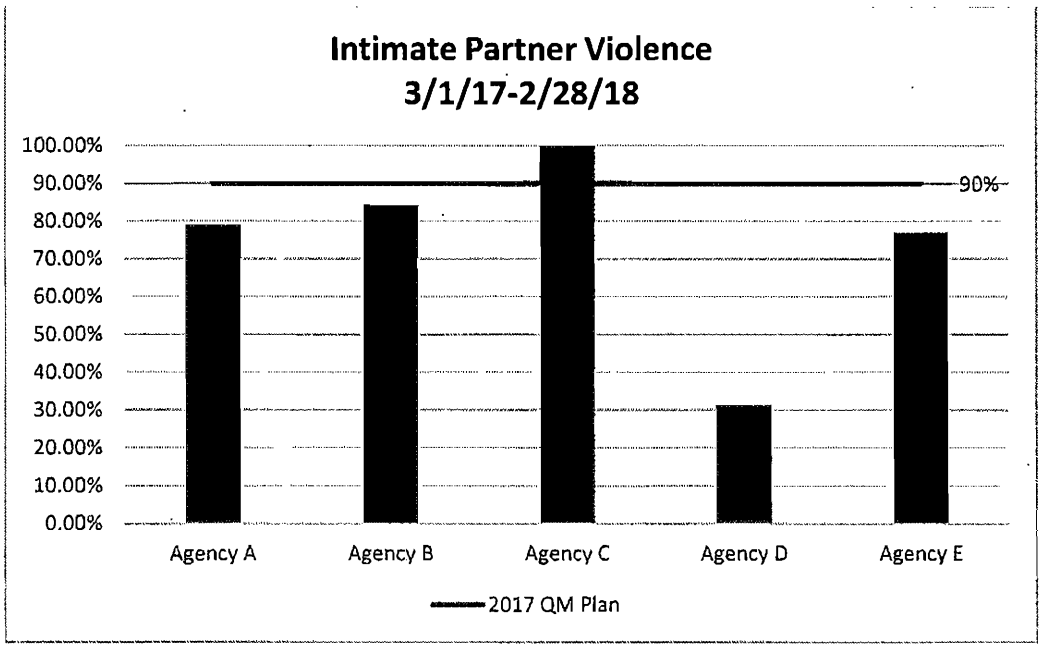


Intimate Partner Violence Screening

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

	2015	2016	2017
Number of clients who received screening for current intimate partner violence	569	520	499
Number of clients who: • had a medical visit with a provider with prescribing privileges at least twice in the measurement period	635	635	635
Rate	**89.6%**	**81.9%**	**78.6%**
	-.2%	**-7.7%**	**-3.3%**

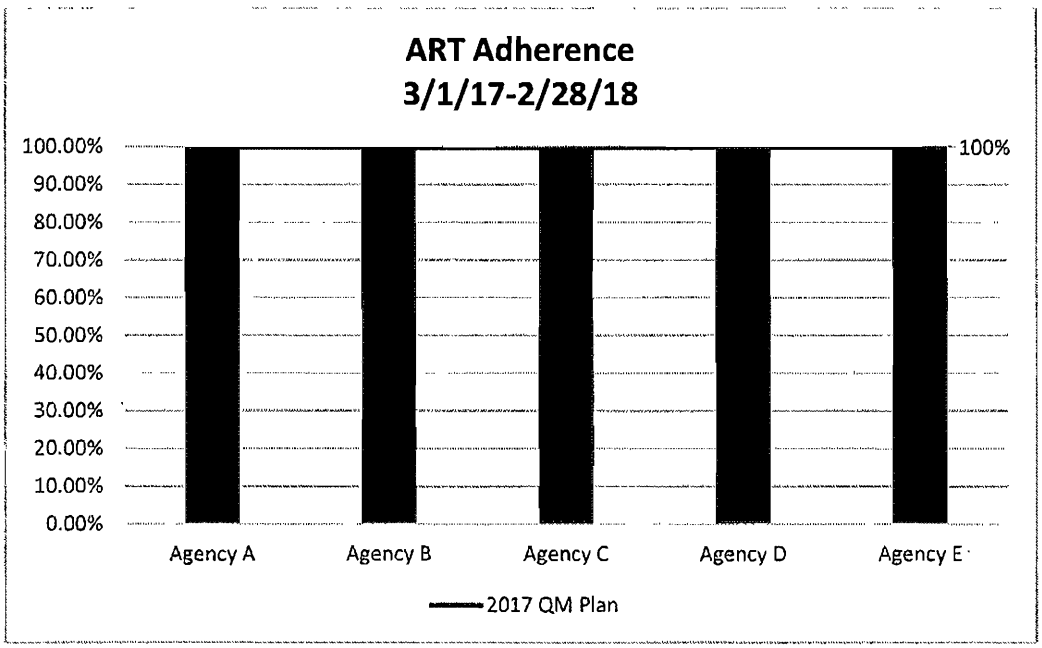
* 4/635 screened positive



Adherence Assessment & Counseling

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

	Adherence Assessment		
	2015	2016	2017
Number of clients, as part of their primary care, who were assessed for adherence at least once per year	607	617	627
Number of clients on ART who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	613	620	627
Rate	**99%**	**99.5%**	**100%**
Change from Previous Years Results	**0%**	**.5%**	**.5%**



ART for Pregnant Women

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

	2015	2016	2017
Number of pregnant women who were prescribed ART during the 2nd and 3rd trimester	5	3	3
Number of pregnant women who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year	5	3	3
Rate	**100%**	**100%**	**100%**
Change from Previous Years Results	**0%**	**0%**	**0%**

Primary Care: Diabetes Control

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

	2015	2016	2017
Number of diabetic clients whose last HbA1c in the measurement year was <8%	27	51	48
Number of diabetic clients who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year	47	70	74
Rate	**57.4%**	**72.9%**	**64.9%**
Change from Previous Years Results	**-2.9%**	**15.5%**	**-8%**

- 635/635 (100%) of clients where screened for diabetes and 74/635 (11.7%) were diagnosed diabetic

Primary Care: Hypertension Control

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

	2015	2016	2017
Number of hypertensive clients whose last blood pressure of the measurement year was <140/90	131	133	166
Number of hypertensive clients who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year	173	180	206
Rate	**75.7%**	**73.9%**	**80.6%**
Change from Previous Years Results	**3%**	**-1.8%**	**6.7%**

- 206/635 (32.4%) of clients where were diagnosed with hypertension

Primary Care: Breast Cancer Screening

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

	2015	2016	2017
Number of women over age 41 who had a mammogram or a referral for a mammogram documented in the previous two years	131	133	150
Number of women over age 41 who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year	173	180	171
Rate	**75.7%**	**73.9%**	**87.7%**
Change from Previous Years Results	**3%**	**-1.8%**	**13.8%**

Primary Care: Colon Cancer Screening

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

	2015	2016	2017
Number of clients over age 50 who had colon cancer screening or a referral for colon cancer screening	72	82	93
Number of clients over age 50 who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year	142	152	151
Rate	**50.7%**	**53.9%**	**61.6%**
Change from Previous Years Results		**3.2%**	**7.7%**

Conclusions

The Houston EMA continues to demonstrate high quality clinical care. Overall, performance rates were comparable to the previous year. There have been several positive trends over the past few years: cervical cancer screening, sexually transmitted infection screening, and ART prescription rates have continued to improve. However, there have been decreases in Hepatitis B and C screening, IPV screening and Reproductive Health Care. Performance Measures that rely on data beyond the measurement year may have been affected by new Electronic Medical Record data systems that had not yet imported historic data. RWGA will monitor these measures closely and initiate quality improvement initiatives as needed. In addition, racial and ethnic disparities continue to be seen for most measures. Eliminating racial and ethnic disparities in care are a priority for the EMA, and will continue to be a focus for quality improvement.

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Oral Health Care-Rural Target Chart Review FY 2017

Ryan White Part A Quality Management Program–Houston EMA

October 2018

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HCPH is the local public health agency for the Harris County, Texas jurisdiction. It provides a wide variety of public health activities and services aimed at improving the health and well-being of the Harris County community.

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Introduction

Part A funds of the Ryan White Care Act are administered in the Houston Eligible Metropolitan Area (EMA) by the Ryan White Grant Administration Section of Harris County Public Health. During FY 17, a comprehensive review of client dental records was conducted for services provided between 3/1/17 to 2/28/18. This review included one provider of Adult Oral Health Care that received Part A funding for rural-targeted Oral Health Care in the Houston EMA.

The primary purpose of this annual review process is to assess Part A oral health care provided to people living with HIV in the Houston EMA. Unlike primary care, there are no federal guidelines published by the U.S Health and Human Services Department for oral health care targeting people living with HIV. Therefore, Ryan White Grant Administration has adopted general guidelines from peer-reviewed literature that address oral health care for people living with HIV, as well as literature published by national dental organizations such as the American Dental Association and the Academy of General Dentistry, to measure the quality of Part A funded oral health care. The Ryan White Grant Administration Project Coordinator for Clinical Quality Improvement (PC/CQI) performed the chart review.

Scope of This Report

This report provides background on the project, supplemental information on the design of the data collection tool, and presents the pertinent findings of the FY 17 oral health care chart review. Any additional data analysis of items or information not included in this report can likely be provided after a request is submitted to Ryan White Grant Administration.

The Data Collection Tool

The data collection tool employed in the review was developed through a period of in-depth research and a series of working meetings between Ryan White Grant Administration. By studying the processes of previous dental record reviews and researching the most recent HIV-related and general oral health practice guidelines, a listing of potential data collection items was developed. Further research provided for the editing of this list to yield what is believed to represent the most pertinent data elements for oral health care in the Houston EMA. Topics covered by the data collection tool include, but are not limited to the following: basic client information, completeness of the health history, hard & soft tissue examinations, disease prevention, and periodontal examinations.

The Chart Review Process

All charts were reviewed by the PC/CQI, a Master's-level registered nurse experienced in identifying documentation issues and assessing adherence to published guidelines. The collected data for each site was recorded directly into a preformatted database. Once all data collection was completed, the database was queried for analysis. The data collected during this process is intended to be used for the purpose of service improvement.

The specific parameters established for the data collection process were developed from HIV-related and general oral health care guidelines available in peer-reviewed literature, and the professional experience of the reviewer on standard record documentation practices. Table 1 summarizes the various documentation criteria employed during the review.

Table 1. Data Collection Parameters

Review Area	Documentation Criteria
Health History	Completeness of Initial Health History: includes but not limited to past medical history, medications, allergies, substance use, HIV MD/primary care status, physician contact info, etc.; Completed updates to the initial health history
Hard/Soft Tissue Exam	Findings—abnormal or normal, diagnoses, treatment plan, treatment plan updates
Disease Prevention	Prophylaxis, oral hygiene instructions
Periodontal screening	Completeness

The Sample Selection Process

The sample population was selected from a pool of 322 unduplicated clients who accessed Part A oral health care between 3/1/17 and 2/28/18. The medical charts of 75 of these clients were used in the review, representing 23.3% of the pool of unduplicated clients.

In an effort to make the sample population as representative of the actual Part A oral health care population as possible, the EMA's Centralized Patient Care Data Management System (CPCDMS) was used to generate a list of client codes to be reviewed. The demographic make-up (race/ethnicity, gender, age) of clients accessing oral health services between 3/1/17 and 2/28/18 was determined by CPCDMS, which in turn allowed Ryan White Grant Administration to generate a sample of specified size that closely mirrors that same demographic make-up.

Characteristics of the Sample Population

The review sample population was generally comparable to the Part A population receiving rural-targeted oral health care in terms of race/ethnicity, gender, and age. It is important to note that the chart review findings in this report apply only to those who received rural-targeted oral health care from a Part A provider and cannot be generalized to all Ryan White clients or to the broader population of people living with HIV. Table 2 compares the review sample population with the Ryan White Part A rural-targeted oral health care population as a whole.

Table 2. Demographic Characteristics of FY 17 Houston EMA Ryan White Part A Oral Health Care Clients

	Sample		Ryan White Part A EMA	
Race/Ethnicity	Number	Percent	Number	Percent
African American	28	37.3%	130	40.4%
White	46	61.3%	184	57.1%
Asian	1	1.3%	6	1.9%
Native Hawaiian/Pacific Islander	0	0%	0	0%
American Indian/Alaska Native	0	0%	2	.6%
Multi-Race	0	0%	0	0%
	75		**322**	
Hispanic Status				
Hispanic	21	22.7%	82	25.5%
Non-Hispanic	54	77.3%	240	74.5%
	75		**322**	
Gender				
Male	51	62.7%	213	66.1%
Female	24	34.7%	108	33.5%
Transgender	0	2.7%	1	.3%
	75		**322**	
Age				
<=24	2	5.3%	16	5%
25 – 34	17	20%	70	21.7%
35 – 44	22	28%	95	29.5%
45 – 49	9	26.7%	43	13.4%
50 – 64	19	14.7%	91	28.3%
65+	2	4%	7	2.2%
	75		**322**	

Findings

Clinic Visits

Information gathered during the 2017 chart review included the number of visits during the study period. The average number of oral health visits per patient in the sample population was seven.

Health History

A complete and thorough assessment of a client's medical history is essential. Such information, such as current medications or any history of alcoholism for example, offers oral health care providers key information that may determine the appropriateness of prescriptions, oral health treatments and procedures.

Assessment of Medical History

	2015	2016	2017
Primary Care Provider	88%	93%	100%
Medical/Dental Health History*	93%	87%	95%
Medical History 6 month Update	94%	100%	100%

*HIV/AIDS Bureau (HAB) Performance Measures

Health Assessments

	2015	2016	2017
Vital Signs	99%	95%	99%
CBC documented	63%	78%	97%
Screening for Antibiotic Prophylaxis	91%	52%	95%

Prevention and Detection of Oral Disease

Maintaining good oral health is vital to the overall quality of life for people living with HIV because the condition of one's oral health often plays a major role in how well patients are able manage their HIV disease. Poor oral health due to a lack of dental care may lead to the onset and progression of oral manifestations of HIV disease, which makes maintaining proper diet and nutrition or adherence to antiretroviral therapy very difficult to achieve. Furthermore, poor oral health places additional burden on an already compromised immune system.

	2015	2016	2017
Oral Health Education*	80%	88%	99%
Intraoral Exam	88%	88%	88%
Extraoral Exam	88%	86%	88%
Periodontal screening*	92%	84%	81%
X-rays present	92%	91%	92%
Treatment plan*	81%	94%	99%

*HIV/AIDS Bureau (HAB) Performance Measures

Treatment Plan Status

	2017
Treatment plan complete	27%
Dental procedures done, additional procedures needed	60%
No dental procedures needed	11%
No dental procedures done	3%

Conclusions

Overall, oral health care services continues its trend of high quality care. The Houston EMA oral health care program has established a strong foundation for preventative care and we expect continued high levels of care for Houston EMA clients in future.

Appendix A – Resources

Dental Alliance for AIDS/HIV Care. (2000). *Principles of Oral Health Management for the HIV/AIDS Patient.* Retreived from: http://aidsetc.org/sites/default/files/resources_files/Princ_Oral_Health_HIV.pdf.

HIV/AIDS Bureau. (2013). *HIV Performance Measures.* Retrieved from: http://hab.hrsa.gov/deliverhivaidscare/habperformmeasures.html.

Mountain Plains AIDS Education and Training Center. (2013). Oral Health Care for the HIV-infected Patient. Retrieved from: http://aidsetc.org/resource/oral-health-care-hiv-infected-patient.

New York State Department of Health AIDS Institute. (2004). *Promoting Oral Health Care for People with HIV Infection.* Retrieved from: http://www.hivdent.org/_dentaltreatment_/pdf/oralh-bp.pdf.

U.S. Department of Health and Human Services Health Resources and Services Administration. (2014). *Guide for HIV/AIDS Clinical Care.* Retrieved from: http://hab.hrsa.gov/deliverhivaidscare/2014guide.pdf.

U.S. Department of Health and Human Services Health Resources and Services Administration, HIV/AIDS Bureau Special Projects of National Significance Program. (2013). *Training Manual: Creating Innovative Oral Health Care Programs.* Retrieved from: http://hab.hrsa.gov/deliverhivaidscare/2014guide.pdf.

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Vision Care Chart Review Report FY 2017

Ryan White Part A Quality Management Program–Houston EMA

October 2018

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Introduction

Part A funds of the Ryan White Care Act are administered in the Houston Eligible Metropolitan Area (EMA) by the Ryan White Grant Administration of Harris County Public Health. During FY 17, a comprehensive review of client vision records was conducted for services provided between 3/1/17 to 2/28/18.

The primary purpose of this annual review process is to assess Part A vision care provided to people living with HIV in the Houston EMA. Unlike primary care, there are no federal guidelines published by the U.S Department of Health and Human Services for general vision care targeting people living with HIV. Therefore, Ryan White Grant Administration has adopted general guidelines published by the American Optometric Association, as well as internal standards determined by the clinic, to measure the quality of Part A funded vision care. The Ryan White Grant Administration Project Coordinator for Clinical Quality Improvement (PC/CQI) performed the chart review.

Scope of This Report

This report provides background on the project, supplemental information on the design of the data collection tool, and presents the pertinent findings of the FY 17 vision care chart review. Also, any additional data analysis of items or information not included in this report can likely be provided after a request is submitted to Ryan White Grant Administration.

The Data Collection Tool

The data collection tool employed in the review was developed through a period of in-depth research conducted by the Ryan White Grant Administration. By researching the most recent vision practice guidelines, a listing of potential data collection items was developed. Further research provided for the editing of this list to yield what is believed to represent the most pertinent data elements for vision care in the Houston EMA. Topics covered by the data collection tool include, but are not limited to the following: completeness of the Client Intake Form (CIF), CD4 and VL measures, eye exams, and prescriptions for lenses. See Appendix A for a copy of the tool.

The Chart Review Process

All charts were reviewed by the PC/CQI, a Master's-level registered nurse experienced in identifying documentation issues and assessing adherence to published guidelines. The collected data for each site was recorded directly into a preformatted database. Once all data collection was completed, the database was queried for analysis. The data collected during this process is intended to be used for the purpose of service improvement.

The specific parameters established for the data collection process were developed from vision care guidelines and the professional experience of the reviewer on standard record documentation practices. Table 1 summarizes the various documentation criteria employed during the review.

Table 1. Data Collection Parameters	
Review Area	**Documentation Criteria**
Laboratory Tests	Current CD4 and Viral Load Measures
Client Intake Form (CIF)	Completeness of the CIF: includes but not limited to documentation of primary care provider, medication allergies, medical history, ocular history, and current medications
Complete Eye Exam (CEE)	Documentation of annual eye exam; completeness of eye exam form; comprehensiveness of eye exam (visual acuity, refraction test, binocular vision assessment, fundus/retina exam, and glaucoma test)
Ophthalmology Consult (DFE)	Performed/Not performed
Lens Prescriptions	Documentation of the Plan of Care (POC) and completeness of the dispensing form

The Sample Selection Process

The sample population was selected from a pool of 2,438 unduplicated clients who accessed Part A vision care between 3/1/17 and 2/28/18. The medical charts of 150 of these clients were used in the review, representing 6.2% of the pool of unduplicated clients.

In an effort to make the sample population as representative of the actual Part A vision care population as possible, the EMA's Centralized Patient Care Data Management System (CPCDMS) was used to generate the lists of client codes. The demographic make-up (race/ethnicity, gender, age) of clients accessing vision care services between 3/1/17 and 2/28/18 was determined by CPCDMS, which in turn allowed Ryan White Grant Administration to generate a sample of specified size that closely mirrors that same demographic make-up.

Characteristics of the Sample Population

The review sample population was generally comparable to the Part A population receiving vision care in terms of race/ethnicity, gender, and age. It is important to note that the chart review findings in this report apply only to those who receive vision care from a Part A provider and cannot be generalized to all Ryan White clients or to the broader population of people with HIV or AIDS. Table 2 compares the review sample population with the Ryan White Part A vision care population as a whole.

Table 2. Demographic Characteristics of FY 17 Houston EMA Ryan White Part A Vision Care Clients				
	Sample		Ryan White Part A EMA	
Race/Ethnicity	Number	Percent	Number	Percent
African American	75	50%	1,199	49%
White	73	49%	1,180	48%
Asian	1	<1%	29	1%
Native Hawaiian/Pacific Islander	0	0%	4	<1%
American Indian/Alaska Native	0	0%	9	<1%
Multi-Race	1	<1%	17	<1%
TOTAL	**150**		**2,438**	
Hispanic Status				
Hispanic	51	34%	871	36%
Non-Hispanic	99	66%	1,567	64%
TOTAL	**150**		**2,438**	
Gender				
Male	111	74%	1,807	74%
Female	37	25%	607	25%
Transgender Male to Female	2	1%	24	1%
Transgender Female to Male	0	0%	0	0
TOTAL	**150**		**2,438**	
Age				
<= 24	3	2%	122	5%
25 – 34	35	23%	565	23%
35 – 44	31	21%	563	23%
45 – 49	20	13%	364	15%
50 – 64	57	38%	751	31%
65+	4	3%	73	3%
TOTAL	**150**		**2,438**	

Findings

Laboratory Tests

Having up-to-date lab measurements for CD4 and viral load (VL) levels enhances the ability of vision providers to ensure that the care provided is appropriate for each patient. CD4 and VL measures indicate stage of disease, so in cases where individuals are in the late stage of HIV disease, special considerations may be required.

Patient chart records should provide documentation of the most recent CD4 and VL information. Ideally this information should be updated in coordination with an annual complete eye exam.

	2015	2016	2017
CD4	64%	91%	80%
VL	64%	91%	80%

Client Intake Form (CIF)

A complete and thorough assessment of a patient's health history is essential when caring for individuals living with HIV or anyone who is medically compromised. The agency assesses this information by having patients complete the CIF. Information provided on the CIF, such as ocular history or medical history, guides clinic providers in determining the appropriateness of diagnostic procedures, prescriptions, and treatments. The CIF that is used by the agency to assess patient's health history captures a wide range of information; however, for the purposes of this review, this report will highlight findings for only some of the data collected on the form.

Below are highlights of the findings measuring completeness of the CIF.

	2015	2016	2017
Primary Care Provider	50%	50%	81%
Medication Allergies	100%	100%	99%
Medical History	100%	100%	99%
Current Medications	100%	100%	99%
Reason for Visit	100%	100%	100%
Ocular History	100%	100%	99%

Eye Examinations (Including CEE/DFE) and Exam Findings

Complete and thorough examination of the eye performed on a routine basis is essential for the prevention, detection, and treatment of eye and vision disorders. When providing care to people living with HIV, routine eye exams become even more important because there are a number of ocular manifestations of HIV disease, such as CMV retinitis.

CMV retinitis is usually diagnosed based on characteristic retinal changes observed through a DFE. Current standards of care recommend yearly DFE performed by an ophthalmologist for clients with CD4 counts <50 cells/mm3 (2). Five clients in this sample had CD4 counts <50 cells/mm3, and all five had a DFE performed.

	2014	2016	2017
Complete Eye Exam	100%	100%	100%
Dilated Fundus Exam	95%	98%	98%
Internal Eye Exam	100%	100%	100%
Documentation of Diagnosis	100%	100%	100%
Documentation of Treatment Plan	100%	100%	100%
Visual Acuity	100%	100%	100%
Refraction Test	100%	100%	100%
Observation of External Structures	100%	100%	100%
Glaucoma Test	100%	100%	100%
Cytomegalovirus (CMV) screening	95%	98%	98%

Ocular Disease

Thirteen clients (8.7%) demonstrated ocular disease, including zoster keratitis, pinguecula, posterior synechiae, cataracts, and glaucoma. Four clients received treatment for ocular disease, three clients were referred to a specialty eye clinic, and six clients did not need treatment at the time of visit.

Prescriptions

Of records reviewed, 99% (95%-FY16) documented new prescriptions for lenses at the agency within the year.

Conclusions

Findings from the FY 17 Vision Care Chart Review indicate that the vision care providers perform comprehensive vision examinations for the prevention, detection, and treatment of eye and vision disorders. Performance rates are very high overall, and are consistent with quality vision care.

Appendix A—FY 17-Vision Chart Review Data Collection Tool

Mar 1, 17 to Feb 28, 18

Pt. ID # _____ Site Code:_____

CLIENT INTAKE FORM (CIF)

1. PRIMARY CARE PROVIDER documented: Y - Yes N - No
2. MEDICATION ALLERGIES documented: Y - Yes N - No
3. MEDICAL HISTORY documented: Y - Yes N - No
4. CURRENT MEDS are listed: Y - Yes N - No
5. REASON for TODAY's VISIT is documented: Y - Yes N - No
6. OCULAR HISTORY is documented: Y - Yes N - No

CD4 & VL

7. Most recently documented CD4 count is within past 12 months: Y - Yes N - No
8. CD4 count is < 50: Y - Yes N - No
9. Most recently documented VL count is within past 12 months: Y - Yes N – No

EYE CARE:

10. COMPLETE EYE EXAM (CEE) performed: Y - Yes N - No
11. Eye Exam included ASSESSMENT OF VISUAL ACUITY: Y - Yes N - No
12. Eye Exam included REFRACTION TEST: Y - Yes N - No
13. Eye Exam included OBSERVATION OF EXTERNAL STRUCTURES: Y - Yes N - No
14. Eye Exam included GLAUCOMA TEST (IOP): Y - Yes N - No
15. Internal Eye Exam findings are documented: Y - Yes N - No
16. Dilated Fundus Exam (DFE) done within year: Y - Yes N - No
17. Eye Exam included CYTOMEGALOVIRUS (CMV) SCREENING: Y - Yes N – No
18. New prescription lenses were prescribed: Y - Yes N - No
19. Eye Exam written diagnoses are documented: Y - Yes N - No
20. Eye Exam written treatment plan is documented: Y - Yes N - No
21. Ocular disease identified? Y - Yes N – No
22. Ocular disease treated appropriately? Y - Yes N - No
23. Total # of visits to eye clinic within year:_____

Revised March, 2013

Appendix B – Resources

1. Casser, L., Carmiencke, K.., Goss, D.A., Knieb, B.A., Morrow, D., & Musick, J.E. (2005). Optometric Clinical Practice Guideline—Comprehensive Adult Eye and Vision Examination. *American Optometric Association*. Retrieved from http://www.aoa.org/Documents/CPG-1.pdf on April 15, 2012.

2. Heiden D., Ford N., Wilson D., Rodriguez W.R., Margolis T., et al. (2007). Cytomegalovirus Retinitis: The Neglected Disease of the AIDS Pandemic. *PLoS Med* 4(12): e334. Retrieved from: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2100142/ on April 15, 2012.

3. International Council of Ophthalmology. (2011). *ICO International Clinical Guideline, Ocular HIV/AIDS Related Diseases.* Retrieved from http://www.icoph.org/resources/88/ICO-International-Clinical-Guideline-Ocular-HIVAIDS-Related-Diseases-.html on December 15, 2012.

4. Panel on Opportunistic Infections in HIV-Infected Adults and Adolescents. Guidelines for the prevention and treatment of opportunistic infections in HIV-infected adults and adolescents: recommendations from the Centers for Disease Control and Prevention, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. Available at http://aidsinfo.nih.gov/contentfiles/lvguidelines/adult_oi.pdf. Accessed July 25, 2013.

RYAN WHITE GRAND ADMINSITRATION - HARRIS COUNTY, TX

Case Management Chart Review Cumulative De-identified Report

2017-2018

Anne Russey, MEd, LPC-Supervisor

Independent Contractor

This reports summarizes the data collected from the 2017-2018 chart review of non-medical and medical case management services. Site visits and remote reviews occurred during October and November of 2018.

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Overview

A total of 312 medical case management and non-medical case management (or service linkage) client charts were reviewed. The dates of service included in the review period were March 1, 2017 - February 28, 2018, with the exception of AIDS Healthcare Foundation, the newest addition to Harris County Ryan White Part A services, whose dates of service under review were May 1, 2018-October 29, 2018. Progress notes, brief assessments, comprehensive assessments, supporting documents in any format available (electronic, hard copy, scanned documents) were reviewed as provided by each site. The sample selection was provided to this contractor by RWGA staff and included clients whom received services under each of the service category types identified above.

This contractor proposed changes to the Chart Review Tool following the 2016-2017 review, but the proposed changes were not considered by the required parties in time to implement any significant changes for this 2017-2018 review. Carin Martin of RWGA did however, approve use of an addendum page that was added to this year's review. This writer also utilized the notes section of the tool to track a number of co-occurring medical conditions to begin to gather data on other conditions that may influence or impact health outcomes of people living with HIV in the Harris County EMA.

Case management is defined by the Harris County RWGA Standards of Care as "services in HIV care [that] facilitate client access to health care services, assist clients to navigate through the wide array of health care programs and ensure coordination of services to meet the unique needs of People Living with HIV (PLWH)." Case managers serving in the agency and clinic settings are helping clients navigate very complex and fragmented systems at agency, local, state and federal levels that sometimes feel like they're working against the very clients they were designed to serve, treat and protect.

If we consider conditions outside of an HIV+ diagnosis, such as active mental health and substance use disorders, unstable or insufficient housing, employment, income or transportation, poor support networks, lack of health insurance, barriers to medication among many other psychical and psychosocial factors contribute to lower retention in care and viral load suppression rates and increased risk and rates of new HIV transmissions, it is clear that case management has the potential to affect and in many cases improve health outcomes for the clients it serves. Licensed case managers are uniquely positioned by their education and training to assist clients struggling with complex mental health and substance use issues.

One can see threads of the old models of case management running through the 312 charts reviewed, with a very small handful of examples of a client quickly completing an assessment and service plan followed by intensive and frequent contact from a non-medical or medical case manager who documents in progress notes as obstacles and barriers are overcome, goals are accomplished and needs are met in their and 6 months later in their re-assessment and service plan review before eventually being discharged. This contractor wants to be clear that those appear to be the exception and not the norm. The majority of charts reviewed (44%) did not have a brief or comprehensive assessment completed at all. Only 152 clients (48%) had 3 or more phone or in person encounters with a case manager during the review year. This The Ryan White Standards of Care seem to presume much more intense and frequent contact between case manager and client than is actually happening in practice. Due presumably to increased demand for services and volume of clients served by each site, case management services seem to be delivered mostly on demand based on the needs of the individual clients in front of the case manager at the moment in which the provider, client or someone else requests help. Gone are the days of a case manager having a small manageable case load that allows for

close monitoring, following up on service plan goals and referrals, and regular discharges from services when goals are met and services are "complete"- unless the system somehow evolves and changes too.

Cumulative Data Summaries

Brief Assessments

# clients with brief assessment in review period 3/1/17-2/28/18	Site						
	A	B	C	D	E	F	Total
0	7	0	15	56	34	13	125
	39%	0%	31%	55%	42%	25%	40%
1	4	0	24	41	25	10	104
	22%	0%	50%	40%	31%	20%	33%
2	0	0	1	3	1	0	5
	0%	0%	2%	3%	1%	0%	2%
Not applicable	7	12	8	2	21	28	78
	39%	100%	17%	2%	26%	55%	25%
Total	18	12	48	102	81	51	312
	100%	100%	100%	100%	100%	100%	100%

40% of the 312 charts reviewed in the review period 3/1/17-2/28/18 did not have a brief assessment completed. 25% of the 312 charts reviewed were not required to have a brief assessment completed due to no contact with a non-medical case manager. When there was contact with a non-medical case manager noted, reasons for lack of brief assessments varied but often included client showing up unannounced and/or having a very short period of time to spend with SLW or sometimes frequent phone call contacts rather than in office visits and thus time and attention was spent on meeting client's immediate need and helping overcome a specific barrier rather than on completion of the brief assessment. Client crises especially around medication access clearly take priority (as they should) over completion of the brief assessment. 33% of the 312 charts reviewed had one brief assessment completed and 2% had two completed. The majority of the brief assessments reviewed identified only one or two needs such as transportation, vision, dental and/or other specialty care or supportive service need and noted appropriate referrals were made. In the rare cases more complicated needs were identified there was generally documentation of referral to medical case management noted.

Comprehensive Assessments

# clients with comprehensive assessment in review period 3/1/17-2/28/18	Site						
	A	B	C	D	E	F	Total
0	8	0	28	15	21	23	95
	44%	0%	58%	15%	26%	45%	30%
1	10	12	5	7	21	13	68
	56%	100%	10%	7%	26%	25%	22%
2	0	0	0	3	1	1	5
	0%	0%	0%	3%	1%	2%	2%
Not applicable	0	0	15	77	38	14	144
	0%	0%	31%	75%	47%	27%	46%
Total	18	12	48	102	81	51	312
	100%	100%	100%	100%	100%	100%	100%

30% of the 312 charts reviewed in the review period 3/1/17-2/28/18 did not have a comprehensive assessment completed. 46% of the 312 charts reviewed were not required to have a comprehensive assessment completed due to no contact with a medical case manager. When there was contact with a medical case manager, reasons for lack of comprehensive assessments varied but often included client showing up unannounced and/or having a very short period of time to spend with MCM or sometimes frequent phone call contacts rather than in office visits and thus time and attention was spent on meeting client's immediate need and helping overcome a specific barrier rather than on completion of the comprehensive assessment. Client crises especially around medication access clearly take priority (as they should) over completion of the comprehensive assessment. In some cases there was documentation of justification for delay of completion of comprehensive assessment noted in the progress notes of the client's chart. 22% of the 312 charts reviewed had one comprehensive assessment completed and 2% had two completed.

Assessment Needs

Need identified on assessment	Total	
Transportation	74	43%
Mental Health	62	36%
OAMC	55	32%
Insurance	51	29%
Dental	49	28%
Treatment Adherence	42	24%
Vision	42	24%
Housing	33	19%
HIV Education	29	17%
Self Efficacy	29	17%
Substance Abuse	25	14%
Income	24	14%
Basic	23	13%
Support	23	13%
HIV Related Legal	19	11%
Cultural	17	10%
Food	10	6%
General Education	9	5%
Emergency Financial	6	3%
Translation	3	2%
Kids/Child Care	1	1%
Benefits	0	0%

Of the 175 comprehensive, brief and brief-transportation assessments reviewed in detail, the most common need identified in 43% of the charts was transportation. The following came in as the four next most commonly identified needs: mental health (36%), outpatient ambulatory medical care (32%), insurance (29%) and dental (28%). At sites where dental and vision services were readily available, it seemed those needs almost always made it to the service plan. Needs besides transportation may be under represented due to the standard of care requirement of an assessment being on file in order to provide a bus pass. In the cases where an assessment is needed to provide a bus pass, transportation is the focus of the time and the encounter and other needs may be deferred or ignored until subsequent or return encounters. Other needs such as barriers to medication or primary care were addressed in progress notes rather than on the service plan(s). It seemed that more important than the identified need making it to the service plan, was whether or not a client received information, referral or assistance accessing services or support to help them meet their need. Information, referrals and assistance to overcome obstacles or barriers and the outcomes of those efforts was typically documented in detail in progress note encounters or consultation/coordination encounters with other providers rather than in the assessment or service plan.

Service Plans

# clients with service plan in review period 3/1/17-2/28/18	Site						
	A	B	C	D	E	F	Total
0	10	5	28	14	23	23	103
	56%	42%	58%	14%	28%	45%	33%
1	7	7	5	4	19	13	55
	39%	58%	10%	4%	23%	25%	18%
2	1	0	0	6	1	1	9
	6%	0%	0%	6%	1%	2%	3%
Not applicable	0	0	15	78	38	14	145
	0%	0%	31%	76%	47%	27%	46%
Total	18	12	48	102	81	51	312
	100%	100%	100%	100%	100%	100%	100%

33% of the 312 charts reviewed in the review period 3/1/17-2/28/18 did not have a service plan completed. 46% of the 312 charts reviewed were not required to have a comprehensive assessment completed due to no contact with a medical case manager. When there was contact with a medical case manager, reasons for lack of service plans varied but as service plans are generally completed following a comprehensive assessment it makes sense that the number of clients missing both an assessment and a service plan would be similar and due to similar obstacles. In follow up to the 2016-2017 review where Agency A and Agency C had some issues with incomplete scanned documents/missing service plans where one was noted, this was not a problem in this year's review. In almost every case if there was a note indicating a service plan was completed, it was readily available in the chart for all sites.

Encounters

# of progress notes during review period	Site						
	A	B	C	D	E	F	Total
1 or more	18	12	48	102	80	51	311
2 or more	18	5	31	69	56	36	215
3 or more	18	2	25	48	36	23	152
4 or more	16	1	15	34	26	15	107
5 or more	14	0	11	19	21	11	76

It seems worth noting that less than half of the clients receiving services during the review period had 3 or more contacts with a case manager during the one year review period. The Ryan White Standards of Care requirements seem to presume much more frequent contacts between case manager and client during a one year period that would allow for more intense case management and follow up. It should come as no surprise that if contact is limited to 1, 2 or 3 instances that opportunities to complete assessments and service plans and subsequent reviews and follow ups are extremely limited if not non-existent.

Assessment Summary

# clients with brief, comprehensive, both or no assessment in review period 3/1/17-2/28/18	Site						
	A	B	C	D	E	F	Total
Brief	0	0	24	35	25	10	94
	0%	0%	50%	34%	31%	20%	30%
Comprehensive	6	12	4	9	23	14	68
	33%	100%	8%	9%	28%	27%	22%
Both	4	0	1	8	0	0	13
	22%	0%	2%	8%	0%	0%	4%
None	8	0	19	50	33	27	137
	44%	0%	40%	49%	41%	53%	44%
Total	18	12	48	102	81	51	312
	100%	100%	100%	100%	100%	100%	100%

#** and Type of Assessment Reviewed	Site						
	A	B	C	D	E	F	Total
Brief	0	0	25	2	26	10	63
Brief-Transportation	0	0	0	40	0	0	40
Comprehensive	10	12	4	10	22	13	71
Total	10	12	29	52	48	23	174

** Tool did not allow for review of more than one assessment per chart

In summary, 44% of the 312 charts reviewed did not have any assessment completed. 22% had only comprehensive plan completed, 30% had only a brief assessment completed and only 4% had both a comprehensive and brief assessment completed. It should be noted that according to the standards of care, a brief assessment is not required in the event a non-medical case manager provides only basic referral or assistance, thus in cases where there was only contact from a non-medical case manager it may be appropriate that no assessment was completed.

174 assessments (brief, brief-transportation and comprehensive) were reviewed. Brief assessments were not required to have a service plan, and the service plans accompanying comprehensive assessments were often incongruent with the needs identified in the assessment. There were several instances where a need was identified but a note was added to indicate the client was declining to address the need as part of their service plan. Agency D was the only site who documented a separate type of brief assessment being used for clients in need of a Ryan White funded Metro bus pass. Agency B did not have a non-medical case manager on staff during the review period, thus all encounters reviewed were MCM encounters.

Lost to Care Status

Lost to Care Status	Site						
	A	B	C	D	E	F	Total
LTC Prior to Episode	1	0	3	10	3	3	20
	6%	0%	6%	10%	4%	6%	6%
LTC During Episode	1	0	1	14	7	1	24
	6%	0%	2%	14%	9%	2%	8%
Not LTC	16	12	44	78	71	47	268
	89%	100%	92%	76%	88%	92%	86%
Total	18	12	48	102	81	51	312
	100%	100%	100%	100%	100%	100%	100%

6% of charts reviewed indicated the client was lost to care prior to the review period. 8% of charts reviewed indicated the client was lost to acre during the review period. The remaining 86% of charts did not indicate a client was lost to care. In several cases efforts were noted to re-engage a client to care, including calling the last known number and even field visits to a client's last known address, sometimes successfully resulting in re-engaging a client to care and sometimes not. The 14% lost to care rate is likely lower than what actually occurs in the EMA as this sample only included clients who had a billable service encounter (meaning actual contact with a client- not efforts to retain or re-engage a client that did not result in contact) during the review period. If a client had billable contact with a non-medical or medical case manager during the review period it makes sense that they would most likely not be lost to care.

This reviewer utilized progress notes to identify clients who appeared to have been lost to care prior to or during the episode of care taking place during the review period. The tool did not allow for differentiation between prior to and during the review period so the reviewer utilized margin space of the tool to indicate if a client was lost prior to the review period. In the event the client was lost prior to the review (often indicated by a progress note stating the client attended a "RTC" or "return to care" appointment), the interventions taken to re-engage the client were often unclear.

It is notable that during this review period several sites utilized non-medical case managers (SLWs) dedicated specifically to the task of retaining or returning clients to care. It is the understanding of this reviewer that in future years the retention in care work will be funded and performed separate from non-medical case management under an Outreach service category so it may not be relevant to a qualitative review of this nature at that point.

Viral Load Suppression

Viral Load Suppression Information	Site						
	A	B	C	D	E	F	Total
Viral Load < 20	8 44%	2 17%	17 35%	61 60%	30 37%	15 29%	133 43%
Viral Load not suppressed, but evidence	9 50%	10 83%	21 44%	29 28%	47 58%	31 61%	147 47%
Viral Load not suppressed and no evidence of	0 0%	0 0%	0 0%	5 5%	0 0%	1 2%	6 2%
No Viral Load data	1 6%	0 0%	10 21%	7 7%	4 5%	4 8%	26 8%
Total	18 100%	12 100%	48 100%	102 100%	81 100%	51 100%	312 100%

Of the 312 charts reviewed, 43% had evidence (lab results) of an undetectable viral load <20 copies per ml. 47% had evidence of at least one lab test during the review period that the viral load rose above 20 copies per ml, but also had evidence (progress notes) of an intervention or contact by a non-medical or medical case manager after or around the time of the lab test result. There were many cases where a client had a detectable viral load at one point in the review period, but later another result indicating their viral load was later suppressed. This positive change may correlate with the social service interventions they received (likely help accessing medication, overcoming barriers to primary care, referrals to mental health and substance use treatment, etc.) but further evaluation and adaptation of the tool would be needed to assess more closely. 2% of the charts reviewed had evidence of a detectable viral load at least once during the review period but no evidence of an intervention, contact or follow up after a viral load was detected. 8% of the charts did not have any lab tests/results in the chart- usually the case of a patient who was documented to be in primary care elsewhere but accessing non-medical case management services to access a specialty service like dental or vision care or a social service referral (housing, etc.).

It makes sense that of this sample of clients accessing non-medical and medical case management support that there would be a high percentage of individuals with an unsuppressed viral load due to the nature of support services. Considering the eligibility requirements in Standards of Care, to access non-medical and medical case management services, the clients accessing the service categories under review are likely experiencing risk factors that predispose them to having an increased viral load to begin with.

Co-occurring Conditions

Co-occurring Condition	Site	
	Total	% of Total
No Substance Use/MH dx	196	63%
Depression dx	73	23%
STD Dx	70	22%
Hypertension	69	22%
Other Substance Use	44	14%
Anxiety dx	39	13%
Diabetes II	32	10%
Other Mental Health dx	27	9%
Bipolar dx	25	8%
Homelessness noted	16	5%
Hep C	16	5%
Alcohol use disorder	13	4%
Cancer/Leukemia	5	2%
Pregnancy during episode	3	1%

Of the 312 charts reviewed 63% indicated no substance use or mental health diagnosis or problem. Progress notes and the problem lists/dashboards in the EHRs were utilized to identify co-occurring conditions. The most common mental health diagnosis or problem indicated was a depressive disorder at 23%. 22% of the charts reviewed indicated an STD/STI diagnosis. Anecdotally syphilis was identified frequently, however the review tool did not easily allow for documentation of specific STI/STD diagnoses and thus it is impossible to know for sure. This could be worth future consideration and may indicate additional training needs for support service staff who may be instrumental in helping clients access medication and treatment for various co-occurring conditions that ultimately affect the client's health outcomes.

Hypertension and Diabetes II were also noted by this reviewer as common co-occurring conditions. In many cases where a client had seemingly well managed HIV care, they were struggling with hypertension or diabetes and would likely benefit from additional support around those co-occurring conditions. This would likely require additional training and access to information and resources for the support staff tasked with helping a client navigate those conditions.

"Other Substance Use" (frequently methamphetamine, crack and marijuana) was noted in 14% of the charts. Again, the review tool did not allow for indication of specific substances being used besides alcohol so specific data is not available about the other substances being used.

Conclusion

The HIV care systems clients and providers must navigate in order to access and provide care is complex and at times burdensome. It is clear that non-medical and medical case managers play an important and useful role in helping clients overcome barriers to support services and primary care. Both non-medical and medical case managers appear to spend much of their time helping clients with eligibility and paperwork requirements mandated by the local, state and federal programs under which client's are served in order to access basic needs like medications, housing, transportation, primary and specialty medical care including dental and vision services and mental health or substance use treatment. The ways in which the most complex cases are funneled to the licensed medical case managers should continue to be evaluated and perhaps re-worked in some cases to ensure licensed medical case managers are being appropriately utilized to serve the most at risk and vulnerable clients who will benefit from the highest level of case management support available. Alternatively, consideration should be given to suggestions put forth by case management providers during the prior year's chart review process that may allow for billing simple information and referral encounters by licensed staff at a lower rate to give the sites flexibility in how they utilize available staff in their existing agency systems while still honoring and fulfilling their contract agreements and the standards of care.

Appendix

Review Tool

MCM and SLW Chart Review Tool

Services received 3/1/13-2/28/14

/___/___/201___/ Client Case Status: ☐ Open/Active ☐ Closed ☐ Unk

Brief Assessment Date 1:		Brief Assessment Date 2:	
Comp Assessment Date 1:		Comp Assessment Date 2:	
Service Plan Date 1:		Service Plan Date 2:	
Case Closure Date:			
Last OAMC Date:			
Last MCM Date:			

HIV/AIDS STAGE OF ILLNESS UPDATE, AND BEHAVIORAL HEALTH CONDITIONS

1. Most current documented HIV stage? ☐ HIV+, not AIDS ☐ AIDS ☐ HIV+/Status Unk
2. Was the client identified as needing MH/SA therapy/counseling? ☐ Yes ☐ No ☐ NA ☐ Unk
3. Does the client have an active diagnosis of the following diagnoses? (Check ALL That Apply)
   - ☐ Alcohol abuse/dependence
   - ☐ Other substance abuse/substance dependence
   - ☐ Depression
   - ☐ Bipolar disorder
   - ☐ Anxiety disorders
   - ☐ Other mental disorders _____
4. Was the client reported to have any of these conditions? (Check ALL That Apply)
   - ☐ Sexually transmitted infections (STIs)
   - ☐ Pregnancy
   - ☐ Homeless

SERVICE LINKAGE

5. How was the client assisted by a SLW in the observation period
   - ☐ **NA (Client not assisted by SLW)**
   - ☐ Brief assessment
   - ☐ SLW referred client to OAMC
   - ☐ OAMC visit scheduled by SLW
   - ☐ SLW accompanied the client to OAMC visit
   - ☐ SLW called client to remind about the OAMC visit
   - ☐ Client did not keep OAMC appointment and SLW contacted the client
   - ☐ Other SLW activity: _____

LOST TO CARE AND COORDINATION ACTIVITIES

6. Was the client lost to OAMC care? ☐ Yes ☐ No ☐ NA
7. Was there acknowledgement in the chart that the client was lost to OAMC care? ☐ Yes ☐ No ☐ NA
8. What activities did the **MCM** undertake because the client was lost to care? (Check all that apply)
   - ☐ **NA (Client not lost to care)**
   - ☐ No activities documented to contact client lost to care
   - ☐ Letter to client's last known address
   - ☐ Telephone call to client's last known telephone number
   - ☐ Telephone call to client's emergency contact person
   - ☐ Referral to outreach program: _____
9. Did the MCM receive information from the program about the client's status? ☐ Yes ☐ No ☐ NA
   a. Client status? _____

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10. Was there evidence of coordination of services between MCM, clinician, and support service providers in the chart?
- ☐ Yes, there is coordination of services
- ☐ There is no evidence of coordination of services
- ☐ Client refusal documented in client's records
  - a. Evidence: _____

NEEDS REQUIRING COMPREHENSIVE CASE MANAGEMENT

CPCDMS Insurance Status: Uninsured

11. Insurance, Benefits, and FPL

Health Insurer	Coverage?	Disability/Survivor Benefits
Medicaid	Full? Managed Care? Share of Cost? Medically Needy? QMB?	SSA Old Age (≥ 65 Years)
Medicare	Part A? Part B? Part D?	SSA SSI
Commercial Name?		SSA SSDI
VA		Survivor Benefits (Widow, Widower, Child)
Other Insurers Name?		Commercial Disability/Worker's Comp

Client	Spouse/partner	Client's children	Client's Mother	Client's father	Client's sisters	Client's brothers	Other		HOUSEHOLD SIZE
1	1	1 2 3 4 5 6 7 8	1	1	1 2 3	1 2 3	1 2 3	→	1 2 3 4 5 6 7 8 9 10 UNK

Client 1	$	Other Member1	$	Total Income:
Client 2	$	Other Member2	$	$
Spouse	$	Other Income	$	

CLINICAL CASE MANAGEMENT

12. Was the client referred for clinical case management services in the review period?
☐ Yes ☐ No ☐ Unk

If YES, was there evidence of coordination of services between primary care provider and clinical case management at least every three months in the client's chart?
- ☐ Yes, there is coordination of services
- ☐ There is no evidence of coordination of services
- ☐ Client refusal documented in client's record
- ☐ NA, client not referred to clinical case management services

CASE DISCHARGE/TERMINATION/CLOSURE

13. Was case discharged/closed case during the review period? ☐1. Yes ☐ 0. No ☐ 8. NA ☐ 9. Unk

Case Closure	Closure 1	Closure 2	Closure 3
Client met agency criteria for closure?			
Date of closure noted?			
Summary of services received noted?			
Referrals noted?			
Instructions given to client at discharge noted?			
Reason for closure			
All goals met / no needs			
Client continues no show, lack of follow-up			
Client refused service			
Client died			
Client lost to care			
Client moves out of service area			
Client incarcerated			
Unk, unclear, contradictory documentation			

14. If an assessment was completed, were the following components assessed, addressed in the service plan, and addressed by referrals?

Worker Completing Assessment:	Assessment		Service Plan		Referral		Follow-up to Achieve Goal Documented?
	Domain Assessed?	Need Identified?	Resources Identified?	Timelines?	Referral Made?	Follow-up to Referral?	
Basic Necessities							
Benefits							
Children/Dependents							
Cultural/Linguistic							
Dental Care							
Emergency Financial Assistance							
Family Planning/Safer Sex							
Food/Nutrition							
General Education, Vocation, Literacy							
Health Insurance							
Health Insurance Premium Assistance							
Hearing Care							
HIV Ed/Prevention							
HIV Medications							
Housing Services							
Income							
Legal							
Mental Health Treatment							
Outpatient Ambulatory Medical Care							
Self-Efficacy							
Substance Abuse Treatment							
Support System							
Translation Services							
Transportation							
Treatment Adherence							
Vision Care Other:							

Addendum:

15. Viral load suppressed during review period?

- Yes
- No, intervention/follow up/linkage by SLW/MCM documented
- No, ***no documentation*** of intervention/follow up/linkage by SLW/MCM
- Unknown; no lab results containing VL information documented during review period

16. Was there a primary care visit within review period?

- Yes
- No

17. If no to 16, was there documentation by SLW/MCM to link client back to care?

- Yes
- No
- Not applicable (client moved out of EMA, client deceased, client refused service, etc.)

18. If any conditions applicable under 3 or 4, was there an attempt to link client to SLW/MCM care?

- Yes
- No, client was virally suppressed
- No, client had viral load and no linkage attempts documented

19. Progress notes: Were the five most recent progress notes (involving face to face or phone contact) in the review period dated, signed, indicative of the type of service delivered, the nature and extent of the service and the next steps or future plans?

F2F/PC date	Dated		Signed		Type of service noted?		Nature and extent of service noted?		Next steps or future plans noted?		Progress notes clear and concise?	
	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N

Chart Review Performance Measures

HAB Performance Measures	FY16 Rate	FY17 Rate	Change	Goal	Action
Viral Load Suppression	88.5%	85.5%	↓	90%	QI plan for agencies not at goal/ECHO/Outreach
ART Rx	97.6%	98.7%	↑	95%	none
PCP prophylaxis	100%	93%	↓	100%	QI plan for agencies not at goal
VL monitoring	94.6%	98%	↑	90%	none
HIV Drug Resistance Testing	69.2%	71.4%	↑	85%	none
Influenza Vaccination	53.1%	53.5%	–	65%	QI plan for agencies not at goal
Lipid Screening	88.9%	88.8%	–	90%	QI plan for agencies not at goal
TB Screening	66.9%	67.2%	–	75%	QI plan for agencies not at goal
Cervical Cancer	80.1%	82.5%	↑	75%	QI plan for agencies not at goal
STD Testing	72.9%	77.6%	↑	65%	none
Hep B Screening	96.1%	87.1%	↓	95%	QI plan for agencies not at goal
Hep B Vaccination	55.6%	51.4%	↓	55%	QI plan for agencies not at goal
Hep C Screening	99.1%	92.8%	↓	95%	QI plan for agencies not at goal
HIV Risk Counseling	69.4%	90.7%	↑	85%	QI plan for agencies not at goal
Pneumococcal	86.7%	83.4%	↓	90%	QI plan for agencies not at goal
Mental Health Screening	87.9%	96.4%	↑	95%	none
Tobacco Screening	99.4%	100%	–	100%	none
Smoking Cessation Counseling	57.7%	55.7%	↓	100%	QI plan for agencies not at goal
Substance Use Screening	98.6%	99.1%	↑	95%	none
Syphilis Screening	94%	92.4%	↓	85%	QI plan for agencies not at goal
Reproductive Health Care	54%	34.9%	↓	75%	QI plan for agencies not at goal
IPV	81.9%	78.6%	↓	90%	QI plan for agencies not at goal
ART Adherence	99.5%	100%	–	100%	none

CPCDMS Performance Measures

Performance Measures	FY16 Rate	Current Rate	Change	Goal	Action
Lost to Care	19.6%	17.9%	↓	<20%	QI plan for agencies not at goal/ECHO/Outreach
Retained in Care	75.3%	72.6%	↓	90%	QI plan for agencies not at goal/ECHO/Outreach
VL Suppression	72.6%	76.6%	↑	90%	QI plan for agencies not at goal/ECHO/Outreach
Linked to Care	45.8%	48.2%	↑	60%	CM QI initiative/Outreach
Medical Visit Frequency		23%		35%	QI plan for agencies not at goal/ECHO/Outreach
Oral Exam	24.8%	24.4%	–	30%	none

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Selected Core Performance Measures by Gender

Viral Load Suppression

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

2017 Viral Load Suppression by Gender			
	Female	Male	Transgender
Number of clients with HIV infection with viral load below limits of quantification at last test during the measurement year	240	262	33
Number of HIV-infected clients who: • had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year, and • were prescribed ART for at least 6 months	277	308	41
Rate	**86.6%**	**85.1%**	**80.5%**

ART Prescription

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

2017 ART Prescription by Gender			
	Female	Male	Transgender
Number of clients who were prescribed an ART regimen within the measurement year	278	308	41
Number of clients who: • had at least two medical visit with a provider with prescribing privileges, i.e. MD, PA, NP in the measurement year	283	310	42
Rate	**98.2%**	**99.4%**	**97.6%**

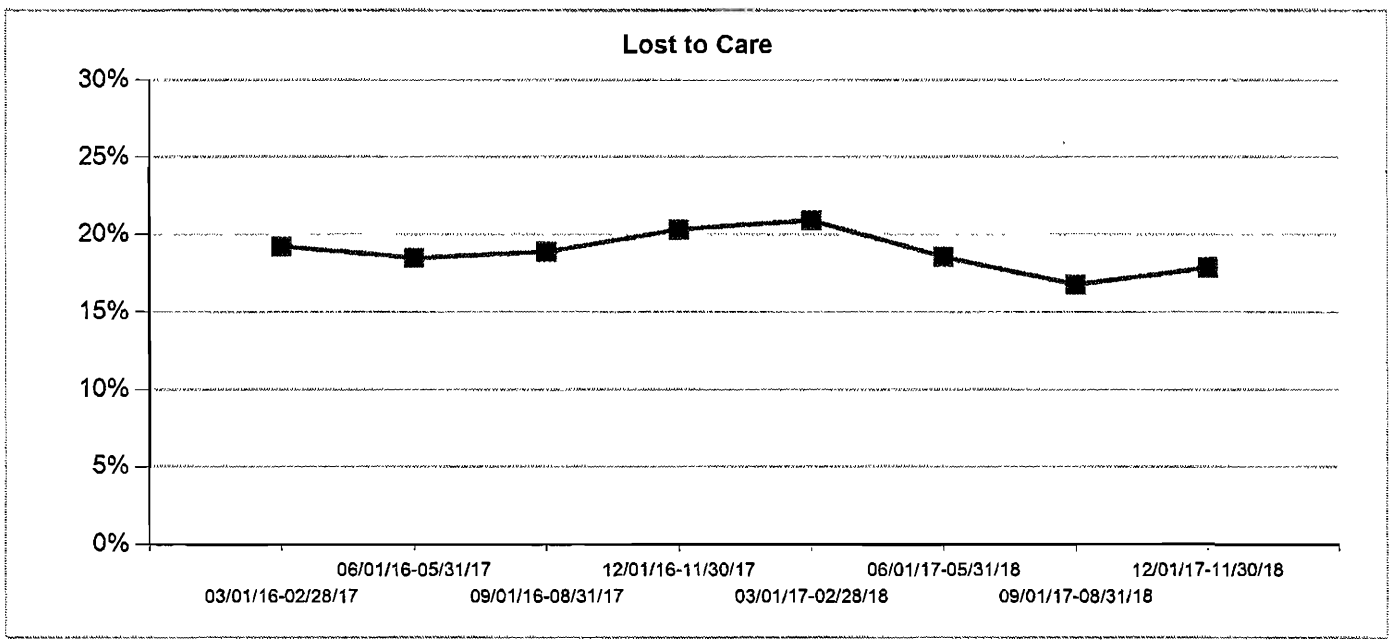
- Of the 8 clients not on ART, none had a CD4 <200, 5 were long-term non-progressors, and 3 refused

HARRIS COUNTY PUBLIC HEALTH AND ENVIRONMENTAL SERVICES - RWGA

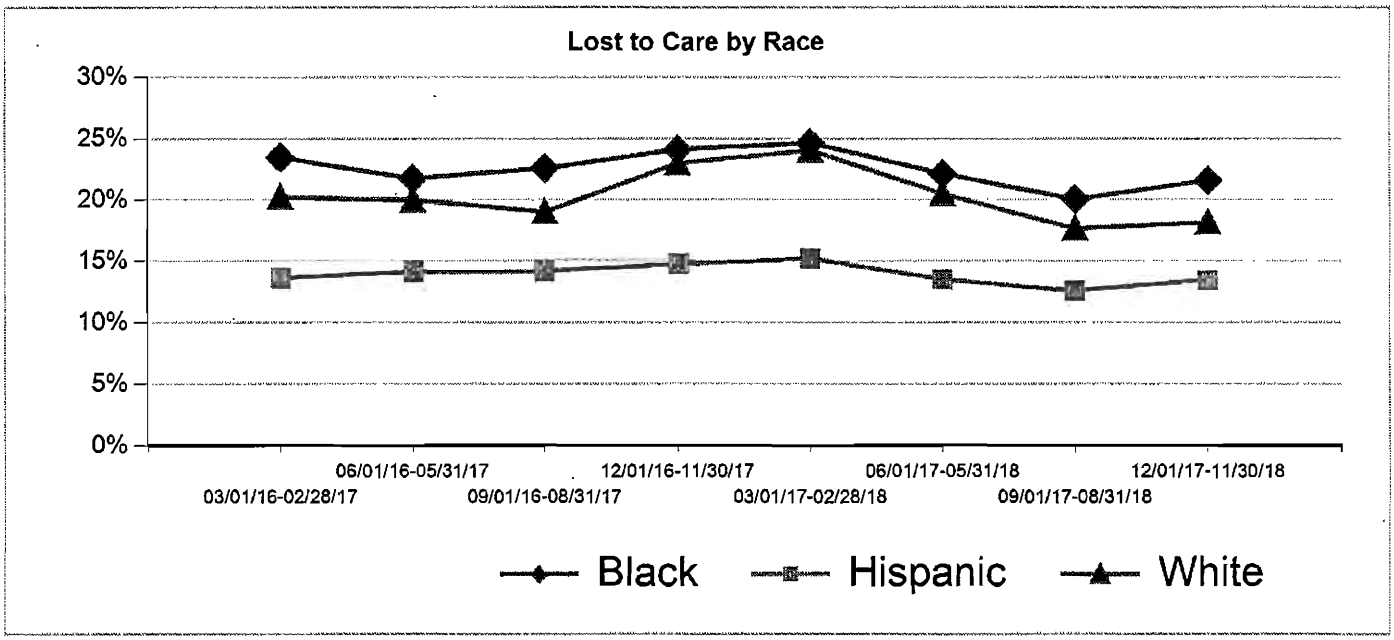
Clinical Quality Management Committee Quarterly Report

Last Quarter Start Date: **12/1/2017**

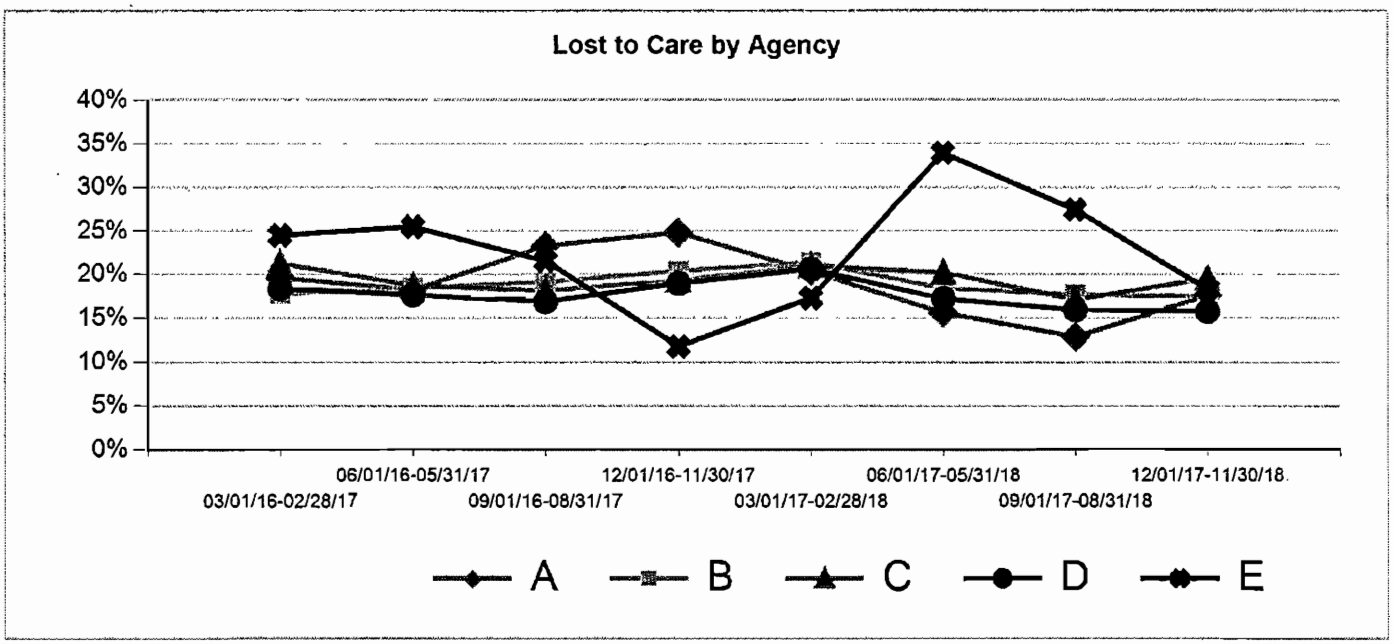
Lost to Care				
In+Care Campaign Gap Measure				
	03/01/17 - 02/28/18	06/01/17 - 05/31/18	09/01/17 - 08/31/18	12/01/17 - 11/30/18
Number of uninsured clients who had no medical visits and a detectable or missing viral load in the last 6 months of the measurement year	1,106	962	883	992
Number of uninsured clients who had a medical visit with a provider with prescribing privileges at least once in the first 6 months of the measurement year	5,286	5,185	5,263	5,554
Percentage	20.9%	18.6%	16.8%	17.9%
Change from Previous Quarter Results	0.6%	-2.4%	-1.8%	1.1%



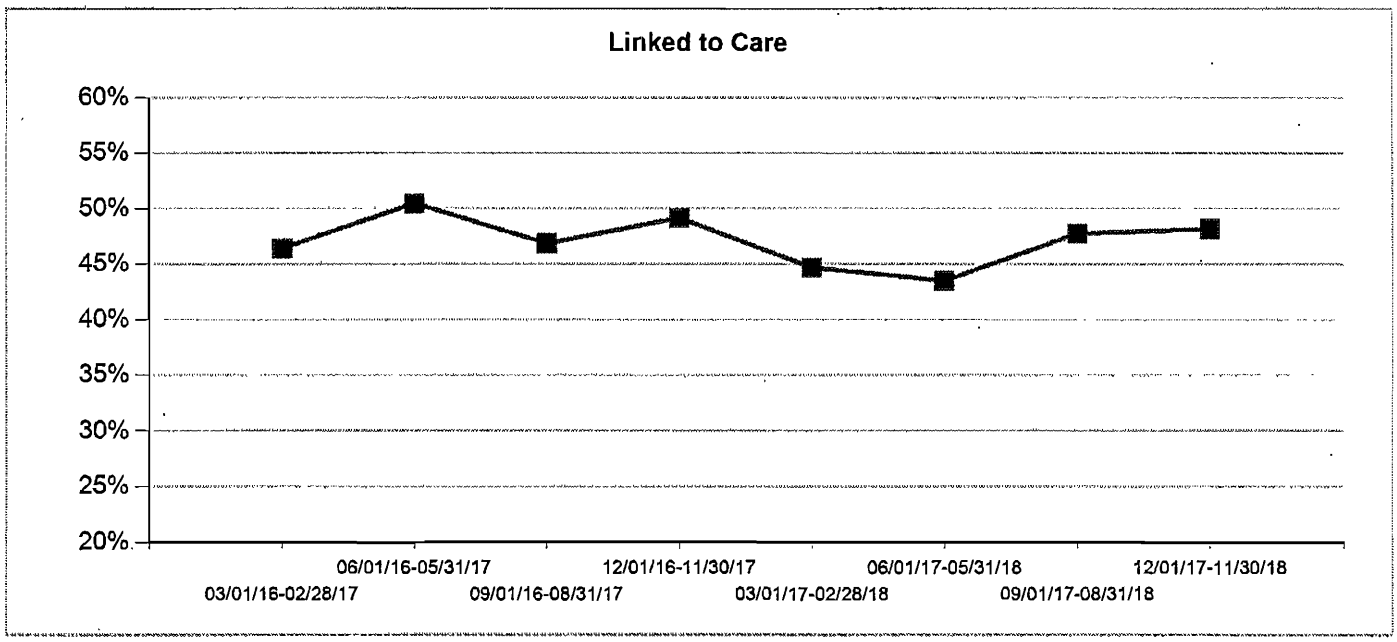
Lost to Care by Race/Ethnicity									
	06/01/17 - 05/31/18			09/01/17 - 08/31/18			12/01/17 - 11/30/18		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of uninsured clients who had no medical visits and a detectable or missing viral load in the last 6 months of the measurement year	538	268	135	491	257	116	563	285	127
Number of uninsured clients who had a medical visit with a provider with prescribing privileges at least once in the first 6 months of the measurement year	2,430	1,981	659	2,447	2,046	656	2,611	2,126	699
Percentage	22.1%	13.5%	20.5%	20.1%	12.6%	17.7%	21.6%	13.4%	18.2%
Change from Previous Quarter Results	-2.5%	-1.7%	-3.6%	-2.1%	-1.0%	-2.8%	1.5%	0.8%	0.5%



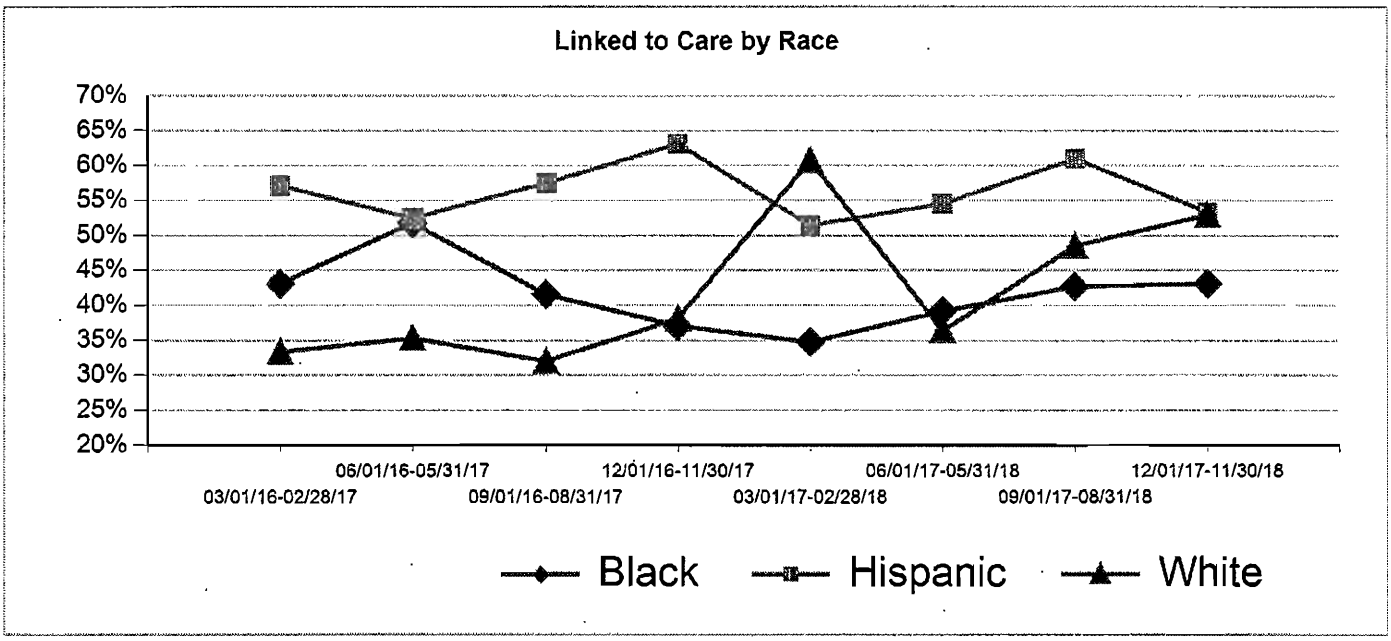
Lost to Care by Agency										
	09/01/17 - 08/31/18					12/01/17 - 11/30/18				
	A	B	C	D	E	A	B	C	D	E
Number of uninsured clients who had no medical visits and a detectable or missing viral load in the last 6 months of the measurement year	73	330	264	203	17	105	333	314	214	11
Number of uninsured clients who had a medical visit with a provider with prescribing privileges at least once in the first 6 months of the measurement year	567	1,864	1,542	1,273	62	598	1,905	1,607	1,357	60
Percentage	12.9%	17.7%	17.1%	15.9%	27.4%	17.6%	17.5%	19.5%	15.8%	18.3%
Change from Previous Quarter Results	-2.7%	-0.7%	-3.1%	-1.3%	-6.5%	4.7%	-0.2%	2.4%	-0.2%	-9.1%



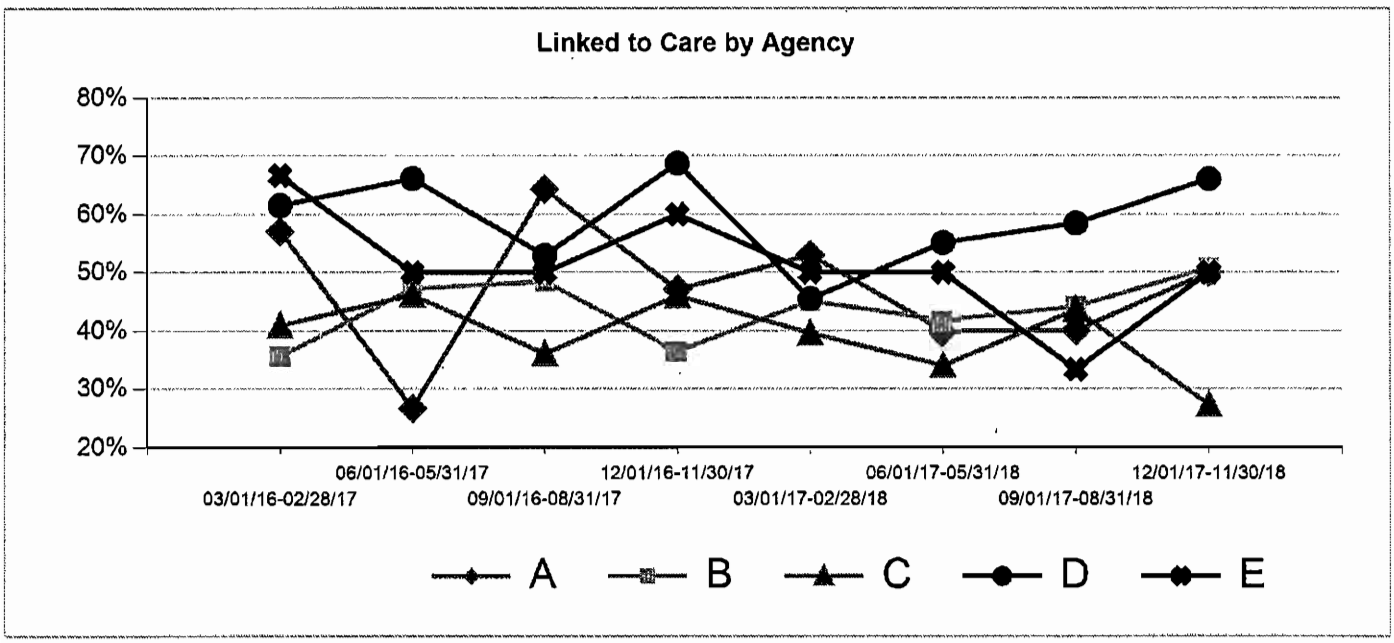
Linked to Care				
In+Care Campaign clients Newly Enrolled in Medical Care Measure				
	03/01/17 - 02/28/18	06/01/17 - 05/31/18	09/01/17 - 08/31/18	12/01/17 - 11/30/18
Number of newly enrolled uninsured clients who had at least one medical visit in each of the 4-month periods of the measurement year	88	77	96	92
Number of newly enrolled uninsured clients who had a medical visit with a provider with prescribing privileges at least once in the first 4 months of the measurement year	197	177	201	191
Percentage	44.7%	43.5%	47.8%	48.2%
Change from Previous Quarter Results	-4.5%	-1.2%	4.3%	0.4%
* exclude if vl<200 in 1st 4 months				



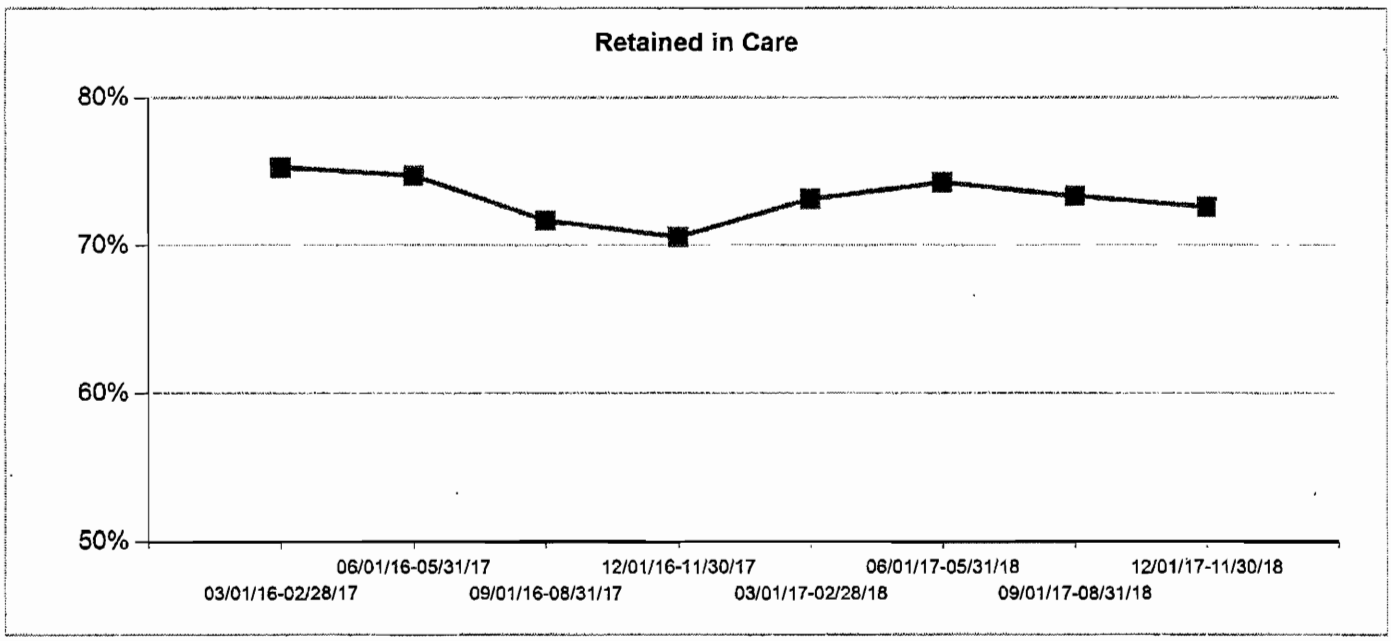
Linked to Care by Race/Ethnicity									
	06/01/17 - 05/31/18			09/01/17 - 08/31/18			12/01/17 - 11/30/18		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of newly enrolled uninsured clients who had at least one medical visit in each of the 4-month periods of the measurement year	38	30	8	44	36	16	41	32	18
Number of newly enrolled uninsured clients who had a medical visit with a provider with prescribing privileges at least once in the first 4 months of the measurement year	97	55	22	103	59	33	95	60	34
Percentage	39.2%	54.5%	36.4%	42.7%	61.0%	48.5%	43.2%	53.3%	52.9%
Change from Previous Quarter Results	4.4%	3.1%	-24.4%	3.5%	6.5%	12.1%	0.4%	-7.7%	4.5%
* exclude if vl<200 in 1st 4 months									



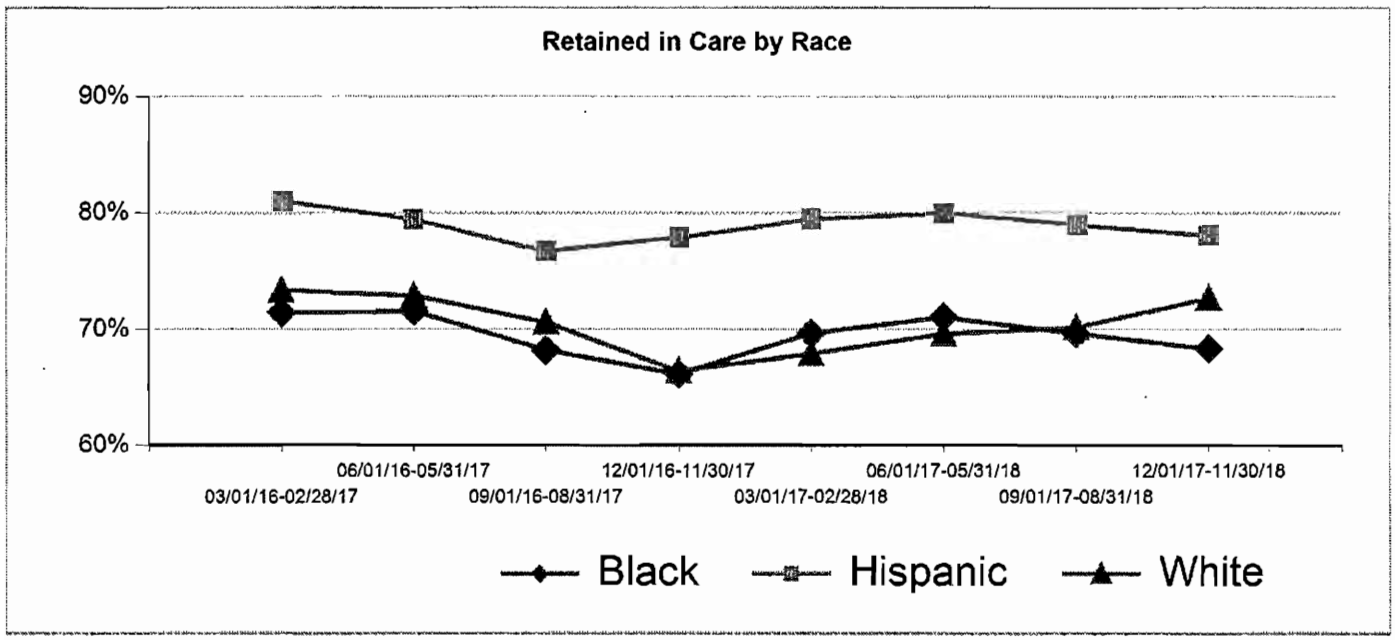
Linked to Care by Agency										
	09/01/17 - 08/31/18					12/01/17 - 11/30/18				
	A	B	C	D	E	A	B	C	D	E
Number of newly enrolled uninsured clients who had at least one medical visit in each of the 4-month periods of the measurement year	2	30	27	38	1	5	33	15	35	3
Number of newly enrolled uninsured clients who had a medical visit with a provider with prescribing privileges at least once in the first 4 months of the measurement year	5	68	62	65	3	10	65	55	53	6
Percentage	40.0%	44.1%	43.5%	58.5%	33.3%	50.0%	50.8%	27.3%	66.0%	50.0%
Change from Previous Quarter Results	0.0%	2.3%	9.5%	3.4%	-16.7%	10.0%	6.7%	-16.3%	7.6%	16.7%
* exclude if vl<200 in 1st 4 months										



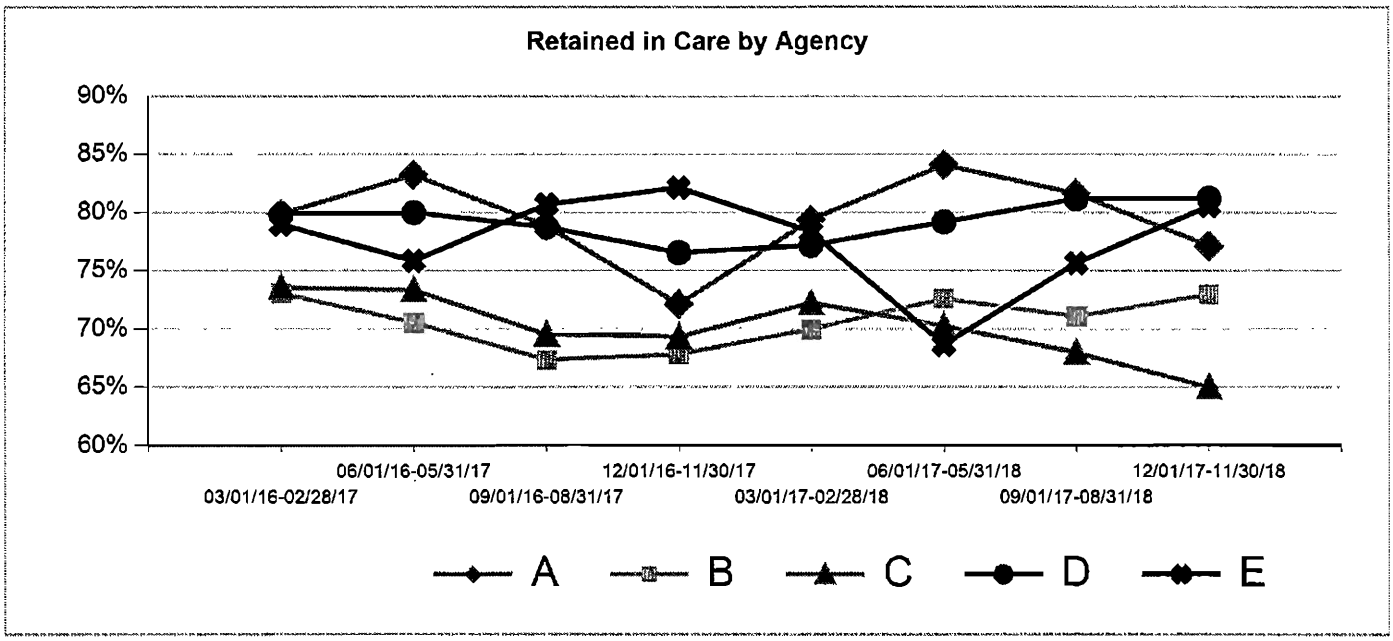
Retained in Care				
Houston EMA Medical Visits Measure				
	03/01/17 - 02/28/18	06/01/17 - 05/31/18	09/01/17 - 08/31/18	12/01/17 - 11/30/18
Number of clients who had 2 or more medical visits at least 3 months apart during the measurement year*	4,229	4,202	4,247	4,367
Number of clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year*	5,781	5,659	5,790	6,014
Percentage	73.2%	74.3%	73.4%	72.6%
Change from Previous Quarter Results	2.6%	1.1%	-0.9%	-0.7%
* Not newly enrolled in care				



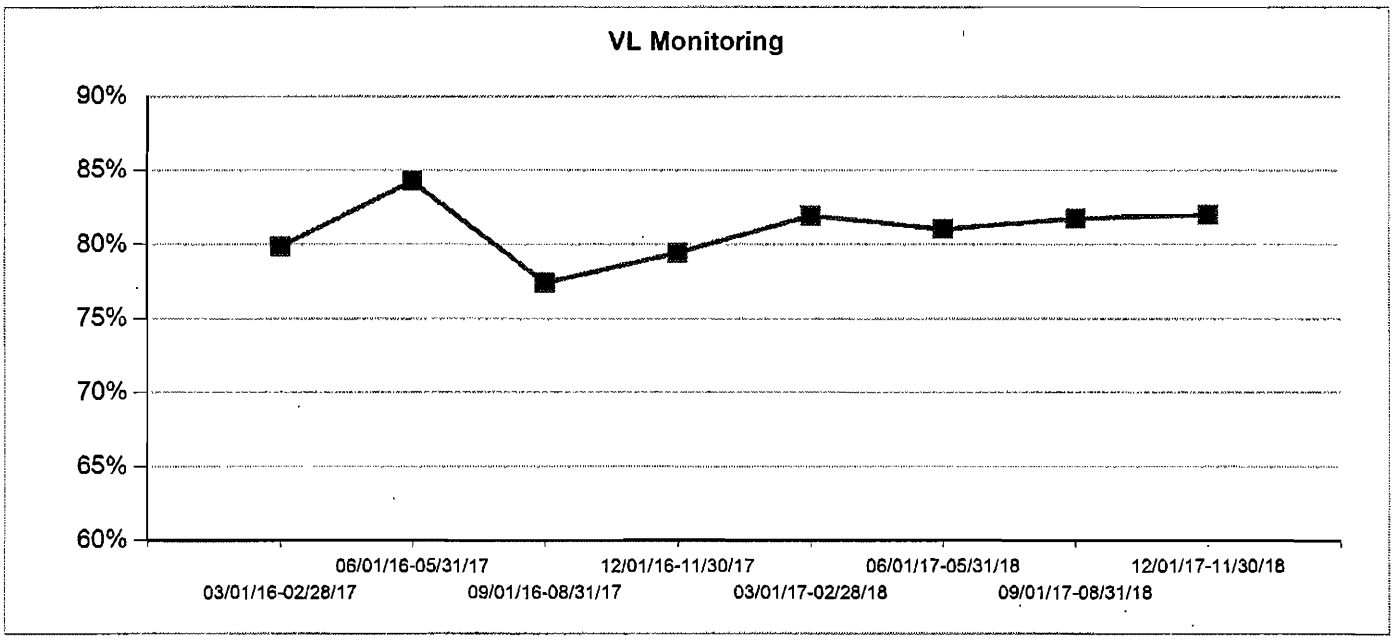
Retained in Care by Race/Ethnicity									
	06/01/17 - 05/31/18			09/01/17 - 08/31/18			12/01/17 - 11/30/18		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of clients who had 2 or more medical visits at least 3 months apart during the measurement year	1,905	1,693	508	1,902	1,738	512	1,957	1,772	545
Number of clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year*	2,682	2,118	730	2,732	2,202	730	2,865	2,270	750
Percentage	71.0%	79.9%	69.6%	69.6%	78.9%	70.1%	68.3%	78.1%	72.7%
Change from Previous Quarter Results	1.4%	0.5%	1.7%	-1.4%	-1.0%	0.5%	-1.3%	-0.9%	2.5%



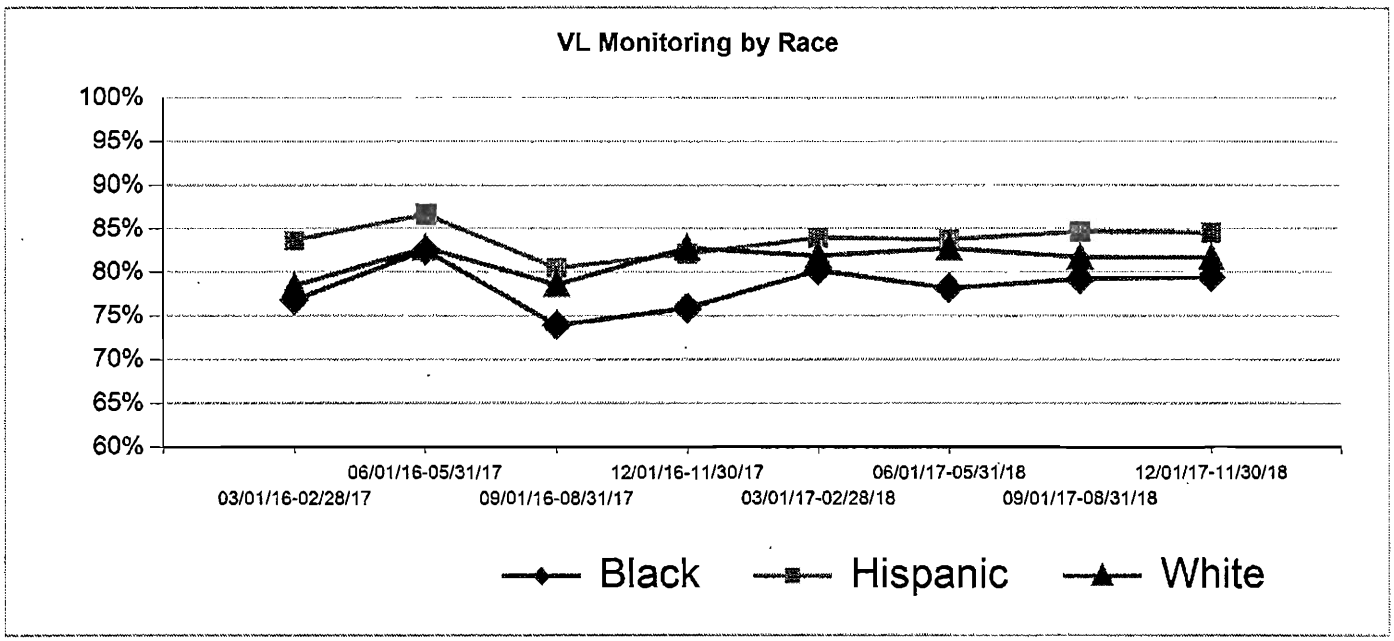
Retained in Care by Agency										
	09/01/17 - 08/31/18					12/01/17 - 11/30/18				
	A	B	C	D	E	A	B	C	D	E
Number of clients who had 2 or more medical visits at least 3 months apart during the measurement year	494	1,423	1,221	1,160	56	486	1,483	1,172	1,230	58
Number of clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year*	605	2,002	1,796	1,429	74	630	2,032	1,803	1,514	72
Percentage	81.7%	71.1%	68.0%	81.2%	75.7%	77.1%	73.0%	65.0%	81.2%	80.6%
Change from Previous Quarter Results	-2.5%	-1.5%	-2.3%	2.0%	7.0%	-4.5%	1.9%	-3.0%	0.1%	4.9%



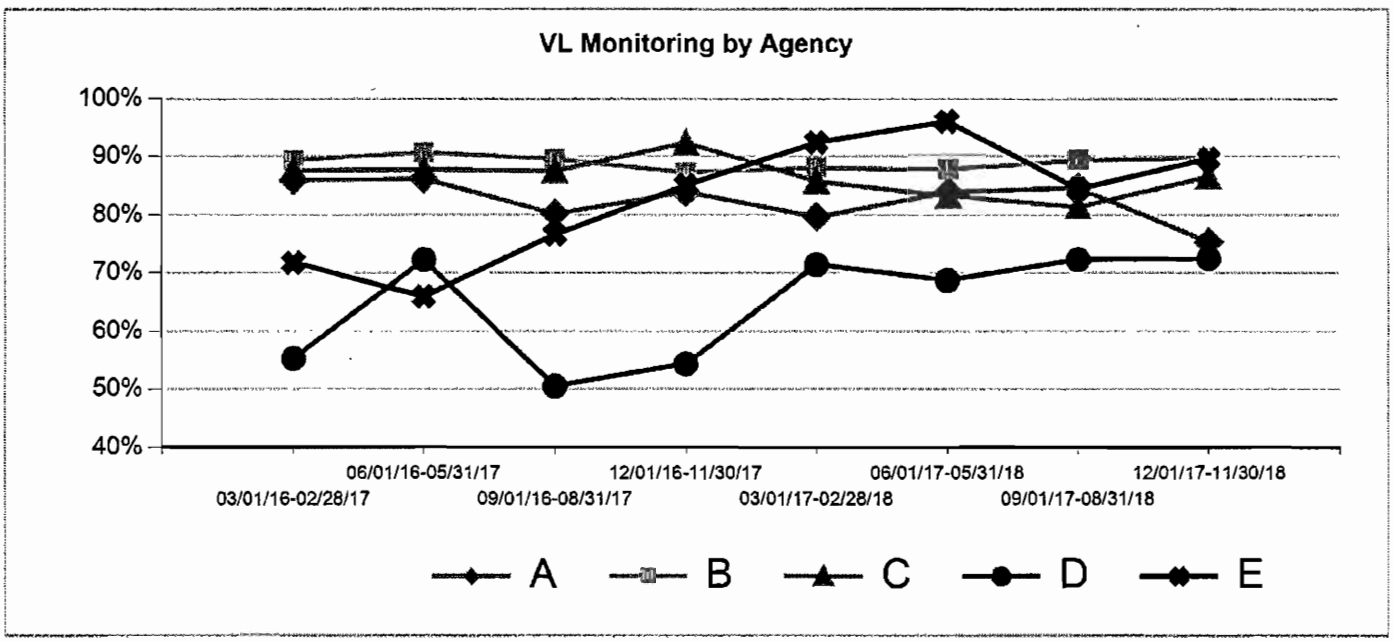
Viral Load Monitoring				
	03/01/17 - 02/28/18	06/01/17 - 05/31/18	09/01/17 - 08/31/18	12/01/17 - 11/30/18
Number of clients who had 2 or more Viral Load counts at least 3 months apart during the measurement year	3,707	3,638	3,762	3,849
Number of clients who had 2 or more medical visits at least 3 months apart with a provider with prescribing privileges, i.e. MD, PA, NP in the measurement year	4,522	4,488	4,600	4,692
Percentage	82.0%	81.1%	81.8%	82.0%
Change from Previous Quarter Results	2.5%	-0.9%	0.7%	0.3%



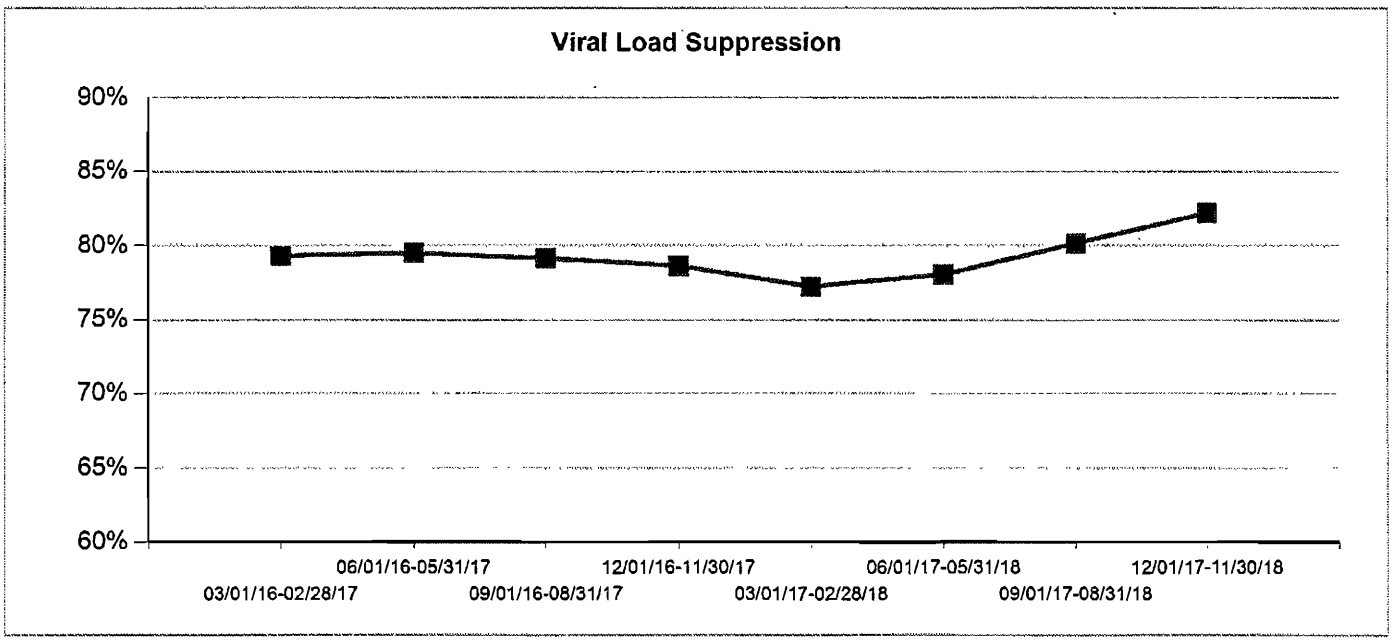
VL Monitoring Data by Race/Ethnicity									
	06/01/17 - 05/31/18			09/01/17 - 08/31/18			12/01/17 - 11/30/18		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of clients who had 2 or more Viral Load counts at least 3 months apart during the measurement year	1,597	1,503	456	1,652	1,571	457	1,674	1,606	477
Number of clients who had 2 or more medical visits at least 3 months apart with a provider with prescribing privileges, i.e. MD, PA, NP in the measurement year	2,043	1,794	551	2,085	1,855	559	2,107	1,899	584
Percentage	78.2%	83.8%	82.8%	79.2%	84.7%	81.8%	79.4%	84.6%	81.7%
Change from Previous Quarter Results	-2.0%	-0.2%	0.9%	1.1%	0.9%	-1.0%	0.2%	-0.1%	-0.1%



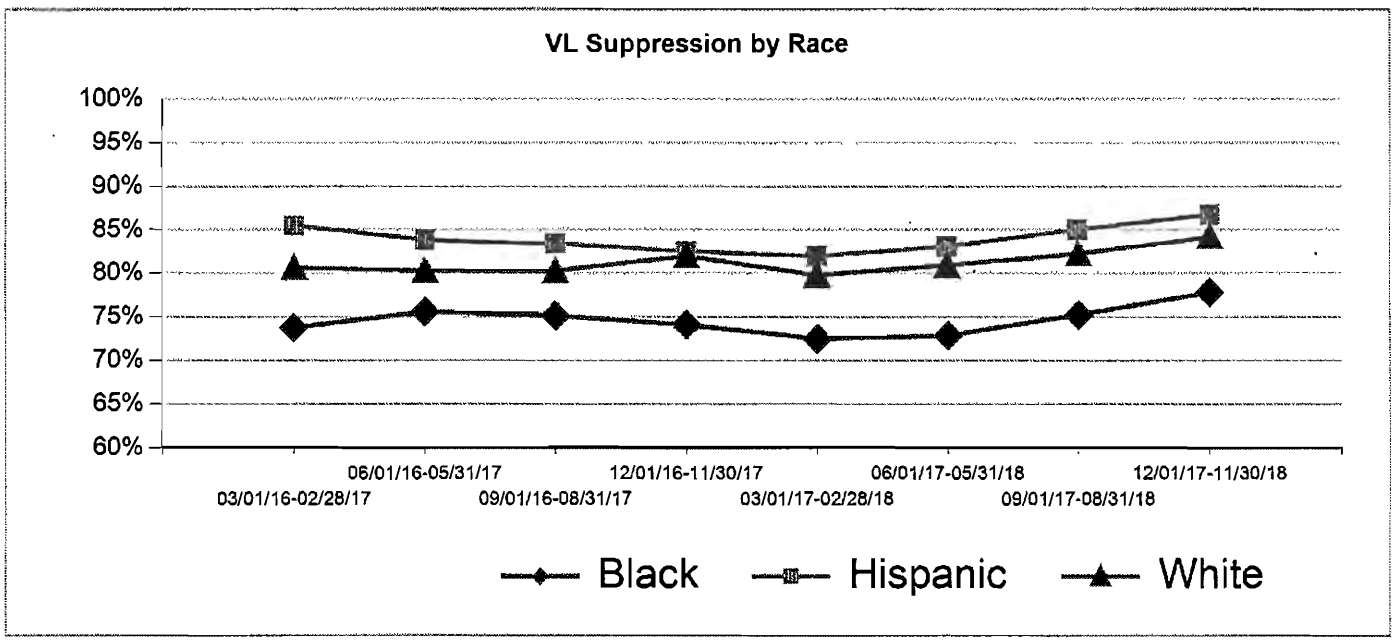
VL Monitoring by Agency										
	09/01/17 - 08/31/18					12/01/17 - 11/30/18				
	A	B	C	D	E	A	B	C	D	E
Number of clients who had 2 or more Viral Load counts at least 3 months apart during the measurement year	430	1,317	1,039	897	49	373	1,385	1,049	941	52
Number of clients who had 2 or more medical visits at least 3 months apart with a provider with prescribing privileges, i.e. MD, PA, NP in the measurement year	508	1,474	1,277	1,241	58	495	1,542	1,212	1,298	58
Percentage	84.6%	89.3%	81.4%	72.3%	84.5%	75.4%	89.8%	86.6%	72.5%	89.7%
Change from Previous Quarter Results	0.8%	1.6%	-1.9%	3.5%	-11.6%	-9.3%	0.5%	5.2%	0.2%	5.2%



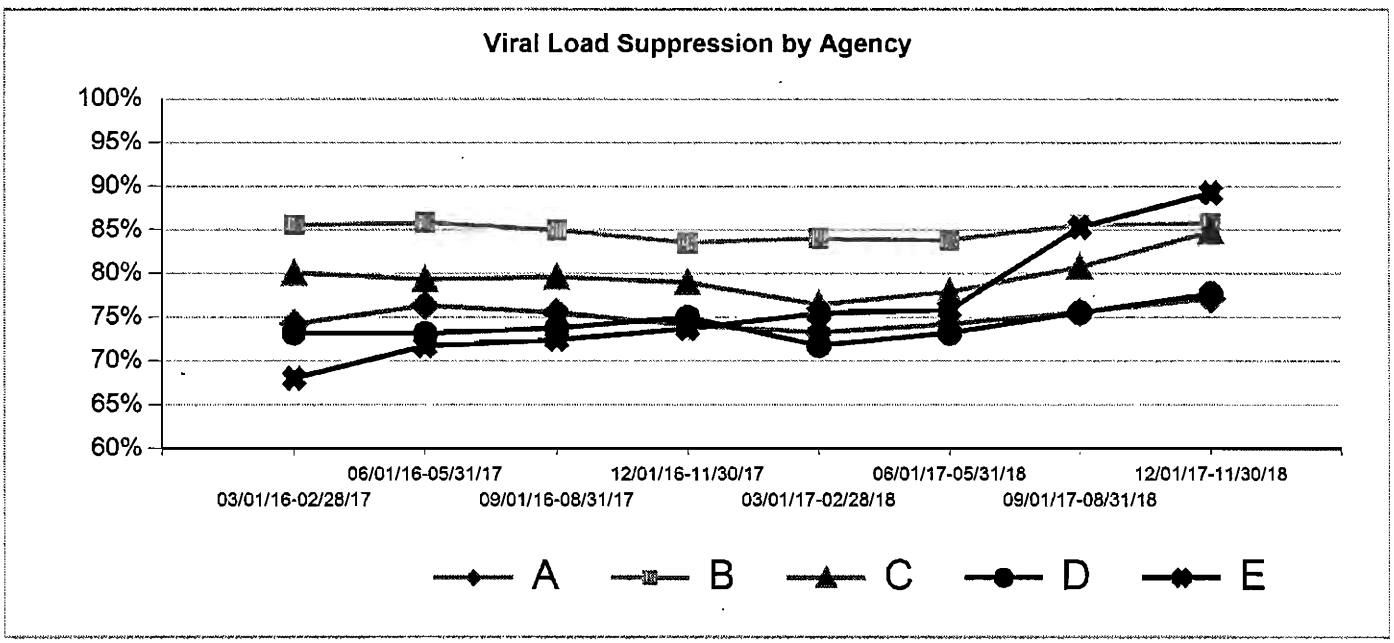
Viral Load Suppression				
	03/01/17 - 02/28/18	06/01/17 - 05/31/18	09/01/17 - 08/31/18	12/01/17 - 11/30/18
Number of clients who have a viral load of <200 copies/ml during the measurement year	4,091	4,118	4,349	4,524
Number of clients who have had at least 2 medical visits with a provider with prescribing privileges and have been enrolled in care at least six month	5,296	5,277	5,425	5,503
Percentage	77.2%	78.0%	80.2%	82.2%
Change from Previous Quarter Results	-1.4%	0.8%	2.1%	2.0%



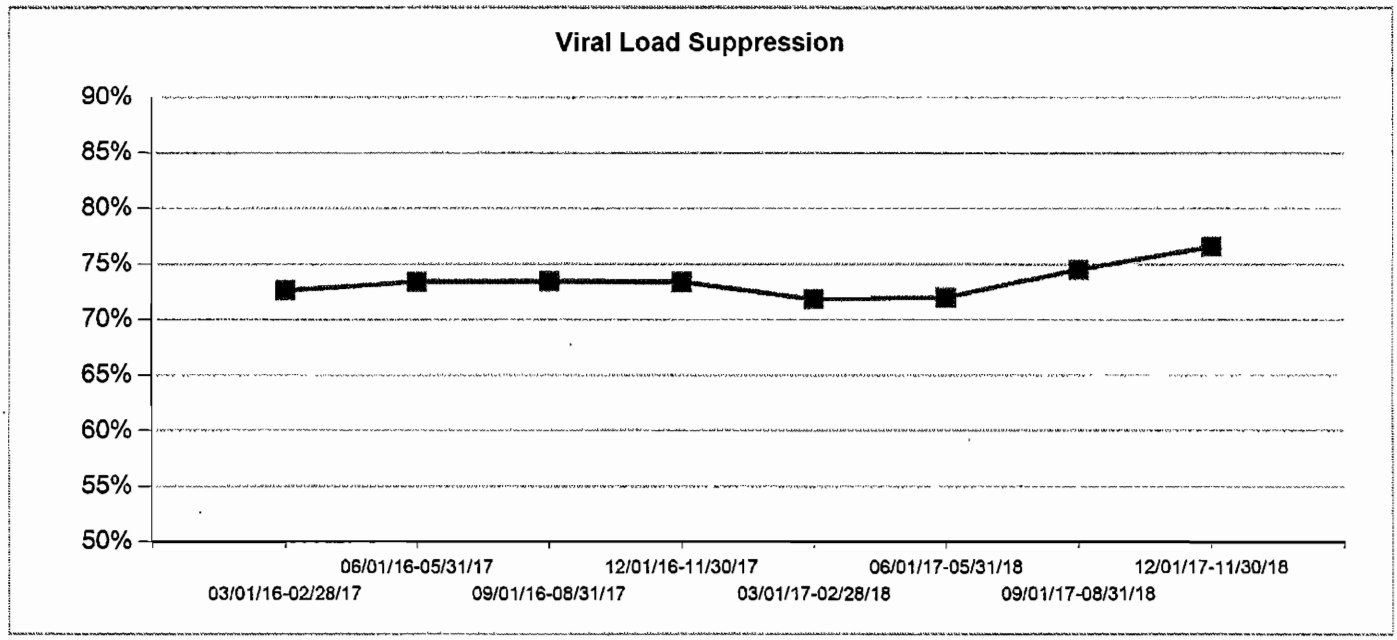
VL Suppression by Race/Ethnicity									
	06/01/17 - 05/31/18			09/01/17 - 08/31/18			12/01/17 - 11/30/18		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of clients who have a viral load of <200 copies/ml during the measurement year	1,816	1,669	534	1,924	1,765	557	2,020	1,831	577
Number of clients who have had at least 2 medical visits with a provider with prescribing privileges and have been enrolled in care at least six month	2,493	2,009	660	2,556	2,074	677	2,596	2,110	685
Percentage	72.8%	83.1%	80.9%	75.3%	85.1%	82.3%	77.8%	86.8%	84.2%
Change from Previous Quarter Results	0.3%	1.1%	1.1%	2.4%	2.0%	1.4%	2.5%	1.7%	2.0%



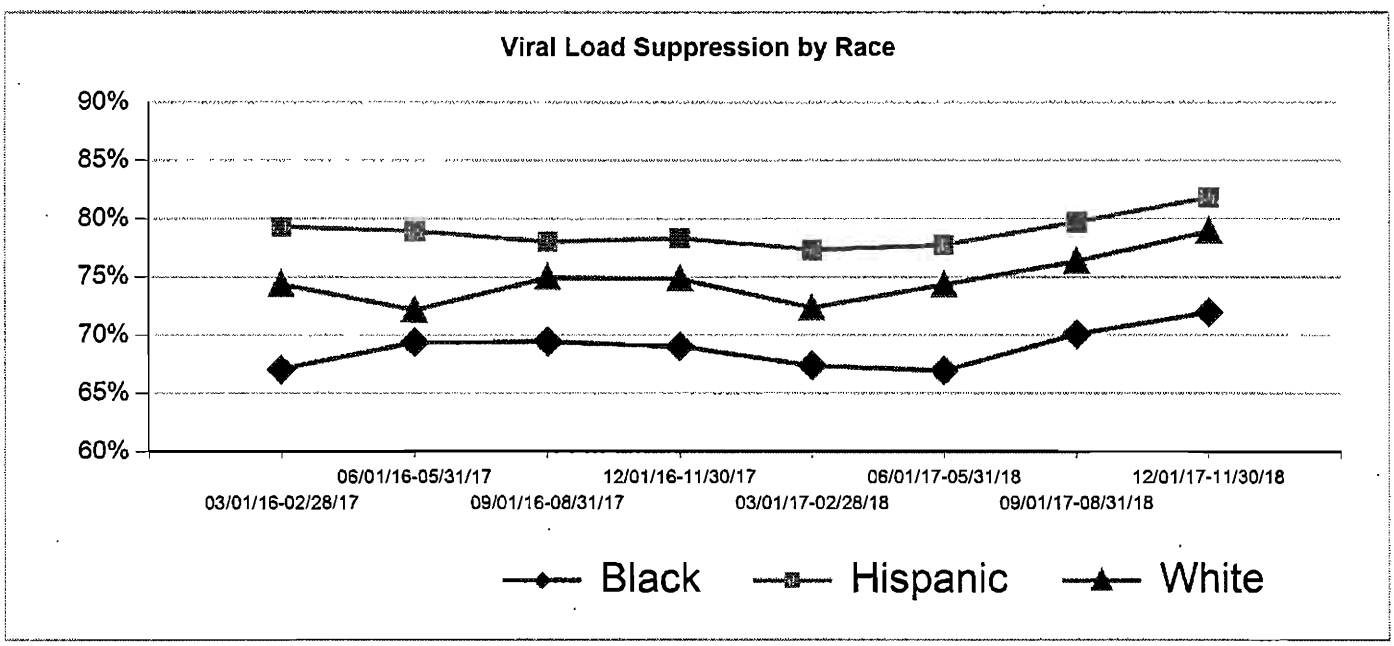
VL Suppression by Agency										
	09/01/17 - 08/31/18					12/01/17 - 11/30/18				
	A	B	C	D	E	A	B	C	D	E
Number of clients who have a viral load of <200 copies/ml during the measurement year	459	1,508	1,228	1,113	58	466	1,561	1,232	1,173	58
Number of clients who have had at least 2 medical visits with a provider with prescribing privileges and have been enrolled in care at least six month	607	1,762	1,521	1,473	68	604	1,821	1,453	1,510	65
Percentage	75.6%	85.6%	80.7%	75.6%	85.3%	77.2%	85.7%	84.8%	77.7%	89.2%
Change from Previous Quarter Results	1.4%	1.7%	2.8%	2.4%	9.4%	1.5%	0.1%	4.1%	2.1%	3.9%



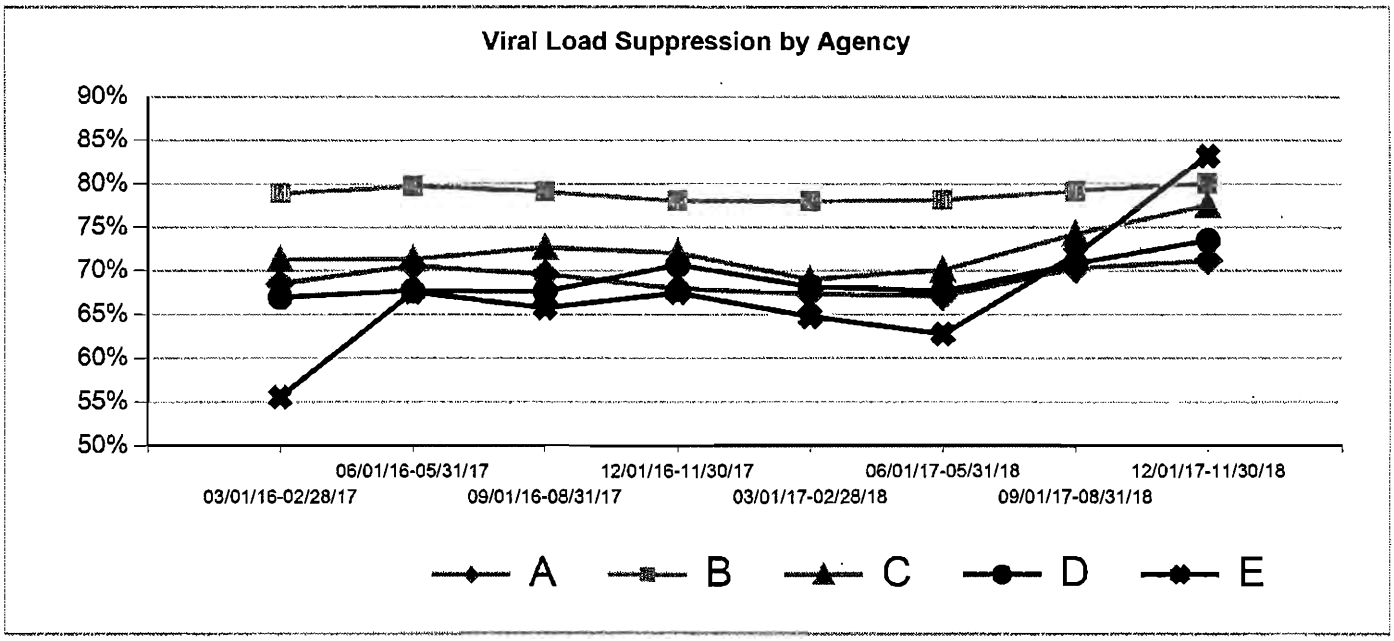
Viral Load Suppression 2- HAB Measure				
	03/01/17 - 02/28/18	06/01/17 - 05/31/18	09/01/17 - 08/31/18	12/01/17 - 11/30/18
Number of clients who have a viral load of <200 copies/ml during the measurement year	5,396	5,486	5,860	6,001
Number of clients who have had at least 1 medical visit with a provider with prescribing privileges	7,510	7,619	7,860	7,834
Percentage	71.9%	72.0%	74.6%	76.6%
Change from Previous Quarter Results	-1.6%	0.2%	2.6%	2.0%



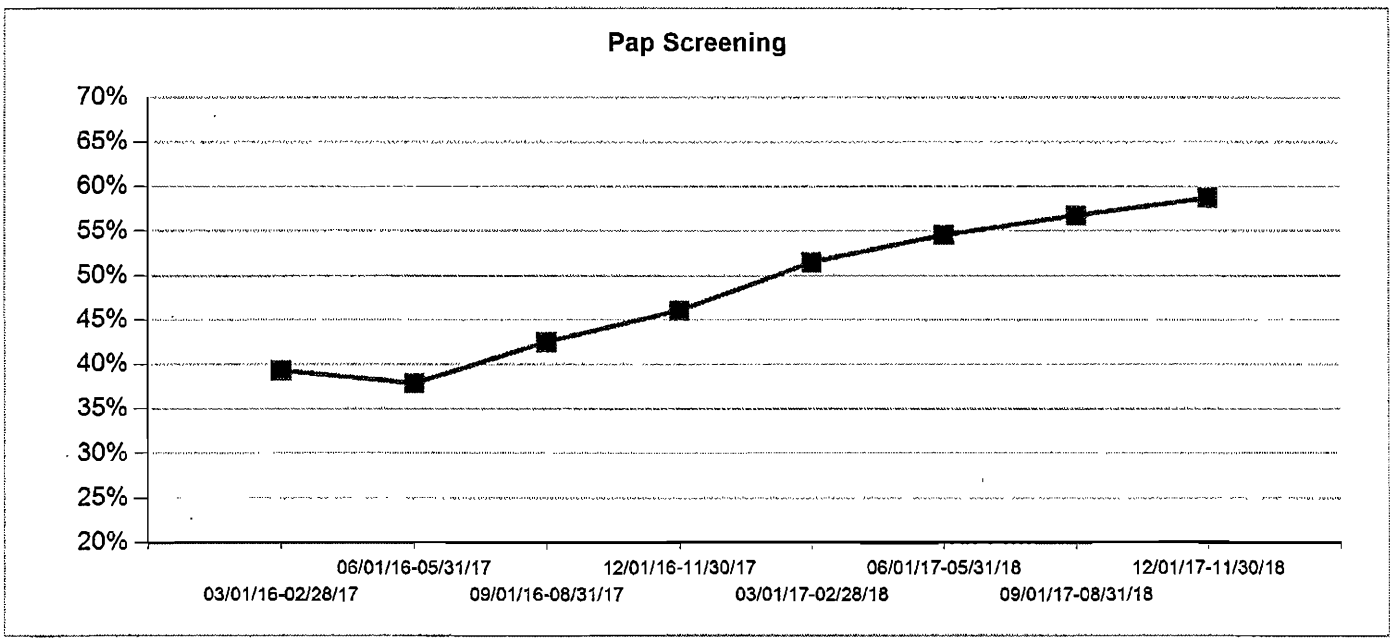
VL Suppression by Race/Ethnicity									
	06/01/17 - 05/31/18			09/01/17 - 08/31/18			12/01/17 - 11/30/18		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of clients who have a viral load of <200 copies/ml during the measurement year	2,489	2,134	736	2,677	2,275	774	2,749	2,348	767
Number of clients who have had at least 1 medical visits with a provider with prescribing privileges and have been enrolled in care at least six month	3,719	2,745	990	3,820	2,854	1,014	3,820	2,869	972
Percentage	66.9%	77.7%	74.3%	70.1%	79.7%	76.3%	72.0%	81.8%	78.9%
Change from Previous Quarter Results	-0.4%	0.4%	2.0%	3.2%	2.0%	2.0%	1.9%	2.1%	2.6%



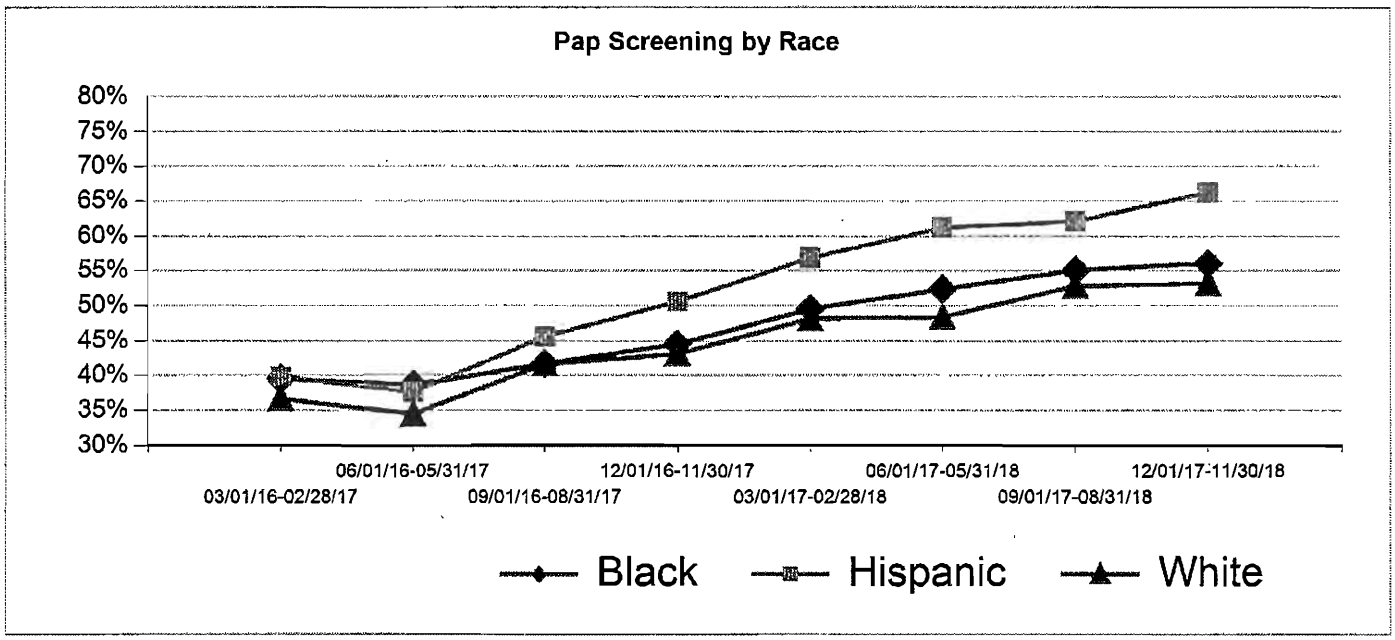
Viral Load Suppression by Agency										
	09/01/17 - 08/31/18					12/01/17 - 11/30/18				
	A	B	C	D	E	A	B	C	D	E
Number of clients who have a viral load of <200 copies/ml during the measurement year	525	2,149	1,789	1,323	69	533	2,169	1,762	1,398	79
Number of clients who have had at least 1 medical visits with a provider with prescribing privileges and have been enrolled in care at least six month	747	2,715	2,410	1,868	96	749	2,712	2,273	1,902	95
Percentage	70.3%	79.2%	74.2%	70.8%	71.9%	71.2%	80.0%	77.5%	73.5%	83.2%
Change from Previous Quarter Results	3.1%	1.0%	4.1%	3.2%	9.1%	0.9%	0.8%	3.3%	2.7%	11.3%



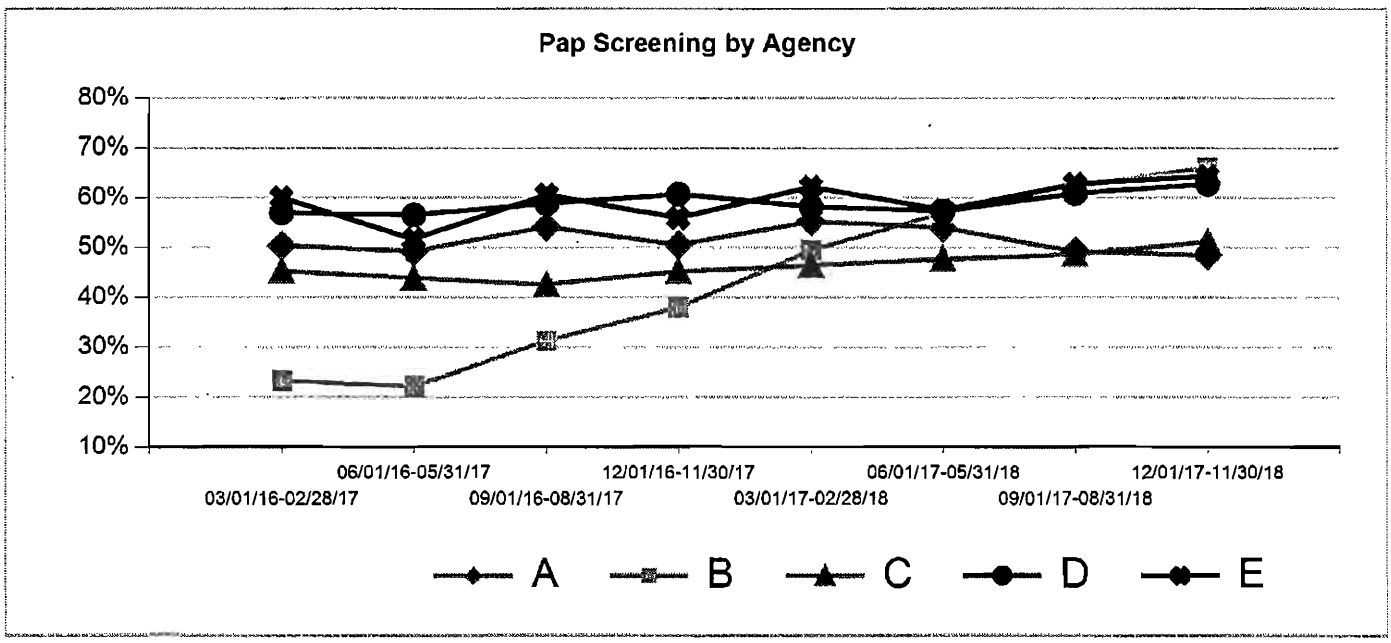
Cervical Cancer Screening				
	03/01/17 - 02/28/18	06/01/17 - 05/31/18	09/01/17 - 08/31/18	12/01/17 - 11/30/18
Number of female clients who had Pap screen results documented in the 3 years previous to the end of the measurement year	942	1,002	1,092	1,130
Number of female clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year	1,830	1,837	1,924	1,924
Percentage	51.5%	54.5%	56.8%	58.7%
Change from Previous Quarter Results	5.4%	3.1%	2.2%	2.0%



Cervical Cancer Screening Data by Race/Ethnicity									
	06/01/17 - 05/31/18			09/01/17 - 08/31/18			12/01/17 - 11/30/18		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of female clients who had Pap screen results documented in the 3 years previous to the end of the measurement year	589	319	75	653	334	84	671	354	83
Number of female clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year	1,124	521	155	1,185	538	159	1,195	534	156
Percentage	52.4%	61.2%	48.4%	55.1%	62.1%	52.8%	56.2%	66.3%	53.2%
Change from Previous Quarter Results	2.9%	4.4%	0.3%	2.7%	0.9%	4.4%	1.0%	4.2%	0.4%



Pap Smear Screening by Agency										
	09/01/17 - 08/31/18					12/01/17 - 11/30/18				
	A	B	C	D	E	A	B	C	D	E
Number of female clients who had Pap screen results documented in the 3 years previous to the end of the measurement year	90	518	192	280	27	89	541	185	296	27
Number of female clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year	183	830	395	460	43	184	819	362	472	42
Percentage	49.2%	62.4%	48.6%	60.9%	62.8%	48.4%	66.1%	51.1%	62.7%	64.3%
Change from Previous Quarter Results	-4.8%	5.5%	1.0%	3.6%	5.3%	-0.8%	3.6%	2.5%	1.8%	1.5%



Footnotes:
1. Table/Chart data for this report run was taken from "ABR152 v3.5.0 6/2/17 [MAI=ALL]", "ABR076A v1.4.1 10/15/15 [ExcludeVL200=yes]", and "ABR163 v2.0.6 4/25/13"
A. OPR Measures used for the ABR152 portions: "Viral Load Suppression", "Linked to Care", "CERV", "Medical Visits - 3 months", and "Viral Load Monitoring"

2019 Ryan White Planning Council

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(Updated 01-28-19)

Red Text = Committee Mentor

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Ted Artiaga, Co-Chair, Comprehensive HIV Planning	

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(Over)

QUEERTY*

US government developing virtual reality simulation for young gay men

By Dan Tracer January 2, 2019 at 1:01pm

The National Institutes of Health is developing a virtual reality experience to help young gay men who've contracted HIV disclose their status to future sex partners.

"Tough Talks" allows users to practice what can be a difficult and necessary conversation — how to tell someone you may not know very well that you're HIV-positive prior to having sex.

In the simulation, characters are able to exhibit and roleplay various emotional states like "anger, fear, rejection, blame, ignorance, curiosity, confusion, support, concern, sympathy, empathy, acceptance, [and] love."

Users are able to practice several scenarios of communication with casual or primary sex partners.

The Georgia-based Tech training company Virtually Better, Inc., along with the University of North Carolina at Chapel Hill and the University of Southern California Institute for Creative Technologies, are creating the simulation in the hopes of opening up pathways of communication.

According to the grant that led to developing the project, 67% of young gay men not adequately disclose their HIV status to first-time partners.

"Given the potential benefits and challenges associated with disclosure, there is a need for sophisticated interventions that can assist [men who have sex with men] MSM, with the disclosure process," the grant reads. "Virtual reality provides a unique environment for users to practice HIV disclosure."

Starting in 2014 under the Obama administration, researchers recruited young men through Craigslist, Grindr and Facebook.

The results of the study were published in July 2018 in a paper titled 'I Didn't Tell You Sooner Because I Didn't Know How to Handle It Myself' and look promising, with participants reporting the simulation helpful.

The project will continue through May 2020.