DRAFT

Houston Area HIV Services Ryan White Planning Council

Quality Improvement Committee

2:00 p.m., Tuesday, November 17, 2020

Meeting Location (please do not come in person): Join Zoom Meeting
https://us02web.zoom.us/j/84732997951?pwd=WDJnOXVNZm13QW0wODFFR1cweXJOZz09
Meeting ID: 847 3299 7951
Passcode: 723748
Or, call in by dialing: 346 248 7799

Agenda

* Indicates that the report will be provided at the meeting

I. Call to Order — Denis Kelly and Pete Rodriguez, Co-Chairs
   A. Moment of Reflection
   B. Adoption of Agenda
   C. Approval of Minutes

II. Public Comment

(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. Committee members are asked to remember that this is a time to hear from the community. It is not a time for dialogue. Committee members and staff are asked to refrain from asking questions of the person giving public comment.)

III. Reports from Ryan White Administrative Agents
   A. Ryan White Part A/MAI: — Carin Martin, RWGA*
   B. Ryan White Part B and State Services — Patrick Martin, TRG**

IV. FY 2021 Standards of Care and Performance Measures — Rebecca Edwards, RWGA*; Patrick Martin, TRG**

V. Old Business
   A. 2020 Joint Meeting
   B. Committee Quarterly Report
   C. Appreciations

VI. Announcements

VII. Adjourn

*RWGA = Ryan White Grant Administration
**TRG = The Resource Group

Houston Area HIV Services Ryan White Planning Council

Quality Improvement Committee
2:00 p.m., Tuesday, August 18, 2020
Meeting location: Zoom teleconference

Minutes

MEMBERS PRESENT	MEMBERS ABSENT	OTHERS PRESENT
Denis Kelly	Ahmier Gibson	Tana Pradia, RWPC Chair
Pete Rodriguez, Co-Chair	Gregory Hamilton	Carin Martin, RWGA
Kevin Aloysius	Daniel Impastato	Rebecca Edwards, RWGA
Tom Lindstrom	Marcely Macias	Tori Williams, Ofc of Support
Karla Mills	Nancy Miertschin, excused	Amber Harbolt, Ofc of Support
Oscar Perez	Cecilia Oshingbade	Diane Beck, Ofc of Support
Deborah Somoye	Angela Rubio	
Crystal Starr	Gloria Sierra	
	Andrew Wilson	

Call to Order: Denis Kelly, Co-Chair, called the meeting to order at 2:02 p.m. and asked for a moment of reflection.

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

Approval of the Minutes: ***Motion #2****: it was moved and seconded (Rodriguez, Mills) to approve the May 7, 2020 committee meeting minutes.* **Motion carried**.

Approval of the Minutes: ***Motion #3****: it was moved and seconded (Rodriguez, Mills) to approve the June 2, 2020 committee meeting minutes.* **Motion carried**. Abstentions: Aloysius, Starr.

Approval of the Minutes: ***Motion #4****: it was moved and seconded (Starr, Rodriguez) to approve the June 30, 2020 committee meeting minutes.* **Motion carried**.

Comments from the Committee Co-Chair: See attached comments from Rodriguez regarding items in the Performance Measure report that did not meet the goal. Edwards explained the reason for the unmet goals for Clinical and Medical Case Management, see attached. Martin said they thought it was just about this specific measure. RWGA will provide the Clinical Quality Improvement (CQI) Committee's quarterly report to the committee. The CQI committee reviews the unmet goals and determines what they can do to improve them. They will meet again in September and December. The committee agreed that this would be helpful.

Public Comment: None.

Reports from the Administrative Agents
Ryan White Part A and MAI: Martin presented the following attached reports:

- FY20 First Quarter Service Utilization, dated 08/11/20
- FY20 RW Part A and MAI Procurement Report, dated 07/16/20 and 08/13/20

Ryan White Part B and State Services: See the following attached reports:

- FY20/21 Part B Procurement Report, dated 06/30/20 and 07/23/20
- FY20/21 Part B Service Utilization Report, dated 08/05/20
- FY19/20 DSHS State Services Procurement Report, dated 06/30/20 and 07/23/20
- FY19/20 DSHS State Services Service Utilization Report, dated 07/02/20
- Health Insurance Service Utilization Report, dated 07/02/20 and 08/03/20

New Business

FY 2020 Assessment of the RW Part A Administrative Mechanism: See attached. ***Motion #5****: it was moved and seconded (Rodriguez, Starr) to accept the attached FY 2020 Assessment of the Ryan White Part A Administrative Mechanism with no action required.* **Motion carried**.

Training: Standards of Care and Performance Measures: Williams offered to provide the training to any members who were not familiar with the process.

Announcements: Williams said that the committee might not need to meet in September.

Adjourn: ***Motion #5****: it was moved and seconded (Starr, Rodriguez) to adjourn the meeting at 2:45 p.m.* **Motion carried**.

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

2020 Quality Improvement Meeting Voting Record for Meeting Date 08/18/20

MEMBERS:	**Motion #1** Agenda				**Motion #2** 05/07/20 Committee Meeting Minutes				**Motion #3** 06/02/20 Committee Meeting Minutes				**Motion #4** 06/30/20 Committee Meeting Minutes				**Motion #5** Assessment of the Admin Mechanism			
	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN
Denis Kelly, Co-Chair				**C**				**C**				**C**				**C**				**C**
Pete Rodriguez, Co- Chair		**X**				**X**				**X**				**X**				**X**		
Kevin Aloysius		**X**				**X**						**X**		**X**				**X**		
Ahmier Gibson	**X**				**X**				**X**				**X**				**X**			
Gregory Hamilton	**X**				**X**				**X**				**X**				**X**			
Tom Lindstrom		**X**				**X**				**X**				**X**				**X**		
Oscar Perez ja 2:13 pm	**X**				**X**				**X**				**X**					**X**		
Gloria Sierra	**X**				**X**				**X**				**X**				**X**			
Crystal Starr		**X**				**X**						**X**		**X**				**X**		
Andrew Wilson	**X**				**X**				**X**				**X**				**X**			
Daniel Impastato	**X**				**X**				**X**				**X**				**X**			
Marcely Macias	**X**				**X**				**X**				**X**				**X**			
Nancy Miertschin	**X**				**X**				**X**				**X**				**X**			
Karla Mills		**X**				**X**				**X**				**X**				**X**		
Cecilia Oshingbade	**X**				**X**				**X**				**X**				**X**			
Angela Rubio	**X**				**X**				**X**				**X**				**X**			
Deborah Somoye lm 2:30 pm		**X**				**X**				**X**				**X**				**X**		

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

FY 2020 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**	**9,869,619**	**201,116**	**413,485**	**0**	**0**	**10,484,220**	**45.77%**	**10,335,560**	**148,660**		**2,683,173**	**26%**	**50%**
1.a	Primary Care - Public Clinic (a)	3,591,064					3,591,064	15.68%	3,591,064	0	3/1/2020	$288,133	8%	50%
1.b	Primary Care - CBO Targeted to AA (a) (e) (f)	952,498		121,162			1,073,660	4.69%	1,073,660	0	3/1/2020	$698,502	65%	50%
1.c	Primary Care - CBO Targeted to Hispanic (a) (e)	798,473		121,162			919,635	4.02%	919,635	0	3/1/2020	$543,608	59%	50%
1.d	Primary Care - CBO Targeted to White/MSM (a) (e)	1,035,846		121,162			1,157,008	5.05%	1,157,008	0	3/1/2020	$221,825	19%	50%
1.e	Primary Care - CBO Targeted to Rural (a) (e)	1,149,761		25,000			1,174,761	5.13%	1,174,761	0	3/1/2020	$534,939	46%	50%
1.f	Primary Care - Women at Public Clinic (a)	1,874,540					1,874,540	8.18%	1,874,540	0	3/1/2020	$209,667	11%	50%
1.g	Primary Care - Pediatric (a.1)	15,437	1,116				16,553	0.07%	16,553	0	3/1/2020	$4,800	29%	50%
1.h	Vision	452,000		25,000			477,000	2.08%	477,000	0	3/1/2020	$181,700	38%	50%
1.x	Primary Care Health Outcome Pilot	0	200,000				200,000	0.87%	51,340	148,660	7/14/2020	$0	0%	50%
2	**Medical Case Management**	**2,185,802**	**-160,051**	**25,000**	**0**	**0**	**2,050,751**	**8.95%**	**2,050,751**	**0**		**680,778**	**33%**	**50%**
2.a	Clinical Case Management	488,656		25,000			513,656	2.24%	513,656	0	3/1/2020	$226,362	44%	50%
2.b	Med CM - Public Clinic (a)	427,722					427,722	1.87%	427,722	0	3/1/2020	$50,549	12%	50%
2.c	Med CM - Targeted to AA (a) (e)	266,070					266,070	1.16%	266,070	0	3/1/2020	$141,212	53%	50%
2.d	Med CM - Targeted to H/L (a) (e)	266,072					266,072	1.16%	266,072	0	3/1/2020	$71,084	27%	50%
2.e	Med CM - Targeted to W/MSM (a) (e)	52,247					52,247	0.23%	52,247	0	3/1/2020	$40,095	77%	50%
2.f	Med CM - Targeted to Rural (a)	273,760					273,760	1.20%	273,760	0	3/1/2020	$78,993	29%	50%
2.g	Med CM - Women at Public Clinic (a)	125,311					125,311	0.55%	125,311	0	3/1/2020	$36,024	29%	50%
2.h	Med CM - Targeted to Pedi (a.1)	160,051	-160,051				0	0.00%	0	0	3/1/2020	$0	#DIV/0!	50%
2.i	Med CM - Targeted to Veterans	80,025					80,025	0.35%	80,025	0	3/1/2020	$26,831	34%	50%
2.j	Med CM - Targeted to Youth	45,888					45,888	0.20%	45,888	0	3/1/2020	$9,628	21%	50%
3	**Local Pharmacy Assistance Program**	**3,157,166**	**0**	**0**	**0**	**0**	**3,157,166**	**13.78%**	**3,157,166**	**0**	3/1/2020	**$689,910**	**22%**	**50%**
3.a	Local Pharmacy Assistance Program-Public Clinic (a) (e)	610,360					610,360	2.66%	610,360	0	3/1/2020	$55,042	9%	50%
3.b	Local Pharmacy Assistance Program-Untargeted (a) (e)	2,546,806					2,546,806	11.12%	2,546,806	0	3/1/2020	$634,868	25%	50%
4	**Oral Health**	**166,404**	**0**	**0**	**0**	**0**	**166,404**	**0.73%**	**166,404**	**0**	3/1/2020	**44,450**	**27%**	**50%**
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					166,404	0.73%	166,404	0	3/1/2020	$44,450	27%	50%
5	**Health Insurance (c)**	**1,339,239**	**43,898**	**0**	**0**	**0**	**1,383,137**	**6.04%**	**1,383,137**	**0**	3/1/2020	**$437,703**	**32%**	**50%**
6	**Mental Health Services (c)**	**0**					**0**	**0.00%**	**0**	**0**	**NA**	**$0**	**0%**	**0%**
7	**Early Intervention Services (c)**	**0**					**0**	**0.00%**	**0**	**0**	**NA**	**$0**	**0%**	**0%**
8	**Home and Community-Based Services (c)**	**0**					**0**	**0.00%**	**0**	**0**	**NA**	**$0**	**0%**	**0%**
9	**Substance Abuse Services - Outpatient**	**45,677**	**0**	**0**	**0**	**0**	**45,677**	**0.20%**	**45,677**	**0**	3/1/2020	**$1,850**	**0%**	**50%**
10	**Medical Nutritional Therapy (supplements)**	**341,395**	**0**	**40,000**	**0**	**0**	**381,395**	**1.67%**	**381,395**	**0**	3/1/2020	**$191,891**	**50%**	**50%**
11	**Hospice Services**	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**	**NA**	**$0**	**0%**	**0%**
12	**Outreach Services**	**420,000**	**0**				**420,000**	**1.83%**	**420,000**	**0**	**3/1/2020**	**$125,118**	**30%**	**50%**
13	**Emergency Financial Assistance**	**525,000**	**0**	**0**	**0**	**0**	**525,000**	**2.29%**	**525,000**	**0**	**3/1/2020**	**$198,261**	**38%**	**50%**
14	**Referral for Health Care and Support Services (c)**	**0**	**0**	**0**			**0**	**0.00%**	**0**	**0**	NA	$0	**0%**	**0%**
15	**Non-Medical Case Management**	**1,381,002**	**0**	**117,000**	**0**	**0**	**1,498,002**	**6.54%**	**1,498,002**	**0**		**486,927**	**33%**	**50%**
15.a	Service Linkage targeted to Youth	110,793					110,793	0.48%	110,793	0	3/1/2020	$21,691	20%	50%
15.b	Service Linkage targeted to Newly-Diagnosed/Not-in-Care	100,000					100,000	0.44%	100,000	0	3/1/2020	$17,141	17%	50%
15.c	Service Linkage at Public Clinic (a)	427,000					427,000	1.86%	427,000	0	3/1/2020	$98,147	23%	50%
15.d	Service Linkage embedded in CBO Pcare (a) (e)	743,209		117,000			860,209	3.76%	860,209	0	3/1/2020	$349,947	41%	50%
16	**Medical Transportation**	**424,911**	**0**	**0**	**0**	**0**	**424,911**	**1.86%**	**424,911**	**0**		**175,518**	**41%**	**50%**
16.a	Medical Transportation services targeted to Urban	252,680					252,680	1.10%	252,680	0	3/1/2020	$120,046	48%	50%
16.b	Medical Transportation services targeted to Rural	97,185					97,185	0.42%	97,185	0	3/1/2020	$55,472	57%	50%
16.c	Transportation vouchering (bus passes & gas cards)	75,046					75,046	0.33%	75,046	0	3/1/2020	$0	0%	0%
17	**Linguistic Services (c)**	**0**					**0**	**0.00%**	**0**	**0**	**NA**	**$0**	**0%**	**0%**
BEU27516	**Total Service Dollars**	**19,856,215**	**84,963**	**595,485**	**0**	**0**	**20,536,663**	**87.83%**	**20,388,003**	**148,660**		**5,715,579**	**28%**	**50%**
	Grant Administration	**1,795,958**	**0**	**0**	**0**	**0**	**1,795,958**	**7.84%**	**1,795,958**	0	**N/A**	**0**	**0%**	**50%**

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

FY 2020 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
BEU27517	HCPHES/RWGA Section	1,271,050		0		0	1,271,050	5.55%	1,271,050	0	N/A		0%	50%
PC	RWPC Support*	524,908			0	0	524,908	2.29%	524,908	0	N/A		0%	50%
BEU27521	**Quality Management**	**412,940**		**0**	**0**	**0**	**412,940**	**1.80%**	**412,940**	**0**	**N/A**		**0%**	**50%**
		22,065,113	**84,963**	**595,485**	**0**	**0**	**22,745,561**	**97.47%**	**22,596,901**	**148,660**		**5,715,579**	**25%**	**50%**
								Unallocated	Unobligated					
	Part A Grant Award:	**22,309,011**	***Carry Over:***	**595,485**		***Total Part A:***	**22,904,496**	**158,935**	**148,660**					

		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)	**17,105,302**	**84,963**	**478,485**	**0**	**0**	**17,668,750**	**86.04%**	**4,290,203**	**81.32%**
	Non-Core (may not exceed 25% of total service dollars)	**2,750,913**	**0**	**117,000**	**0**	**0**	**2,867,913**	**13.96%**	**985,824**	**18.68%**
	Total Service Dollars (does not include Admin and QM)	**19,856,215**	**84,963**	**595,485**	**0**	**0**	**20,536,663**		**5,276,027**	
	Total Admin (must be ≤ 10% of total Part A + MAI)	**1,795,958**	**0**	**0**	**0**	**0**	**1,795,958**	**7.06%**		
	Total QM (must be ≤ 5% of total Part A + MAI)	**412,940**	**0**	**0**	**0**	**0**	**412,940**	**1.62%**		

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**	**1,887,283**	**115,502**	**106,554**	**0**	**0**	**2,109,339**	**86.82%**	**2,109,339**	**0**		**643,775**	**31%**	**50%**
1.b (MAI)	Primary Care - CBO Targeted to African American	954,912	58,441	53,277			1,066,630	43.90%	1,066,630	0	3/1/2020	$365,750	34%	50%
1.c (MAI)	Primary Care - CBO Targeted to Hispanic	932,371	57,061	53,277			1,042,709	42.92%	1,042,709	0	3/1/2020	$278,025	27%	50%
2	**Medical Case Management**	**320,100**	**0**	**0**	**0**	**0**	**320,100**	**13.18%**	**320,100**	**0**		**$63,073**	**20%**	50%
2.c (MAI)	MCM - Targeted to African American	160,050					160,050	6.59%	160,050	0	3/1/2020	$33,768	21%	50%
2.d (MAI)	MCM - Targeted to Hispanic	160,050					160,050	6.59%	160,050	0	3/1/2020	$29,305	18%	50%
	Total MAI Service Funds	**2,207,383**	**115,502**	**106,554**	**0**	**0**	**2,429,439**	**100.00%**	**2,429,439**	**0**		**706,848**	**29%**	**50%**
	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%**
BEQ 27518	**Total MAI Funds**	**2,207,383**	**115,502**	**106,554**	**0**	**0**	**2,429,439**	**100.00%**	**2,429,439**	**0**		**706,848**	**29%**	**50%**
	MAI Grant Award	**2,429,513**	***Carry Over:***	**106,554**		***Total MAI:***	**2,536,067**							
	Combined Part A and MAI Orginial Allocation Total	**24,272,496**												

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

Ryan White Part B, C, D HOPWA and State Services Grant Administrative Agency

RWPC Steering Committee & Council Report

September 2020

1. **Administrative Agency Update**
   a. Houston HSDA RFP Fall 2020
   b. TRG has teamed up with DSHS to participate in the HRSA Centers for Excellence Trauma Informed Approaches Initiative through December 2020.
      - TRG will be conducting a readiness assessment with Subrecipients through the end of 2020.
      - TRG will be presenting on the Six Principles of Trauma informed approaches and how they related to QM this month.
2. **DSHS Funding Ryan White Part B & State Services Update**
   a. **FY20-21 State Services grant (9/1/20-8/31/21) will remain at level funding.**
   b. **DSHS Emergency Eligibility**
      - DSHS has extended the Emergency Eligibility Process until December 2020 for HIV Services and THMP. The application will be modified to a 2-page application process starting September 1, 2020.
   c. **EIS Workgroup**
      - **Linkage Dialogue with the Community:** No update.
      - **Implementation Workgroup:** SOC approved by DSHS. Full implementation as of September 1st. Assessment Form and Data Reporting being revised.
   d. **Houston ADAP Enrollment Workers**:

      DSHS THMP Trainings
      - THMP training site https://www.dshs.texas.gov/hivstd/training/meds.shtm
      - THMP is outreaching to any client that have not certified since March 2020. No clients are being dropped from the program.
      - THMP continuing to encourage 90-scripts, but automatically giving 60-day scripts

      TRG has filled the Regional ADAP Liaison position
      - New Regional ADAP/Eligibility Liaison
        Haley Malcolm started 7/6/2020

Contact Information
The Resource Group, Inc.
713-526-1016 or www.hivtrg.org
Patrick L. Martin, Program Development Director
plmartin@hivtrg.org
Sha'Terra Johnson, LMSW, Health Planner
sjohnson@hivtrg.org

Ryan White Part B, C, D HOPWA and State Services Grant Administrative Agency

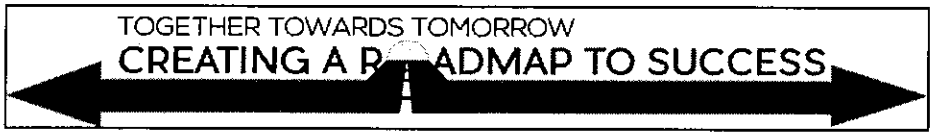
Contact email hmalcolm@hivtrg.org

- Houston AEW Updates: No changes

3. **HRSA Funding Ryan White Part D**
   a. **The Positive VIBE Project (PVP) of Houston and Galveston Update (Ryan White Part D)**
      - The new contract year has started. PVP has one provider who has elected not to continue.
      - Patient Navigation will expand this year.
      - TRG will be requesting carryover.
4. **DSHS Funding HOPWA**
   a. **HOPWA in Houston HSDA**
      - The new grant period starts 9/1/20-8/31/21.
      - Reminder: Access Health has TBRA and STRMU (serves 5 outlying counties)
   b. **HOPWA Bridge Re-Entry Initiative (BRI) Project with AIDS Foundation Houston**
      - HOPWA COVID funding ended 8/31/2020
      - BRI program continues to provide hotel/motel assistance (available) and transitional housing (waitlist exists)

Contact Information
The Resource Group, Inc.
713-526-1016 or www.hivtrg.org
Patrick L. Martin, Program Development Director
plmartin@hivtrg.org
Sha'Terra Johnson, LMSW, Health Planner
sjohnson@hivtrg.org

Ryan White Part B, C, D HOPWA and State Services Grant Administrative Agency



Community Initiatives

1. **Serving the Recently Released and Incarcerated**
   a. The August SIRR Meeting was cancelled. The September meeting will focus on Systemic Racism Discussion.
   b. To be added to the distribution list for meeting announcements, contact Felicia Booker fbooker@hivtrg.org
2. **Youth Transition Summit**
   a. No update.
3. **Texas Black Women's Health Initiative (TxBWHI) Houston Team**
   a. Next monthly meeting will be 7/16/2020 at 6 pm @ 500 Via Zoom ID 410-248-849
   b. Contact Sha'Terra Johnson tbwihouston@gmail.com
4. **END HIV Houston**
   a. Contact Crystal Townsend ctownsend@hivtrg.org

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The Houston Regional HIV/AIDS Resource Group, Inc.

FY 1920 DSHS State Services

Procurement Report

September 1, 2019- August 31, 2020

Chart reflects spending through June 2020

Spending Target: 83.33%

Revised 8/26/2020

Priority	Service Category	Original Allocation per RWPC	% of Grant Award	Amendments per RWPC	Contractual Amount	Amendment	Contractual Amount	Date of Original Procurement	Expended YTD	Percent YTD
5	**Health Insurance Premiums and Cost Sharing (1)**	$864,506	43%	**$0**	$864,506	$0	$864,506	9/1/2019	$679,278	79%
6	**Mental Health Services (2)**	$300,000	15%	**$0**	$300,000	$0	$300,000	9/1/2019	$121,018	40%
7	**EIS - Incarcerated**	$175,000	9%	**$0**	$175,000	$0	$175,000	9/1/2019	$131,679	75%
11	**Hospice (3)**	$259,832	13%	**$0**	$259,832	$0	$259,832	9/1/2019	$249,920	96%
	Non Medical Case Management (4)	$350,000	17%	**$0**	$350,000	$0	$350,000	9/1/2019	$195,428	56%
15	**Linguistic Services (5)**	$68,000	3%	**$0**	$68,000	$0	$68,000	9/1/2019	$42,375	62%
	Increased award amount -Approved by RWPC for Health Insurance (a)	$0	0%	**-$142,285**						
	Total Houston HSDA	**2,017,338**	**100%**	**-$142,285**	$2,017,338	$0	$1,667,338		1,419,697	85%

Note

(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

(2) Mental Health reporting services utilization is down and additional back billing has not been submitted. In addition some groups have been suspended for the first two months of COVID.

(3) Hospice- There has been an continuous increase in

(4) N-Medical Case Management service utilization has decreased due to the interruption of COVID. Service is also behind one month of submitting billing.

(5) Linguistic- service utilization has decreased due to the interruption of COVID.

The Houston Regional HIV/AIDS Resource Group, Inc.

FY 2021 Ryan White Part B

Procurement Report

April 1, 2020 - March 31, 2021

Reflects spending through June 2020

Spending Target: 25.0%

Revised 8/26/20

Priority	Service Category	Original Allocation per RWPC	% of Grant Award	Amendment*	Contractual Amount	Amendment	Contractual Amount	Date of Original Procurement	Expended YTD	Percent YTD
4	Oral Health Care (1)	$1,758,878	52%	$0	$1,758,878	$0	$1,758,878	4/1/2020	$186,700	11%
	Oral Health Care -Prosthodontics	$460,000	14%	$0	$460,000	$0	$460,000	4/1/2020	$78,822	17%
5	Health Insurance Premiums and Cost Sharing (2)	$1,028,433	31%	$0	$1,028,433	$0	$1,028,433	4/1/2020	$105,489	10%
8	Home and Community Based Health Services	$113,315	3%	$0	$113,315	$0	$113,315	4/1/2020	$24,080	21%
	Increased RWB Award added to OHS per Increase Scenario*	$0	0%	$0	$0					
	Total Houston HSDA	3,360,626	100%	0	3,360,626	$0	$2,900,626		395,091	14%

Note: Spending variances of 10% of target will be addressed:

(1) OHC- service utilization has decreased due to the interruption of COVID.

(2) 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

Houston Ryan White Health Insurance Assistance Service Utilization Report

Period Reported: 09/01/2019-7/31/20

Revised: 9/2/2020

	Assisted			NOT Assisted		
Request by Type	Number of Requests (UOS)	*Dollar Amount of Requests*	Number of Clients (UDC)	*Number of Requests (UOS)*	*Dollar Amount of Requests*	*Number of Clients (UDC)*
Medical Co-Payment	1932	$172,288.60	829			*0*
Medical Deductible	129	$20,904.36	111			*0*
Medical Premium	6525	$2,390,090.28	802			*0*
Pharmacy Co-Payment	17201	$557,113.50	1468			*0*
APTC Tax Liability	1	$500.00	1			*0*
Out of Network Out of Pocket	0	$0.00	0			*0*
ACA Premium Subsidy Repayment	17	$1,614.02	9	*NA*	*NA*	*NA*
Totals:	25805	$3,139,282.72	3220	0	$0.00	

Comments: This report represents services provided under all grants.

Umair A. Shah, M.D., M.P.H.
Executive Director

Harris County
Public Health
Building a Healthy Community

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2021-2022 Houston EMA: RWGA Part A Standards of Care for HIV Services Ryan White Grant Administration Section SUMMARY OF PROPOSED CHANGES AS OF 10/15/2020

*= Initiated based on feedback received from RWPC

ISSUE	LOCATION	CURRENT	PROPOSED
***Clarify requirements of communication pathways to specify plan for clients**	General Standards 7.3 Emergency Management	"The emergency preparedness plan shall address the six critical areas for emergency management including • Communication pathways • Essential resources and assets…"	"The emergency preparedness plan shall address the six critical areas for emergency management including • Communication pathways (for both clients and staff) • Essential resources and assets…"
Addition of Emergency Financial Assistance- Other	N/A	N/A	SEE ATTACHMENT
Reduce unnecessary burden on CCM when not indicated as necessary by assessment	Clinical Case Management 2.3	"Case conferences must at a minimum include the clinical case manager; mental health/counselor and/or medical case manager and occur at least every three (3) months for the duration of Clinical Case Management services."	"Case conferences must at a minimum include the clinical case manager; mental health/counselor and/or medical case manager and occur at least every six (6) months or more often if clinically indicated for the duration of Clinical Case Management services."

Harris County
Public Health
Building a Healthy Community

2021~~1~~–2022~~2~~ HOUSTON ELIGIBLE METROPOLITAN AREA: RYAN WHITE CARE ACT PART A
STANDARDS OF CARE FOR HIV SERVICES
RYAN WHITE GRANT ADMINISTRATION SECTION
HARRIS COUNTY PUBLIC HEALTH (HCPH)

TABLE OF CONTENTS

Introduction

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

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

Scope
The Houston EMA SOCs apply to Part A funded HRSA defined core and support services including the following services in FY 2020-2021:

- *Primary Medical Care*
- *Vision Care*
- *Medical Case Management*
- *Clinical Case Management*
- *Local AIDS Pharmaceutical Assistance Program (LPAP)*
- *Oral Health*
- ***Health Insurance Assistance***
- Hospice Care
- Mental Health Services
- *Substance Abuse services*
- Home & Community Based Services (Facility-Based)
- Early Intervention Services
- *Medical Nutrition Supplement*
- *Outreach*
- *Non-Medical Case Management (Service Linkage)*
- *Transportation*
- Linguistic Services
- *Emergency Financial Assistance*
- Referral for Healthcare & Support Services

Part A funded services
Combination of Parts A, B, and/or Services funding

Standards Development
The first group of standards was developed in 1999 following HRSA requirements for sub grantees to implement monitoring systems to ensure subcontractors complied with contract requirements. Subsequently, the RWGA facilitates annual work group meetings to review the standards and to make

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

applicable changes. Workgroup participants include physicians, nurses, case managers and executive staff from subcontractor agencies as well as consumers.

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

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

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

GENERAL STANDARDS

	Standard	Measure
1.0	**Staff Requirements**	
1.1	Staff Screening (Pre-Employment) Staff providing services to clients shall be screened for appropriateness by provider agency as follows: • Personal/Professional references • Personal interview • Written application Criminal background checks, if required by Agency Policy, must be conducted prior to employment and thereafter for all staff and/or volunteers per Agency policy.	• Review of Agency's Policies and Procedures Manual indicates compliance • Review of personnel and/or volunteer files indicates compliance
1.2	Initial Training: Staff/Volunteers Initial training includes eight (8) hours of: HIV basics, safety issues (fire & emergency preparedness, hazard communication, infection control, universal precautions), confidentiality issues, role of staff/volunteers (e.g. job description), agency-specific information (e.g. Drug Free Workplace policy) and customer service training must be completed within 60 days of hire. https://www.sba.gov/course/customer-service/	• Documentation of all training in personnel file. • Specific training requirements are specified in Agency Policy and Procedure • Materials for staff training and continuing education are on file • Staff interviews indicate compliance
1.3	Staff Performance Evaluation Agency will perform annual staff performance evaluation.	• Completed annual performance evaluation kept in employee's file • Signed and dated by employee and supervisor (includes electronic signature)
1.4	Cultural and HIV Mental Health Co-morbidity Competence Training/Staff and Volunteers All staff tenured 0 – 5 year with their current employer must receive four (4) hours of cultural competency training to include information on working with people of all races, ethnicities, nationalities, gender identities, and sexual orientations and an	• Documentation of training is maintained by the agency in the personnel file

	additional one (1) hour of HIV/Mental Health co-morbidity sensitivity training annually. All new employees must complete these within ninety (90) days of hire. All staff with greater than 5 years with their current employer must receive two (2) hours of cultural competency training and an additional one (1) hour of HIV/Mental Health co-morbidity sensitivity training annually.	
1.5	Required trainings offered through RWGA For required trainings that RWGA offers (IPV, Cultural Competency, and Field Safety), Agency must request a waiver for agency-based training alternative that meets or exceeds the RWGA requirements.	• RWGA Waiver is approved prior to Agency utilizing agency-based training curriculum
1.6	Staff education on eligibility determination and fee schedule Agency must provide training on agency's policies and procedures for eligibility determination and sliding fee schedule for, but not limited to, case managers, and eligibility & intake staff annually. All new employees must complete within ninety (90) days of hire.	• Documentation of training in employee's record
2.0	**Services utilize effective management practices such as cost effectiveness, human resources and quality improvement.**	
2.1	Service Evaluation Agency has a process in place for the evaluation of client services.	• Review of Agency's Policies and Procedures Manual indicates compliance • Staff interviews indicate compliance.
2.2	Subcontractor Monitoring Agency that utilizes a subcontractor in delivery of service, must have established policies and procedures on subcontractor monitoring that include: • Fiscal monitoring • Program • Quality of care • Compliance with guidelines and standards Reviewed Annually	• Documentation of subcontractor monitoring • Review of Agency's Policies and Procedures Manual indicates compliance
2.3	Staff Guidelines Agency develops written guidelines for staff, which include, at a minimum, agency-specific policies and procedures (staff selection, resignation and	• Personnel file contains a signed statement acknowledging that staff guidelines were reviewed and that the

	termination process, and position descriptions); client confidentiality; health and safety requirements; complaint and grievance procedures; emergency procedures; and statement of client rights; staff must review these guidelines annually	employee understands agency policies and procedures
2.4	Work Conditions Staff/volunteers have the necessary tools, supplies, equipment and space to accomplish their work.	• Inspection of tools and/or equipment indicates that these are in good working order and in sufficient supply • Staff interviews indicate compliance
2.5	Staff Supervision Staff services are supervised by a paid coordinator or manager.	• Review of personnel files indicates compliance • Review of Agency's Policies and Procedures Manual indicates compliance
2.6	Professional Behavior Staff must comply with written standards of professional behavior.	• Staff guidelines include standards of professional behavior • Review of Agency's Policies and Procedures Manual indicates compliance • Review of personnel files indicates compliance • Review of agency's complaint and grievance files
2.7	Communication There are procedures in place regarding regular communication with staff about the program and general agency issues.	• Review of Agency's Policies and Procedures Manual indicates compliance • Documentation of regular staff meetings • Staff interviews indicate compliance
2.8	Accountability There is a system in place to document staff work time.	• Staff time sheets or other documentation indicate compliance

2.9	Staff Availability Staff are present to answer incoming calls during agency's normal operating hours.	• Published documentation of agency operating hours • Staff time sheets or other documentation indicate compliance
3.0	**Clients Rights and Responsibilities**	
3.1	Clients Rights and Responsibilities Agency reviews Client Rights and Responsibilities Statement with each client in a language and format the client understands. Agency provides client with written copy of client rights and responsibilities, including: • Informed consent • Confidentiality • Grievance procedures • Duty to warn or report certain behaviors • Scope of service • Criteria for end of services	• Documentation in client's record
3.2	Confidentiality Agency maintains Policy and Procedure regarding client confidentiality in accordance with RWGA site visit guidelines, local, state and federal laws. Providers must implement mechanisms to ensure protection of clients' confidentiality in all processes throughout the agency. There is a written policy statement regarding client confidentiality form signed by each employee and included in the personnel file.	• Review of Agency's Policies and Procedures Manual indicates compliance • Clients interview indicates compliance • Agency's structural layout and information management indicates compliance • Signed confidentiality statement in each employee's personnel file
3.3	Consents All consent forms comply with state and federal laws, are signed by an individual legally able to give consent and must include the Consent for Services form and a consent for release/exchange of information for every individual/agency to whom client identifying information is disclosed, regardless of whether or not HIV status is revealed.	• Agency Policy and Procedure and signed and dated consent forms in client record

3.4	Up to date Release of Information Agency obtains an informed written consent of the client or legally responsible person prior to the disclosure or exchange of certain information about client's case to another party (including family members) in accordance with the RWGA Site Visit Guidelines, local, state and federal laws. The release/exchange consent form must contain: • Name of the person or entity permitted to make the disclosure • Name of the client • The purpose of the disclosure • The types of information to be disclosed • Entities to disclose to • Date on which the consent is signed • The expiration date of client authorization (or expiration event) no longer than two years • Signature of the client/or parent, guardian or person authorized to sign in lieu of the client. • Description of the *Release of Information*, its components, and ways the client can nullify it Release/exchange of information forms must be completed entirely in the presence of the client. Any unused lines must have a line crossed through the space.	• Current Release of Information form with all the required elements signed by client or authorized person in client's record
3.5	Grievance Procedure Agency has Policy and Procedure regarding client grievances that is reviewed with each client in a language and format the client can understand and a written copy of which is provided to each client. Grievance procedure includes but is not limited to: • to whom complaints can be made • steps necessary to complain • form of grievance, if any • time lines and steps taken by the agency to resolve the grievance • documentation by the agency of the process, including a standardized grievance/complaint form available in a language and format understandable to the client • all complaints or grievances initiated by clients are documented on the Agency's standardized form	• Signed receipt of agency Grievance Procedure, filed in client chart • Review of Agency's Policies and Procedures Manual indicates compliance • Review of Agency's Grievance file indicates compliance, • Source Citation: HAB Monitoring Standards; Part l: Universal Standards; Section A: Access to Care #2

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

3.8	Client Feedback In addition to the RWGA standardized client satisfaction survey conducted on an ongoing basis (no less than annually), Agency must have structured and ongoing efforts to obtain input from clients (or client caregivers, in cases where clients are unable to give feedback) in the design and delivery of services. Such efforts may include client satisfaction surveys, focus groups and public meetings conducted at least annually. Agency may also maintain a visible suggestion box for clients' inputs. Analysis and use of results must be documented. Agency must maintain a file of materials documenting Consumer Advisory Board (CAB) membership and meeting materials (applicable only if agency has a CAB). • Agencies that serve an average of 100 or more unduplicated clients monthly under combined RW/A, MAI, RW/B and SS funding must implement a CAB. The CAB must meet regularly (at least 4 times per year) at a time and location conducive to consumer participation to gather, support and encourage client feedback, address issues which impact client satisfaction with services and provide Agency with recommendations to improve service delivery, including accessibility and retention in care.	• Documentation of clients' evaluation of services is maintained • Documentation of CAB and public meeting minutes • Documentation of existence and appropriateness of a suggestion box or other client input mechanism • Documentation of content, use, and confidentiality of a client satisfaction survey or focus groups conducted annually • Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #1
3.9	Patient Safety (Core Services Only) Agency shall establish mechanisms to implement National Patient Safety Goals (NPSG) modeled after the current Joint Commission accreditation *for Ambulatory Care* (www.jointcommission.org) to ensure patients' safety. The NPSG to be addressed include the following as applicable: • "Improve the accuracy of patient identification • Improve the safety of using medications • Reduce the risk of healthcare-associated infections • Accurately and completely reconcile medications across the continuum of care • Universal Protocol for preventing Wrong Site, Wrong Procedure and Wrong Person Surgery" (www.jointcommission.org)	• Review of Agency's Policies and Procedures Manual indicates compliance
3.10	Client Records Provider shall maintain all client records.	• Review of agency's policy and procedure for records administration indicates compliance

4.0	**Accessibility**	
4.1	Cultural Competence Agency demonstrates a commitment to provision of services that are culturally sensitive and language competent for Limited English Proficient (LEP) individuals and people of all gender identities and sexual orientations	• Agency has procedures for obtaining translation services • Client satisfaction survey indicates compliance • Policies and procedures demonstrate commitment to the community and culture of the clients • Availability of interpretive services, bilingual staff, and staff trained in cultural competence • Agency has vital documents including, but not limited to applications, consents, complaint forms, and notices of rights translated in client record • Agency has facilities available for consumers of all gender identities, including gender-neutral restrooms.
4.2	Client Education Agency demonstrates capacity for client education and provision of information on community resources	• Availability of the blue book and other educational materials • Documentation of educational needs assessment and client education in clients' records
4.3	Special Service Needs Agency demonstrates a commitment to assisting individuals with special needs	• Agency compliance with the Americans with Disabilities Act (ADA). • Review of Policies and Procedures indicates compliance • Environmental Review shows a facility that is handicapped accessible
4.4	Provision of Services for low-Income Individuals Agency must ensure that facility is handicap accessible and is also accessible by public transportation (if in area served by METRO). Agency must have policies and procedures in place that ensures access to transportation services if facility is not accessible by public transportation. Agency should not have policies that dictate a dress code or conduct that may act as barrier to care for low income individuals.	• Facility is accessible by public transportation • Review of Agency's Policies and Procedures Manual indicates compliance

		• Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #4
4.5	Proof of HIV Diagnosis Documentation of the client's HIV status is obtained at or prior to the initiation of services or registration services. An anonymous test result may be used to document HIV status temporarily (up to sixty [60] days). It must contain enough information to ensure the identity of the subject with a reasonable amount of certainty.	• Documentation in client record as per RWGA site visit guidelines or TRG Policy SG-03 • Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #3
4.6	Provision of Services Regardless of Current or Past Health Condition Agency must have Policies and Procedures in place to ensure that clients living with HIV are not denied services due to current or pre-existing health condition or non-HIV related condition. A file must be maintained on all clients who are refused services and the reason for refusal.	• Review of Policies and Procedures indicates compliance • A file containing information on clients who have been refused services and the reasons for refusal • Source Citation: HAB Program Standards; Section D: #1
4.7	Client Eligibility In order to be eligible for services, individuals must meet the following: • HIV+ • Residence in the Houston EMA/ HSDA (With prior approval, clients can be served if they reside outside of the Houston EMA/HSDA.) • Income no greater than 300% of the Federal Poverty level (unless otherwise indicated) • Proof of identification • Ineligibility for third party reimbursement	• Documentation of HIV+ status, residence, identification and income in the client record • Documentation of ineligibility for third party reimbursement • Documentation of screening for Third Party Payers in accordance with RWGA site visit guidelines • Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section B:Eligibility Determination/Screening #1
4.8	Re-certification of Client Eligibility Agency conducts six (6) month re-certification of eligibility for all clients. At a minimum, agency confirms an individual's income, residency and re-screens, as	• Client record contains documentation of re-certification of client residence,

	appropriate, for third-party payers. Third party payers include State Children's Health Insurance Programs (SCHIP), Medicare (including Part D prescription drug benefit) and private insurance. At one of the two required re-certifications during a year, agency may accept client self-attestation for verifying that an individual's income, residency, and insurance status complies with the RWGA eligibility requirements. Appropriate documentation is required for changes in status and at least once a year (defined as a 12-month period) with renewed eligibility with the CPCDMS. Agency must ensure that Ryan White is the Payer of last resort and must have policies and procedures addressing strategies to enroll all eligible uninsured clients into Medicare, Medicaid, private health insurance and other programs. Agency policy must also address coordination of benefits, billing and collection. Clients eligible for Department of Veterans Affairs (VA) benefits are duly eligible for Ryan White services and therefore exempted from the payer of last resort requirement. • Agency must verify 3rd party payment coverage for eligible services at every visit or monthly (whichever is less frequent)	income and rescreening for third party payers at least every six (6) months • Review of Policies and Procedures indicates compliance • Information in client's files that includes proof of screening for insurance coverage (i.e. hard/scanned copy of results) • Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section B:Eligibility Determination/Screening #1 and #2 • Source Citation: HIV/AIDS Bureau (HAB) Policy Clarification Notice #13-02
4.9	Charges for Services Agency must institute Policies and Procedures for cost sharing including enrollment fees, premiums, deductibles, co-payments, co-insurance, sliding fee discount, etc. and an annual cap on these charges. Agency should not charge any of the above fees regardless of terminology to any Ryan White eligible patient whose gross income level (GIL)is ≤ 100% of the Federal Poverty Level (FPL) as documented in the CPCDMS for any services provided. Clients whose gross income is between 101-300% may be charged annual aggregate fees in accordance with the legislative mandate outlined below: • 101%-200% of FPL---5% or less of GIL • 201%-300% of FPL---7% or less of GIL • >300% of FPL ---------10% or less of GIL Additionally, agency must implement the following: • Six (6) month evaluation of clients to establish individual fees and cap (i.e. the six (6) month CPCDMS registration or registration update.) • Tracking of charges • A process for alerting the billing system when the cap is reached so client will not be charged for the rest of the calendar year. • Documentation of fees	• Review of Policies and Procedures indicates compliance • Review of system for tracking patient charges and payments indicate compliance • Review of charges and payments in client records indicate compliance with annual cap • Sliding fee application forms on client record is consistent with Federal guidelines

4.10	Information on Program and Eligibility/Sliding Fee Schedule Agency must provide broad-based dissemination of information regarding the availability of services. All clients accessing services must be provided with a clear description of their sliding fee charges in a simple understandable format at intake and annually at registration update. Agency should maintain a file documenting promotion activities including copies of HIV program materials and information on eligibility requirements. Agency must proactively inform/educate clients when changes occur in the program design or process, client eligibility rules, fee schedule, facility layout or access to program or agency.	• Agency has a written substantiated annual plan to targeted populations • Zip code data show provider is reaching clients throughout service area (as applicable to specific service category). • Agency file containing informational materials about agency services and eligibility requirements including the following: Brochures Newsletters Posters Community bulletins any other types of promotional materials • Signed receipt for client education/ information regarding eligibility and sliding fees on client record • Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #5
4.11	Linkage Into Core Services Agency staff will provide out-of-care clients with individualized information and referral to connect them into ambulatory outpatient medical care and other core medical services.	• Documentation of client referral is present in client record • Review of agency's policies & procedures' manual indicates compliance
4.12	Wait Lists It is the expectation that clients will not be put on a Wait List nor will services be postponed or denied. Agency must notify the Administrative agency when funds for service are either low or exhausted for appropriate measures to be taken to ensure adequate funding is available. Should a wait list become required, the agency must, at a minimum, develop a policy that addresses how they will handle situations where service(s) cannot be immediately provided and a process by which client information will be obtained and maintained to ensure that all clients	• Review of Agency's Policies and Procedures Manual indicates compliance • Documentation that agency notified their Administrative Agency when funds for services were either low or exhausted

	that requested service(s) are contacted after service provision resumes. A wait list is defined as a roster developed and maintained by providers of patients awaiting a particular service when a demand for a service exceeds available appointments used on a first come next serviced method. The Agency will notify RWGA of the following information when a wait list must be created: An explanation for the cessation of service; and A plan for resumption of service. The Agency's plan must address: • Action steps to be taken Agency to resolve the service shortfall; and • Projected date that services will resume. The Agency will report to RWGA in writing on a monthly basis while a client wait list is required with the following information: • Number of clients on the wait list. • Progress toward completing the plan for resumption of service. • A revised plan for resumption of service, if necessary.	
4.13	Intake The agency conducts an intake to collect required data including, but not limited to, eligibility, appropriate consents and client identifiers for entry into CPCDMS. Intake process is flexible and responsive, accommodating disabilities and health conditions. In addition to office visits, client is provided alternatives such as conducting business by mail, online registration via the internet, or providing home visits, when necessary. Agency has established procedures for communicating with people with hearing impairments.	• Documentation in client record • Review of Agency's Policies and Procedures Manual indicates compliance
5.0	**Quality Management**	
5.1	Continuous Quality Improvement (CQI) Agency demonstrates capacity for an organized CQI program and has a CQI Committee in place to review procedures and to initiate Performance Improvement activities. The Agency shall maintain an up-to-date Quality Management (QM) Manual. The QM Manual will contain at a minimum: • The Agency's QM Plan	• Review of Agency's Policies and Procedures Manual indicates compliance • Up to date QM Manual • Source Citation: HAB Universal Standards; Section F: #2

	• Meeting agendas and/or notes (if applicable) • Project specific CQI Plans • Root Cause Analysis & Improvement Plans • Data collection methods and analysis • Work products • QM program evaluation • Materials necessary for QM activities	
5.2	Data Collection and Analysis Agency demonstrates capacity to collect and analyze client level data including client satisfaction surveys and findings are incorporated into service delivery. Supervisors shall conduct and document ongoing record reviews as part of quality improvement activity.	• Review of Agency's Policies and Procedures Manual indicates compliance • Up to date QM Manual • Supervisors log on record reviews signed and dated • Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #2
6.0	**Point Of Entry Agreements**	
6.1	Points of Entry (Core Services Only) Agency accepts referrals from sources considered to be points of entry into the continuum of care, in accordance with HIV Services policy approved by HRSA for the Houston EMA.	• Review of Agency's Policies and Procedures Manual indicates compliance • Documentation of formal agreements with appropriate Points of Entry • Documentation of referrals and their follow-up
7.0	**Emergency Management**	
7.1	Emergency Preparedness Agency leadership including medical staff must develop an Emergency Preparedness Plan modeled after the Joint Commission's regulations and/or Centers for Medicare and Medicaid guidelines for Emergency Management. The plan should, at a minimum utilize "all hazard approach" (hurricanes, floods, earthquakes, tornadoes, wide-spread fires, infectious disease outbreak and other public health threats, terrorist attacks, civil disturbances and collapse of buildings and bridges) to ensure a level of preparedness sufficient to support a range of	• Emergency Preparedness Plan • Review of Agency's Policies and Procedures Manual indicates compliance

	emergencies. Agencies shall conduct an annual Hazard Vulnerability Analysis (HVA) to identify potential hazards, threats, and adverse events and assess their impact on care, treatment, and services they must sustain during an emergency. The agency shall communicate hazards identified with its community emergency response agencies and together shall identify the capability of its community in meeting their needs. The HVA shall be reviewed annually.	
7.2	Emergency Management Training In accordance with the Department of Human Services recommendations, all applicable agency staff (such as, executive level, direct client services, supervisory staff) must complete the following National Incident Management System (NIMS) courses developed by the Department of Homeland Security: • IS -100.HC – Introduction to the Incident command system for healthcare/hospitals • IS-200.HC- Applying ICS to Healthcare organization • IS-700.A-National Incident Management System (NIMS) Introduction • IS-800.B National Response Framework (management) The above courses may be accessed at: training.fema.gov/nims/ . Agencies providing support services only may complete alternate courses listed for the above areas All applicable new employees are required to complete the courses within 90 days of hire.	• Agency criteria used to determine appropriate staff for training requirement • Documentation of all training including certificate of completion in personnel file
7.3	Emergency Preparedness Plan The emergency preparedness plan shall address the six critical areas for emergency management including • Communication ~~pathways~~pathways (for both clients and staff) • Essential resources and assets • patients' safety and security • staff responsibilities • Supply of key utilities such as portable water and electricity • Patient clinical and support activities during emergency situations. (www.jointcommission.org)	• Emergency Preparedness Plan
7.4	Emergency Management Drills Agency shall implement emergency management drills twice a year either in response to actual emergency or in a planned exercise. Completed exercise should be evaluated by a multidisciplinary team including administration, clinical and	• Emergency Management Plan • Review of Agency's Policies and Procedures Manual indicates compliance

	support staff. The emergency plan should be modified based on the evaluation results and retested.	
8.0	**Building Safety**	
8.1	Required Permits All agencies will maintain Occupancy and Fire Marshal's permits for the facilities.	• Current required permits on file

SERVICE SPECIFIC STANDARDS OF CARE

Case Management (All Case Management Categories)

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

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

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

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

1.2	Required Training for New Employees Within the first ninety (90) days of employment in the case management system, case managers will successfully complete HIV Case Management 101 2013 Update, through the State of Texas TRAIN website (https://tx.train.org) with a minimum of 70% accuracy. RWGA expects HIV Case Management 101 2013 Update, course completion to take no longer than 16 hours. Within the first six (6) months of employment, case managers will complete at least four (4) hours review of Community resources, and at least four (4) hours cultural competency training offered by RWGA. Mandatory Intimate Partner Violence Training is Required annually and during orientation for all Ryan White Part A funded, primary care co-located, case management staff (SLW, MCM, CCM). RWGA will host two (2) IPV training opportunities annually. Staff who provide field-based services should receive at least two (2) hours of field safety training within their first six (6) months of employment. For required trainings that RWGA offers (IPV, Cultural Competency, and Field Safety), Agency must request a waiver for agency based training alternative that meets or exceeds the RWGA requirements for the first year training for case management staff.	• Certificates of completion for applicable trainings in the case manager's file • Sign-in sheets for agency based trainings maintained by Agency • RWGA Waiver is approved prior to Agency utilizing agency-based training curriculum
1.3	Certified Application Counselor (CAC) Training & Certification Within the first ninety (90) days of employment in the case management system, applicable case managers will successfully complete CAC training. Applicable case management staff must maintain CAC certification by their Certificated Application Counselor Designated Organization employer annually. RWGA expects CAC training completion to take no longer than 6 hours.	• Certificates of completion in case manager's file
1.4	Case Management Supervisor Peer-led Training Supervisory Training: On an annual basis, Part A/B-funded clinical supervisors of Medical, Clinical and Community (SLW) Case Managers must fully participate in the four (4) Case Management Supervisor Peer-Led three-hour training curriculum conducted by RWGA.	• Review of attendance sign-in sheet indicates compliance
1.5	Child Abuse Screening, Documenting and Reporting Training Case Managers are trained in the agency's policy and procedure for determining, documenting and reporting instances of abuse, sexual or nonsexual, in	• Documentation of staff training

	accordance with the DSHS Child Abuse Screening, Documenting and Reporting Policy prior to patient interaction.	
1.6	Warm Handoff Procedure Agency must have policies and procedures in place that ensures a warm handoff for clients within the healthcare system. A warm handoff is applicable when a transfer of care between two members of the health care team needs to take place, i.e. medical case manager to primary care provider, and transitions between agencies. Warm handoff policy should be consistent with AHRQ Warm Handoff guidelines.	• Agency has a warm handoff policy to specify procedures and appropriate patient population(s) for conducting a warm handoff
2.0	**Timeliness of Services**	
2.1	Initial Case Management Contact Contact with client and/or referring agent is attempted within one working day of receiving a case assignment. If the case manager is unable to make contact within one (1) working day, this is documented and explained in the client record. Case manager should also notify their supervisor. All subsequent attempts are documented.	• Documentation in client record
2.2	Progress Notes All case management activities, including but not limited to all contacts and attempted contacts with or on behalf of clients are documented in the client record within 72 business hours of their occurrence.	• Legible, signed and dated documentation in client record. • Documentation of time expended with or on behalf of patient in progress notes
2.3	Client Referral and Tracking Agency will have policies and procedures in place for referral and follow-up for clients with medical conditions, nutritional, psychological/social and financial problems. The agency will maintain a current list of agencies that provide primary medical care, prescription medications, assistance with insurance payments, dental care, transportation, nutritional counseling and supplements, support for basic needs (rent, food, financial assistance, etc.) and other supportive services (e.g. legal assistance, partner elicitation services and Client Risk Counseling Services (CRCS). The Case Manager will: • Initiate referrals within two (2) weeks of the plan being completed and agreed upon by the Client and the Case Manager • Work with the Client to determine barriers to referrals and facilitate access to referrals • Utilize a tracking mechanism to monitor completion of all case	• Review of Agency's Policies and Procedures Manual indicates compliance • Documentation of follow-up tracking activities in clients records • A current list of agencies that provide services including availability of the Blue Book

	management referrals	
2.4	Client Notification of Service Provider Turnover Client must be provided notice of assigned service provider's cessation of employment within 30 days of the employee's departure.	• Documentation in client record
2.5	Client Transfers between Agencies: Open or Closed less than One Year The case manager should facilitate the transfer of clients between providers. All clients are transferred in accordance with Case Management Policy and Procedure, which requires that a "consent for transfer and release/exchange of information" form be completed and signed by the client, the client's record be forwarded to the receiving care manager within five (5) working days and a Request for Transfer form be completed for the client and kept on file with the receiving agency.	• Documentation in client record
2.6	Caseload Case load determination should be based on client characteristics, acuity level and the intensity of case management activities.	• Review of the agency's policies and procedures for Staffing ratios

Clinical Case Management Services

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

1.0	**Staff Requirements**	
1.1	Minimum Qualifications All clinical case managers must have a current and in good standing State of Texas license (LCSW, LPC, LPC-I, LMFT, LMFT-A). Staff providing Clinical Case Management services with LBSW or LMSW licensure must have accompanying LCDC, CI, Substance Abuse Counselor, or Addictions Counselor certification. Other training experiences may be considered under a waiver agreement. LMSWs receiving clinical supervision hours towards LCSW requirements may provide Clinical Case Management services under a waiver agreement.	• A file will be maintained on each clinical case manager • Supportive documentation of credentials and job description is maintained by the agency in each clinical case manager file. Documentation should include transcripts and/or diplomas and proof of licensure
1.2	Scope of Services The clinical case management services will include at a minimum, comprehensive assessment including mental health and substance abuse/use; development, implementation and evaluation of care plans; follow-up; advocacy; direction of clients through the entire spectrum of health and support services and peer support. Other functions include facilitation and coordination of services from one service provider to another including mental health, substance abuse and primary medical care providers.	• Review of client records indicates compliance • Agency Policy and Procedures indicates compliance
1.3	Ongoing Education/Training for Clinical Case Managers After the first year of employment in the case management system each clinical case manager will obtain the minimum number of hours of continuing education to maintain his or her licensure and four (4) hours of training in current Community Resources conducted by RWGA	• Certificates of completion are maintained by the agency • Current License on case manager's file
2.0	**Timeliness of Services/Documentation**	

2.1	Client Eligibility In addition to the general eligibility criteria, individuals must meet one or more of the following criteria in order to be eligible for clinical case management services: • Individual living with HIV in mental health treatment/counseling and/or substance abuse treatment services or whose history or behavior may indicate the individual may need mental health and/or substance abuse treatment/counseling now or in the future. • Clinical criteria for admission into clinical case management must include one of the following: ➢ Client is actively symptomatic with a DSM (most current, American Psychiatric Association approved) diagnosis, especially including substance-related disorders (abuse/dependence), mood disorders (Bipolar depression), depressive disorders, anxiety disorders, and other psychotic disorders; or DSM (most current, American Psychiatric Association approved) diagnosis personality disorders. ➢ Client has a mental health condition or substance abuse pattern that interferes with his/her ability to adhere to medical/medication regimen and needs motivated to access mental health or substance abuse treatment services. ➢ Client is in mental health counseling or chemical dependency treatment.	• Documentation of HIV+ status, mental health and substance abuse status, residence, identification, and income in the client record
2.2	Discharge/Closure from Clinical Case Management Services In addition to the general requirements, a client may be discharged from clinical case management services for the following reasons. • Client has achieved a sustainable level of stability and independence. ➢ Substance Abuse – Client has successfully completed an outpatient substance abuse treatment program. ➢ Mental Health – Client has successfully accessed and is engaged in mental health treatment and/or has completed mental health treatment plan objectives.	• Documentation in client record.
2. 3	Coordination with Primary Medical Care and Medical Case Management Provider Agency will have policies and procedures in place to ensure effective clinical coordination with Ryan White Part A funded Medical Case Management programs.	• Review of Agency's Policies and Procedures Manual indicates compliance

	Clinical Case Management services provided to clients accessing primary medical care from a Ryan White Part A funded primary medical care provider other than Agency will require Agency and Primary Medical Care/Medical Case Management provider to conduct regular multi-disciplinary case conferences to ensure effective coordination of clinical and psychosocial interventions. Case conferences must at a minimum include the clinical case manager; mental health/counselor and/or medical case manager and occur at least every sixthree (63) months for the duration of Clinical Case Management services. Client refusal to provide consent for the clinical case manager to participate in multi-disciplinary case conferences with their Primary Medical Care provider must be documented in the client record.	• Case conferences are documented in the client record
2.4	Assessment Assessment begins at intake. The case manager will provide client, and if appropriate, his/her support system information regarding the range of services offered by the case management program during intake/assessment. The comprehensive client assessment will include an evaluation of the client's medical and psychosocial needs, strengths, resources (including financial and medical coverage status), limitations, beliefs, concerns and projected barriers to service. Other areas of assessment include demographic information, health history, sexual history, mental history/status, substance abuse history, medication adherence and risk behavior practices, adult and child abuse (if applicable). A RWGA-approved comprehensive client assessment form must be completed within two weeks after initial contact. Clinical Case Management will use a RWGA-approved assessment tool. This tool may include Agency specific enhancements tailored to Agency's Mental Health and/or Substance Abuse treatment program(s).	• Documentation in client record on the comprehensive client assessment form, signed and dated, or agency's equivalent form. Updates to the information included in the assessment will be recorded in the comprehensive client assessment. • A completed DSHS checklist for screening of suspected sexual child abuse and reporting is evident in case management records, when appropriate
2.5	Reassessment Clients will be reassessed at six (6) month intervals following the initial assessment or more often if clinically indicated including when unanticipated events or major changes occur in the client's life (e.g. needing referral for services from other providers, increased risk behaviors, recent hospitalization, suspected child abuse, significant changes in income and/or loss of psychosocial support system). A RWGA approved reassessment form as applicable must be utilized.	• Documentation in client record on the comprehensive client reassessment form or agency's equivalent form signed and dated

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

Non-Medical Case Management Services (Service Linkage Worker)

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

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

	• Newly diagnosed (within the last six (6) months) and not currently receiving case management services as documented by the CPCDMS	
2.2	Service Linkage Worker Assessment Assessment begins at intake. The service linkage worker will provide client and, if appropriate, his/her personal support system information regarding the range of services offered by the case management program during intake/assessment. The service linkage worker will complete RWGA -approved brief assessment tool within five (5) working days, on all clients to identify those who need comprehensive assessment. Clients with mental health, substance abuse and/or housings issues should receive comprehensive assessment. Clients needing comprehensive assessment should be referred to a licensed case manager.	• Documentation in client record on the brief assessment form, signed and dated • A completed DSHS checklist for screening of suspected sexual child abuse and reporting is evident in case management records, when appropriate
2.3	Service Linkage Worker Reassessment Clients on receiving services will be reassessed at six (6) month intervals following the initial assessment. A RWGA/ TRG-approved reassessment form as applicable must be utilized.	• Documentation in RWGA approved client reassessment form or agency's equivalent form, signed and dated
2.4	Transfer of Not-in-Care and Newly Diagnosed Clients (HHD Only) Service linkage workers targeting their services to Not-in-Care and newly diagnosed clients will work with clients for a maximum of 90 days. Clients must be transferred to a Ryan White-funded primary medical care, clinical case management or medical case management program, or a private (non-Ryan White funded) physician within 90 days of the initiation of services. Those clients who chose to access primary medical care from a non-Ryan White funded source may receive ongoing service linkage services from provider or from a Ryan White-funded Clinic or Medical Case Management provider.	• Documentation in client record and in the CPCDMS
2.5	Primary Care Newly Diagnosed and Lost to Care Clients Agency must have a written policy and procedures in place that address the role of Service Linkage Workers in the linking and re-engaging of clients into primary medical care. The policy and procedures must include at minimum: • Methods of routine communication with testing sites regarding newly diagnosis and referred individuals • Description of service linkage worker job duties conducted in the field	• Review of Agency's Policies and Procedures Manual indicates compliance.

	• Process for re-engaging agency patients lost to care (no primary care visit in 6 months)	
3.0	**Supervision and Caseload**	
3.1	Service Linkage Worker Supervision A minimum of four (4) hours of supervision per month must be provided to each service linkage worker by a master's level health professional.) At least one (1) hour of supervision must be individual supervision. Supervision includes, but is not limited to, one-to-one consultation regarding issues that arise in the case management relationship, case staffing meetings, group supervision, and discussion of gaps in services or barriers to services, intervention strategies, case assignments, case reviews and caseload assessments.	• Documentation in supervision notes, which must include: ➢ date ➢ name(s) of case manager(s) present ➢ topic(s) covered and/or client(s) reviewed ➢ plan(s) of action ➢ supervisor's signature • Supervision notes are never maintained in the client record
3.2	Caseload Coverage – Service Linkage Workers Supervisor ensures that there is coverage of the caseload in the absence of the service linkage worker or when the position is vacant. Service Linkage Workers may assist clients who are routinely seen by other CM team members in the absence of the client's "assigned" case manager.	• Documentation of all client encounters in client record and in the Centralized Patient Care Data Management System
3.3	Case Reviews – Service Linkage Workers. Supervisor reviews a random sample equal to 10% of unduplicated clients served by each service linkage worker at least once every ninety (90) days, and concurrently ensures that all required record components are present, timely, legible, and that services provided are appropriate.	• Documentation of case reviews in client record, signed and dated by supervisor and/or quality assurance personnel and SLW

Medical Case Management

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

1.0	**Staff/Training**	
1.1	Qualifications/Training Minimum Qualifications - The program must utilize a Social Worker licensed by the State of Texas to provide Medical Case Management Services. A file will be maintained on each medical case manager. Supportive documentation of medical case manager credentials is maintained by the agency and in each medical case manager's file. Documentation may include, but is not limited to, transcripts, diplomas, certifications, and/or licensure.	• Documentation of credentials and job description in medical case manager's file
1.2	Scope of Services The medical case management services will include at a minimum, screening of primary medical care patients to determine each patient's level of need for medical case management; comprehensive assessment, development, implementation and evaluation of medical case management service plan; follow-up; direction of clients through the entire spectrum of health and support services; facilitation and coordination of services from one service provider to another. Others include referral to clinical case management if indicated, client education regarding wellness, medication and health care compliance and peer support.	• Review of clients' records indicates compliance
1.3	Ongoing Education/Training for Medical Case Managers After the first year of employment in the case management system each medical case manager will obtain the minimum number of hours of continuing education to maintain his or her licensure.	• Attendance sign-in sheets and/or certificates of completion are maintained by the agency
2.0	**Timeliness of Service/Documentation** Medical case management for persons with HIV should reflect competence and experience in the assessment of client medical need and the development and monitoring of medical service delivery plans.	

2.1	<u>Screening Criteria for Medical Case Management</u> In addition to the general eligibility criteria, agencies are advised to use screening criteria before enrolling a client in medical case management. Examples of such criteria include the following: i. Newly diagnosed ii. New to ART iii. CD4<200 iv. VL>100,000 or fluctuating viral loads v. Excessive missed appointments vi. Excessive missed dosages of medications vii. Mental illness that presents a barrier to the patient's ability to access, comply or adhere to medical treatment viii. Substance abuse that presents a barrier to the patient's ability to access, comply or adhere to medical treatment ix. Housing issues x. Opportunistic infections xi. Unmanaged chronic health problems/injury/Pain xii. Lack of viral suppression xiii. Positive screening for intimate partner violence xiv. Clinician's referral Clients with one or more of these criteria would indicate need for medical case management services. The following criteria are an indication a client may be an appropriate referral for Clinical Case Management services. • Client is actively symptomatic with an axis I DSM (most current, American Psychiatric Association approved) diagnosis especially including substance-related disorders (abuse/dependence), mood disorders (major depression, Bipolar depression), anxiety disorders, and other psychotic disorders; or axis II DSM (most current, American Psychiatric Association approved) diagnosis personality disorders; • Client has a mental health condition or substance abuse pattern that interferes with his/her ability to adhere to medical/medication regimen and needs motivated to access mental health or substance abuse treatment services;	• Review of agency's screening criteria for medical case management

	• Client is in mental health counseling or chemical dependency treatment.	
2.2	Assessment Assessment begins at intake. The case manager will provide client, and if appropriate, his/her support system information regarding the range of services offered by the case management program during intake/assessment. Medical case managers will provide a comprehensive assessment at intake and at least annually thereafter. The comprehensive client assessment will include an evaluation of the client's medical and psychosocial needs, strengths, resources (including financial and medical coverage status), limitations, beliefs, concerns and projected barriers to service. Other areas of assessment include demographic information, health history, sexual history, mental history/status, substance abuse history, medication adherence and risk behavior practices, adult and child abuse (if applicable). A RWGA-approved comprehensive client assessment form must be completed within two weeks after initial contact. Medical Case Management will use an RWGA-approved assessment tool. This tool may include Agency specific enhancements tailored to Agency's program needs.	• Documentation in client record on the comprehensive client assessment forms, signed and dated, or agency's equivalent forms. Updates to the information included in the assessment will be recorded in the comprehensive client assessment. • A completed DSHS checklist for screening of suspected sexual child abuse and reporting is evident in case management records, when appropriate.
2.3	Reassessment Clients will be reassessed at six (6) month intervals following the initial assessment or more often if clinically indicated including when unanticipated events or major changes occur in the client's life (e.g. needing referral for services from other providers, increased risk behaviors, recent hospitalization, suspected child abuse, significant changes in income and/or loss of psychosocial support system). A RWGA or TRG -approved reassessment form as applicable must be utilized.	• Documentation in client record on the comprehensive client reassessment form or agency's equivalent form signed and dated • Documentation of initial and updated service plans in the URS (applies to TDSHS – funded case managers only)
2.4	Service Plan Service planning begins at admission to medical case management services and is based upon assessment. The medical case manager shall develop the service plan in collaboration with the client and if appropriate, other members of the support system. An RWGA-approved service plan form will be completed no later than ten (10) working days following the comprehensive	• Documentation in client's record on the medical case management service plan or agency's equivalent form • Service Plan signed by the client and the case manager

	client assessment. A temporary care plan may be executed upon intake based upon immediate needs or concerns). The service plan will seek timely resolution to crises, short-term and long-term needs, and may document crisis intervention and/or short term needs met before full service plan is completed. Service plans reflect the needs and choices of the client based on their health and related needs (including support services) and are consistent with the progress notes. A new service plan is completed at each six (6) month reassessment or each reassessment. The case manager and client will update the care plan upon achievement of goals and when other issues or goals are identified and reassessed. Service plan must reflect an ongoing discussion of primary care, mental health treatment and/or substance abuse treatment, treatment and medication adherence and other client education per client need.	
3.0	**Supervision and Caseload**	
3.1	<u>Clinical Supervision and Caseload Coverage</u> The medical case manager must receive supervision in accordance with their licensure requirements. Agency policies and procedures should account for clinical supervision and coverage of caseload in the absence of the medical case manager or when the position is vacant.	• Review of the agency's Policies and Procedures for clinical supervision, and documentation of supervisor qualifications in personnel files. • Documentation on file of date of supervision, type of supervision (e.g., group, one on one), and the content of the supervision

Emergency Financial Assistance Program

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

1.0	**Services are offered in such a way as to overcome barriers to access and utilization. Service is easily accessible to persons with HIV.**	
1.1	Client Eligibility In addition to the general eligibility criteria individuals must meet the following in order to be eligible for EFA services: • Income no greater than 500% of the Federal poverty level for HIV medications	• Documentation of income in the client record.
1.2	Timeliness of Service Provision • Agency will process prescription for approval within two (2) business days • Pharmacy will fill prescription within one (1) business day of approval	• Documentation in the client record and review of pharmacy summary sheets • Review of agency's Policies & Procedures Manual indicates compliance
1.3	Medication Formulary RW funded prescriptions for program eligible clients shall be based on current medications on the RWGA LPAP medication formulary. Ryan White funds may not be used for non-prescription medications or drugs not on the approved formulary. Providers wishing to prescribe other medications not on the formulary must obtain a waiver from the RWGA prior to doing so. Any EFA service greater than 30 days of medication must also have prior waiver approval from RWGA. Agency policies and procedures must ensure that MDs and physician extenders comply with the current clinical/Public Health Services guidelines for ART and treatment of opportunistic infections.	• Review of agency's Policies & Procedures Manual indicates compliance • Review of billing history indicates compliance • Documentation in client's record
2.0	**Staff HIV knowledge is based on documented training.**	

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

Emergency Financial Assistance Program (OTHER)

Emergency Financial Assistance (EFA) is to provide one-time or short-term payments to assist the RWHAP client with an emergent need for paying for essential utilities, food (including groceries, and food vouchers), and transportation. Emergency financial assistance can occur as a direct payment to an agency or through a voucher program.

1.0	**Services are offered in such a way as to overcome barriers to access and utilization. Service is easily accessible to persons with HIV.**	
1.1	EFA funds may be used on the following essential items or services: • Utilities (may include household utilities including gas, electricity, propane, water, and all required fees). • Telephone • Food (groceries or food vouchers) Other RWHAP allowable costs needed to improve health outcomes.	• Review of agency's Policies & Procedures Manual indicates compliance • Review of billing history indicates compliance • Documentation in the client chart
1.2	Client Eligibility Applicants must demonstrate an urgent need resulting in their inability to pay their applicable bills without financial assistance for essential items or services necessary to improve health outcomes. Demonstrated need is made by the following: • A significant increase in bills • A recent decrease in income • High unexpected expenses on essential items • The cost of their shelter is more than 30% of the household income • The cost of their utility consumption is more than 10% of the household income • They are unable to obtain credit necessary to provide for basic needs and shelter • A failure to provide emergency financial assistance will result in danger to the physical health of client or dependent children	• Documentation of client assessment • Copy of invoice/bill paid. • Copy of check for payment

	• Other emergency needs as deemed appropriate by the agency The invoice/bill which is to be paid with emergency financial assistance funds must be in the client's name. An exception may be made only in instances where it is documented that, although the service (e.g. utility) is in another person's name, it directly benefits the client.	
1.3	Client Confidentiality Payment for assistance made to service providers will protect client confidentiality through use of checks and envelopes that de-identify agency as an HIV/AIDS provider to protect client confidentiality.	• Agency financial records indicate compliance • Documentation in the client chart
1.4	Assessment • An assessment must demonstrate an urgent need resulting in their inability to pay their applicable bills without financial assistance for essential items or services necessary to improve health outcomes. • Client will be assessed for ongoing status and outcome of the emergency assistance. Referrals for services, as applicable, will be documented in the client file. • Emergent need must be documented each time funds are used.	• Documentation in the client chart
1.5	Documentation • Plans are developed jointly with the client and must include an approach to mitigate the need in the future. • Client's chart contains documented plan for EFA that indicates emergent need, other resources pursued, and outcome of EFA provided.	• Documentation in the client chart
1.6	Timeliness of Service Provision All completed requests for assistance shall be approved or denied within three (3) business days following the completed request.	• Documentation in the client chart
2.0	**Agency requirements**	

2.1	Budget Requirements or Restrictions • Direct cash payments to clients are not permitted. • RWHAP funds will be the payer of last resort, and for limited amounts, uses, and periods of time. Continuous provision of an allowable service to a client must not be funded through EFA. • At least **75%** of the total amount of the budget must be solely allocated to the actual cost of disbursements. • The agency must set priorities, delineate and monitor what part of the overall allocation for emergency assistance is obligated for each subcategory. Careful monitoring of expenditures within a subcategory of "emergency assistance" is necessary to assure that planned amounts for specific services are being implemented, and to determine when reallocations may be necessary. • Maximum allowable unit cost for provision of food vouchers or and/or utility assistance to an eligible client = $30.00/unit	• Documentation includes copies of checks paid and vouchers purchased • Review of agency's Policies & Procedures Manual indicates compliance • Documentation that at least **75%** of the total amount of the budget must be solely allocated to the actual cost of disbursements.
2.2	Agency providing emergency financial assistance shall have procedures in place to ensure that funds are distributed fairly and consistently.	• Agency written procedure
2.3	Agency must be dually awarded as HOWPA sub-recipient and work closely with other service providers to minimize duplication of services and ensure that assistance is given only when no reasonable alternatives are available. Agency must document procedures.	• Agency written procedure

Health Insurance Assistance

The Health Insurance Premium and Cost Sharing Assistance service category is intended to help PLWH continue medical care without gaps in health insurance coverage or discretion of treatment. A program of financial assistance for the payment of health insurance premiums and co-pays, co-insurance and deductibles to enable eligible individuals with HIV to utilize their existing third party or public assistance (e.g. Medicare) medical insurance. Agency may provide help with client co-payments, co-insurance, deductibles, and Medicare Part D premiums.

Co-Payment: A cost-sharing requirement that requires the insured to pay a specific dollar amount for each unit of service. Co-Insurance: A cost-sharing requirement that requires the insured to pay a percentage of costs for covered services/prescription. Deductible: A cost-sharing requirement that requires the insured pay a certain amount for health care or prescription, before the prescription drug plan or other insurance begins to pay. Premium: The amount paid by the insured to an insurance company to obtain or maintain and insurance policy.

1.0	**Staff/Training**	
1.1	Ongoing Training Eight (8) hours annually of continuing education in HIV related or other specific topics including a minimum of two (2) hours training in Affordable Care Act is required as needed.	• Materials for staff training and continuing education are on file • Staff interviews indicate compliance
1.2	Staff Experience A minimum of one year documented HIV work experience is preferred.	• Documentation of work experience in personnel file
2.0	**Client Eligibility**	
2.1	Comprehensive Intake/Assessment Agency performs a comprehensive financial intake/application to determine client eligibility for this program as needed to insure that these funds are used as a last resort in order for the client to utilize his/her existing insurance or be eligible to purchase a qualified health plan through the Marketplace. Assessment should include review of individual's premium and cost sharing subsidies through the health insurance marketplace.	• Review of agency's Policies & Procedures Manual indicates compliance. • Review of client intake/assessment for service indicates compliance
2.2	Advance Premium Tax Credit Reconciliation Agency will ensure all clients receiving assistance for Marketplace QHP premiums: • Designate Premium Tax Credit to be taken in advance during Marketplace Insurance enrollment	• Review of client record

	• Update income information at Healthcare.gov every 6 months, at minimum, with one update required during annual Marketplace open enrollment or Marketplace renewal periods
	• Submit prior year tax information no later than May 31st. Tax information must include:
	  o Federal Marketplace Form 1095-A
	  o IRS Form 8962
	  o IRS Form 1040 (excludes 1040EZ)
	• Reconciliation of APTC credits or liabilities	

3.0	**Client Access**	
3.1	Clients Referral and Tracking Agency receives referrals from a broad range of HIV service providers and makes appropriate referrals out when necessary.	• Documentation of referrals received • Documentation of referrals out • Staff reports indicate compliance
3.2	Prioritization of Service Agency implements a system to utilize the RW Planning Council-approved prioritization of cost sharing assistance when limited funds warrant it. Agency use the Planning Council-approved consumer out-of-pocket methodology. **Priority Ranking of Cost Sharing Assistance (in descending order):** 1. HIV medication co-pays and deductibles (medications on the Texas ADAP formulary) 2. Non-HIV medication co-pays and deductibles (all other allowable HIV-related medications) 3. Doctor visit co-pays/deductibles (physician visit and/or lab copayments) Medicare Part D (Rx) premiums	• Review of agency's Policies & Procedures Manual indicates compliance. • Review of agency's monthly reimbursement indicates compliance
3.3	Decreasing Barriers to Service Agency establishes formal written agreements with all Houston HSDA Ryan White-funded (Part A, B, C, D) primary care, mental health and substance use provider agencies to enable clients of these agencies to enroll in Health Insurance assistance at his/her primary care, mental health or substance use provider site. (i.e. No need for client to physically present to Health Insurance provider.)	• Review of agency's Policies & Procedures Manual indicates compliance. • Review of client intake/assessment for service indicates compliance

Local Pharmacy Assistance Program

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

1.0	**Services are offered in such a way as to overcome barriers to access and utilization. Service is easily accessible to persons with HIV.**	
1.1	Client Eligibility In addition to the general eligibility criteria individuals must meet the following in order to be eligible for LPAP services: • Income no greater than 500% of the Federal poverty level for HIV medications and no greater than 400% of the Federal poverty level for HIV-related medications	• Documentation of income in the client record.
1.2	Timeliness of Service Provision • Agency will process prescription for approval within two (2) business days • Pharmacy will fill prescription within one (1) business day of approval	• Documentation in the client record and review of pharmacy summary sheets • Review of agency's Policies & Procedures Manual indicates compliance
1.3	LPAP Medication Formulary RW funded prescriptions for program eligible clients shall be based on the current RWGA LPAP medication formulary. Ryan White funds may not be used for non-prescription medications or drugs not on the approved formulary. Providers wishing to prescribe other medications not on the formulary must obtain a waiver from the RWGA prior to doing so. Agency policies and procedures must ensure that MDs and physician extenders comply with the current clinical/HHS guidelines for ART and treatment of opportunistic infections.	• Review of agency's Policies & Procedures Manual indicates compliance • Review of billing history indicates compliance • Documentation in client's record
2.0	**Staff HIV knowledge is based on documented training.**	

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

Medical Nutritional Therapy/Supplements

HRSA defines core Medical Nutrition Therapy as the provision of food, nutritional services and nutritional supplements provided outside of a primary care visit by a licensed registered dietician based on physician's recommendation and a nutritional plan developed by a licensed registered dietician. The Houston EMA Part A/B Medical Nutrition Therapy includes nutritional counseling, provision nutritional supplements (of up to 90 day supply) for eligible people living with HIV in the Houston EMA. Clients must have a written referral or prescription from a physician or physician extender and a written nutritional plan prepared by a licensed, registered dietician

1.0	**Services are individualized and tailored to client needs.**	
1.1	Education/Counseling – Clients Receiving New Supplements All clients receiving a supplement for the first time will receive appropriate education/counseling. This must include written information regarding supplement benefits, side effects and recommended dosage in client's primary language.	• Client record indicates compliance
1.2	Education/Counseling – Follow-Up Clients receive education/counseling regarding supplement(s) again at: • follow-up • when there is a change in supplements • at the discretion of the registered dietician if clinically indicated	• Client record indicates compliance
2.0	**Services adhere to professional standards and regulations.**	
2.1	Nutritional Supplement Formulary RW funded nutritional supplement disbursement for program eligible clients shall be based on the current RWGA nutritional supplement formulary. Ryan White funds may not be used for nutritional supplements not on the approved formulary. Providers wishing to prescribe/order other supplements not on the formulary must obtain a waiver from the RWGA prior to doing so. Agency policies and procedures must ensure that MDs and physician extenders comply with the current clinical/Department of Health and Human Services guidelines for ART and treatment of opportunistic infections.	• Review of agency's Policies & Procedures Manual indicates compliance • Review of billing history indicates compliance • Documentation in client's record
2.2	Inventory Supplement inventory is updated and rotated as appropriate on a first-in, first-out basis, and shelf-life standards and applicable laws are observed.	• Review of agency's Policies & Procedures Manual indicates compliance • Staff interviews

2.3	Licensure Providers/vendors maintain proper licensure. A physician or physician extender (PE) with prescribing privileges at a Part A/B/C and/or MAI-funded agency or qualified primary care provider must write an order for Part A-funded nutritional supplements. A licensed registered dietician must provide an individualized nutritional plan including education/counseling based on a nutritional assessment	• Documentation of current licensure • Nutritional plan in client's record
2.4	Protocols Nutrition therapy services will use evidence-based guides, protocols, best practices, and research in the field of HIV including the *American Dietetic Association's HIV-related protocols in Medical Nutrition Therapy Across the Continuum of Care.*	• Chart Review shows compliance • Review of agency's Policies & Procedures Manual indicates compliance

Oral Health

Oral Health Care as "diagnostic, preventive, and therapeutic services provided by the general dental practitioners, dental specialist, dental hygienist and auxiliaries and other trained primary care providers". The Ryan White Part A/B oral health care services include standard preventive procedures, diagnosis and treatment of HIV-related oral pathology, restorative dental services, oral surgery, root canal therapy and oral medication (including pain control) for PLWH 15 years old or older based on a comprehensive individual treatment plan. Additionally, the category includes prosthodontics services (Part B) to people living with HIV including but not limited to examinations and diagnosis of need for dentures, crowns, bridgework and implants, diagnostic measurements, laboratory services, tooth extraction, relines and denture repairs.

1.0	**Staff HIV knowledge is based on documented training.**	
1.1	Continuing Education • Sixteen (16) hours of training in HIV and clinically-related issues is required every 2 years for licensed staff. (does not include any training requirements outlined in General Standards) • One (1) hour of training in HIV is required annually for all other staff. (does not include any training requirements outlined in General Standards)	• Materials for staff training and continuing education are on file • Documentation of continuing education in personnel file
1.2	Experience – HIV A minimum of one (1) year documented work experience with PLWH is preferred for licensed staff.	• Documentation of work experience in personnel file
1.3	Staff Supervision Supervision of clinical staff shall be provided by a practitioner with at least two years experience in dental health assessment and treatment of persons living with HIV. All licensed personnel shall receive supervision consistent with the State of Texas license requirements.	• Review of personnel files indicates compliance • Review of agency's Policies & Procedures Manual indicates compliance
2.0	**Patient Care**	
2.1	HIV Primary Care Provider Contact Information Agency obtains and documents HIV primary care provider contact information for each client.	• Documentation of HIV primary care provider contact information in the client record. At minimum, agency should collect the clinic and/or physician's name and telephone number
2.2	Consultation for Treatment Agency consults with client's medical care providers when indicated.	• Documentation of communication in the client record
2.3	Health History Information	• Documentation of health history information in the client record. Reasons

	Agency collects and documents health history information for each client prior to providing care. This information should include, but not be limited to, the following: • A baseline (current within the last 12 months) CBC laboratory test results for all new clients, and an annual update thereafter, and when clinically indicated • Current (within the last 6 months) Viral Load and CD4 laboratory test results, when clinically indicated • Client's chief complaint, where applicable • Medication names • Sexually transmitted diseases • HIV-associated illnesses • Allergies and drug sensitivities • Alcohol use • Recreational drug use • Tobacco use • Neurological diseases • Hepatitis • Usual oral hygiene • Date of last dental examination • Involuntary weight loss or weight gain • Review of systems	for missing health history information are documented
2.4	Client Health History Update An update to the health history should be made, at minimum, every six (6) months or at client's next general dentistry visit whichever is greater.	• Documentation of health history update in the client record
2.5	Comprehensive Periodontal Examination (Part B Only) Agency has a written policy and procedure regarding when a comprehensive periodontal examination should occur. Comprehensive periodontal examination should be done in accordance with professional standards and current US Public Health Service guidelines	• Review of agency's Policies & Procedures Manual indicates compliance • Review of client records indicate compliance
2.6	Treatment Plan • A comprehensive, multidisciplinary Oral Health treatment plan will be developed in conjunction with the patient. • Patient's primary reason for dental visit should be addressed in treatment plan	• Treatment plan dated and signed by both the provider and patient in patient file • Updated treatment plan dated and signed by both the provider and patient in patient file

	• Patient strengths and limitations will be considered in development of treatment plan • Treatment priority should be given to pain management, infection, traumatic injury or other emergency conditions • Treatment plan will be updated as deemed necessary	
2.7	Annual Hard/Soft Tissue Examination The following elements are part of each client's annual hard/soft tissue examination and are documented in the client record: • Charting of caries; • X-rays; • Periodontal screening; • Written diagnoses, where applicable; • Treatment plan. Determination of clients needing annual examination should be based on the dentist's judgment and criteria outlined in the agency's policy and procedure, however the time interval for all clients may not exceed two (2) years.	• Documentation in the client record • Review of agency's Policies & Procedures Manual indicates compliance
2.8	Oral Hygiene Instructions Oral hygiene instructions (OHI) should be provided annually to each client. The content of the instructions is documented.	• Documentation in the client record

Outreach Services

Outreach workers focus on locating clients who are on the cusp of falling out of care, for reengagement back into care. The Ryan White Part A Outreach Worker (OW) provides field-based services to clients based on criteria identified by each agency. These services include the provision of information, referrals and assistance with linkage to medical, mental health, substance abuse and psychosocial services as needed and advocating on behalf of clients to decrease service gaps and remove barriers to services.

1.0	**Staff Training**	
1.1	**Minimum/Qualifications** Minimum Qualifications – High School Diploma or GED. Six months of working with or volunteering with PLWH.	• Documentation of credentials and job description in outreach worker's file • Documentation includes, but is not limited to high school diploma, GED and experience
1.2	Scope of Services The OW will generate EMR reports to determine eligibility for services. Monthly, during OW-RWGA meetings OW will provide client status updates on engagement activities. Outreach workers are expected to document client's immediate needs and barriers to service in order to relink and reengage them back in to care. Upon successfully re-engaging clients back in to care, outreach workers will provide a warm handoff to a service linkage worker or medical case manager for additional assistance of the client's needs as necessary.	• Review of reporting records indicates compliance • Monthly review of spreadsheet engagement activities • Documentation of assessment will be maintained in the client file
1.3	Ongoing Education/Training for Outreach Workers Staff who provide field-based services should receive at least two (2) hours of field safety training within their first six (6) months of employment. The Outreach Workers are required to attend a minimum of five (5) of the six (6) Outreach Worker meetings and four (4) of the five (5) bi-monthly networking meetings facilitated by RWGA within the grant year, and one of the Joint Prevention and Care Collaborative Workshops presented by RGWA & HHD.	• Documentation of attendance will be maintain by the agency. RWGA will also maintain sign-in logs • Review of reporting records indicates compliance • Certificates of completion for applicable trainings in the outreach worker's file •
1.4	Documentation and Reporting Outreach Workers are trained in the agency's policy and procedure for determining, documenting and reporting instances of abuse, sexual or nonsexual, in accordance with DSHS Child Abuse Screening, Documenting and Reporting Policy prior to interaction.	• Documentation of staff training in employee record

1.5	Warm Handoff Procedure Agency must have policies and procedures in place that ensures a warm handoff for clients within the healthcare system. A warm handoff is applicable when a transfer of care between two members of the health care team needs to take place, i.e. Outreach worker to primary care provider, and transitions between agencies. Warm handoff policy should be consistent with AHRQ Warm Handoff guidelines.	• Agency has a warm handoff policy to specify procedures and appropriate patient population for conducting a warm handoff.
2.0	**Timeliness of Service/Documentation**	
2.1	**Progress Notes** All Outreach Worker activities, including but not limited to all contacts and attempted contacts with or on behalf of clients are documented in the client record within 72 business hours of the occurrence.	• Documentation of client's needs and progress notes will be maintained in client's files • Legible signed and dated in documentation in the client record
2.2	Eligibility Criteria for Outreach Eligibility for outreach will vary and is specific to each agency. Criteria can include but is not limited to clients: • Who have missed 2 or more HIV-related medical appointments in the last 6 months, have one appointment scheduled in the next 3 weeks; • Missed 3 appointments in last 6 months and have one scheduled in next 3 weeks; • Clients who have not been seen in 4 months by their primary care provider; and/or • Three missed appointments in past 12 months (do not have to be consecutive).	• Documentation of eligibility criteria will be maintained in client's files • Legible signed and dated in documentation in the client record
3.0	**Supervision**	
3.1	Outreach Worker Supervision Four (4) hours of supervision per month must be provided to each outreach worker. At least one (1) hour of supervision must be individual supervision. The remaining three (3) hours may be individual or group. Supervision includes, but is not limited to, one-to-one consultation regarding issues that arise in the outreach worker relationship, case staffing meetings, group supervision, and discussion of gaps in services or barriers to services, intervention strategies, case assignments, case reviews and caseload assessments	• Documentation in supervision notes, which must include: ➢ Date & duration of time ➢ name(s) of outreach worker(s) present ➢ topic(s) covered and/or client(s) reviewed ➢ plan(s) of action ➢ supervisor's signature

		Supervision notes are never maintained in the client record
3.2	Case Reviews – Outreach Worker Supervisor reviews a random sample equal to 10% of unduplicated clients served by each Outreach Worker at least once every ninety (90) days, and concurrently ensures that all required record components are present, timely, legible and that services provided appropriately.	• Documentation of case reviews in client record, signed and dated by supervisor and/or quality assurance personnel and Outreach Worker.

Primary Medical Care

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

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

1.0	**Medical Care for persons with HIV should reflect competence and experience in both primary care and therapeutics known to be effective in the treatment of HIV infection and is consistent with the most current published HHS treatment guidelines**	
1.1	Minimum Qualifications Medical care for persons living with HIV shall be provided by MD, NP, CNS or PA licensed in the State of Texas and has at least two years paid experience in HIV care including fellowship.	• Credentials on file
1.2	Licensing, Knowledge, Skills and Experience • All staff maintain current organizational licensure (and/or applicable certification) and professional licensure • The agency must keep professional licensure of all staff providing clinical services including physicians, nurses, social workers, etc. • Supervising/attending physicians of the practice show continuous professional development through the following HRSA recommendations for HIV-qualified physicians (www.hivma.org): • Clinical management of at least 25 people living with HIV patients within the last year • Maintain a minimum of 30 hours of HIV-specific CME (including a minimum of 10 hours related to antiretroviral therapy) every two years in accordance with State licensure renewal dates. Agencies using	• Documentation in personnel record

	contractors must ensure that this requirement is met and must provide evidence at the annual program monitoring site visits. • Psychiatrists only: after the first biennium, psychiatrists must maintain a minimum of 10 hours of HIV-specific CME every two years in accordance with State licensure renewal dates • Physician extenders must obtain this experience within six months of hire • All staff receive professional supervision • Staff show training and/or experience with the medical care of adults living with HIV	
1.3	Peer Review Agency/Provider will conduct peer review for all levels of licensed/credentialed providers (i.e. MD, NP, PA).	• Provider will document peer review has occurred annually
1.4	**Standing Delegation Orders (SDO)** Standing delegation orders provide direction to RNs, LVNs and, when applicable, Medical Assistants in supporting management of patients seen by a physician. Standing Delegation Orders must adhere to Texas Administrative Code, Title 22, Part 9; Chapter 193; Rule §193.1 and must be congruent with the requirements specified by the Board of Nursing (BON) and Texas State Board of Medical Examiners (TSBME).	• Standing Delegation Orders for a specific population shall be approved by the Medical Director for the agency or provider. • Standing Delegation Orders will be reviewed, updated as needed and signed by the physician annually. • Use of standing delegation orders will be documented in patient's primary record system.
1.5	Primary Care Guidelines Primary medical care must be provided in accordance with the most current published U.S. HHS treatment guidelines (http://www.aidsinfo.nih.gov/guidelines/) and other nationally recognized evidence-based guidelines. Immunizations should be given according to the most current Advisory Committee on Immunization Practices (ACIP) guidelines.	• Documentation in client's record • Exceptions noted in client's record
1.6	Medical Evaluation/Assessment All people living with HIV receiving medical care shall have an initial comprehensive medical evaluation/assessment and physical examination. The comprehensive assessment/evaluation will be completed by the MD, NP, CNS	• Completed assessment in client's record

	or PA in accordance with professional and established HIV practice guidelines (www.hivma.org) within 3 weeks of initial contact with the client. A comprehensive reassessment shall be completed on an annual basis or when clinically indicated. The initial assessment and reassessment shall include at a minimum, general medical history, a comprehensive HIV related history and a comprehensive physical examination. Comprehensive HIV related history shall include: • Psychosocial history • HIV treatment history and staging • Most recent CD4 counts and VL test results • Resistance testing and co receptor tropism assays as clinically indicated • Medication adherence history • History of HIV related illness and infections • History of Tuberculosis • History of Hepatitis and vaccines • Psychiatric history • Transfusion/blood products history • Past medical care • Sexual history • Substance abuse history • Review of Systems	
1.7	Medical Records Medical Records should clearly document the following components, separate from progress notes: • A central "Problems List" which clearly prioritizes problems for primary care management, including mental health and substance use/abuse disorders (if applicable) • A vaccination record, including dates administered • The status of routine screening procedures (i.e., pap smears, mammograms, colonoscopies)	• Documentation in client's record
1.8	Plan of Care	• Plan of Care documented in client's record

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

	➢ If 3 consecutive pap tests are normal, follow-up pap tests should be done every 3 years ➢ Women 30 years old and older may have pap test and HPV co-testing, and if normal, repeated every 3 years ➢ A pap test showing abnormal results should be managed per guidelines • Screening for anal cancer, if indicated • Resistance Testing if clinical indicated • Chem. panel with LFT and renal function test • Influenza vaccination • Annual Mental Health Screening with standardized tool • TST or IGRA (this should be done in accordance with current U.S Public Health Service guidelines (US Public Health Service, Infectious Diseases Society of America. *Guidelines for preventing opportunistic infections among people living with HIV*) (Available at aidsinfo.nih.gov/Guidelines/) • Annual STD testing including syphilis, gonorrhea and Chlamydia for those at risk, or more frequently as clinically indicated	
1.11	Preconception Care for Women Living with HIV of Child Bearing Age In accordance with the US Department of Health and Human Services recommendations (http://aidsinfo.nih.gov/contentfiles/PerinatalGL.pdf), preconception care shall be a component of routine primary care for women of child bearing age living with HIV and should include preconception counseling. In addition to the general components of preconception counseling, health care providers should, at a minimum: • Assess women's pregnancy intentions on an ongoing basis and discuss reproductive options • Offer effective and appropriate contraceptive methods to women who wish to prevent unintended pregnancy • Counsel on safe sexual practices • Counsel on eliminating of alcohol, illicit drugs and smoking • Educate and counsel on risk factors for perinatal HIV transmission, strategies to reduce those risks, and prevention and potential effects of HIV and treatment on pregnancy course and outcomes	• Documentation of preconception counseling and care at initial visit and annual updates in Client's record as applicable

	• Inform women of interventions to prevent sexual transmission of HIV when attempting conception with a partner who does not have HIV Other preconception care consideration should include: • The choice of appropriate antiretroviral therapy effective in treating maternal disease with no teratogenicity or toxicity should pregnancy occur • Maximum suppression of viral load prior to conception	
1.12	Obstetrical Care for Pregnant Women Living with HIV Obstetrical care for pregnant women living with HIV shall be provided by board certified obstetricians experienced in the management of high risk pregnancy and has at least two years experience in caring for pregnant women living with HIV. Antiretroviral therapy during ante partum, perinatal and postpartum should be based on the current HHS guidelines http://www.aidsinfo.nih.gov/Guidelines.	• Documentation in client's record
1.13	Coordination of Services in Prenatal Care To ensure adherence to treatment, agency must ensure coordination of services among prenatal care providers, primary care and HIV specialty care providers, mental health and substance abuse treatment services and public assistance programs as needed.	• Documentation in client's records.
1.14	Care of and Infants, Children and Pre-pubertal Adolescents Care and monitoring of children exposed to HIV must be done in accordance to the HHS guidelines. Treatment of infants and children living with HIV should be managed by a specialist in pediatric and adolescent HIV infection. Where this is not possible, primary care providers must consult with such specialist. Providers must utilize current HHS Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Care (http://aidsinfo.nih.gov/contentfiles/PediatricGuidelines.pdf) in providing and monitoring antiretroviral therapy in infants, children and pre pubertal adolescents. Patients should also be monitored for growth and development, drug toxicities, neurodevelopment, nutrition and symptoms management. A multidisciplinary team approach must be utilized in meeting clients' need and team should consist of physicians, nurses, case managers, pharmacists, nutritionists, dentists, psychologists and outreach workers.	• Documentation in client's record

1.15	Patient Medication Education All clients must receive comprehensive documented education regarding their most current prescribed medication regimen. Medication education must include the following topics, which should be discussed and then documented in the patient record: the names, actions and purposes of all medications in the patient's regimen; the dosage schedule; food requirements, if any; side effects; drug interactions; and adherence. Patients must be informed of the following: how to pick up medications; how to get refills; and what to do and who to call when having problems taking medications as prescribed. Medication education must also include patient's return demonstration of the most current prescribed medication regimen. The program must utilize an RN, LVN, PA, NP, CNS, pharmacist or MD licensed by the State of Texas, who has at least one year paid experience in HIV care, to provide the educational services.	• Documentation in the patient record. Documentation in patient record must include the clinic name; the session date and length; the patient's name, patient's ID number, or patient representative's name; the Educator's signature with license and title; the reason for the education (i.e. initial regimen, change in regimen, etc.) and documentation of all discussed education topics.
1.16	Adherence Assessment Agency will incorporate adherence assessment into primary care services. Clients who are prescribed on-going ART regimen must receive adherence assessment and counseling on every HIV-related clinical encounter. Adherence assessment shall be provided by an RN, LVN, PA, NP, CNS, Medical/Clinical Case Manager, pharmacist or MD licensed by the State of Texas. Agency must utilize the RWGA standardized adherence assessment tool. Case managers must refer clients with adherence issues beyond their scope of practice to the appropriate health care professional for counseling.	• Completed adherence tool in client's record • Documentation of counseling in client records
1.17	Documented Non-Adherence with Prescribed Medication Regimen The agency must have in place a written policy and procedure regarding client non-adherence with a prescribed medication regimen. The policy and procedure should address the agency's process for intervening when there is documented non-adherence with a client's prescribed medication regimen.	• Review of Policies and Procedures Manual indicates compliance.
1.18	Client Mental Health and Substance Use Policy The agency must have in place a written policy and procedure regarding client mental health and substance use. The policy and procedure should address: the agency's process for assessing clients' mental health and substance use; the treatment and referral of clients for mental illness and substance abuse; and care	• Review of Policies and Procedures Manual indicates compliance.

	coordination with mental health and/or substance abuse providers for clients who have mental health and substance abuse issues.	
1.19	Intimate Partner Violence Screening Policy The agency must have in place a written policy and procedure regarding client Intimate Partner Violence (IPV) Screening that is consistent with the Houston EMA IPV Protocol. The policy and procedure should address: • process for ensuring clients are screened for IPV no less than annually • intervention procedures for patients who screen positive for IPV, including referral to Medical/Clinical Case Management • State reporting requirements associated with IPV • Description of required medical record documentation • Procedures for patient referral including available resources, procedures for follow-up and responsible personnel Plan for training all appropriate staff (including non-RW funded staff)	• Review of Policies and Procedures Manual indicates compliance. • Documentation in patient record
1.20	Patient Retention in Care The agency must have in place a written policy and procedure regarding client retention in care. The policy and procedure must include: • process for client appointment reminders (e.g. timing, frequency, position responsible) • process for contacting clients after missed appointments (e.g. timing, frequency, position responsible) • measures to promote retention in care process for re-engaging those lost to care (no primary care visit in 6 months)	• Review of Agency's Policies and Procedures Manual indicates compliance •
2.0	**Psychiatric care for persons with HIV should reflect competence and experience in both mental health care and therapeutics known to be effective in the treatment of psychiatric conditions and is consistent with the most current published Texas Society of Psychiatric Physicians/American Psychiatric Association treatment guidelines.**	
2.1	Psychiatric Guidelines Outpatient psychiatric care must be provided in accordance with the most current published treatment guidelines, including: Texas Society of Psychiatric Physicians guidelines (www.txpsych.org) and the American Psychiatric Association (www.psych.org/aids) guidelines.	• Documentation in patient record
3.0	**In addition to demonstrating competency in the provision of HIV specific care, HIV clinical service programs must show evidence that their performance follows norms for ambulatory care.**	

3.1	Access to Care Primary care providers shall ensure all new referrals from testing sites are scheduled for a new patient appointment within 15 working days of referral. (All exceptions to this timeframe will be documented) Agency must assure the time-appropriate delivery of services, with 24 hour on-call coverage including: • Mechanisms for urgent care evaluation and/or triage • Mechanisms for in-patient care • Mechanisms for information/referral to: ➢ Medical sub-specialties: Gastroenterology, Neurology, Psychiatry, Ophthalmology, Dermatology, Obstetrics and Gynecology and Dentistry ➢ Social work and case management services ➢ Mental health services ➢ Substance abuse treatment services ➢ Anti-retroviral counseling/therapy for pregnant women ➢ Local federally funded hemophilia treatment center for persons with inherited coagulopathies ➢ Clinical investigations	• Agency Policy and Procedure regarding continuity of care.
3.2	Continuity with Referring Providers Agency must have a formal policy for coordinating referrals for inpatient care and exchanging patient information with inpatient care providers.	• Review of Agency's Policies and Procedures Manual indicates compliance
3.3	Clients Referral and Tracking Agency receives referrals from a broad range of sources and makes appropriate referrals out when necessary. Agencies must implement tracking systems to identify clients who are out of care and/or need health screenings (e.g. Hepatitis b & c, cervical cancer screening, etc., for follow-up).	• Documentation of referrals out • Staff interviews indicate compliance • Established tracking systems
3.4	Client Notification of Service Provider Turnover Client must be provided notice of assigned service primary care provider's cessation of employment within 30 days of the employee's departure.	• Documentation in patient record
3.5	Recommended Format for Operational Standards Detailed standards and routines for program assessment are found in most recent Joint Commission performance standards.	• Ambulatory HIV clinical service should adopt and follow performance standards for ambulatory care as established by the Joint Commission

3.6	Client Accommodation for Same Day Provider Cancellations Agency must have a policy in place that outlines a timeline for client notification of provider cancellations, and a protocol for how patients will be accommodated when they do not receive notification in advance of arriving to the clinic.	• Review of Agency's Policies and Procedures Manual indicates compliance
3.7	Client Prescription Refill Policy Agency must have a policy in place that details short term prescription refill availability in when office visit is not feasible prior to patient depletion of medication.	• Review of Agency's Policies and Procedures Manual indicates compliance

Substance Use Services

The Houston EMA Substance Abuse Treatment/Counseling service is an outpatient service providing treatment and/or counseling to people living with HIV who have substance use disorders. Services provided must be integrated with HIV-related issues that trigger relapse and must be coordinated with local TDSHS/SAS HIV Early Intervention funded programs. All services must be provided in accordance with the Texas Department of State Health Services/Substance Abuse services (TDSHS/SAS) Chemical Dependency Treatment Facility Standards as well as current treatment guidelines.

1.0	**Services are offered in such a way as to overcome barriers to access and utilization. Service is easily accessible to persons with HIV.**	
1.1	Comprehensive Assessment A comprehensive assessment including the following will be completed within ten (10 days) of intake or no later than and prior to the third therapy session. • Presenting Problem • Developmental/Social history • Social support and family relationships • Medical history • Substance use history • Psychiatric history • Complete mental status evaluation (including appearance and behavior, talk, mood, self attitude, suicidal tendencies, perceptual disturbances, obsessions/compulsions, phobias, panic attacks) • Cognitive assessment (level of consciousness, orientation, memory and language) Specific assessment tools such as the Addiction Severity Index(ASI) could be used for substance use and sexual history and the Mini Mental State Examination (MMSE) for cognitive assessment.	• Completed assessment in client's record
1.2	Psychosocial History A psychosocial history will be completed and must include: • Education and training • Employment • Military service • Legal history • Family history and constellation	• Completed assessment in client's record

	• Physical, emotional and/or sexual abuse history • Sexual and relationship history and status • Leisure and recreational activities • General psychological functioning	
1.3	Treatment Plan Treatment plans are developed jointly with the counselor and client and must contain all the elements set forth in the Texas Department of State Health Services Administrative code for substance abuse including: • Statement of the goal(s) of counseling • The plan of approach • Mechanism for review The plan must also address full range of substances the patient is abusing Treatment plans must be completed no later than five working days of admission. Individual or group therapy should be based on professional guidelines. Supportive and educational counseling should include prevention of HIV related risk behaviors including substance use as clinically indicated.	• Completed treatment plan in client's record • Treatment Plan review documented in client's records
1.4	Treatment Plan Review In accordance with the Texas Department of State Health Services Administrative code on Substance Abuse, the treatment plan shall be reviewed at a minimum, midway through treatment and must reflect ongoing reassessment of client's problems, needs and response to therapy. The treatment plan duration, review interval and process must be stated in the agency policies and procedures and must follow criteria outlined in the Administrative Code.	• Review of agency's Policy and Procedure Manual indicates compliance • Updated treatment plan in client's record
2.0	**Services are part of the coordinated continuum of HIV services.**	
2.1	Clients Referral and Tracking Agency receives referrals from a broad range of sources and makes appropriate referrals out when necessary. Agency must have collaboration agreements with mental health and primary care providers or demonstrate that they offer these services on-site.	• Documentation of referrals received • Documentation of referrals out • Staff interviews indicate compliance • Collaborative agreements demonstrate that these services are offered on an off-site
2.2	Facility License	• Documentation of current agency licensure

	Agency is appropriately licensed by the Texas Department of State Health Services – Substance Abuse Services (TDSHS/SAS) with outpatient treatment designations.	
2.3	Minimum Qualifications All agency staff that provides direct client services must be properly licensed per current TDSHS/SAS requirements. Non-licensed staff must meet current TDSHS/SAS requirements.	• Documentation of current licensure in personnel files
3.0	**Staff HIV knowledge is based on documented training and experience.**	
3.1	Staff Training All agency staff, volunteers and students shall receive initial and subsequent trainings in accordance to the Texas Administrative Code, rule §448.603 (a), (c) & (d).	• Review of training curriculum indicates compliance • Documentation of all training in personnel file • Specific training requirements are specified in the staff guidelines • Documentation of all trainings must be done in accordance with the Texas Administrative Code §448.603 (b)
3.2	Experience – HIV A minimum of one (1) year documented HIV work experience is required. Those who do not meet this requirement must be supervised by a staff member with at least 1 year of documented HIV work experience.	• Documentation of work experience in personnel file
4.0	**Service providers are knowledgeable, accepting, and respectful of the needs of individuals with HIV Staff efforts are compassionate and sensitive to client needs.**	
4.1	Staff Supervision The agency shall ensure that each substance abuse Supervisor shall, at a minimal, be a Masters level professional (e.g. LPC, LCSW, LMSW, LMFT, Licensed Clinical Psychologist, LCDC if applicable) and licensed by the State of Texas and qualified to provide supervision per applicable TDSHS/SAS licensure requirements. Professional staff must be knowledgeable of the interaction of drug/alcohol use and HIV transmission and the interaction of prescribed medication with other drug/alcohol use.	• Review of personnel files indicates compliance • Review of agency's Policy and Procedure Manual indicates compliance

Transportation Services

The 2006 Care Act classifies Medical Transportation as a support service that provides conveyance services "directly or through voucher to a client so that he or she may access health care services". The Ryan White Part A transportation services include transportation to public and private outpatient medical care and physician services, substance abuse and mental health services, pharmacies and other services where eligible clients receive Ryan White-defined Core Services and/or medical and health-related care services, including clinical trials, essential to their well-being. All drivers utilized by the program must have a valid Texas Driver's license and must complete a "Safe Driving" course. The contractor must ensure that each vehicle has automobile liability insurance as required by the State and all vehicles have current Texas State Inspection.

1.0	**Transportation services are offered to eligible clients to ensure individuals most in need have access to services.**	
1.1	Client Eligibility In order to be eligible for services, individuals must meet the following: • HIV+ • Residence in the Houston EMA/HSDA • Part A Urban Transportation limited to Harris County • Part A Rural/Part B Transportation are limited to Houston EMA/HSDA, as applicable • Income no greater than 300% of the Federal Poverty level • Proof of identification • Documentation of ineligibility for Third Party Reimbursement	• Documentation of HIV+ status, identification, residence and income in the client record
1.2	Voucher Guidelines (Distribution Sites) • Bus Card Voucher (Renewal): Eligible clients who reside in the Metro service area will be issued a Metro bus card voucher by the client's record-owning agency for an annual bus card upon new registration and annually thereafter, within 15 days of bus pass expiration • Bus Card Voucher (Value-Based): Otherwise eligible clients who are not eligible for a renewal bus card voucher may be issued a value-based bus card voucher per RWGA business rules ➢ In order for an existing bus card client to renew their bus card (i.e. obtain another bus card voucher for all voucher types) there must be documentation that the client is engaged in ongoing primary medical care for treatment of HIV, or ➢ Documentation that the bus voucher is needed to ensure an out-of-care client is re-engaged in primary medical care	• Client record indicates guidelines were followed; if not, an explanation is documented • Documentation of the type of voucher(s) issued • Emergency necessitating taxi voucher is documented • Ongoing current **(within the last 180 days)** medical care is documented in the CPCDMS OR • A current (within the last 180 days) copy of client's Viral Load and/or CD4 lab work (preferred) or proof client is on ART (HIV medications) for clients in medical care

	• Gas Card: Eligible clients in the rural area will receive gas cards from their Ryan White Part A/B rural case management provider or their rural primary care provider, if the client is not case managed, per RWGA business rules • Taxi Voucher: for emergencies, to access emergency shelter vouchers and to attend Social Security disability hearings only	with Ryan White or non-Ryan White funded providers in client record OR • Engagement/re-engagement in medical care is documented in client's case management assessment and service plan.
1.3	Eligibility for Van-Based Transportation (Urban Transportation Only) Written certification from the client's principal medical provider (e.g. medical care coordinator) is required to access van-based transportation and must be renewed every 180 days. All clients may receive a maximum of 4 non-certified round trips per year (includes taxi vouchers).	• Client record indicates compliance
2.0	**ACCESSIBILITY** **Transportation services are offered in such a way as to overcome barriers to access and utilization.**	
2.1	Notification of Service Availability Prospective and current clients are informed of service availability, prioritization and eligibility requirements.	• Program information is clearly publicized • Availability of services, prioritization policy and eligibility requirements are defined in the information publicized
2.2	Access Clients must be able to initiate and coordinate their own services with the transportation providers in accordance with transportation system guidelines. This does not mean an advocate (e.g. social worker) for the client cannot assist the client in accessing transportation services. Agency must obtain a signed statement from clients regarding agreement on proper conduct of client in the vehicle. This statement should include the consequences of violating the agreement.	• Agency's policies and procedures for transportation services describe how the client can access the service • Review of agency's complaint and grievances log • Signed agreement in client's records
2.3	Handicap Accessibility Transportation services are handicap accessible. Agency/Driver may refuse service to client with open sores/wounds or real exposure risk.	• Agency compliance with the Americans with Disabilities Act (ADA) • Agency documentation of reason for refusal of service • Documentation of training in personnel records

	Agency must have a policy in place regarding training for drivers on the proper boarding/unloading assistance of passengers with wheel chairs and other durable health devices.	
2.4	EMA Accessibility Services are available throughout the Houston EMA as contractually defined in the RFP.	• Review of agency's Transportation Log and Monthly Activity Reports for compliance
2.5	Service Availability The Contractor must ensure that general transportation service hours are from 7:00 AM to 10:00 PM on weekdays (non-holidays), and coverage must be available for medical and health-related appointments on Saturdays.	• Review of Transportation Logs • Transportation services shall be available on Saturdays, by pre-scheduled appointment for core services • Review of agency policy and procedure
2.6	Service Capacity Agency will notify RWGA and other Ryan White providers when transportation resources are close to being maximized*. Agency will maintain documentation of clients who were refused services. * Maximized means the agency will not be able to provide service to client within the next 72 hours.	• RWGA will be contacted by phone/fax no later than twenty-four (24) working hours after services are maximized • Agency will document all clients who were denied transportation or a voucher
3.0	**Timeliness and Delays: Transportation services are provided in a timely manner**	
3.1	Timeliness There is minimal waiting time for vehicles and vans; appointments are kept • Waiting times longer than 2 hours will also be documented in the client record • If a cumulative incident of clients kept waiting for more than 2 hours reaches 75 clients in the contract year, this must be reported in writing within one business day to the administrative agent • Review of agency's complaint and grievance logs Client interviews and client satisfaction survey	• Waiting times longer than 60 minutes will be documented in Delay Incident Log. • Review of Delay incident log • Review of client's record
3.2	Immediate Service Problems Clients are made aware of problems immediately (e.g. vehicle breakdown) and notification documented.	• Review of Delay Incident Log, Transportation Refusal Log and client record indicates compliance • Review of agency's complaint and grievance logs

		• Client interviews and client satisfaction survey
3.3	Future Service Delays Clients and Ryan White providers are notified of future service delays, changes in appointment or schedules as they occur.	• Review of Delay Incident Log, Transportation Refusal Log and client record indicates compliance • Review of agency's complaint and grievance logs • Client interviews and client satisfaction survey • Documentation exists in the client record
3.4	Confirmation of Appointments Agency must allow clients to confirm appointments at least 48 hours in advance.	• Review of agency's transportation policies and procedures indicates compliance • Review of agency's complaint and grievance logs • Client interviews and client satisfaction survey.
3.5	"No Shows" "No Shows" are documented in Transportation Log and client record. Passengers who do not cancel scheduled rides for two (2) consecutive times or who "no show" for two (2) consecutive times or three times within the contract year *may be* removed from the van/vehicle roster for 30 days. If client is removed from the roster, he or she must be referred to other transportation services. One additional no show and the client can be suspended from service for one (1) year.	• Review of agency's transportation policies and procedures indicates compliance • Documentation on Transportation Log • Documentation in client record
3.6	System Abuse If an agency has verified that a client has falsified the existence of an appointment in order to access transportation, the client can be removed from the agency roster. If a client cancels van/vehicle transportation appointments in excess of three (3) times per month, the client may be removed from the van/vehicle roster for 30 days. Agency must have published rules regarding the consequences to the client in situations of system abuse.	• Documentation in the client record of verification that an appointment did not exist • Documentation in the client record of client cancellation of van/vehicle appointments • Availability of agency's published rules • Written documentation in the client record of specific instances of system abuse

3.7	Documentation of Service Utilization Transportation Provider must ensure: • Follow-up verification between transportation provider and destination service program confirming use of eligible service(s) or • Client provides proof of service documenting use of eligible services at destination agency on the date of transportation or • Scheduling of transportation services by receiving agency's case manager or transportation coordinator • In order to mitigate Agency exposure to clients who may fail to follow through with obtaining the required proof of service, Agency is allowed to provide one (1) one-way trip per client per year without proof of service documentation. The content of the proof of service will include: • Agency's letter head • Date/Time • CPCDMS client code • Name and signature of Agency's staff who attended to client • Agency's stamp	• Documentation of confirmation from destination agency in agency/client record • Client's original receipt from destination agency in agency/client record • Documentation in Case Manager's progress notes • Documentation in agency/client record of the one (1) allowable one-way trip per year without proof of service documentation
4.0	**Safety/Vehicle Maintenance: Transportation services are safe**	
4.1	Vehicle Maintenance and Insurance Vehicles are in good repair and equipped for adverse weather conditions. All vehicles will be equipped with both a fire extinguisher and first aid and CPR kits. A file will be maintained on each vehicle and shall include but not be limited to: description of vehicle including year, make, model, mileage, as well as general condition and integrity and service records. Inspections of vehicle should be routine, and documented not less than quarterly. Seat belts/restraint systems must be operational. When in place, child car seats must be operational and installed according to specifications. All lights and turn signals must be operational, brakes must be in good working order, tires must be in good condition and air conditioning/heating system must be fully operational.	• Inspection of First Aid/CPR kits indicates compliance • Review of vehicle file • Current vehicle State Inspection sticker. • Fire extinguisher inspection date must be current • Proof of current automobile liability and personal injury insurance in the amount of at least $300,000.00

	Driver must have radio or cell phone capability.	
4.2	Emergency Procedures Transportation emergency procedures are in place (e.g. breakdown of agency vehicle). Written procedures are developed and implemented to handle emergencies. Each driver will be instructed in how to handle emergencies before commencing service, and will be in-serviced annually.	• A copy of each in-service and sign-in roster with names both printed and signed and maintained in the driver's personnel file
4.3	Transportation of Children Children must be transported safely. When transporting children, the agency will adhere to the Texas Transportation code 545.412 child Passenger Safety Seat Systems. Information regarding this code can be obtained at http://www.statutes.legis.state.tx.us/docs/tn/htm/tn.545.htm. Necessity of a car seat should be documented on the Transportation Log by staff when appointment is scheduled. Children 15 years old or younger must be accompanied by an adult caregiver in order to be transported.	• Review of Transportation Log indicates compliance • Review of client records indicates compliance • Review of agency policies and procedures
4.4	Staff Requirements Picture identification of each driver must be posted in the vehicle utilized to transport clients. Criminal background checks must be performed on all direct service transportation personnel prior to transporting clients Drivers must have annual proof of a safe driving record, including history of tickets, DWI/DUI, or other traffic violations Conviction on more than three (3) moving violations within the past year will disqualify the driver Conviction of one (1) DWI/DUI within the past three (3) years will disqualify the driver.	• Documentation in vehicle • Documentation in personnel file
5.0	**Records Administration: Transportation services are documented consistently and appropriately**	
5.1	Transportation Consent Prior to receiving transportation services, clients must read and sign the Transportation Consent.	• Review of client records indicates compliance
5.2	Van/Vehicle Transportation Agency must document daily transportation services on the Transportation Log.	• Review of agency files indicates compliance

		• Log must contain driver's name, client's name or identification number, date, destinations, time of arrival, and type of appointment.
5.3	Mileage Documentation Agency must document the mileage between Trip Origin and Trip Destination (e.g. where client is transported to access eligible service) per a standard Internet-based mapping program (e.g. Yahoo Maps, Map Quest, Google Maps) for all clients receiving Van-based transportation services.	• Map is printed out and filed in client chart

Vision Services

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

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

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

Emergency Financial Assistance Program (OTHER)

Emergency Financial Assistance (EFA) is to provide one-time or short-term payments to assist the RWHAP client with an emergent need for paying for essential utilities, food (including groceries, and food vouchers), and transportation. Emergency financial assistance can occur as a direct payment to an agency or through a voucher program.

1.0	**Services are offered in such a way as to overcome barriers to access and utilization. Service is easily accessible to persons with HIV.**	
1.1	EFA funds may be used on the following essential items or services: • Utilities (may include household utilities including gas, electricity, propane, water, and all required fees). • Telephone • Food (groceries or food vouchers) Other RWHAP allowable costs needed to improve health outcomes.	• Review of agency's Policies & Procedures Manual indicates compliance • Review of billing history indicates compliance • Documentation in the client chart
1.2	Client Eligibility Applicants must demonstrate an urgent need resulting in their inability to pay their applicable bills without financial assistance for essential items or services necessary to improve health outcomes. Demonstrated need is made by the following: • A significant increase in bills • A recent decrease in income • High unexpected expenses on essential items • The cost of their shelter is more than 30% of the household income • The cost of their utility consumption is more than 10% of the household income • They are unable to obtain credit necessary to provide for basic needs and shelter • A failure to provide emergency financial assistance will result in danger to the physical health of client or dependent children • Other emergency needs as deemed appropriate by the agency	• Documentation of client assessment • Copy of invoice/bill paid. • Copy of check for payment

	The invoice/bill which is to be paid with emergency financial assistance funds must be in the client's name. An exception may be made only in instances where it is documented that, although the service (e.g. utility) is in another person's name, it directly benefits the client.	
1.3	Client Confidentiality Payment for assistance made to service providers will protect client confidentiality through use of checks and envelopes that de-identify agency as an HIV/AIDS provider to protect client confidentiality.	• Agency financial records indicate compliance • Documentation in the client chart
1.4	Assessment • An assessment must demonstrate an urgent need resulting in their inability to pay their applicable bills without financial assistance for essential items or services necessary to improve health outcomes. • Client will be assessed for ongoing status and outcome of the emergency assistance. Referrals for services, as applicable, will be documented in the client file. • Emergent need must be documented each time funds are used.	• Documentation in the client chart
1.5	Documentation • Plans are developed jointly with the client and must include an approach to mitigate the need in the future. • Client's chart contains documented plan for EFA that indicates emergent need, other resources pursued, and outcome of EFA provided.	• Documentation in the client chart
1.6	Timeliness of Service Provision All completed requests for assistance shall be approved or denied within three (3) business days following the completed request.	• Documentation in the client chart
2.0	**Agency requirements**	
2.1	Budget Requirements or Restrictions • Direct cash payments to clients are not permitted.	• Documentation includes copies of checks paid and vouchers purchased

	• RWHAP funds will be the payer of last resort, and for limited amounts, uses, and periods of time. Continuous provision of an allowable service to a client must not be funded through EFA. • At least **75%** of the total amount of the budget must be solely allocated to the actual cost of disbursements. • The agency must set priorities, delineate and monitor what part of the overall allocation for emergency assistance is obligated for each subcategory. Careful monitoring of expenditures within a subcategory of "emergency assistance" is necessary to assure that planned amounts for specific services are being implemented, and to determine when reallocations may be necessary. • Maximum allowable unit cost for provision of food vouchers or and/or utility assistance to an eligible client = $30.00/unit	• Review of agency's Policies & Procedures Manual indicates compliance • Documentation that at least **75%** of the total amount of the budget must be solely allocated to the actual cost of disbursements.
2.2	Agency providing emergency financial assistance shall have procedures in place to ensure that funds are distributed fairly and consistently.	• Agency written procedure
2.3	Agency must be dually awarded as HOWPA sub-recipient and work closely with other service providers to minimize duplication of services and ensure that assistance is given only when no reasonable alternatives are available. Agency must document procedures.	• Agency written procedure

Ryan White Part A HIV Performance Measures
Emergency Financial Assistance-Other

A minimum of 50% of clients will utilize Parts A/B/C/D primary care services after accessing Emergency Financial Assistance-Other.
A minimum of 85% of clients will utilize any RW Part A/B/C/D or State Services service after accessing Emergency Financial Assistance-Other.

2020 Quarterly Report
Quality Improvement Committee
(November 2020)

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