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

Memorandum

To: Members, Quality Improvement Committee

Denis Kelly, Co-Chair	Nkechi Onyewuenyi
Daphne Jones, Co- Chair	Oscar Perez
Kevin Aloysius	Tana Pradia
Veronica Ardoin	Pete Rodriguez
Skeet Boyle	Andrew Wilson
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Carin Martin	Mackenzie A. Hudson
Heather Keizman	Diane Beck
Mauricia Chatman	Ann Robison
Tiffany Shepherd	Gary Grier
Patrick Martin	

From: Tori Williams

Date: Monday, March 8, 2021

Re: Meeting Notice

Please note the following meeting information:

Tuesday, March 15, 2022

2:00 p.m. – Joint Meeting to Determine Criteria Used to Select the FY 2023 Ryan White Services

2:30 p.m. – Quality Improvement Committee Meeting

Location: Online or via phone
https://us02web.zoom.us/j/81519929661?pwd=cXZPdzkzdjJwWnJPeFRJc1RwOStYUT09
Meeting ID: 811 4450 9622
Passcode: 125672
Or, call in by dialing: 346 248 7799

Please RSVP to Rod, even if you cannot attend the meeting. She can be reached at: Rodriga.Avila@cjo.hctx.net or by telephone at 832 927-7926. And, if you have questions for your committee mentor, do not hesitate to contact her at:

DRAFT

Houston Area HIV Services Ryan White Planning Council
2223 West Loop South, Houston, Texas 77027

Joint Meeting of the Affected Community,
Quality Improvement and Priority and Allocations Committees

2:00 p.m., Tuesday, March 15, 2022

Join the meeting via Zoom, please do not come to the meeting in person
https://us02web.zoom.us/j/81519929661?pwd=cXZPdzkzdjJwWnJPeFRJc1RwOStYUT09
Meeting ID: 811 4450 9622
Passcode: 125672

Or, use your cell phone to dial in at: 346 248 7799

Agenda

Purpose of the Joint Meeting: To determine the criteria used to select the FY 2023 Service Categories.

I. Call to Order — Daphne L. Jones & Denis Kelly, Co-Chairs, Quality Improvement Committee
   A. Moment of Reflection
   B. Adoption of the Agenda

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 yourself, please state that you are attending as an individual and not as an agency representative. Individuals can also submit written comments to a member of the staff who would be happy to read the comments on behalf of the individual at this point in the meeting. All information from the public must be provided in this portion of the meeting.)

III. HRSA Service Categories — Tori Williams, Office of Support
   A. Review HRSA service definitions
   B. HRSA Defined Core Services
   C. Review list of FY 2022 Houston Part A, B and State Service-funded services

VI. Justification Tools — Daphne L. Jones & Denis Kelly
   A. FY 2023 Justification Chart

VII. Next Meeting (if necessary)
   A. Date and time
   B. Agenda items

VIII. Adjournment

THE QUALITY IMPROVEMENT COMMITTEE MEETING WILL BEGIN IMMEDIATELY AFTER THE JOINT MEETING ADJOURNS.

Appendix

RWHAP Legislation: Core Medical Services

Outpatient/Ambulatory Health Services
Description:
Outpatient/Ambulatory Health Services are diagnostic and therapeutic services provided directly to a client by a licensed healthcare provider in an outpatient medical setting. Outpatient medical settings include clinics, medical offices, and mobile vans where clients do not stay overnight. Emergency room or urgent care services are not considered outpatient settings. Allowable activities include:

- Medical history taking
- Physical examination
- Diagnostic testing, including laboratory testing
- Treatment and management of physical and behavioral health conditions
- Behavioral risk assessment, subsequent counseling, and referral
- Preventive care and screening
- Pediatric developmental assessment
- Prescription, and management of medication therapy
- Treatment adherence
- Education and counseling on health and prevention issues
- Referral to and provision of specialty care related to HIV diagnosis

Program Guidance:
Treatment Adherence services provided during an Outpatient/Ambulatory Health Service visit should be reported under the Outpatient/Ambulatory Health Services category whereas Treatment Adherence services provided during a Medical Case Management visit should be reported in the Medical Case Management service category.

See Policy Notice 13-04: Clarifications Regarding Clients Eligibility for Private Health Insurance and Coverage of Services by Ryan White HIV/AIDS Program
See Early Intervention Services

AIDS Drug Assistance Program Treatments
Description:
The AIDS Drug Assistance Program (ADAP) is a state-administered program authorized under Part B of the RWHAP to provide FDA-approved medications to low-income clients with HIV disease who have no coverage or limited health care coverage. ADAPs may also use program funds to purchase health insurance for eligible clients and for services that enhance access to, adherence to, and monitoring of antiretroviral therapy. RWHAP ADAP recipients must conduct a cost effectiveness analysis to ensure that purchasing health insurance is cost effective compared to the cost of medications in the aggregate.

Eligible ADAP clients must be living with HIV and meet income and other eligibility criteria as established by the state.

Program Guidance:
See PCN 07-03: The Use of Ryan White HIV/AIDS Program, Part B (formerly Title II), AIDS Drug Assistance Program (ADAP) Funds for Access, Adherence, and Monitoring Services;
PCN 13-05: Clarifications Regarding Use of Ryan White HIV/AIDS Program Funds for Premium and Cost-Sharing Assistance for Private Health Insurance; and

PCN 13-06: Clarifications Regarding Use of Ryan White HIV/AIDS Program Funds for Premium and Cost-Sharing Assistance for Medicaid

See also AIDS Pharmaceutical Assistance and Emergency Financial Assistance

AIDS Pharmaceutical Assistance
Description:
AIDS Pharmaceutical Assistance services fall into two categories, based on RWHAP Part funding.

1. Local Pharmaceutical Assistance Program (LPAP) is operated by a RWHAP Part A or B recipient or subrecipient as a supplemental means of providing medication assistance when an ADAP has a restricted formulary, waiting list and/or restricted financial eligibility criteria.

   RWHAP Part A or B recipients using the LPAP service category must establish the following:
   - Uniform benefits for all enrolled clients throughout the service area
   - A recordkeeping system for distributed medications
   - An LPAP advisory board
   - A drug formulary approved by the local advisory committee/board
   - A drug distribution system
   - A client enrollment and eligibility determination process that includes screening for ADAP and LPAP eligibility with rescreening at minimum of every six months
   - Coordination with the state's RWHAP Part B ADAP
     - A statement of need should specify restrictions of the state ADAP and the need for the LPAP
   - Implementation in accordance with requirements of the 340B Drug Pricing Program and the Prime Vendor Program

2. Community Pharmaceutical Assistance Program is provided by a RWHAP Part C or D recipient for the provision of long-term medication assistance to eligible clients in the absence of any other resources. The medication assistance must be greater than 90 days.

RWHAP Part C or D recipients using this service category must establish the following:

- A financial eligibility criteria and determination process for this specific service category
- A drug formulary consisting of HIV primary care medications not otherwise available to the client
- Implementation in accordance with the requirements of the 340B Drug Pricing Program and the Prime Vendor Program

Program Guidance:
For LPAPs: Only RWHAP Part A grant award funds or Part B Base award funds may be used to support an LPAP. ADAP funds may not be used for LPAP support. LPAP funds are not to be used for Emergency Financial Assistance. Emergency Financial Assistance may assist with medications not covered by the LPAP.

For Community Pharmaceutical Assistance: This service category should be used when RWHAP Part C or D funding is expended to routinely refill medications. RWHAP Part C or D recipients should use the Outpatient Ambulatory Health Services or Emergency Financial Assistance service for non-routine, short-term medication assistance.

See Ryan White HIV/AIDS Program Part A and B National Monitoring Standards
See also LPAP Policy Clarification Memo
See also AIDS Drug Assistance Program Treatments and Emergency Financial Assistance

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

Program Guidance:
None at this time.

Early Intervention Services (EIS)
Description:
The RWHAP legislation defines EIS for Parts A, B, and C. See § 2651(e) of the Public Health Service Act.

Program Guidance:
The elements of EIS often overlap with other service category descriptions; however, EIS is the combination of such services rather than a stand-alone service. RWHAP Part recipients should be aware of programmatic expectations that stipulate the allocation of funds into specific service categories.

- RWHAP Parts A and B EIS services must include the following four components:
    - Targeted HIV testing to help the unaware learn of their HIV status and receive referral to HIV care and treatment services if found to be HIV-infected
        - Recipients must coordinate these testing services with other HIV prevention and testing programs to avoid duplication of efforts
        - HIV testing paid for by EIS cannot supplant testing efforts paid for by other sources
    - Referral services to improve HIV care and treatment services at key points of entry
    - Access and linkage to HIV care and treatment services such as HIV Outpatient/Ambulatory Health Services, Medical Case Management, and Substance Abuse Care
    - Outreach Services and Health Education/Risk Reduction related to HIV diagnosis

- RWHAP Part C EIS services must include the following four components:
    - Counseling individuals with respect to HIV
    - High risk targeted HIV testing (confirmation and diagnosis of the extent of immune deficiency)
        - Recipients must coordinate these testing services under Part C EIS with other HIV prevention and testing programs to avoid duplication of efforts
        - The HIV testing services supported by Part C EIS funds cannot supplant testing efforts covered by other sources
    - Referral and linkage to care of HIV-infected clients to Outpatient/Ambulatory Health Services, Medical Case Management, Substance Abuse Care, and other services as part of a comprehensive care system including a system for tracking and monitoring referrals
    - Other clinical and diagnostic services related to HIV diagnosis

Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals

Description:

Health Insurance Premium and Cost Sharing Assistance provides financial assistance for eligible clients living with HIV to maintain continuity of health insurance or to receive medical and pharmacy benefits under a health care coverage program. To use RWHAP funds for health insurance premium and cost-sharing assistance, a RWHAP Part recipient must implement a methodology that incorporates the following requirements:

- RWHAP Part recipients must ensure that clients are buying health coverage that, at a minimum, includes at least one drug in each class of core

antiretroviral therapeutics from the Department of Health and Human Services (HHS) treatment guidelines along with appropriate HIV outpatient/ambulatory health services

- RWHAP Part recipients must assess and compare the aggregate cost of paying for the health coverage option versus paying for the aggregate full cost for medications and other appropriate HIV outpatient/ambulatory health services, and allocate funding to Health Insurance Premium and Cost Sharing Assistance only when determined to be cost effective

The service provision consists of either or both of the following:

- Paying health insurance premiums to provide comprehensive HIV Outpatient/Ambulatory Health Services and pharmacy benefits that provide a full range of HIV medications for eligible clients
- Paying cost-sharing on behalf of the client

Program Guidance:
Traditionally, RWHAP Parts A and B funding support health insurance premiums and cost-sharing assistance. If a RWHAP Part C or D recipient has the resources to provide this service, an equitable enrollment policy must be in place and it must be cost-effective and sustainable.

See PCN 07-05: Program Part B ADAP Funds to Purchase Health Insurance;
PCN 13-05: Clarifications Regarding Use of Ryan White HIV/AIDS Program Funds for Premium and Cost-Sharing Assistance for Private Health Insurance;
PCN 13-06: Clarifications Regarding Use of Ryan White HIV/AIDS Program Funds for Premium and Cost-Sharing Assistance for Medicaid; and
PCN 14-01: Revised 4/3/2015: Clarifications Regarding the Ryan White HIV/AIDS Program and Reconciliation of Premium Tax Credits under the Affordable Care Act

Home Health Care
Description:
Home Health Care is the provision of services in the home that are appropriate to a client's needs and are performed by licensed professionals. Services must relate to the client's HIV disease and may include:

- Administration of prescribed therapeutics (e.g. intravenous and aerosolized treatment, and parenteral feeding)
- Preventive and specialty care
- Wound care
- Routine diagnostics testing administered in the home
- Other medical therapies

Program Guidance:

The provision of Home Health Care is limited to clients that are homebound. Home settings do not include nursing facilities or inpatient mental health/substance abuse treatment facilities.

Medical Nutrition Therapy
Description:
Medical Nutrition Therapy includes:

- Nutrition assessment and screening
- Dietary/nutritional evaluation
- Food and/or nutritional supplements per medical provider's recommendation
- Nutrition education and/or counseling

These services can be provided in individual and/or group settings and outside of HIV Outpatient/Ambulatory Health Services.

Program Guidance:
All services performed under this service category must be pursuant to a medical provider's referral and based on a nutritional plan developed by the registered dietitian or other licensed nutrition professional. Services not provided by a registered/licensed dietician should be considered Psychosocial Support Services under the RWHAP.

See Food-Bank/Home Delivered Meals

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

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

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

To meet the need for hospice services, a physician must certify that a patient is terminally ill and has a defined life expectancy as established by the recipient. Counseling services provided in the context of hospice care must be consistent with the definition of mental health counseling. Palliative therapies must be consistent with those covered under respective state Medicaid programs.

Home and Community-Based Health Services

Description:

Home and Community-Based Health Services are provided to a client living with HIV in an integrated setting appropriate to a client's needs, based on a written plan of care established by a medical care team under the direction of a licensed clinical provider. Services include:

- Appropriate mental health, developmental, and rehabilitation services
- Day treatment or other partial hospitalization services
- Durable medical equipment
- Home health aide services and personal care services in the home

Program Guidance:

Inpatient hospitals, nursing homes, and other long-term care facilities are not considered an integrated setting for the purposes of providing home and community-based health services.

Mental Health Services

Description:

Mental Health Services are the provision of outpatient psychological and psychiatric screening, assessment, diagnosis, treatment, and counseling services offered to clients living with HIV. Services are based on a treatment plan, conducted in an outpatient group or individual session, and provided by a mental health professional licensed or authorized within the state to render such services. Such professionals typically include psychiatrists, psychologists, and licensed clinical social workers.

Program Guidance:

Mental Health Services are allowable only for HIV-infected clients.

See Psychosocial Support Services

Substance Abuse Outpatient Care

Description:

Substance Abuse Outpatient Care is the provision of outpatient services for the treatment of drug or alcohol use disorders. Services include:

- Screening
- Assessment
- Diagnosis, and/or
- Treatment of substance use disorder, including:
    - Pretreatment/recovery readiness programs
    - Harm reduction
    - Behavioral health counseling associated with substance use disorder
    - Outpatient drug-free treatment and counseling
    - Medication assisted therapy
    - Neuro-psychiatric pharmaceuticals
    - Relapse prevention

Program Guidance:
Acupuncture therapy may be allowable under this service category only when, as part of a substance use disorder treatment program funded under the RWHAP, it is included in a documented plan.

Syringe access services are allowable, to the extent that they comport with current appropriations law and applicable HHS guidance, including HRSA- or HAB-specific guidance.

See Substance Abuse Services (residential)

Medical Case Management, including Treatment Adherence Services
Description:
Medical Case Management is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum. Activities may be prescribed by an interdisciplinary team that includes other specialty care providers. Medical Case Management includes all types of case management encounters (e.g., face-to-face, phone contact, and any other forms of communication). Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Continuous client monitoring to assess the efficacy of the care plan
- Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems
- Treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments
- Client-specific advocacy and/or review of utilization of services

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

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

Visits to ensure readiness for, and adherence to, complex HIV treatments shall be considered Medical Case Management or Outpatient/Ambulatory Health Services. Treatment Adherence Services provided during a Medical Case Management visit should be reported in the Medical Case Management service category whereas Treatment Adherence services provided during an Outpatient/Ambulatory Health Service visit should be reported under the Outpatient/Ambulatory Health Services category.

RWHAP Legislation: Support Services

Non-Medical Case Management Services

Description:

Non-Medical Case Management Services (NMCM) provide guidance and assistance in accessing medical, social, community, legal, financial, and other needed services. Non-Medical Case management services may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, or health insurance Marketplace plans. This service category includes several methods of communication including face-to-face, phone contact, and any other forms of communication deemed appropriate by the RWHAP Part recipient. Key activities include:

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

Program Guidance:

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

Child Care Services

Description:

The RWHAP supports intermittent child care services for the children living in the household of HIV-infected clients for the purpose of enabling clients to attend medical visits, related appointments, and/or RWHAP-related meetings, groups, or training sessions.

Allowable use of funds include:

- A licensed or registered child care provider to deliver intermittent care

- Informal child care provided by a neighbor, family member, or other person (with the understanding that existing federal restrictions prohibit giving cash to clients or primary caregivers to pay for these services)

Program Guidance:
The use of funds under this service category should be limited and carefully monitored. Direct cash payments to clients are not permitted.

Such arrangements may also raise liability issues for the funding source which should be carefully weighed in the decision process.

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

Program Guidance:
Direct cash payments to clients are not permitted.

It is expected that all other sources of funding in the community for emergency financial assistance will be effectively used and that any allocation of RWHAP funds for these purposes will be as the payer of last resort, and for limited amounts, uses, and periods of time. Continuous provision of an allowable service to a client should not be funded through emergency financial assistance.

See AIDS Drug Assistance Program Treatments, AIDS Pharmaceutical Assistance, and other corresponding categories

Food Bank/Home Delivered Meals
Description:
Food Bank/Home Delivered Meals refers to the provision of actual food items, hot meals, or a voucher program to purchase food. This also includes the provision of essential non-food items that are limited to the following:

- Personal hygiene products
- Household cleaning supplies
- Water filtration/purification systems in communities where issues of water safety exist

Program Guidance:
Unallowable costs include household appliances, pet foods, and other non-essential products.

See Medical Nutrition Therapy. Nutritional services and nutritional supplements provided by a registered dietitian are considered a core medical service under the RWHAP.

Health Education/Risk Reduction

Description:

Health Education/Risk Reduction is the provision of education to clients living with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes sharing information about medical and psychosocial support services and counseling with clients to improve their health status. Topics covered may include:

- Education on risk reduction strategies to reduce transmission such as pre-exposure prophylaxis (PrEP) for clients' partners and treatment as prevention
- Education on health care coverage options (e.g., qualified health plans through the Marketplace, Medicaid coverage, Medicare coverage)
- Health literacy
- Treatment adherence education

Program Guidance:

Health Education/Risk Reduction services cannot be delivered anonymously.

See Early Intervention Services

Housing

Description:

Housing services provide limited short-term assistance to support emergency, temporary, or transitional housing to enable a client or family to gain or maintain outpatient/ambulatory health services. Housing-related referral services include assessment, search, placement, advocacy, and the fees associated with these services.

Housing services are transitional in nature and for the purposes of moving or maintaining a client or family in a long-term, stable living situation. Therefore, such assistance cannot be provided on a permanent basis and must be accompanied by a strategy to identify, relocate, and/or ensure the client or family is moved to, or capable of maintaining, a long-term, stable living situation.

Eligible housing can include housing that provides some type of medical or supportive services (such as residential substance use disorder services or mental health services, residential foster care, or assisted living residential services) and housing that does not provide direct medical or supportive services, but is essential for a client or family to gain or maintain access to and compliance with HIV-related outpatient/ambulatory health services and treatment.

Program Guidance:

RWHAP Part recipients must have mechanisms in place to allow newly identified clients access to housing services. Upon request, RWHAP recipients must provide HAB with an individualized written housing plan, consistent with RWHAP Housing

Policy 11-01, covering each client receiving short term, transitional and emergency housing services. RWHAP recipients and local decision making planning bodies, (i.e., Part A and Part B) are strongly encouraged to institute duration limits to provide transitional and emergency housing services. The US Department of Housing and Urban Development (HUD) defines transitional housing as up to 24 months and HRSA/HAB recommends that recipients consider using HUD's definition as their standard.

Housing services funds cannot be in the form of direct cash payments to clients and cannot be used for mortgage payments.

See PCN 11-01 The Use of Ryan White HIV/AIDS Program Funds for Housing Referral Services and Short-term or Emergency Housing Needs

Legal Services
See Other Professional Services

Linguistic Services
Description:
Linguistic Services provide interpretation and translation services, both oral and written, to eligible clients. These services must be provided by qualified linguistic services providers as a component of HIV service delivery between the healthcare provider and the client. These services are to be provided when such services are necessary to facilitate communication between the provider and client and/or support delivery of RWHAP-eligible services.

Program Guidance:
Services provided must comply with the National Standards for Culturally and Linguistically Appropriate Services (CLAS).

Medical Transportation
Description:
Medical Transportation is the provision of nonemergency transportation services that enables an eligible client to access or be retained in core medical and support services.

Program Guidance:
Medical transportation may be provided through:

- Contracts with providers of transportation services
- Mileage reimbursement (through a non-cash system) that enables clients to travel to needed medical or other support services, but should not in any case exceed the established rates for federal Programs (Federal Joint Travel Regulations provide further guidance on this subject)
- Purchase or lease of organizational vehicles for client transportation programs, provided the recipient receives prior approval for the purchase of a vehicle

- Organization and use of volunteer drivers (through programs with insurance and other liability issues specifically addressed)
- Voucher or token systems

Unallowable costs include:

- Direct cash payments or cash reimbursements to clients
- Direct maintenance expenses (tires, repairs, etc.) of a privately-owned vehicle
- Any other costs associated with a privately-owned vehicle such as lease, loan payments, insurance, license, or registration fees

Other Professional Services

Description:

Other Professional Services allow for the provision of professional and consultant services rendered by members of particular professions licensed and/or qualified to offer such services by local governing authorities. Such services may include:

- Legal services provided to and/or on behalf of the individual living with HIV and involving legal matters related to or arising from their HIV disease, including:
    - Assistance with public benefits such as Social Security Disability Insurance (SSDI)
    - Interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the RWHAP
    - Preparation of:
        - Healthcare power of attorney
        - Durable powers of attorney
        - Living wills
- Permanency planning to help clients/families make decisions about the placement and care of minor children after their parents/caregivers are deceased or are no longer able to care for them, including:
    - Social service counseling or legal counsel regarding the drafting of wills or delegating powers of attorney
    - Preparation for custody options for legal dependents including standby guardianship, joint custody, or adoption
- Income tax preparation services to assist clients in filing Federal tax returns that are required by the Affordable Care Act for all individuals receiving premium tax credits

Program Guidance:

Legal services exclude criminal defense and class-action suits unless related to access to services eligible for funding under the RWHAP.

See 45 CFR § 75.459

Outreach Services
Description:
Outreach Services include the provision of the following three activities:

- Identification of people who do not know their HIV status and linkage into Outpatient/Ambulatory Health Services
- Provision of additional information and education on health care coverage options
- Reengagement of people who know their status into Outpatient/Ambulatory Health Services

Program Guidance:
Outreach programs must be:

- Conducted at times and in places where there is a high probability that individuals with HIV infection and/or exhibiting high-risk behavior
- Designed to provide quantified program reporting of activities and outcomes to accommodate local evaluation of effectiveness
- Planned and delivered in coordination with local and state HIV prevention outreach programs to avoid duplication of effort
- Targeted to populations known, through local epidemiologic data or review of service utilization data or strategic planning processes, to be at disproportionate risk for HIV infection

Funds may not be used to pay for HIV counseling or testing under this service category.

See Policy Notice 12-01: The Use of Ryan White HIV/AIDS Program Funds for Outreach Services. Outreach services cannot be delivered anonymously as personally identifiable information is needed from clients for program reporting.

See Early Intervention Services

Permanency Planning
See Other Professional Services

Psychosocial Support Services
Description:
Psychosocial Support Services provide group or individual support and counseling services to assist eligible people living with HIV to address behavioral and physical health concerns. These services may include:

- Bereavement counseling
- Caregiver/respite support (RWHAP Part D)
- Child abuse and neglect counseling
- HIV support groups

- Nutrition counseling provided by a non-registered dietitian (*see* Medical Nutrition Therapy Services)
- Pastoral care/counseling services

Program Guidance:
Funds under this service category may not be used to provide nutritional supplements (*See* Food Bank/Home Delivered Meals).

RWHAP-funded pastoral counseling must be available to all eligible clients regardless of their religious denominational affiliation.

Funds may not be used for social/recreational activities or to pay for a client's gym membership.

For RWHAP Part D recipients, outpatient mental health services provided to affected clients (people not identified with HIV) should be reported as Psychosocial Support Services; this is generally only a permissible expense under RWHAP Part D.

See Respite Care Services

Referral for Health Care and Support Services
Description:
Referral for Health Care and Support Services directs a client to needed core medical or support services in person or through telephone, written, or other type of communication. This service may include referrals to assist eligible clients to obtain access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, and other state or local health care and supportive services, or health insurance Marketplace plans).

Program Guidance:
Referrals for Health Care and Support Services provided by outpatient/ambulatory health care providers should be reported under the Outpatient/Ambulatory Health Services category.

Referrals for health care and support services provided by case managers (medical and non-medical) should be reported in the appropriate case management service category (i.e., Medical Case Management or Non-Medical Case Management).

Rehabilitation Services
Description:
Rehabilitation Services are provided by a licensed or authorized professional in accordance with an individualized plan of care intended to improve or maintain a client's quality of life and optimal capacity for self-care.

Program Guidance:

Examples of allowable services under this category are physical and occupational therapy.

Respite Care
Description:
Respite Care is the provision of periodic respite care in community or home-based settings that includes non-medical assistance designed to provide care for an HIV-infected client to relieve the primary caregiver responsible for the day-to-day care of an adult or minor living with HIV.

Program Guidance:
Recreational and social activities are allowable program activities as part of a respite care service provided in a licensed or certified provider setting including drop-in centers within HIV Outpatient/Ambulatory Health Services or satellite facilities.

Funds may not be used for off premise social/recreational activities or to pay for a client's gym membership.

Funds may be used to support informal, home-based Respite Care, but liability issues should be included in the consideration of this expenditure. Direct cash payments to clients are not permitted.

See Psychosocial Support Services

Substance Abuse Services (residential)
Description:
Substance Abuse Services (residential) is the provision of services for the treatment of drug or alcohol use disorders in a residential setting to include screening, assessment, diagnosis, and treatment of substance use disorder. This service includes:

- Pretreatment/recovery readiness programs
- Harm reduction
- Behavioral health counseling associated with substance use disorder
- Medication assisted therapy
- Neuro-psychiatric pharmaceuticals
- Relapse prevention
- Detoxification, if offered in a separate licensed residential setting (including a separately-licensed detoxification facility within the walls of an inpatient medical or psychiatric hospital)

Program Guidance:
Substance Abuse Services (residential) is permitted only when the client has received a written referral from the clinical provider as part of a substance use disorder treatment program funded under the RWHAP.

Substance Abuse Services (residential) are not allowable services under RWHAP Parts C and D.

Acupuncture therapy may be allowable funded under this service category only when it is included in a documented plan as part of a substance use disorder treatment program funded under the RWHAP.

RWHAP funds may not be used for inpatient detoxification in a hospital setting, unless the detoxification facility has a separate license.

HIV/AIDS Bureau (HAB) Ryan White HIV/AIDS Program (RWHAP)

Policy Clarification Notice 16-02: Eligible Individuals and Allowable Uses of Funds

Frequently Asked Questions

GENERAL:

1. Are practitioners who provide RWHAP services required to have a professional license?

   When licensure/certification is required by state and/or local regulations, providers must be appropriately licensed and in compliance with those regulations.

2. Do subrecipients have to adhere to the service category descriptions?

   Yes, subrecipients must adhere to the service category descriptions. RWHAP recipients must ensure that subrecipients adhere to the service categories descriptions when developing contracts or memorandums of understanding and through their monitoring processes and procedures.

CORE MEDICAL SERVICES:

3. Which service categories can be used to purchase medications?

   Purchasing of medications can be done through many service categories. To determine the appropriate category, review the program guidance under: AIDS Drug Assistance Program (ADAP) Treatments, Outpatient Ambulatory Health Services (OAHS), Emergency Financial Assistance (EFA), AIDS Pharmaceutical Assistance (i.e., Local Pharmaceutical Assistance Program (LPAP), Community Pharmaceutical Assistance), Substance Abuse Outpatient Care, Substance Abuse Services (residential), and/or Hospice Services.

4. During a medical care visit, there are immediate needs by the client to obtain a medication. Can a provider dispense this medication as part of that medical care visit and have the service categorized under Outpatient Ambulatory Health Services or EFA?

   RWHAP recipients should not make the dispensing of medications a standard practice. When this does occur, on a rare occasion, the recipient should document such service under EFA. If EFA is not available (due to lack of contract or processes in place), the service can be documented under OAHS if the medication is dispensed as part of a medical visit and there is an immediate and urgent medical need.

5. As a direct medical care provider funded by Part C, which category should be used to capture the dispensing of medication?

   Depending on the model of care, a direct provider of care could provide services under three different categories: AIDS Pharmaceutical Assistance (Community Pharmaceutical

Assistance), OAHS (prescription and management of prescription therapy), or EFA. Availability of pharmaceutical resources will influence which category is used.

6. Under OAHS, does prescription and management of medication include dispensing?

   When the medications are not funded by any other source (such as ADAP or LPAP as part of AIDS Pharmaceutical Assistance), OAHS is an option if resources are available until such time that the client can be enrolled in other programs to pay for medications. The dispensing of medication should be in the context of a medical visit. This should be on a short term basis until recipients enroll clients in ADAP, AIDS Pharmaceutical Assistance or EFA.

7. What is the difference between a local pharmaceutical assistance program for indigent populations that is run and funded by a state or local government and the AIDS Pharmaceutical Assistance/LPAP service category described by HRSA/HAB?

   HAB's use of the term LPAP is intended to differentiate this service from the state ADAP. It is a supplemental means of providing medication assistance for people living with HIV (PLWH) where there are various limits on the state ADAP; it is created and supported by the RWHAP recipient, although, in some instances, the RWHAP-supported LPAP may also receive state or local funding. HAB recognizes that many governments fund and provide, with their own generated resources, more general pharmaceutical assistance to a wide range of indigent populations within their jurisdiction, some of which are called local pharmaceutical assistance programs. To the extent that such programs are available to PLWH, they should be utilized, but the term "LPAP" under RWHAP does not constitute a reference to such programs.

8. Can I provide targeted HIV testing and referral services under Early Intervention Services (EIS)?

   Yes, in conjunction with the other required components of EIS. RWHAP Parts A and B EIS must include the following four components: targeted HIV testing, referral services, access and linkage to HIV care and treatment services, and health education/risk reduction related to HIV diagnosis. Part C EIS services must include the following four components: counseling individuals with respect to HIV, high risk targeted HIV testing (confirmation and diagnosis of the extent of immune deficiency), referral and linkage to care of HIV-infected clients, and other clinical and diagnostic services related to HIV diagnosis.

9. I am a Part C recipient. Can I use the Health Insurance Premium and Cost-Sharing Assistance for Low-Income Individuals service category?

   Traditionally, RWHAP Parts A and B funding support health insurance premiums and cost-

sharing assistance. If a RWHAP Part C or D recipient has the resources to provide this service, an equitable enrollment policy must be in place and it must be cost-effective. Equitable is a systematic approach that is fair.

10. How are medical case management and non-medical case management services different?

    Medical Case Management (MCM) services help clients improve health care outcomes. MCM providers should be able to analyze the care that a client receives to ensure that the client is obtaining the services necessary to improve his/her health outcomes. Non-Medical Case Management (NMCM) services provide guidance and assistance to clients to help them to access needed services (medical, social, community, legal, financial, and other needed services), but may not analyze the services to enhance their care toward improving their health outcomes.

    Both MCM and NMCM services may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, or health insurance Marketplace plans.

    Both service categories include several methods of communication including face-to-face, phone contact, and any other forms of communication deemed appropriate by the RWHAP Part recipient.

11. How do I know which service category should be used for treatment adherence?

    Treatment adherence services are provided conjointly with many service categories such as OAHS, MCM, or ADAP. As such, recipients may choose to record treatment adherence within the service category during which the adherence service was given. In addition, if treatment adherence services are provided as a stand-alone activity, it can be reported under Health Education/Risk Reduction.

12. Who are authorized to provide Home Health Care services to RWHAP clients?

    Home health care services must be prescribed by a licensed medical provider and can be performed by licensed medical professionals, such as physicians, mid-level providers, nurses, and certified medical assistants. This does not include non-licensed, in-home care providers.

SUPPORT SERVICES:

13. If there is another professional service that clients need, can I include it under other professional services?

Other Professional Services allow for the provision of professional and consultant services rendered by members of particular professions licensed and/or qualified to offer such services by local governing authorities. Such services may include: legal services, permanency planning, and income tax preparation services. Recipients should work with their project officer to discuss other allowable professional services that may fall within this category.

14. Can I include vocational therapy under the rehabilitation services category?

    Yes, this is an allowable activity, but a recipient should establish policies regarding the use of this service, and ensure it is cost effective.

15. How do recipients define the length of life expectancy an individual must have in order to receive hospice care?

    Recipients have the flexibility to define life expectancy, but must establish that criterion and implement it consistently.

16. Can a RWHAP recipient support intermittent child care services for the children living in the house of HIV-infected clients?

    Recipients may use funds to cover child care services for HIV-infected clients to enable their attendance at medical visits, related appointments, and/or RWHAP and HIV-related meetings, groups, or training sessions. Direct cash payments to clients are not permitted. Funds used for this service should be limited and carefully monitored.

17. Should EFA funds that are used for allowable services (food, housing, transportation, etc.) be accounted under the corresponding service category or the specific category of EFA?

    The funds should be counted under EFA regardless of how the funds were used.

18. Is transitional housing an allowable service under the RWHAP?

    Yes. Recipients and local decision making planning bodies are strongly encouraged to institute duration limits to provide transitional and emergency housing services. HAB recommends that recipients consider using the U.S. Department of Housing and Urban Development's definition of transitional housing as 24 months.

19. Can linguistic services be used to pay for translating printed materials such as ADAP application?

    Yes, this activity would facilitate discussion between the provider and client regarding their service needs through a language that is understood.

HIV/AIDS Bureau (HAB) Ryan White HIV/AIDS Program (RWHAP)

Policy Clarification Notice 16-02: Eligible Individuals and Allowable Uses of Funds

Standalone Dental Insurance Frequently Asked Questions

1. Can recipients offer both standalone dental insurance premiums and/or cost sharing assistance under the service category Health Insurance Premiums and Cost Sharing Assistance **and** RWHAP Oral Health Care services in their program?

   Recipients and subrecipients are able to provide both service categories within their programs as long as the standalone dental insurance premium and/or cost sharing assistance and Oral Health Care services are provided in compliance with the requirements for each described in *PCN #16-02 Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds*.

2. Can recipients/subrecipients use RWHAP funds to pay for oral health care services that exceed annual expenditure caps established by standalone dental insurance plans?

   RWHAP recipients and subrecipients are in the best position to understand the unique needs of their client populations, determine which costs are cost-effective to pay, and ensure availability of the resources equitably for eligible clients. It is up to the recipient and subrecipient to identify which costs they will cover related to standalone dental insurance, which can include: premiums, deductibles, co-payments, and/or costs above the cap. The recipient or subrecipient must have policies and procedures in place to ensure these services are available to all eligible RWHAP clients.

3. Can ADAP funds or pharmaceutical rebates be used to purchase standalone dental insurance premiums and/or cost sharing assistance?

   ADAP funds cannot be used to purchase standalone dental insurance premiums and cost sharing assistance because standalone dental insurance does not cover the cost of medications necessary in treatment for people living with HIV. See *PCN #13-05 Clarifications Regarding Use of Ryan White HIV/AIDS Program Funds for Premium and Cost Sharing Assistance for Private Health Insurance* for requirements for ADAPs to pay for Health Insurance Premiums and Cost Sharing Assistance for Individuals.

   However, as *PCN #15-04 Utilization and Reporting of Pharmaceutical Rebates* explains, "the RWHAP legislation requires that rebates collected on ADAP medication purchases be applied to the RWHAP Part B Program with a priority, but not a requirement, that the rebates be placed back into ADAP. These rebates must be used for the statutorily permitted purposes under the RWHAP Part B Program which are limited to core medical services including ADAP, support services, clinical quality management, and administrative expenses (including planning and evaluation) as part of a comprehensive system of care for low-income individuals living with

HIV." Pharmaceutical rebates earned by the RWHAP Part B Program may be used to pay for standalone dental insurance premiums and/or cost sharing assistance.

4. When does the addition of standalone dental insurance to the Health Insurance Premiums and Cost Sharing Assistance for Low-Income Individuals service category take effect?

   PCN #16-02 is in effect for all awards made on or after October 1, 2016, including competing continuations, noncompeting continuations, supplements, and new awards.

HIV/AIDS Bureau (HAB) Ryan White HIV/AIDS Program (RWHAP)

Policy Clarification Notice 16-02: Eligible Individuals and Allowable Uses of Funds

Housing Services Frequently Asked Questions

1. What service category should be used if the housing service is a one-time payment for a utility bill? Is a housing assessment required for this one-time payment?

   The housing service category covers transitional, short-term, or emergency housing assistance to enable a client or family to gain or maintain outpatient/ambulatory health services and treatment that extends beyond a one-time service. If a RWHAP recipient makes a one-time payment for a client's utility or housing bill, this should be categorized as emergency financial assistance. A housing assessment and individualized housing plan would not be required for a one-time housing payment provided under emergency financial assistance.

2. A client comes in to receive services and it is determined that their housing needs extend beyond a one-time payment. If the client's housing needs were previously assessed, would that client need an additional assessment?

   If a RWHAP client's housing needs extend beyond a one-time payment, and there is a need for additional housing services, this service should be categorized as housing. Clients receiving housing services must have their housing needs assessed annually and an individualized written housing plan developed to determine if there is a need for new or additional housing services.

3. Can RWHAP funds be used for rental deposits?

   No, RWHAP funds may not be used for rental deposits. Because rental deposits are typically returned to clients as cash, this would violate the prohibition on providing cash payments to clients. In some instances, deposits may be retained as payment (e.g., damage to the property). As such costs would additionally be unallowable, recipients cannot pay for a rental deposit using federal funds, program income generated from federal funds, or pharmaceutical rebates generated from federal funds.

Service Categories

CORE MEDICAL SERVICES	SUPPORT SERVICES
Outpatient/Ambulatory Health Services	Non-Medical Case Management Services
AIDS Drug Assistance Program Treatments	Child Care Services
AIDS Pharmaceutical Assistance	Emergency Financial Assistance
Oral Health Care	Food Bank/Home Delivered Meals
Early Intervention Services (EIS)	Health Education/Risk Reduction
Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals	Housing
Home Health Care	Other Professional Services
Home and Community-Based Health Services	Linguistic Services
Hospice Services	Medical Transportation
Mental Health Services	Outreach Services
Medical Nutrition Therapy	Psychosocial Support Services
Medical Case Management, including Treatment Adherence Services	Referral for Health Care and Support Services
Substance Abuse Outpatient Care	Rehabilitation Services
	Respite Care
	Substance Abuse Services (residential)

FY 2022 Ryan White Part A and B and State Services
Funded Service Categories

** = HRSA-defined core service

Part A Funded Service Categories:

**Ambulatory/Outpatient Medical Care (includes Rural, OB/GYN and Vision care)
**Case Management – Medical (including treatment adherence services)
Case Management – Non-medical (community based)
**Emergency Financial Assistance
**Health Insurance Assistance
**Local Pharmacy Assistance Program
**Medical Nutrition Therapy (including supplements)
**Oral Health (Rural)
Outreach Services
Program Support (Project LEAP, Case Management Training and Blue Book)
**Substance Abuse Treatment (Outpatient)
Transportation (Van-based and bus passes)

Part B Funded Service Categories:

**Health Insurance Assistance
**Home and Community based Health Services – Facility Based
**Oral Health Care (untargeted and prosthodontics)
Referral for Health Care and Support Services (ADAP Eligibility Workers)

State Services Funded Service Categories:

**Early Medical Intervention (Incarcerated)
**Health Insurance Assistance
**Hospice Services
Linguistics Services
**Mental Health

Note: As of 03/07/22, Pediatric outpatient medical services are currently being re-bid for FY 2022 and Ryan White Part A funds are no longer being used for Pediatric Case Management as The Resource Group is providing alternative funding.

Service Category	**Is this a core service?** If no, how does the service support access to core services & support clients achieving improved outcomes?	**How does this service assist individuals *not in care** to access primary care?** **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV infections by addressing four strategies – diagnose, treat, protect, and respond.	**Documentation of Need** (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	**Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate funding or the need to fill in a gap.** (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	**Justify the use of Ryan White Part A, Part B and State Services funds for this service.** **Is this a duplicative service or activity?**	**Service Efficiency** **Can we make this service more efficient? For:** a) Clients b) Providers **Can we bundle this service?** **Has a recent capacity issue been identified?** **Does this service assist special populations to access primary care?** *Examples:* a) Youth transitioning into adult care b) Recently released individuals moving into free world care c) Pregnant women no longer needing OB/GYN care	**Recommendation(s)**
Part 1: Services offered by Ryan White Part A, Part B, and State Services in the Houston EMA/HSDA as of 03-16-21							
Ambulatory/Outpatient Primary Medical Care (incl. Vision):							
CBO, Adult – Part A, Including LPAP, MCM & Svc Linkage (Includes OB/GYN) *See below for Public Clinic, Rural, Pediatric, Vision*	✔ Yes ___No	☐ EIIHA ☐ Unmet Need ☐ Continuum of Care ☐ Ending the HIV Epidemic		Covered under QHP? ✔ Yes ___No			

‡ Service Category for Part B/State Services only.

THE REMAINDER OF THIS PACKET
IS FOR THE
QUALITY IMPROVEMENT COMMITTEE
MEETING

DRAFT

Houston Area HIV Services Ryan White Planning Council

Quality Improvement Committee
2:30 p.m., Tuesday, March 15, 2022

Join the meeting via Zoom, please do not come to the meeting in person
https://us02web.zoom.us/j/81519929661?pwd=cXZPdzkzdjJwWnJPeFRJc1RwOStYUT09
Meeting ID: 811 4450 9622
Passcode: 125672

Or, use your cell phone to dial in at: 346 248 7799

Agenda

* = Handout to be distributed at the meeting

I. Call to Order — Daphne L. Jones and Denis Kelly, Co-Chair
   A. Welcoming Remarks and Moment of Reflection
   B. Adoption of Agenda
   C. Approval of Minutes
   D. Approve Criteria for Selecting FY 2023 Service Categories

II. Public Comments and Announcements

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

III. Reports from the Administrative Agents
   A. Part A and MAI reports: — Carin Martin
      1. Part A/MAI Procurement
      2. Chart Reviews: — Heather Keizman and Mauricia Chatman
         a) Primary Care
         b) Case Management
         c) Oral Health
         d) Vision Care
   B. Part B and State Services Reports* — Patrick Martin

VII. Announcements

No Committee meeting in April so that members can attend the How To Best Meet the Need Workgroup meetings

VIII. Adjourn

Optional: New members meet with committee mentor — Tana Pradia

Houston Area HIV Services Ryan White Planning Council

Quality Improvement Committee
2:00 p.m., Thursday, February 15, 2022
Meeting location: Zoom Teleconference

Minutes

MEMBERS PRESENT	MEMBERS ABSENT	OTHERS PRESENT
Denis Kelly, Co-Chair	Veronica Ardoin	Sha'Terra Johnson-Fairley, TRG
Daphne Jones, Co- Chair	Ardry "Skeet" Boyle, excused	Patrick Martin, TRG
Kevin Aloysius	Tom Lindstrom, excused	Tiffany Shepherd, TRG
Titan Capri	Andrew Wilson	Carin Martin, RWGA
Nkechi Onyewuenyi		Heather Keizman, RWGA
Oscar Perez		Mauricia Chatman, RWGA
Tana Pradia		Tori Williams, Ofc of Support
Pete Rodriguez		Mackenzie Hudson, Ofc of Support
Gloria Sierra		Diane Beck, Ofc of Support
Deborah Somoye		

Call to Order: Denis Kelly, Co-Chair, called the meeting to order at 2:08 p.m. and asked for a moment of reflection. He then invited members to introduce themselves.

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

Approval of the Minutes: ***Motion #2****: it was moved and seconded (Rodriguez, Pradia) to approve the November 16, 2021 minutes.* ***Motion carried.*** Abstentions: Capri, Jones.

Public Comment: None.

Committee Orientation: Williams reviewed the attached documents related to: Nuts and Bolts for New Members, End of Year Petty Cash Procedures, Texas Open Meetings Act Training, and Committee Meeting Date and Time.

Committee Orientation: Williams reviewed the attached documents: Committee Description, 2022 Committee Goals, Conflict of Interest Statement and Voting Policy, and Timeline of Critical 2022 Council Activities. ***Motion #3****: it was moved and seconded (Rodriguez, Pradia) to accept the 2022 Committee goals.* **Motion carried**.

Elect a Vice Chair: Rodriguez nominated Aloysius to be the committee vice chair. Aloysius accepted the nomination and was elected via acclamation.

Training in How to Read Reports from the Administrative Agents:
P. Martin explained to Committee members how to review Part B and State Services Procurement, Service Utilization, and Health Insurance Assistance reports. See attached 2022 Schedule of Reports, How to Read TRG Reports 2022, State Services Procurement Report -

dated 01/25/22, Part B Procurement Report – dated 01/25/22, Part B Service Utilization Report – dated 02/01/22, State Services Service Utilization Report – dated 01/03/22, and Health Insurance Program Reports – dated 01/07/22.

C. Martin explained to Committee members how to review a Part A and MAI quarterly Service Utilization Report and Procurement Reports.

Reports from Ryan White Grant Administration
Keizman presented the results of the Part A Clinical Quality Management Committee Quarterly Report. See attached dated 12/07/2021.

Criteria for FY23 Service Categories: Williams said that the March committee meeting will be a joint meeting with the other committees and they will determine the Criteria for FY 2023 Service Categories.

Announcements: Beck said there will be a Joint Training: Looking at HIV Services through a Racial Justice Lens on February 24th at 4:00 p.m. A flyer with the registration link was emailed to everyone and posted on Facebook, if you need it again please let her know.

Adjourn: The meeting was adjourned at 3:49 p.m.

Submitted by:

Tori Williams, Director Date

Approved by:

Committee Chair Date

Scribe: Beck

ja = Just arrived at meeting
lr = Left room temporarily
lm = Left the meeting
C = Chaired the meeting

2022 Quality Improvement Meeting Voting Record for Meeting Date 02/15/22

MEMBERS:	**Motion #1** Agenda				**Motion #2** Minutes				**Motion #3** 2022 Committee Goals			
	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN
Denis Kelly, Co-Chair				**C**				**C**				**C**
Daphne Jones, Co-Chair		**X**						**X**		**X**		
Kevin Aloysius		**X**				**X**				**X**		
Veronica Ardoin	**X**				**X**				**X**			
Ardry "Skeet" Boyle	**X**				**X**				**X**			
Titan Capri		**X**						**X**		**X**		
Tom Lindstrom	**X**				**X**				**X**			
Nkechi Onyewuenyi ja 2:20pm	**X**				**X**					**X**		
Oscar Perez		**X**				**X**				**X**		
Tana Pradia		**X**				**X**				**X**		
Pete Rodriguez		**X**				**X**				**X**		
Andrew Wilson	**X**				**X**				**X**			
Gloria Sierra		**X**				**X**				**X**		
Deborah Somoye		**X**				**X**				**X**		
Angela Rubio		**X**				**X**				**X**		
Deborah Somoye		**X**				**X**				**X**		

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Harris County
Public Health
Building a Healthy Community

Oral Health Care-Rural Target Chart Review FY 2020

Ryan White Part A Quality Management Program–Houston EMA

December 2021

CONTACT:

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

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Introduction

Part A funds of the Ryan White Care Act are administered in the Houston Eligible Metropolitan Area (EMA) by the Ryan White Grant Administration Section of Harris County Public Health. During FY 20, a comprehensive review of client dental records was conducted for services provided between 3/1/20 to 2/29/21. This review included one provider of Adult Oral Health Care that received Part A funding for rural-targeted Oral Health Care in the Houston EMA.

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

Scope of This Report

This report provides background on the project, supplemental information on the design of the data collection tool, and presents the pertinent findings of the FY 20 oral health care chart review. Any additional data analysis of items or information not included in this report can likely be provided after a request is submitted to Ryan White Grant Administration.

The Data Collection Tool

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

The Chart Review Process

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

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

Table 1. Data Collection Parameters

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

The Sample Selection Process

The sample population was selected from a pool of 366 unduplicated clients who accessed Part A oral health care between 3/1/20 and 2/29/21. The medical charts of 75 of these clients were used in the review, representing 20% of the pool of unduplicated clients.

In an effort to make the sample population as representative of the actual Part A oral health care population as possible, the EMA's Centralized Patient Care Data Management System (CPCDMS) was used to generate a list of client codes to be reviewed. The demographic make-up (race/ethnicity, gender, age) of clients accessing oral health services between 3/1/20 and 2/29/21 was determined by CPCDMS, which in turn allowed Ryan White Grant Administration to generate a sample of specified size that closely mirrors that same demographic make-up.

Characteristics of the Sample Population

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

Table 2. Demographic Characteristics of FY 20 Houston EMA Ryan White Part A Oral Health Care Clients

	Sample		**Ryan White Part A EMA**	
Race/Ethnicity	Number	Percent	Number	Percent
African American	30	40%	162	44.2%
White	44	58.7%	199	54.4%
Asian	0	0%	1	.3%
Native Hawaiian/Pacific Islander	0	0%	0	0%
American Indian/Alaska Native	1	1.3%	3	.8%
Multi-Race	0	0%	1	.3%
	75		**366**	
Hispanic Status				
Hispanic	22	29.3%	103	28.1%
Non-Hispanic	53	70.7%	263	71.9%
	75		**366**	
Gender				
Male	54	72%	245	66.9%
Female	21	28%	116	31.7%
Transgender	0	0%	5	1.4%
	75		**366**	
Age				
<=24	2	2.7%	15	4.1%
25 – 34	15	20%	83	22.7%
35 – 44	20	26.7%	91	24.9%
45 – 54	19	25.3%	89	24.3%
55 – 64	14	18.7%	70	19.1%
65+	5	6.7%	18	4.9%
	75		**366**	

Findings

Clinic Visits

Information gathered during the FY 20 chart review included the number of visits during the study period. The average number of oral health visits per patient in the sample population was seven.

Health History

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

Assessment of Medical History

	2018	2019	2020
Primary Care Provider	97%	100%	100%
Medical/Dental Health History* (annual form)	100%	99%	76%
Medical History 6-month Update (in medical notes)	96%	95%	93%

*HIV/AIDS Bureau (HAB) Performance Measures

Health Assessments

	2018	2019	2020
Vital Signs	100%	100%	100%
CBC documented	92%	96%	96%
Antibiotic Prophylaxis Given if Indicated	0% (0/1)	100% (1/1)	N/A

Prevention and Detection of Oral Disease

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

to achieve. Furthermore, poor oral health places additional burden on an already compromised immune system.

	2018	2019	2020
Oral Health Education*	99%	99%	99%
Hard Tissue Exam	96%	92%	99%
Soft Tissue Exam	96%	92%	99%
Periodontal screening*	97%	94%	99%
X-rays present	99%	88%	99%
Treatment plan*	99%	100%	100%

*HIV/AIDS Bureau (HAB) Performance Measures

Phase I Treatment Plan Status

	2019	2020
Phase I Treatment plan complete*	55%	44%
Dental procedures done, additional procedures needed	35%	54%
No procedures needed	10%	1%

*HIV/AIDS Bureau (HAB) Performance Measures

Conclusions

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

Appendix A – Resources

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

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

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

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

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

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Harris County
Public Health
Building a Healthy Community

Primary Care Chart Review Report FY 2020

Ryan White Part A Quality Management Program – Houston EMA

December 2021

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

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PREFACE

EXPLANATION OF PART A QUALITY MANAGEMENT

In 2020, the Houston Eligible Metropolitan Area (EMA) awarded Part A funds for adult Outpatient Ambulatory Medical Services to six organizations. Approximately 13,000 unduplicated individuals living with HIV receive Ryan White-funded services at these organizations.

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

Introduction

On March 30, 2021, the RWGA PC/CQI commenced the evaluation of Part A funded Primary Medical Care Services funded by the Ryan White Part A grant. This grant is awarded to HCPH by the Health Resources and Services Administration (HRSA) to provide HIV-related health and social services to people living with HIV. The purpose of this evaluation project is to meet HRSA mandates for quality management, with a focus on:

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

A comprehensive review of client medical records was conducted for services provided between 3/1/20 and 2/28/21. The guidelines in effect during the year the patient sample was seen, *Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents Living with HIV* were used to determine degree of compliance. The current treatment guidelines are available for download at: http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf. The initial activity to fulfill the purpose was the development of a medical record data abstraction tool that addresses elements of the guidelines, followed by medical record review, data analysis and reporting of findings with recommendations.

Tool Development

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

Chart Review Process

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

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

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

Tale 1. Data Collection Parameters

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

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

The Sample Selection Process

The sample population was selected from a pool of 8,096 clients (adults age 18+) who accessed Part A primary care (excluding vision care) and had at least two visits, at least 90 days apart, between 3/1/20 and 2/28/21. The medical charts of 635 clients were used in this review, representing 7.8% of the pool of unduplicated clients. The number of clients selected at each site is proportional to the number of primary care clients served there. Three caveats were observed during the sampling process. In an effort to focus on women living with HIV health issues, women were over-sampled, comprising 42.2% of the sample population. Second, providers serving a relatively small number of clients were over-sampled in order to ensure sufficient sample sizes for data analysis. Finally, transgender clients were oversampled in order to collect data on this sub-population.

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

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

Characteristics of the Sample Population

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

Table 2. Demographic Characteristics of Clients During Study Period 3/1/20-2/28/21

	Sample		**Ryan White Part A Houston EMA**	
Gender	Number	Percent	Number	Percent
Male	328	51.7%	6,050	74.7%
Female	268	42.2%	1,860	23%
Transgender Male to Female	39	6.1%	184	2.3%
Transgender Female to Male	0	0%	2	.01%
TOTAL	**635**		**8,096**	
Race				
Asian	8	1.3%	102	1.3%
African-Amer.	303	47.7%	3.926	48.5%
Pacific Islander	0	0%	8	.1%
Multi-Race	4	.6%	66	.8%
Native Amer.	2	.3%	25	.3%
White	318	50.1%	3,969	49%
TOTAL	**635**		**8,096**	
Hispanic				
Non-Hispanic	380	59.8%	4,973	61.4%
Hispanic	255	40.2%	3,123	38.6%
TOTAL	**635**		**8,096**	
Age				
<=24	14	2.2%	381	4.7%
25-34	157	24.7%	2,353	29.1%
35-44	190	29.9%	2,311	28.5%
45-49	69	10.9%	971	12%
50-64	198	31.2%	1,947	24%
65 and older	7	1.1%	133	1.6%
Total	**635**		**8,096**	

Report Structure

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

[1] http://hab.hrsa.gov/deliverhivaidscare/habperformmeasures.html

Findings

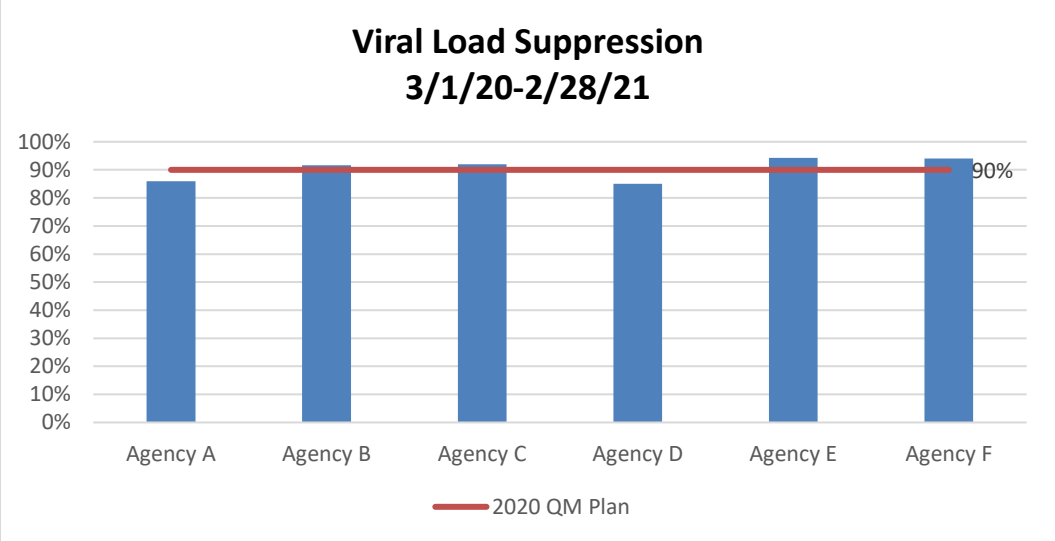
Core Performance Measures

Viral Load Suppression

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

	2018	2019	2020
Number of clients with viral load below limits of quantification at last test during the measurement year	553	559	571
Number of clients who: • had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year, and • were prescribed ART for at least 6 months	630	625	634
Rate	**87.8%**	**89.4%**	**90.1%**
	2.3%	**1.6%**	**.7%**

2020 Viral Load Suppression by Race/Ethnicity			
	Black	Hispanic	White
Number of clients with viral load below limits of quantification at last test during the measurement year	259	235	65
Number of clients who: • had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year, and • were prescribed ART for at least 6 months	294	254	74
Rate	**88.1%**	**92.5%**	**87.8%**

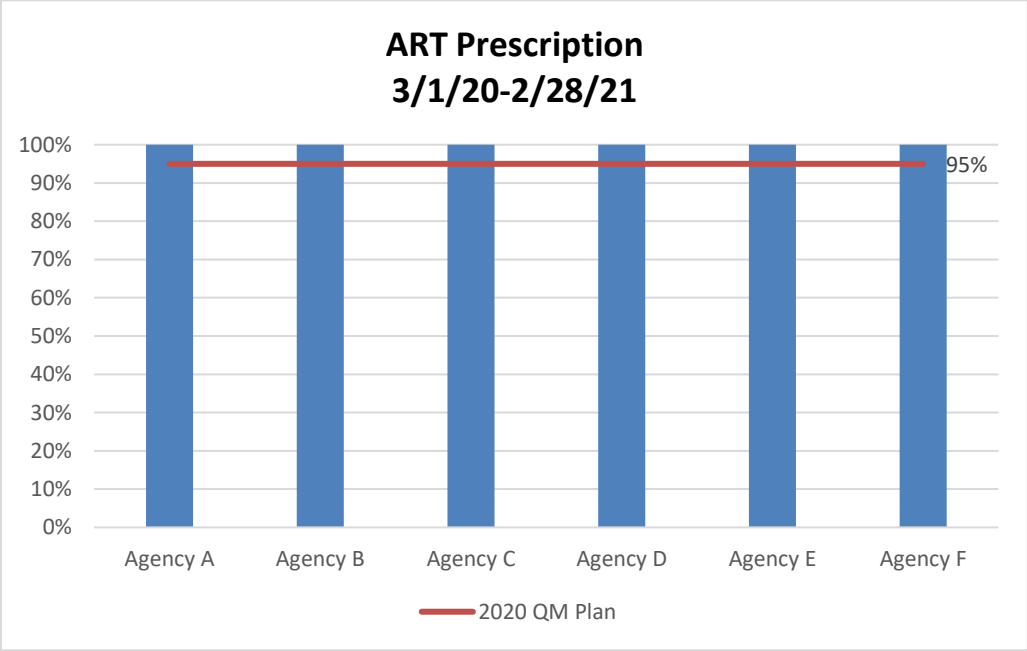


ART Prescription

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

	2018	2019	2020
Number of clients who were prescribed an ART regimen within the measurement year	631	627	635
Number of clients who: • had at least two medical visit with a provider with prescribing privileges, i.e. MD, PA, NP in the measurement year	635	635	635
Rate	**99.4%**	**98.7%**	**100%**
Change from Previous Years Results	**.7%**	**-.7%**	**2.3%**

2020 ART Prescription by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who were prescribed an ART regimen within the measurement year	294	255	74
Number of clients who: • had at least two medical visit with a provider with prescribing privileges, i.e. MD, PA, NP in the measurement year	294	255	74
Rate	**100%**	**100%**	**100%**

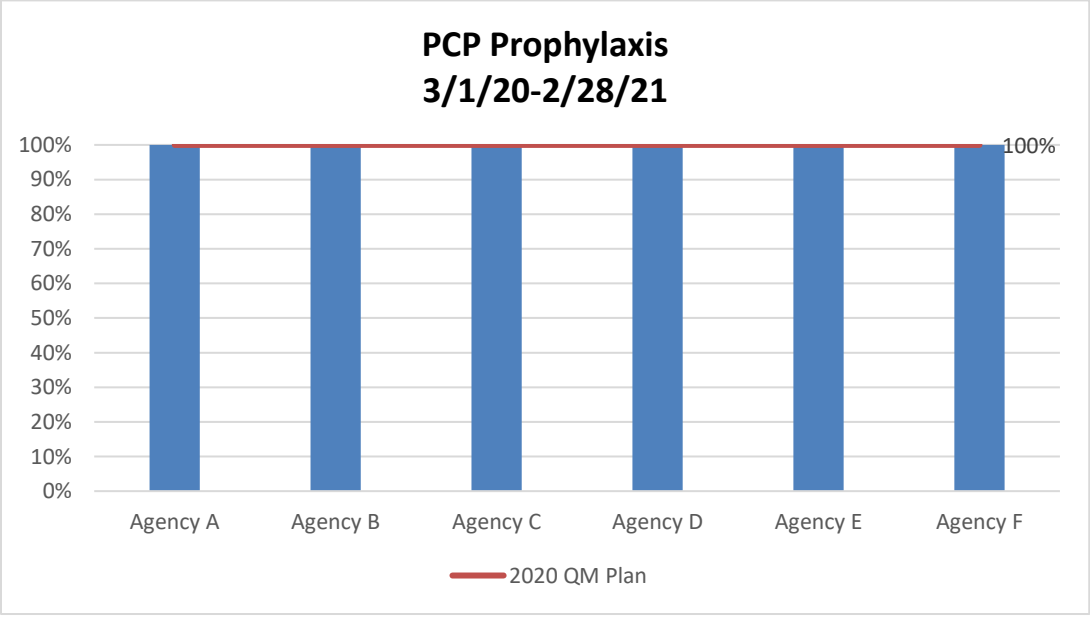


PCP Prophylaxis

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

	2018	2019	2020
Number of clients with CD4 T-cell counts below 200 cells/mm^3 who were prescribed PCP prophylaxis	62	34	41
Number of clients who: • had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year, and • had a CD4 T-cell count below 200 cells/mm^3, or any other indicating condition	66	38	41
Rate	**93.9%**	**89.5%**	**100%**
Change from Previous Years Results	**.9%**	**-4.4%**	**10.5%**

2020 PCP Prophylaxis by Race/Ethnicity			
	Black	Hispanic	White
Number of clients with CD4 T-cell counts below 200 cells/mm^3 who were prescribed PCP prophylaxis	16	22	3
Number of clients who: • had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least once in the measurement year, and • had a CD4 T-cell count below 200 cells/mm^3, or any other indicating condition	16	22	3
Rate	**100%**	**100%**	**100%**



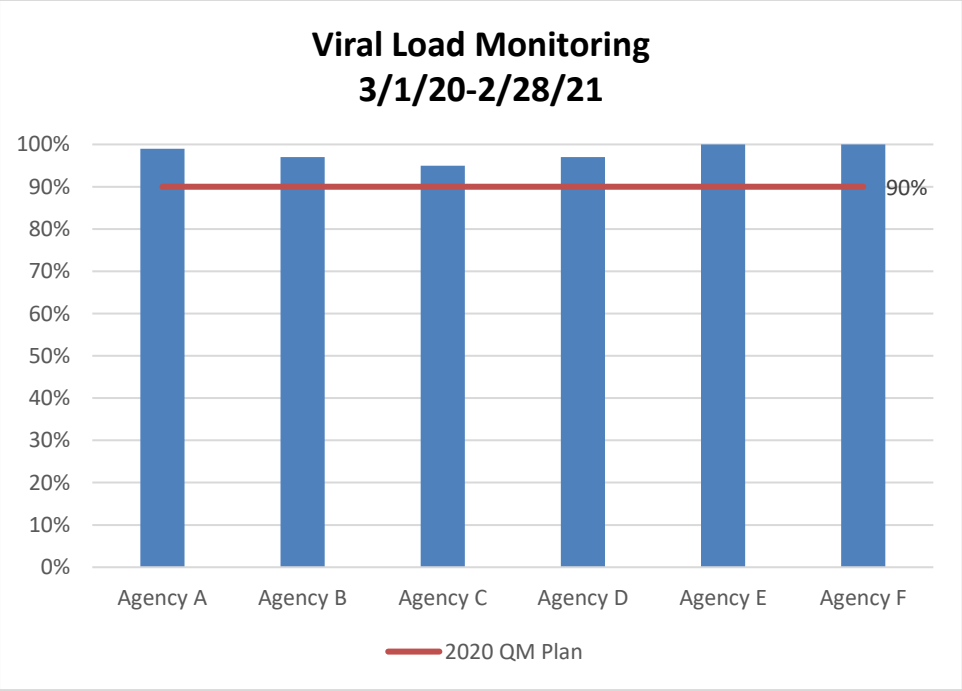
All Ages Performance Measures

Viral Load Monitoring

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

	2018	2019	2020
Number of clients who had a viral load test performed at least every six months during the measurement year	624	619	618
Number of clients who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year	635	635	635
Rate	**98.3%**	**97.5%**	**97.3%**
Change from Previous Years Results	**.3%**	**-.8%**	**-.2%**

2020 Viral Load by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who had a viral load test performed at least every six months during the measurement year	290	248	68
Number of clients who had a medical visit with a provider with prescribing privileges1, i.e. MD, PA, NP at least twice in the measurement year	294	255	74
Rate	**98.6%**	**97.3%**	**91.9%**



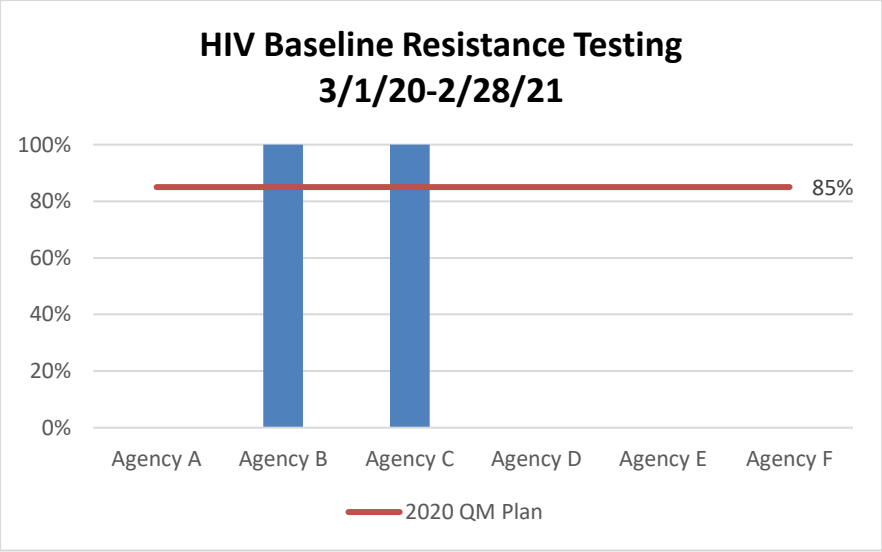
HIV Drug Resistance Testing Before Initiation of Therapy

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

	2018	2019	2020
Number of clients who had an HIV drug resistance test performed at any time before initiation of HIV ART	6	5	4
Number of clients who: • had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year, and • were prescribed ART during the measurement year for the first time	8	7	4
Rate	**75%**	**71.4%**	**100%**
Change from Previous Years Results	**3.6%**	**-3.6%**	**28.6%**

2020 Drug Resistance Testing by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who had an HIV drug resistance test performed at any time before initiation of HIV ART	0	1	3
Number of clients who: • had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year, and • were prescribed ART during the measurement year for the first time	0	1	3
Rate		**100%**	**100%**

*Agencies A, D, E, & F did not have any clients that met the denominator



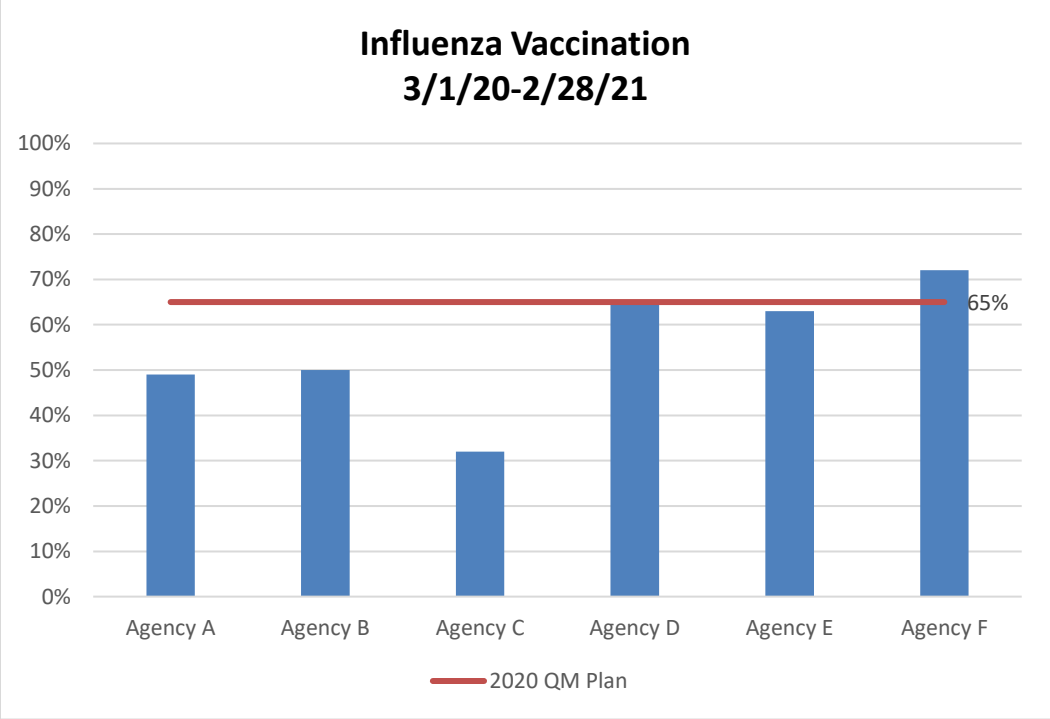
Influenza Vaccination

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

	2018	2019	2020
Number of clients who received influenza vaccination within the measurement year	336	362	281
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement period	534	531	565
Rate	**62.9%**	**68.2%**	**49.7%**
Change from Previous Years Results	**9.4%**	**5.3%**	**-18.5%**

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

2020 Influenza Screening by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who received influenza vaccination within the measurement year	122	124	29
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	250	237	67
Rate	**48.8%**	**52.3%**	**43.3%**

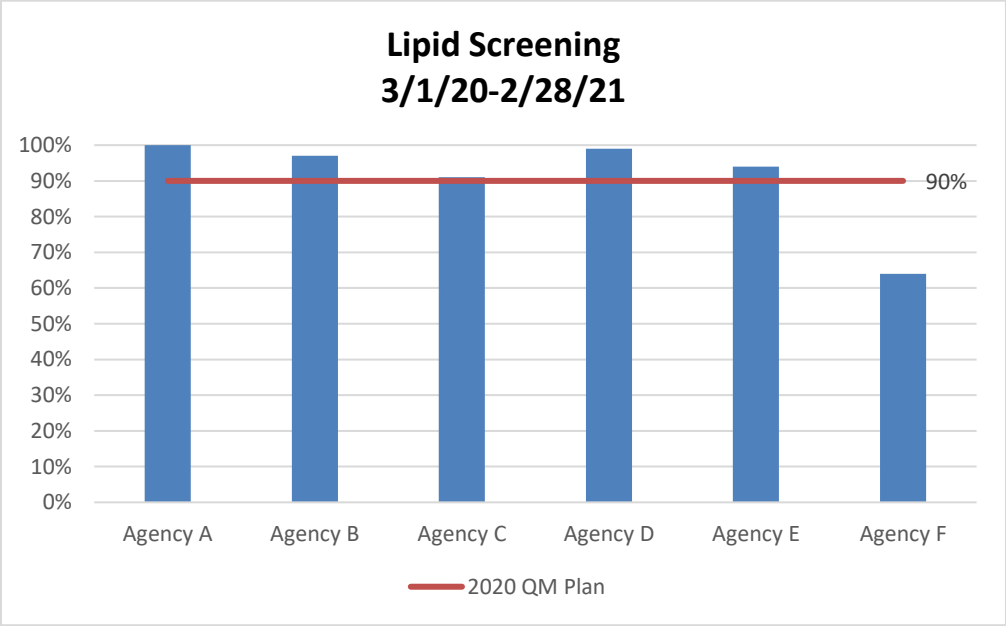


Lipid Screening

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

	2018	2019	2020
Number of clients who: • were prescribed ART, and • had a fasting lipid panel in the measurement year	567	554	594
Number of clients who are on ART and who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	631	627	635
Rate	**89.9%**	**88.4%**	**93.5%**
Change from Previous Years Results	**1.1%**	**-1.5%**	**5.1%**

2020 Lipid Screening by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who: • were prescribed ART, and • had a fasting lipid panel in the measurement year	275	237	71
Number of clients who are on ART and who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	294	255	74
Rate	**93.5%**	**92.9%**	**95.9%**

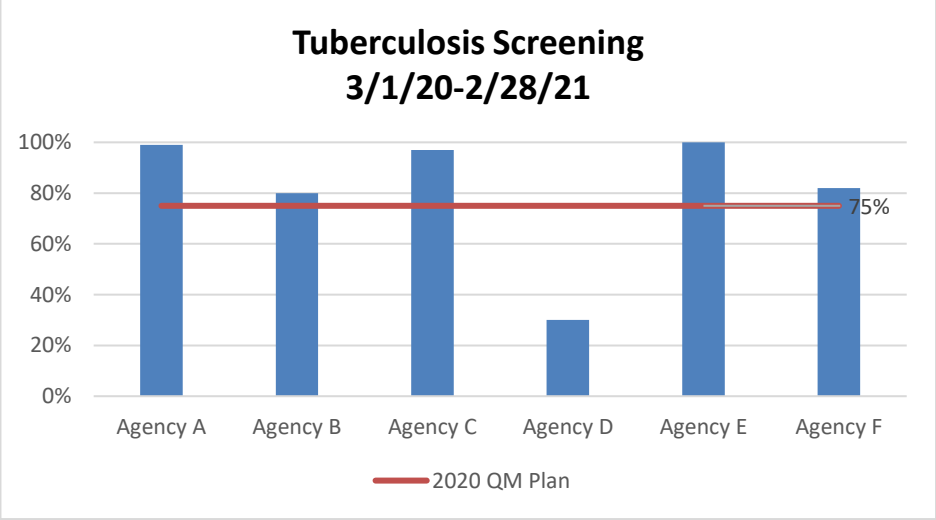


Tuberculosis Screening

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

	2018	2019	2020
Number of clients who received documented testing for LTBI with any approved test (tuberculin skin test [TST] or interferon gamma release assay [IGRA]) since HIV diagnosis	401	426	454
Number of clients who: • do not have a history of previous documented culture-positive TB disease or previous documented positive TST or IGRA; and • had a medical visit with a provider with prescribing privileges at least twice in the measurement year.	565	570	567
Rate	**71%**	**74.7%**	**80.1%**
Change from Previous Years Results	**3.8%**	**3.7%**	**5.4%**

2020 TB Screening by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who received documented testing for LTBI with any approved test (tuberculin skin test [TST] or interferon gamma release assay [IGRA]) since HIV diagnosis	204	187	56
Number of clients who: • do not have a history of previous documented culture-positive TB disease or previous documented positive TST or IGRA; and • had a medical visit with a provider with prescribing privileges at least once in the measurement year.	263	224	71
Rate	**77.6%**	**83.5%**	**78.9%**



Adolescent/Adult Performance Measures

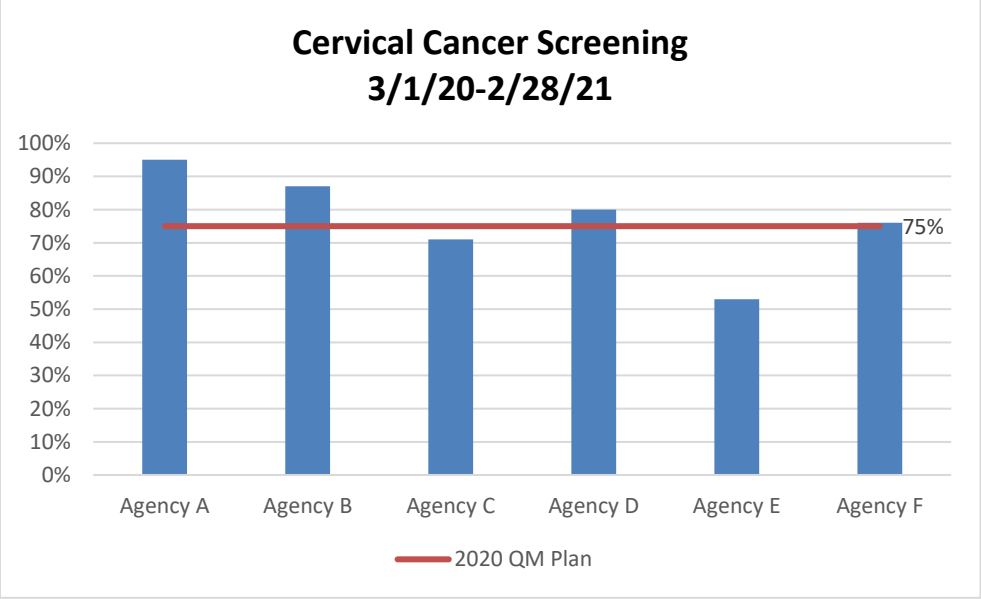
Cervical Cancer Screening

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

	2018	2019	2020
Number of female clients who had Pap screen results documented in the previous three years	199	214	208
Number of female clients: • for whom a pap smear was indicated, and • who had a medical visit with a provider with prescribing privileges at least twice in the measurement year*	244	260	259
Rate	**81.6%**	**82.3%**	**80.3%**
Change from Previous Years Results	**-.9%**	**.7%**	**-2%**

- 13.9% (29/208) of pap smears were abnormal

2020 Cervical Cancer Screening Data by Race/Ethnicity			
	Black	Hispanic	White
Number of female clients who had Pap screen results documented in the previous three years	122	76	8
Number of female clients: • for whom a pap smear was indicated, and • who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	155	92	9
Rate	**78.7%**	**82.6%**	**88.9%**



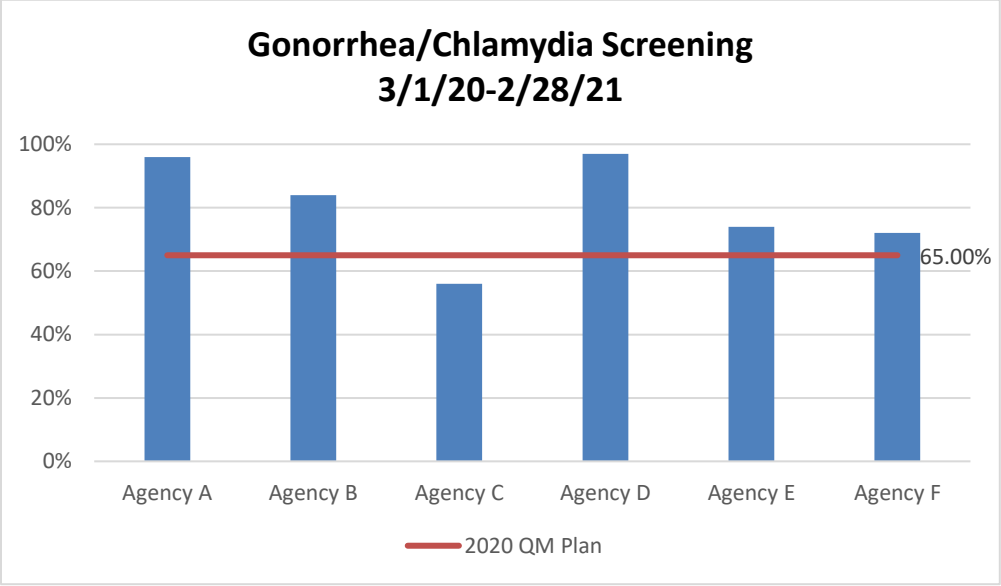
Gonorrhea/Chlamydia Screening

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

	2018	2019	2020
Number of clients who had a test for Gonorrhea/Chlamydia	501	506	503
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	635	635	635
Rate	**78.9%**	**79.7%**	**79.2%**
Change from Previous Years Results	**1.3%**	**.8%**	**-.5%**

- 20 cases of chlamydia and 22 cases of gonorrhea were identified

2020 GC/CT by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who had a serologic test for syphilis performed at least once during the measurement year	237	201	57
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	294	255	74
Rate	**80.6%**	**78.8%**	**77%**



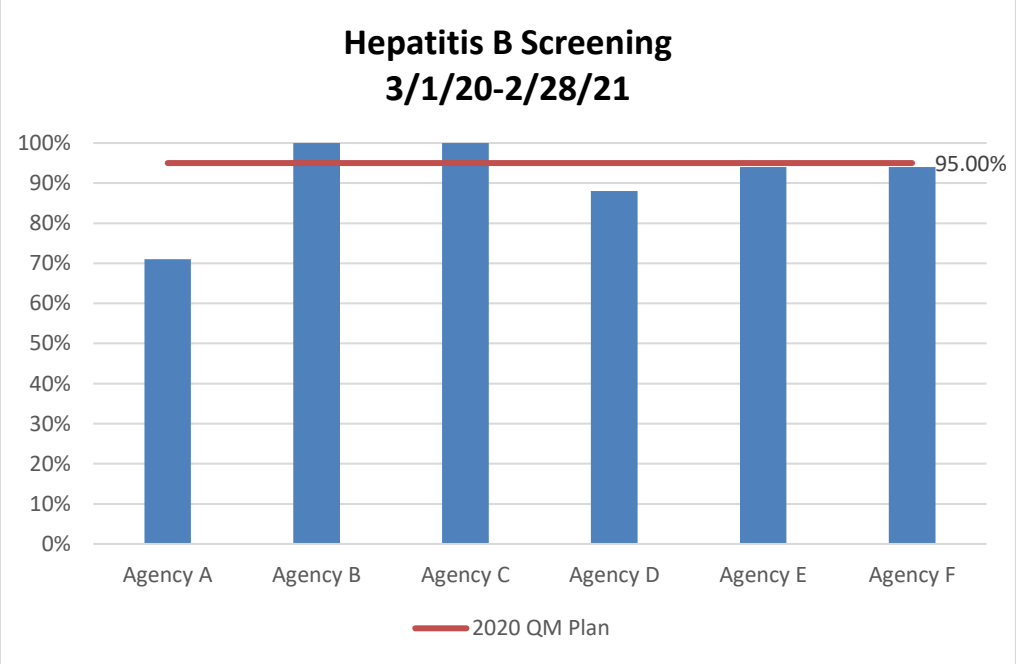
Hepatitis B Screening

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

	2018	2019	2020
Number of clients who have documented Hepatitis B infection status in the health record	577	571	588
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	635	635	635
Rate	**90.9%**	**89.9%**	**92.6%**
Change from Previous Years Results	**3.8%**	**-1%**	**2.7%**

- 1.4% (9/635) were Hepatitis B positive

2020 Hepatitis B Screening by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who have documented Hepatitis B infection status in the health record	275	231	70
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	294	255	74
Rate	**93.5%**	**90.6%**	**94.6%**

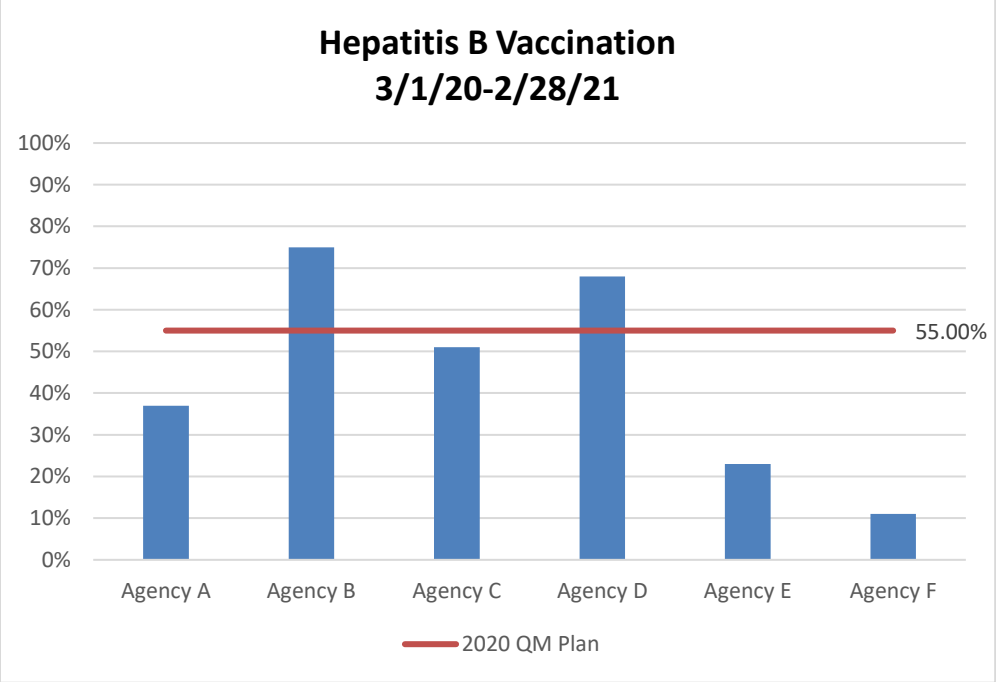


Hepatitis B Vaccination

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

	2018	2019	2020
Number of clients with documentation of having ever completed the vaccination series for Hepatitis B	171	177	179
Number of clients who are Hepatitis B Nonimmune and had a medical visit with a provider with prescribing privileges at least twice in the measurement year	347	342	344
Rate	**49.3%**	**51.8%**	**52%**
Change from Previous Years Results	**-2.1%**	**2.5%**	**.2%**

2020 Hepatitis B Vaccination by Race/Ethnicity			
	Black	Hispanic	White
Number of clients with documentation of having ever completed the vaccination series for Hepatitis B	65	94	18
Number of clients who are Hepatitis B Nonimmune and had a medical visit with a provider with prescribing privileges at least twice in the measurement year	132	170	39
Rate	**49.2%**	**55.3%**	**46.2%**



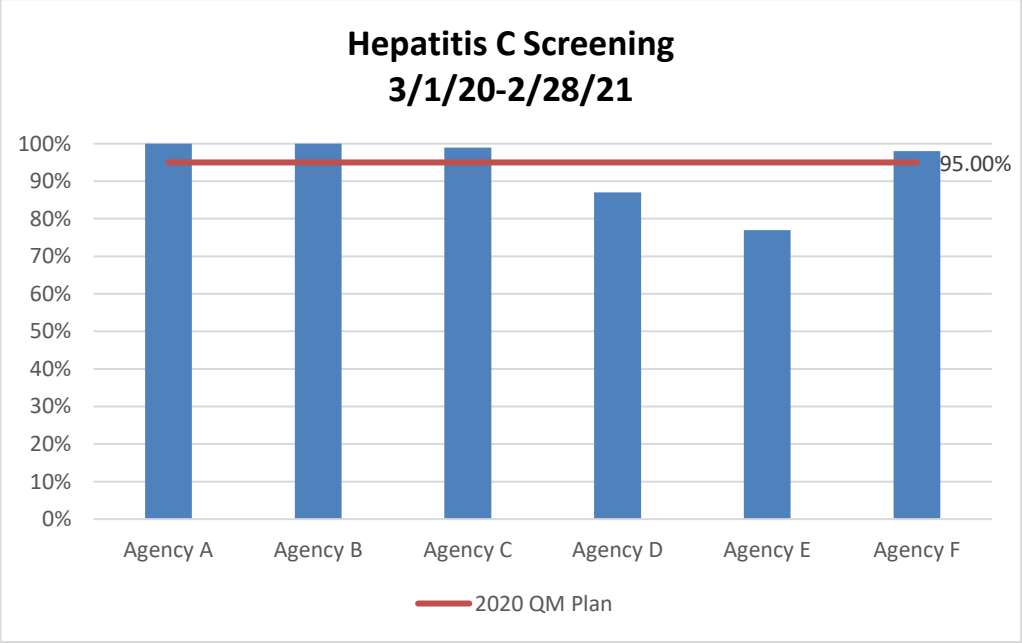
Hepatitis C Screening

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

	2018	2019	2020
Number of clients who have documented HCV status in chart	604	612	611
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	635	635	635
Rate	**95.1%**	**96.4%**	**96.2%**
Change from Previous Years Results	**2.3%**	**1.3%**	**-.2%**

- 9.1% (58/635) were Hepatitis C positive, including 15 acute infections only and 34 cures (79%)

2020 Hepatitis C Screening by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who have documented HCV status in chart	280	246	73
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	294	255	74
Rate	**95.2%**	**96.5%**	**98.6%**

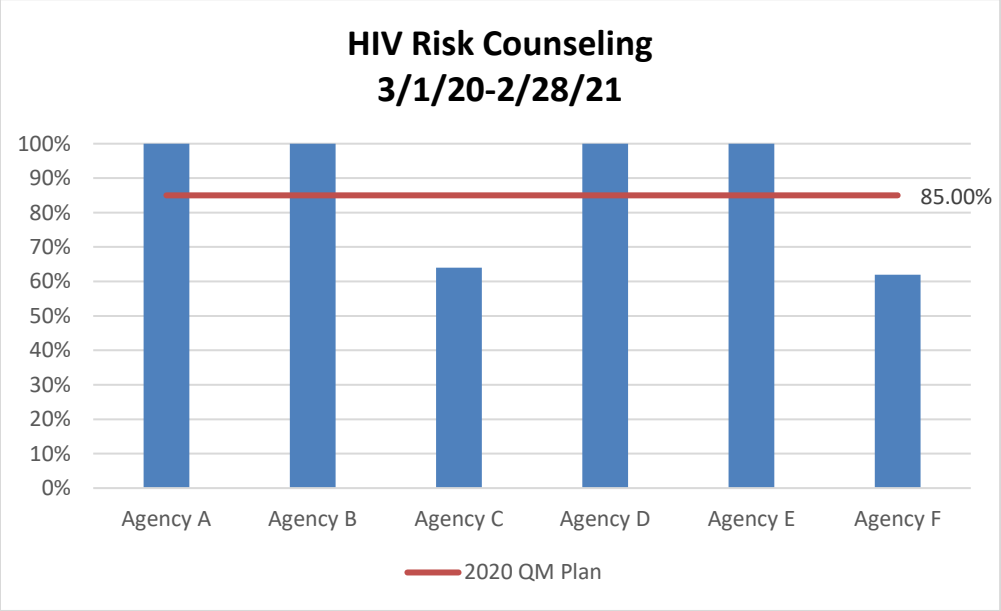


HIV Risk Counseling

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

	2018	2019	2020
Number of clients, as part of their primary care, who received HIV risk counseling	533	520	559
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	635	635	635
Rate	**83.9%**	**81.9%**	**88%**
Change from Previous Years Results	**-6.8%**	**-2%**	**6.1%**

2020 HIV Risk Counseling by Race/Ethnicity			
	Black	Hispanic	White
Number of clients, as part of their primary care, who received HIV risk counseling	260	222	66
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	294	255	74
Rate	**88.4%**	**87.1%**	**89.2%**



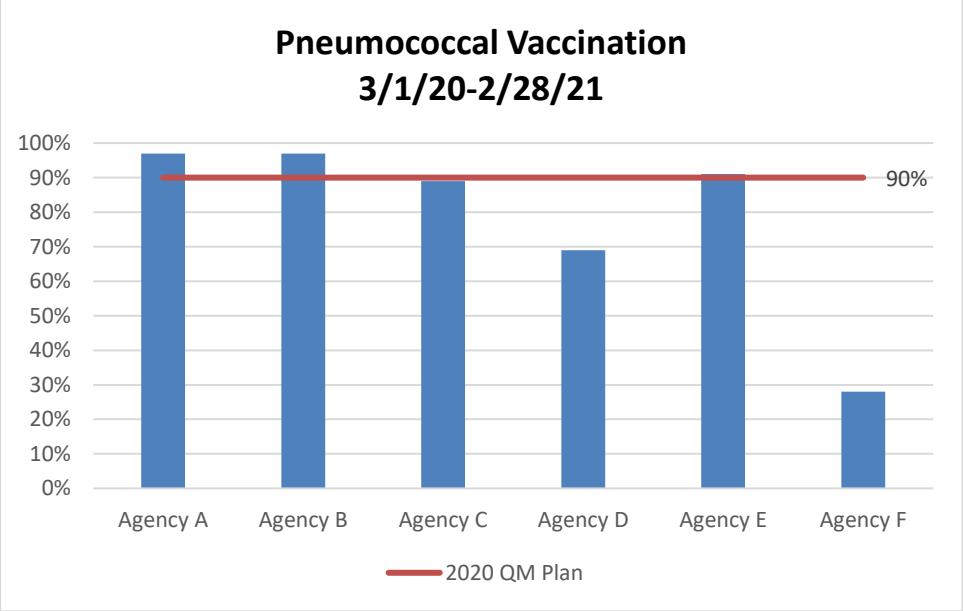
Pneumococcal Vaccination

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

	2018	2019	2020
Number of clients who received pneumococcal vaccination	507	523	518
Number of clients who: • had a CD4 count > 200 cells/mm3, and • had a medical visit with a provider with prescribing privileges at least twice in the measurement period	610	612	608
Rate	**83.1%**	**85.5%**	**85.2%**
Change from Previous Years Results	**-.3%**	**2.4%**	**-.3%**

- 381 clients (62.7%) received both PPV13 and PPV23 (FY19- 59.3%, FY18- 65.1%)

2020 Pneumococcal Vaccination by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who received pneumococcal vaccination	231	223	55
Number of clients who: • had a CD4 count > 200 cells/mm3, and had a medical visit with a provider with prescribing privileges at least twice in the measurement period	280	242	74
Rate	**82.5%**	**92.1%**	**74.3%**

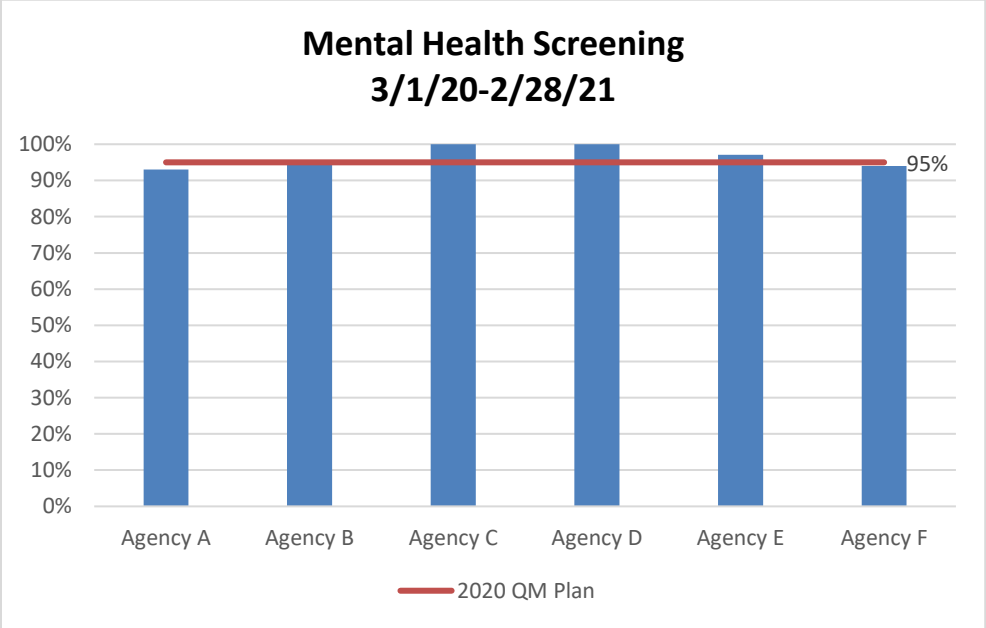


Preventative Care and Screening: Mental Health Screening

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

	2018	2019	2020
Number of clients who received a mental health screening	623	604	614
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement period	635	635	635
Rate	**98.1%**	**95.1%**	**96.7%**
Change from Previous Years Results	**1.7%**	**-3%**	**1.6%**

- 27.6% (175/635) had mental health issues. Of the 64 who needed additional care, 58 (90.6%) were either managed by the primary care provider or referred; 6 clients refused a referral.

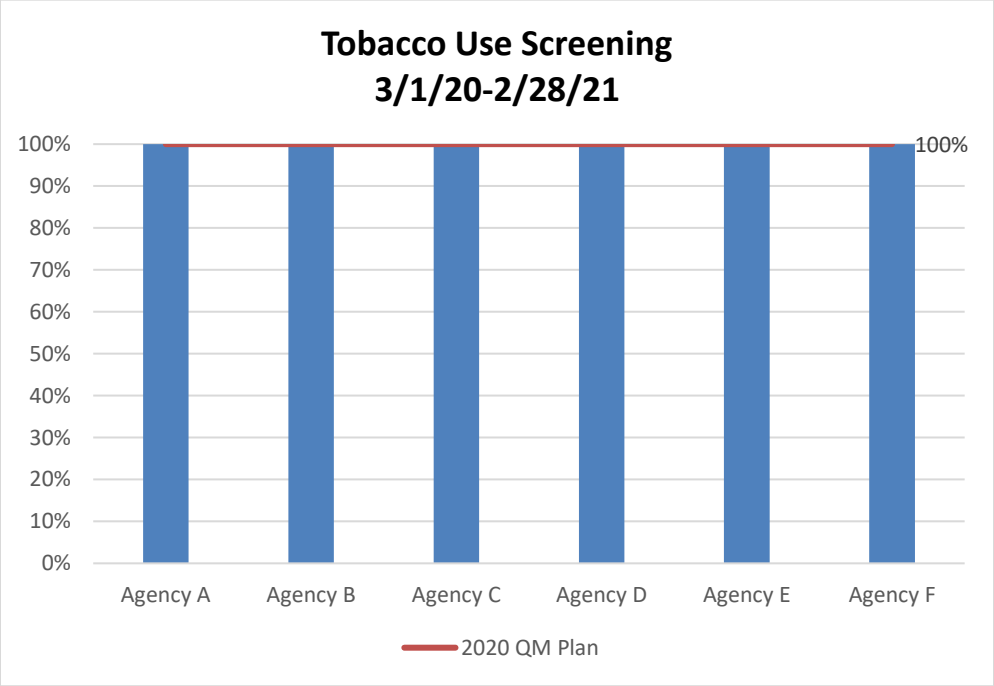


Preventative Care and Screening: Tobacco Use: screening & cessation intervention

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

	2018	2019	2020
Number of clients who were screened for tobacco use in the measurement period	627	634	634
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement period	635	635	635
Rate	**98.7%**	**99.8%**	**99.8%**
Change from Previous Years Results	**-1.3%**	**1.1%**	**0%**

- Of the 634 clients screened, 159 (25.1%) were current smokers.
- Of the 159 current smokers, 114 (71.7%) received smoking cessation counseling, and 5 (3.1%) refused smoking cessation counseling



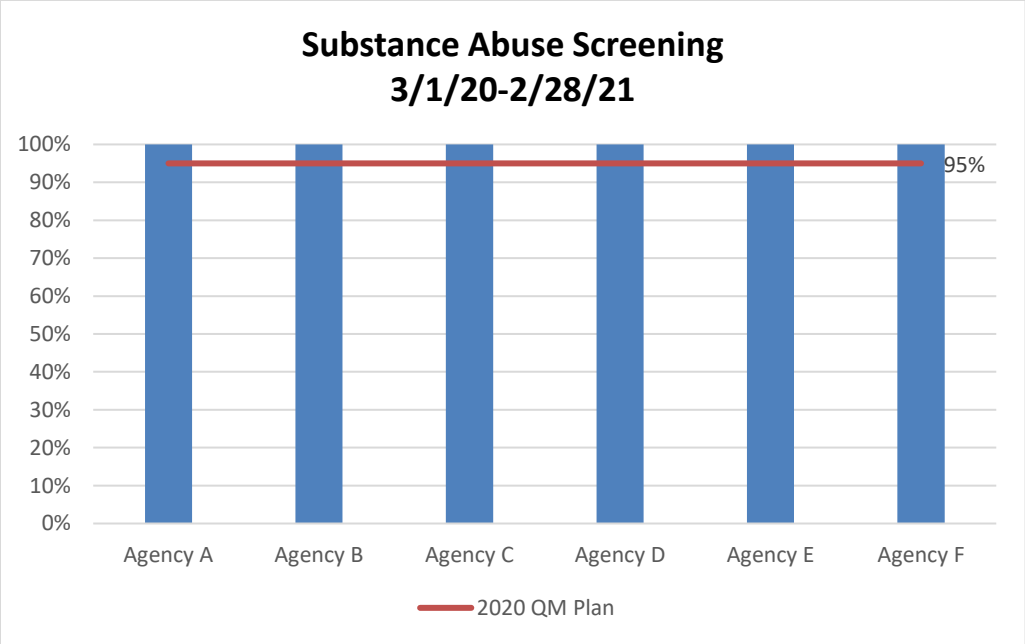
Substance Use Screening

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

	2018	2019	2020
Number of new clients who were screened for substance use within the measurement year	631	632	628
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement period	635	635	635
Rate	**99.4%**	**99.5%**	**98.9%**
Change from Previous Years Results	**.3%**	**.1%**	**-.6%**

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

- 4.9% (31/635) had a substance use disorder. Of the 31 clients who needed referral, 24 (77.4%) received one, and 4 (12.9%) refused.

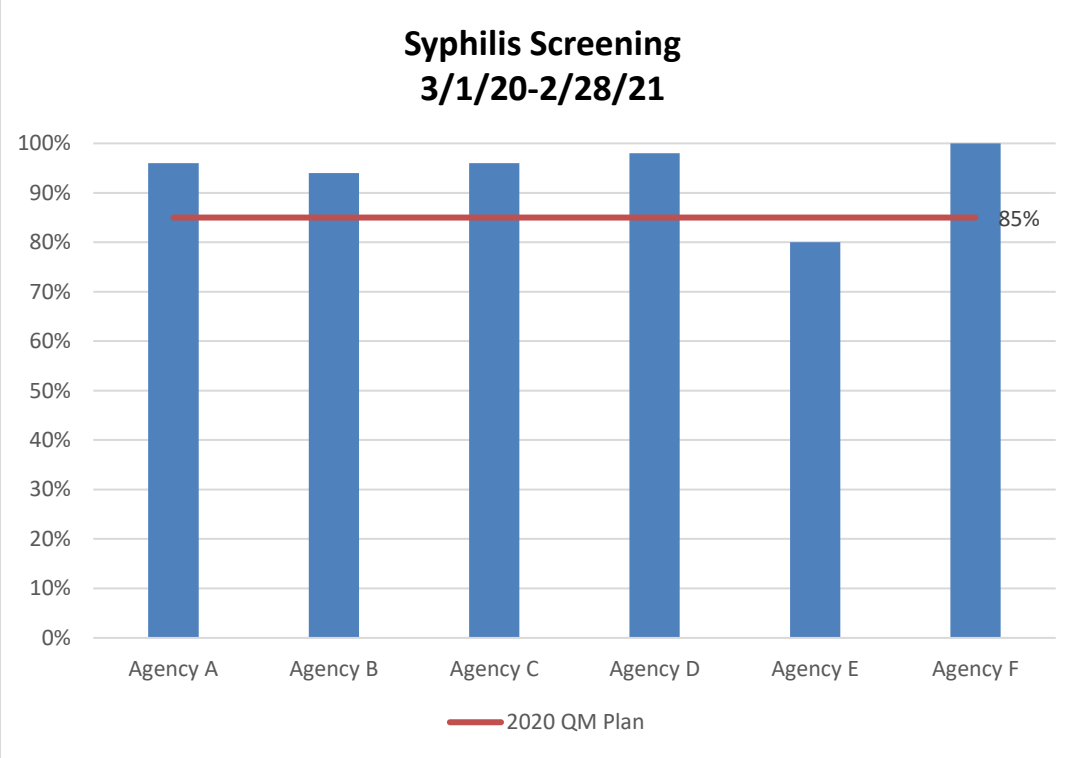


Syphilis Screening

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

	2018	2019	2020
Number of clients who had a serologic test for syphilis performed at least once during the measurement year	602	600	604
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	635	635	635
Rate	**94.8%**	**94.5%**	**95.1%**
Change from Previous Years Results	**2.4%**	**-.3%**	**.6%**

- 8.8% (56/635) new cases of syphilis diagnosed

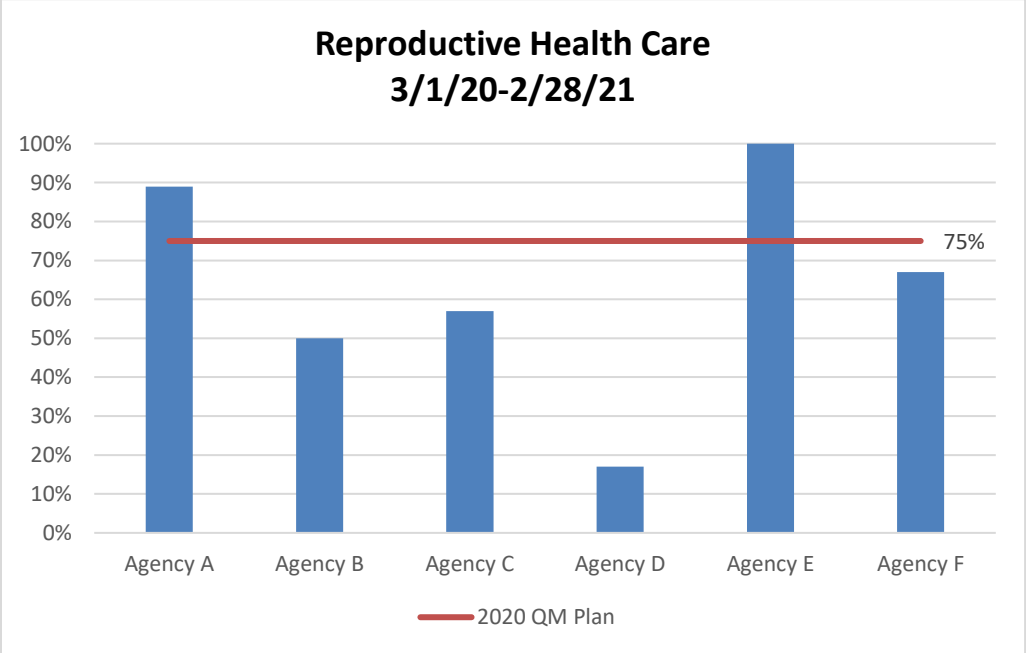


Other Measures

Reproductive Health Care

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

	2018	2019	2020
Number of reproductive-age women who received reproductive health assessment and care	29	37	40
Number of reproductive-age women who: • did not have a hysterectomy or bilateral tubal ligation, and • had a medical visit with a provider with prescribing privileges at least twice in the measurement period	54	66	67
Rate	**53.7%**	**56.1%**	**59.7%**
Change from Previous Years Results	**18.8%**	**2.4%**	**3.6%**

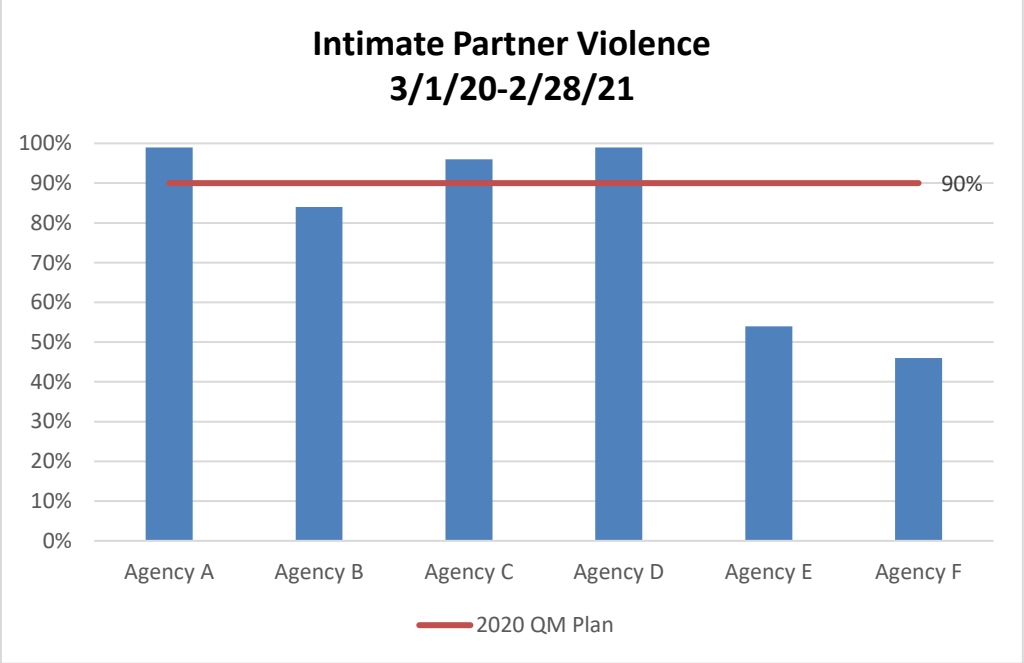


Intimate Partner Violence Screening

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

	2018	2019	2020
Number of clients who received screening for current intimate partner violence	592	577	553
Number of clients who: • had a medical visit with a provider with prescribing privileges at least twice in the measurement period	635	635	635
Rate	**93.2%**	**90.9%**	**87.1%**
	14.6%	**-2.3%**	**-3.8%**

* 1/635 screened positive



Adherence Assessment & Counseling

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

	Adherence Assessment		
	2018	2019	2020
Number of clients, as part of their primary care, who were assessed for adherence at least once per year	631	627	635
Number of clients on ART who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	631	627	635
Rate	**100%**	**100%**	**100%**
Change from Previous Years Results	**0%**	**0%**	**0%**

ART for Pregnant Women

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

	2018	2019	2020
Number of pregnant women who were prescribed ART during the 2nd and 3rd trimester	3	2	3
Number of pregnant women who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year	3	2	3
Rate	**100%**	**100%**	**100%**
Change from Previous Years Results	**0%**	**0%**	**0%**

Primary Care: Diabetes Control

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

	2018	2019	2020
Number of diabetic clients whose last HbA1c in the measurement year was <8%	35	38	55
Number of diabetic clients who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year	67	65	82
Rate	**52.2%**	**58.5%**	**67.1%**
Change from Previous Years Results	**-12.7%**	**6.3%**	**8.6%**

- 635/635 (100%) of clients were screened for diabetes and 82/635 (12.9%) were diagnosed diabetic

Primary Care: Hypertension Control

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

	2018	2019	2020
Number of hypertensive clients whose last blood pressure of the measurement year was <140/90	145	147	157
Number of hypertensive clients who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year	180	181	179
Rate	**80.6%**	**81.2%**	**87.7%**
Change from Previous Years Results	**0%**	**.6%**	**6.5%**

- 179/635 (28.2%) of clients were diagnosed with hypertension

Primary Care: Breast Cancer Screening

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

	2018	2019	2020
Number of women over age 41 who had a mammogram or a referral for a mammogram documented in the previous two years	141	142	145
Number of women over age 41 who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year	164	167	166
Rate	**86%**	**85%**	**87.3%**
Change from Previous Years Results	**-1.7%**	**-1%**	**2.3%**

Primary Care: Colon Cancer Screening

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

	2018	2019	2020
Number of clients over age 50 who had colon cancer screening or a referral for colon cancer screening	127	123	161
Number of clients over age 50 who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year	160	173	192
Rate	**79.4%**	**71.1%**	**83.9%**
Change from Previous Years Results	**17.8%**	**-8.3%**	**12.8%**

Conclusions

The Houston EMA continues to demonstrate high quality clinical care. Overall, performance rates were comparable to the previous year, which is particularly reassuring in light of the COVID-19 pandemic that occurred in FY20. The decreases seen in Influenza Vaccination and IPV screening were likely related to the increase in telehealth services during the measurement year. The increased telehealth services did not appear to impact other performance measures, and in fact, primary care measures such as diabetes and hypertension control improved. Racial and ethnic disparities continue to be seen, particularly for viral load suppression rates. Eliminating racial and ethnic disparities in care are a priority for the EMA, and will continue to be a focus for quality improvement.

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Harris County
Public Health
Building a Healthy Community

Vision Care Chart Review Report FY 2020

Ryan White Part A Quality Management Program–Houston EMA

December 2021

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Introduction

Part A funds of the Ryan White Care Act are administered in the Houston Eligible Metropolitan Area (EMA) by the Ryan White Grant Administration of Harris County Public Health. During FY 20, a comprehensive review of client vision records was conducted for services provided between 3/1/20 to 2/29/21.

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

Scope of This Report

This report provides background on the project, supplemental information on the design of the data collection tool, and presents the pertinent findings of the FY 20 vision care chart review. Also, any additional data analysis of items or information not included in this report can likely be provided after a request is submitted to Ryan White Grant Administration.

The Data Collection Tool

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

The Chart Review Process

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

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

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

The Sample Selection Process

The sample population was selected from a pool of 2,911 unduplicated clients who accessed Part A vision care between 3/1/20 and 2/29/21. The medical charts of 150 of these clients were used in the review, representing 5.2% of the pool of unduplicated clients.

In an effort to make the sample population as representative of the actual Part A vision care population as possible, the EMA's Centralized Patient Care Data Management System (CPCDMS) was used to generate the lists of client codes. The demographic make-up (race/ethnicity, gender, age) of clients accessing vision care services between 3/1/20 and 2/29/21 was determined by CPCDMS, which in turn allowed Ryan White Grant Administration to generate a sample of specified size that closely mirrors that same demographic make-up.

Characteristics of the Sample Population

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

Table 2. Demographic Characteristics of FY 20 Houston EMA Ryan White Part A Vision Care Clients				
	Sample		Ryan White Part A EMA	
Race/Ethnicity	Number	Percent	Number	Percent
African American	72	48%	1,496	51%
White	73	49%	1,322	46%
Asian	3	2%	35	1%
Native Hawaiian/Pacific Islander	0	0%	3	<1%
American Indian/Alaska Native	1	<1%	9	<1%
Multi-Race	1	<1%	36	1%
TOTAL	**150**		**2,911**	
Hispanic Status				
Hispanic	56	37%	1,026	35%
Non-Hispanic	94	63%	1,885	65%
TOTAL	**150**		**2,911**	
Gender				
Male	112	75%	2,113	73%
Female	38	25%	757	26%
Transgender Male to Female	0	0%	40	1%
Transgender Female to Male	0	0%	1	<1%
TOTAL	**150**		**2,911**	
Age				
<= 24	4	3%	110	4%
25 – 34	35	23%	708	24%
35 – 44	32	21%	763	26%
45 – 54	41	27%	717	25%
55 – 64	30	20%	497	17%
65+	8	5%	116	4%
TOTAL	**150**		**2,911**	

Findings

Laboratory Tests

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

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

	2018	2019	2020
CD4	83%	94%	93%
VL	83%	94%	93%

Client Intake Form (CIF)

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

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

	2018	2019	2020
Primary Care Provider	87%	97%	92%
Medication Allergies	100%	100%	91%
Medical History	100%	99%	91%
Current Medications	100%	100%	98%
Reason for Visit	100%	100%	98%
Ocular History	100%	100%	91%

Eye Examinations (Including CEE/DFE) and Exam Findings

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

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

	2018	2019	2020
Complete Eye Exam	100%	100%	100%
Dilated Fundus Exam	94%	95%	93%
Internal Eye Exam	100%	100%	100%
Documentation of Diagnosis	100%	100%	100%
Documentation of Treatment Plan	100%	100%	100%
Visual Acuity	100%	100%	100%
Refraction Test	100%	100%	100%
Observation of External Structures	100%	100%	100%
Glaucoma Test	100%	100%	100%
Cytomegalovirus (CMV) screening	94%	95%	93%

Ocular Disease

Seven clients (5%) demonstrated ocular disease, including cataracts, strabismus, diabetic retinopathy, and conjunctivitis. Two clients received treatment for ocular disease, two clients were referred to a specialty eye clinic, and three clients did not need treatment at the time of visit.

Prescriptions

Of records reviewed, 99% documented new prescriptions for lenses at the agency within the year.

Conclusions

Findings from the FY 20 Vision Care Chart Review indicate that the vision care providers perform comprehensive vision examinations for the prevention, detection, and treatment of eye and vision disorders. Performance rates are very high overall, and are consistent with quality vision care.

Appendix A—FY 20-Vision Chart Review Data Collection Tool

Mar 1, 20 to Feb 29, 21

Pt. ID # _____ Site Code:_____

CLIENT INTAKE FORM (CIF)

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

CD4 & VL

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

EYE CARE:

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

Appendix B – Resources

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

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

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

4. Panel on Opportunistic Infections in Adults and Adolescents with HIV. Guidelines for the prevention and treatment of opportunistic infections in adults and adolescents with HIV: recommendations from the Centers for Disease Control and Prevention, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. Available at http://aidsinfo.nih.gov/contentfiles/lvguidelines/adult_oi.pdf. Accessed February 1, 2019.

Harris County
Public Health
Building a Healthy Community

Ryan White Part A
Quality Management Program- Houston EMA
Case Management Chart Review FY 2020-21
Ryan White Grant Administration

CUMMULATIVE SUMMARY, DE-IDENTIFIED

Table of Contents

Overview

Each year, the Ryan White Grant Administration Quality Management team conducts chart review in order to continuously monitor case management services and understand how each agency implements workflows to meet quality standards for their funded service models. This process is a supplemental complement to the programmatic and fiscal audit of each program, as it helps to provide an overall picture of quality of care and monitor quality performance measures.

A total of 624 medical case management client records were reviewed across seven of the ten Ryan White-Part A funded agencies, including a non-primary care site that provides Clinical Case Management services. The dates of service under review were March 1, 2020- February 28, 2021. The sample selection process and data collection tool are described in subsequent sections.

Case Management is defined by the Ryan White legislation 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." Case Managers assist clients in navigating the complex health care system to ensure coordination of care for the unique needs of People Living With HIV. Continuous assessment of need and the development of individualized service plans are key components of case management. Due to their training and skill sets in social services, human development, psychology, social justice, and communication, Case Managers are uniquely positioned to serve clients who face environmental and life issues that can jeopardize their success in HIV treatment, namely, mental health and substance abuse, poverty and access to stable housing and transportation, and poor social support networks.

Ryan White Part-A funds three distinct models of case management: Medical Case Management, Non-Medical Case Management (or Service Linkage Work), and Clinical Case Management, which must be co-located in an agency that offers Mental Health treatment/counseling and/or Substance Abuse treatment. Some agencies are also funded for Outreach Services, which complement Case Management Services and are designed to locate and assist clients who are on the cusp of falling out of care in order to re-engage and retain them back into care.

The Tool

A copy of the Case Management Chart Review tool is available in the Appendix of this report.

The Case Management Chart Review tool is a pen and paper form designed to standardize data collection and analysis across agencies. The purpose of the tool is to capture information and quantify services that can present an overall picture of the quality of case management services provided within the Ryan White Part-A system of care. This way, strengths and areas of improvement can be identified and continuously monitored.

The coversheet of the chart abstraction tool captures basic information about the client, including their demographics, most recent appointments, lab results, and any documented psychological, medical, or social issues or conditions that would be documented in their medical record.

The content of the second sheet focuses on coordination of case management services. There is space for the chart abstractor to record what type of worker assisted the client (Medical Case Manager, Service Linkage Worker, Outreach Worker or Clinical Case Manager) and what types of services were provided. It is expected that any notes about case management closure are recorded, as well as any assessments or service plans or documented reasons for the absence of assessments or service plans.

The Sample

In order to conduct a thorough and comprehensive review, a total of 624 client records were reviewed across seven agencies for the 2020-2021 grant year. This included sixty-one (61) Clinical Case Management charts at a non-primary care site. In this Case Management Chart Review Report, any section that evaluated a primary care related measure excludes the sample of the non-primary care site. Minimum sample size was determined in accordance with *Center for Quality Improvement & Innovation* sample size calculator based on the total eligible population that received case management services at each site.

Agency	A	B	C	D	E	F	G
# of Charts Reviewed	79	85	91	105	105	98	61

TOTAL 624 (563 excluding non-Primary Care site)

For each agency, a randomized sample of clients who received a billable Ryan White- A service under at least one (1) of eleven (11) case management subcategory codes during the March 1, 2020- February 28, 2021 grant year was queried from the Centralized Patient Care Data Management System database. Each sample was determined to be comparable to the racial, ethnic, age, and gender demographics of each site's overall case management patient population.

Cumulative Data Summaries

APPOINTMENTS & ENCOUNTERS

The number of HIV-related primary care appointments and case management encounters in the given year were counted for each client.

HIV-RELATED PRIMARY CARE APPOINTMENTS

For this measure, the number of face-to-face encounters and virtual telehealth visits for an HIV-related primary care appointment with a medical provider was counted. Each encounter was assessed for a minimum of 3 medical appointments. Any Viral Load that accompanied the appointment was also recorded.

HIV MEDICAL # appt	A	B	C	D	E	F	TOTAL	PERCENT
0	1	4	11	31	8	4	59	**10%**
1	5	23	9	40	42	10	129	**23%**
2	18	27	10	26	38	15	134	**24%**
3	55	31	61	8	17	69	241	**43%**
Total	*79*	*85*	*91*	*105*	*105*	*98*	*563*	

The overall sample trends towards a higher number of primary care appointment in the year, with most of the case management review clients having at least 3 appointments in the year (43%), followed by (24%) of the clients having 2 appointments in the year.

CASE MANAGEMENT ENCOUNTERS

Frequency of case management encounters were also reviewed. The number and types of the encounters (face-to-face vs. phone), as well as who provided the service (Clinical, Medical, or Non-Medical Case Manager) were also recorded.

The distribution of frequency of case management encounters could be described as evenly distributed across encounters.

CASE MGMNT # appointments	A	B	C	D	E	F	G	TOTAL	PERCENT
1	19	23	17	35	19	32	8	153	**25%**
2	21	17	13	12	30	23	6	122	**20%**
3	9	10	12	12	22	24	15	104	**17%**
4	17	19	16	22	10	10	13	107	**18%**
5	13	16	33	24	24	9	19	138	**22%**
Total	*79*	*85*	*91*	*105*	*105*	*98*	*61*	*624*	

VIRAL SUPPRESSION

Any results of HIV Viral Load laboratory tests that accompanied HIV-related primary care appointments were recorded as part of the case management chart abstraction. Up to three laboratory tests could be recorded. Lab results with an HIV viral load result of less than 200 copies per milliliter were considered to be virally suppressed.

Upon coding, clients who were suppressed for all of their recorded labs (whether they had one, two, or three tests done within the year), were coded as "Suppressed." Clients who were unsuppressed (>200 copies/mL) for all of their labs were coded as "Unsuppressed." Clients who had more than one laboratory test done and were suppressed for at least one and unsuppressed for at least one were coded as "Mixed Status," and clients who had no laboratory tests done within the entire year were coded as "Unknown."

SUPPRESSION STATUS	A	B	C	D	E	F	TOTAL	PERCENT
Suppressed for all labs	32	31	43	72	72	33	283	**50%**
Mixed status	0	0	0	3	10	0	13	**2%**
Unknown (no recent labs on file)	44	51	37	21	10	55	218	**39%**
Unsuppressed for all labs	3	3	11	9	13	10	49	**9%**
Total	*79*	*85*	*91*	*105*	*105*	*98*	*563*	

Across all primary care sites, the case management clients reviewed for these samples had a viral load suppression rate of 50%. In contrast, this result is much lower than what is typical for the Ryan White Part A Houston Primary Care Chart review, which has hovered around 85% for the past several years. This difference may be due to several factors, mainly the Covid-19 pandemic and reduction of in-person labs due to telehealth visits. The Primary Care chart review sample is collected from a pool of clients who are considered *in care*, or have at least two medical appointments with a provider with prescribing privileges in the review year. Additionally, "fluctuating viral load" is one of the eligibility criteria for medical case management, so clients who have challenges maintaining a suppressed viral load are more likely to be seen by case management and be included in this sample.

CARE STATUS

The chart abstractor also documented any circumstances in the record for which a client was new, lost, returning to care, or some combination of those care statuses. A client was considered "New to Care," if they were receiving services for the first time at that particular agency (not necessarily new to HIV treatment or the Houston Ryan White system of care). "Lost to Care" was defined as not being seen for an HIV-related primary care appointment within the last six months and not having a future appointment scheduled, even beyond the review year. "Re-engaged in Care" was defined as any client who was previously lost to care, either during or before the review year, and later attended an HIV-related primary care appointment.

CARE STATUS	A	B	C	D	E	F	TOTAL	PERCENT
New to Care	11	5	11	1	2	5	35	**6%**
Lost to Care	11	2	1	15	11	2	42	**7%**
Re-engaged in Care	0	0	0	1	0	0	1	**1%**
Both New and later Lost to Care in the same review year	8	2	20	3	17	15	65	**12%**
Re-engaged and later lost again	0	0	0	1	1	0	2	**<1%**
N/A	49	76	59	84	74	76	418	**74%**
Total	*79*	*85*	*91*	*105*	*105*	*98*	*563*	

Overall, 6% of the sample was considered New to Care, 7% was Lost to Care, and <1%was Re-engaged in Care.

When a client's attendance met one of the above care statuses, their medical record was reviewed to understand if case management or other staff was involved in coordinating their care. Activities that counted as "Coordination of Care" were any actions that welcomed the client into or back into care or attempted to retain them in care, such as: reminder phone calls, follow-up calls, attendance, or introduction at the first appointment, or home visits.

COMORBIDITIES

To understand and document common comorbidities within the Houston Ryan White system of care, co-occurring conditions were recorded, including mental health and substance abuse issues, other medical conditions, and social conditions. This inventorying of co-morbidities may prove particularly helpful for selecting future training topics for case management staff.

MENTAL HEALTH & SUBSTANCE USE DISORDER (history or active)

Any diagnosis of a mental health disorder (MH) or substance use disorder issue (SUD) was recorded in the chart review tool, including a history of mental illness or substance use. All Electronic Medical Records include some variation of a "Problem List" template. This list was often a good source of information for MH and SUD diagnoses, but providers sometimes also documented diagnoses or known histories of illness within progress notes without updating the Problem List. Clients sometimes also self-reported that they had been diagnosed with one of the below conditions by a previous medical provider. Any indication of the presence of mental illness or SUD, regardless of where the information was housed within the medical record, was recorded on the chart abstraction tool. Clients could also have or have had more than one of the MH or SUD issues. Any conditions other than alcohol misuse, other SUD, depression, bipolar disorder, anxiety, or schizophrenia were recorded as "Other." The most common types of condition coded as "Other" was Post-Traumatic Stress Disorder.

Diagnosis or Issue	A	B	C	D	E	F	G	TOTAL	PERCENT
Alcohol abuse/dependence	3	2	5	1	13	6	20	50	**9%**
Other Substance dependence	14	1	5	0	15	7	19	61	**10%**
Depression	16	11	32	14	42	33	37	185	**32%**
Bipolar disorder	6	5	7	1	5	10	14	48	**8%**
Anxiety	9	12	14	51	28	22	32	168	**29%**
Schizophrenia	1	1	0	14	1	2	7	26	**4%**
Other	2	0	11	2	12	9	10	46	**8%**

Overall, 93% of the sample had either an active diagnosis or history of a mental health or substance abuse issue documented somewhere within their medical record. This is inclusive of the Clinical Case Management site, for which diagnosis with or clinical indication of a MH or SUD issue is an eligibility criteria.

MENTAL HEALTH & SUBSTANCE USE DISORDER REFERRALS

For clients with an *active* diagnosis of a mental health or SUD issue, the chart abstractor recorded if they were referred or already engaged in MH/SUD services.

MH referral	A	B	C	D	E	F	TOTAL	PERCENT
N/A	75	82	55	100	97	88	497	**88%**
Yes	3	3	13	5	8	10	42	**7%**
No	1	0	23	0	0	0	24	**4%**
Total	82	85	91	105	105	98	563	

Overall, 88% of the sample would not have been appropriate for a MH or SUD referral based on the information available in their medical record. An additional 7% either did receive a referral or were already engaged in treatment and 4% did not receive a referral.

MEDICAL CONDITIONS

Medical conditions other than HIV were also recorded in an effort to understand what co-occurring conditions may be considered commonly managed alongside HIV within the case management population. Sexually Transmitted Infections and Hypertension were common, at 33% and 25% prevalence within the sample, respectively. The site visit tool does not list obesity as a medical condition however, obesity was the most common co-occurring condition that was coded in the "Other" category.

Medical Condition	A	B	C	D	E	F	TOTAL	PERCENT
Smoking (hx or current)	10	7	12	11	33	10	83	**16%**
Opportunistic Infection	0	0	3	6	0	0	9	**2%**
STIs	38	16	48	3	39	31	175	**33%**
Diabetes	5	11	8	4	20	22	70	**13%**
Cancer	0	3	1	6	0	1	11	**2%**
Hepatitis	7	5	1	7	9	9	38	**7%**
Hypertension	12	37	21	11	22	28	131	**25%**
Other	2	3	5	0	8	1	19	**4%**

SOCIAL CONDITIONS

Any indication within the medical record that a client had experienced homelessness/housing-related issues, pregnancy/pregnancy-related issues, a release from jail or prison, or intimate partner violence at any point within the review year was recorded in the chart abstraction tool. Homelessness and housing issues were the most commonly identified "Social Condition" within the sample.

Social Issue	A	B	C	D	E	F	G	TOTAL	PERCENT
Homelessness or housing-related issues	5	0	3	4	15	1	10	38	**6%**
Pregnancy or pregnancy-related issues	6	2	0	0	0	0	0	8	**1%**
Recently released	0	0	1	0	2	0	0	3	**<1%**
Intimate Partner Violence	3	0	0	0	5	0	10	18	**2%**

COMPREHENSIVE ASSESSMENTS

A cornerstone of service provision within case management is the opportunity for the client to be formally assessed at touchpoints throughout the year for their needs, treatment goals, and action steps for how they will work with the case manager or care team to achieve their treatment goals. Agencies need to use an approved assessment tool and service plan, which may either be the sample tools available through Ryan White Grant Administration or a pre-approved tool of the agency's choosing.

The Ryan White Part-A Standards for medical case management state that a comprehensive assessment should be completed with the client at intake and that they should be re-assessed at least every six months for as long as they are receiving medical case management services. A more formal, comprehensive assessment should be used at intake and annually, and a brief reassessment tool is sufficient at the 6-month mark. In other words, the ideal standard is that every client who receives case management services for an entire year should have at least two comprehensive assessments on file. A service plan should accompany each comprehensive assessment to outline the detailed plan of how the identified needs will be addressed with the client.

# of Comp assessments	A	B	C	D	E	F	G	TOTAL	PERCENT
0	62	85	78	100	89	83	0	497	**79%**
1	17	0	13	3	16	15	15	79	**13%**
2	0	0	0	2	0	0	9	11	**2%**
N/A	0	0	0	0	0	0	37	37	**6%**
Total	79	85	95	105	105	98	61	624	

The client was considered "N/A" for a comprehensive assessment if they did not work with a medical case manager throughout the year. As outlined above, 6% of the sample did not work with a Medical Case Manager within the year. 79% of the sample received zero comprehensive assessments, 13% received one, and 2% received two.

SERVICE PLANS

As mentioned, each comprehensive assessment should be accompanied by a service plan, otherwise known as a care plan, to outline what action(s) will be taken to address the needs identified on the comprehensive assessment. A service plan can be thought of as an informal, working, contract between client and social worker for accountability of needed actions, and in what order, to meet a client's determined treatment goals. As with the comprehensive assessment, each completed service plan was recorded in the chart abstraction tool, along with any documented justification for why a service plan was missing if it should have been completed.

# of service plans	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**TOTAL**	**PERCENT**
0	65	82	91	102	95	98	7	540	**87%**
1	14	3	0	2	10	0	10	39	**6%**
2	0	0	0	1	0	0	7	8	**1%**
N/A	0	0	0	0	0	0	37	37	**6%**
Total	79	85	91	105	105	98	61	624	

It is notable that less service plans are completed than comprehensive assessments, even though the two processes are intended to occur together, one right after the other. RWGA experienced a transition in CM chart review auditors midway through the chart review process. As a result, it is unclear what the criteria for determining a client was "N/A" at agency "G".

BRIEF ASSESSMENTS

Like Medical Case Management, Non-Medical Case Management is guided by a continuous process of ongoing assessment, service provision, and evaluation. Clients should be assessed at intake using a Ryan White Grant Administration approved brief assessment form and should be reassessed at six-month intervals if they are still being serviced by a Non-Medical Case Manager.

# of Brief assessments	**A**	**B**	**C**	**D**	**E**	**F**	**TOTAL**	**PERCENT**
0	52	73	55	56	30	80	346	**61%**
1	24	12	34	38	54	18	180	**33%**
2	3	0	2	7	1	0	13	**2%**
N/A	0	0	0	4	20	0	24	**4%**
Total	79	85	91	105	105	98	563	

Completion of brief assessments were recorded. 4% of the sample would not been applicable for a brief assessment, as they did not receive services from a Non-Medical Case Manager. 61% of the sample received zero brief assessments, 33% received one, and 2% received two.

ASSESSED NEEDS

All data from assessment tools was captured in the chart review tool. A total of 624 Comprehensive Assessments and 563 Brief Assessments were reviewed and recorded to quantify the frequency of needs. The count recorded is a raw count of how many times a need was recorded, encompassing both comprehensive and brief assessments and including clients who may have had the same need identified more than once at different points in time.

The most frequently assessed needs were: 1) Medical/Clinical, 2) Dental Care, 3) Vision Care, 4) Medication Adherence Counseling, 5) Mental Health, and (6) Insurance. It should be noted, however, that there are no universal standards or instructions across case management systems on how to use these tools or how these needs are defined. Anecdotally, some case managers reported that they automatically checked "Medical/Clinical" and "Medication Adherence Counseling" as a need, regardless of whether or not the client needed assistance accessing medical care, because it was their understanding that this section *always* needed to be checked in order to justify billing for medical case management services. Therefore, this compilation of comprehensive and brief assessments should not be considered representative of *true need* within the HIV community in Houston, but rather, as representative of issues that case managers are discussing with clients.

Need identified on assessment	A	B	C	D	E	F	G	TOTAL	PERCENT
Medical/Medication	42	12	41	37	24	35	8	199	8%
Vaccinations	10	7	0	44	22	0	6	89	4%
Nutrition/Food Pantry	10	8	16	0	18	1	4	57	3%
Dental	31	11	18	16	29	14	8	127	5%
Vision	19	11	31	12	14	13	5	105	4%
Hearing Care	15	9	26	1	0	12	1	64	3%
Home Health Care	10	3	8	0	1	2	0	24	1%
Basic Necessities/Life Skills	41	9	28	4	5	32	5	124	5%
Mental Health	33	9	45	16	24	44	14	185	7%
Substance Use Disorder	43	12	37	4	5	35	6	142	6%
Abuse	27	11	17	1	12	15	2	85	4%
Housing/Living Situation	41	12	35	9	10	34	8	149	6%
Support Systems	47	12	42	3	3	33	1	141	6%
Child Care	14	6	4	0	0	4	0	28	1%
Insurance	52	11	31	3	9	46	4	156	6%
Transportation	36	12	55	11	6	35	6	161	6%
HIV-Related Legal Assistance	25	8	21	0	1	27	0	82	3%
Cultural/Linguistic	28	1	12	0	0	20	0	61	3%
Self-Efficacy	40	1	12	0	0	40	4	97	4%
HIV Education/Prevention	21	12	40	3	4	36	0	116	5%
Family Planning/ Safer Sex	9	11	7	0	4	2	1	34	2%
Employment	39	7	39	0	4	33	4	126	5%
Education/Vocation	35	10	30	0	0	10	0	85	4%
Financial Assistance	8	10	12	21	15	8	13	87	4%
Medication Adherence Counseling	44	9	43	19	27	43	17	182	7%
Client Strengths	1	0	0	1	0	0	3	5	1%

Conclusion

The 2020-2021 Case Management chart review highlighted many trends about the case management client population, strengths in case management performance, and areas identified for future attention and improvement. This report also gives consideration to challenges and barriers related to Covid-19 pandemic.

The most common co-occurring conditions were: Sexually Transmitted Infections (33%), Depression (32%), and Hypertension (25%). Diabetes and Obesity were also relatively common and providing overview information on nutrition counseling may be a useful topic in frontline case management trainings. The prevalence of complex co-morbidities emphasizes the unique benefit that case managers contribute to the HIV treatment setting.

There were also areas of high performance displayed in this chart review. Most (43 %) of the clients in the sample had at least three HIV-related primary care appointments within the review year. Case Management staff demonstrated a high level of coordination of care in areas. For example, 90% of the clients who were New, Lost, or Returning to Care (or some combination) received coordination of care activities from case management to retain them in care.

Appendix (Case Management Chart Review Tool)

CASE MANAGEMENT CHART REVIEW TOOL
Chart Review Date _____/_____/_____
Agency: ☐ AHF ☐ AH ☐ Ave360 ☐ HHS ☐ Legacy ☐ SHF

Review Period:
3/1/20__ - 2/28/20__

CLIENT INFORMATION

Pt. ID # _____ Race: _____

Client Case Status: ☐ Open/Active ☐ Closed ☐ Unk. Gender: _____

Last OAMC Appts:	Virally Suppressed?	← If No, linked to CM?
1.	☐ Y ☐ N ☐ Unk.	
2.	☐ Y ☐ N ☐ Unk.	
3.	☐ Y ☐ N ☐ Unk.	
☐ No appts. during review period		

Last CMngmt. Contact:	Type (F2F/PC/Consult.) + short description)	Signed/Dated/Clear?
1.		
2.		
3.		
4.		
5.		

During the review period, was the client: ☐ New to care ☐ Lost to care ☐ Re-engaged in care ☐ NA
If yes.... was there documentation of coordination of care or contact attempts? ☐ Y ☐ N ☐ NA

Does the client have an active diagnosis of the following diagnoses? (Check ALL that apply)
☐ Alcohol abuse/dependence
☐ Other substance abuse/dependence: _____
☐ Depression
☐ Bipolar disorders
☐ Anxiety disorders
☐ Schizophrenia
☐ Other: _____

Was the client referred or already engaged with MH/SA services?
☐ N/A ☐ Yes ☐ No

Does the client have any co-morbidity?
☐ Opportunistic Infection
☐ Sexually Transmitted Infections (STIs) : _____
☐ Diabetes
☐ Cancer
☐ Hepatitis
☐ Hypertension
☐ Other: _____

Was the client reported to have any of the following conditions?
☐ Homelessness
☐ Pregnancy (or other pregnancy-related conditions)
☐ Recently released
☐ IPV

INSURANCE, BENEFITS, AND INCOME INFORMATION

Health Insurance: ☐ Uninsured ☐ Medicaid _____ ☐ Medicare_____ ☐ Commercial _____
☐ VA ☐ Other? _____

Spouse/partner:	Children:	Other Dependents:	TOTAL HOUSEHOLD SIZE 1 2 3 4 5 6 7 8 9 10 Unk
Client Income $:	Spouse Income $:	Other Income $:	TOTAL HOUSEHOLD INCOME $:

Did the client lose insurance or coverage during the review period? ☐ Y N ☐ Unk. ☐
If so, were they provided with information/education or assistance? ☐ Y N ☐ NA ☐

CASE MANAGEMENT SERVICES

What types of services were provided by a **Medical Case Manager** (MCM?)	What types of services were provided by a **Service Linkage Worker** (SLW?)	Was the client referred for **Clinical Case Management** services in the review period?
☐ **NA (Client not assisted by MCM)** ☐ Comprehensive assessment ☐ Service Plan ☐ Medication adherence counseling ☐ Coordination of medical care ☐ Transportation ☐ ADAP/medication assistance ☐ Eligibility ☐ Community resource/benefits brokerage ☐ Other _____ Did client meet criteria for MCM? Y ☐ N ☐ Unk. ☐	☐ **NA (Client not assisted by SLW)** ☐ Brief assessment ☐ SLW referred client to OAMC ☐ OAMC visit scheduled by SLW ☐ SLW accompanied client to OAMC ☐ SLW called client to remind about OAMC visit ☐ Client did not keep OAMC appt. and SLW contacted them ☐ ADAP/medication assistance ☐ Transportation voucher ☐ Eligibility Were any of the above services provided by an Outreach Worker? Y ☐ N ☐ Unk. ☐	☐ **No- not applicable** ☐ No- applicable, but no referral documented ☐ Yes- and there is evidence of coordination of services ☐ Yes- and there is no evidence of coordination of services ☐ Yes- but client refused services or is already engaged in treatment

Was the case discharged/closed for CM during the review period?		Y ☐	N ☐	NA ☐	Unk. ☐
If yes.....	Client met agency criteria for closure?	Y ☐	N ☐	NA ☐	Unk. ☐
	Client completed treatment program (CCM)	Y ☐	N ☐	NA ☐	Unk. ☐
	Date and reason noted?	Y ☐	N ☐	NA ☐	Unk. ☐
	Summary of services received?	Y ☐	N ☐	NA ☐	Unk. ☐
	Referrals noted?	Y ☐	N ☐	NA ☐	Unk. ☐
	Instructions given to client at discharge?	Y ☐	N ☐	NA ☐	Unk. ☐

ASSESSMENTS & SERVICE PLANS

		If no assessment or plan:		
Brief Assess. Date 1:	Brief Assess. Date 2:	☐ evidence of one just outside of review period	☐ reason documented	☐ enough info to complete
Comp. Assess. Date 1:	Comp. Assess. Date 2:	☐ evidence of one just outside of review period	☐ reason documented	☐ enough info to complete
Service Plan Date 1:	Service Plan Date 2:	☐ evidence of one just outside of review period	☐ reason documented	☐ enough info to complete

COMPLETED ASSESSMENTS

	MOST RECENT ASSESSMENT TYPE (circle one) Comprehensive Brief					NEXT MOST RECENT ASSESSMENT TYPE (circle one) Comprehensive Brief				
Domain	Assessed?	Need Identified?	Accounted for in Service Plan?	Accounted for in progress notes?	Follow-up (referral, action, etc.)	Assessed?	Need Identified?	Accounted for in Service Plan?	Accounted for in progress notes?	Follow-up (referral, action, etc.)
Medical/Clinical										
Vaccination										
Nutrition/Food Pantry										
Dental Care										
Vision Care										
Hearing Care										
Home Care Needs										
Basic Necessities/Life Skills										
Mental Health										
Substance/Alcohol Use										
Abuse History										
Housing/Living Situation										
Support System										
Child Care/Guardianship										
Insurance Benefits										
Transportation										
HIV-Related Legal										
Cultural/Linguistic										
Self-Efficacy										
HIV Education/Prevention										
Family Planning/Safer Sex										
Employment/Income										
General Education/Vocation										
Financial Assistance										
Medication Adherence										
Client Strengths										
Other										

Prepared by: Ryan White Grant Administration

FY 2021 Ryan White Part A and MAI Service Utilization Report

RW PART A SUR- 3rd Quarter (3/1-11/30)																		
Priority	**Service Category**	**Goal**	**Unduplicated Clients Served YTD**	**Male**	**Female**	**Trans gender**	**AA (non-Hispanic)**	**White (non-Hispanic)**	**Other (non-Hispanic)**	**Hispanic**	**0-12**	**13-19**	**20-24**	**25-34**	**35-44**	**45-49**	**50-64**	**65 plus**
1	**Outpatient/Ambulatory Primary Care (excluding Vision)**	**6,467**	**7,274**	**75%**	**23%**	**2%**	**46%**	**13%**	**3%**	**39%**	**0%**	**0%**	**4%**	**28%**	27%	12%	26%	2%
1.a	Primary Care - Public Clinic (a)	2,350	2,455	72%	27%	1%	44%	9%	2%	45%	0%	0%	3%	16%	26%	14%	37%	4%
1.b	Primary Care - CBO Targeted to AA (a)	1,060	2,042	69%	28%	3%	99%	0%	1%	0%	0%	0%	6%	38%	28%	10%	16%	1%
1.c	Primary Care - CBO Targeted to Hispanic (a)	960	1,607	81%	15%	4%	0%	0%	0%	100%	0%	0%	6%	31%	30%	12%	20%	1%
1.d	Primary Care - CBO Targeted to White and/or MSM (a)	690	703	88%	11%	1%	0%	85%	15%	0%	0%	0%	3%	24%	26%	11%	33%	2%
1.e	Primary Care - CBO Targeted to Rural (a)	400	654	69%	30%	1%	48%	22%	2%	29%	0%	0%	3%	31%	28%	11%	25%	2%
1.f	Primary Care - Women at Public Clinic (a)	1,000	661	0%	99%	1%	53%	5%	2%	40%	0%	0%	1%	11%	26%	18%	39%	5%
1.g	Primary Care - Pediatric (a)	7	6	83%	17%	0%	50%	0%	0%	50%	17%	67%	17%	0%	0%	0%	0%	0%
1.h	Vision	1,600	2,240	73%	25%	2%	48%	12%	3%	37%	0%	0%	4%	25%	24%	13%	29%	5%
2	**Medical Case Management (f)**	**3,075**	**4,462**															
2.a	Clinical Case Management	600	747	73%	24%	3%	57%	12%	1%	30%	0%	0%	4%	23%	27%	12%	29%	5%
2.b	Med CM - Targeted to Public Clinic (a)	280	495	91%	6%	2%	54%	12%	2%	33%	0%	1%	2%	26%	23%	10%	33%	5%
2.c	Med CM - Targeted to AA (a)	550	1,321	68%	29%	3%	98%	0%	2%	0%	0%	1%	6%	31%	26%	11%	23%	3%
2.d	Med CM - Targeted to H/L(a)	550	706	79%	16%	5%	0%	0%	0%	100%	0%	0%	6%	27%	30%	12%	22%	2%
2.e	Med CM - Targeted to White and/or MSM (a)	260	372	84%	14%	2%	0%	88%	12%	0%	0%	0%	3%	23%	22%	7%	37%	7%
2.f	Med CM - Targeted to Rural (a)	150	397	66%	33%	1%	47%	30%	2%	21%	0%	0%	2%	25%	25%	10%	31%	7%
2.g	Med CM - Targeted to Women at Public Clinic (a)	240	234	0%	100%	0%	73%	7%	2%	18%	0%	0%	2%	21%	33%	12%	29%	5%
2.h	Med CM - Targeted to Pedi (a)	125	0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
2.i	Med CM - Targeted to Veterans	200	176	95%	5%	0%	71%	20%	1%	8%	0%	0%	0%	0%	4%	3%	51%	42%
2.j	Med CM - Targeted to Youth	120	14	86%	7%	7%	71%	0%	0%	29%	0%	21%	79%	0%	0%	0%	0%	0%
3	**Local Drug Reimbursement Program (a)**	**2,845**	**4,490**	**73%**	**23%**	**4%**	**47%**	**13%**	**2%**	**38%**	**0%**	**0%**	**4%**	**28%**	**28%**	**13%**	**26%**	**2%**
4	**Oral Health**	**200**	**331**	**69%**	**30%**	**1%**	**48%**	**25%**	**1%**	**27%**	**0%**	**0%**	**2%**	**24%**	**24%**	**14%**	**31%**	**5%**
4.a	Oral Health - Untargeted (d)	NA	NA															
4.b	Oral Health - Rural Target	200	331	69%	30%	**1%**	48%	25%	1%	27%	0%	0%	2%	24%	24%	14%	31%	5%
5	**Mental Health Services (d)**	**NA**	**NA**															
6	**Health Insurance**	**1,700**	**1,380**	**80%**	**18%**	**1%**	**43%**	**27%**	**2%**	**28%**	**0%**	**0%**	**1%**	**14%**	**17%**	**11%**	**43%**	**14%**
7	**Home and Community Based Services (d)**	**NA**	**NA**															
8	**Substance Abuse Treatment - Outpatient**	**40**	**21**	**86%**	**5%**	**10%**	**33%**	**43%**	**0%**	**24%**	**0%**	**0%**	**0%**	**29%**	**38%**	**14%**	**19%**	**0%**
9	**Early Medical Intervention Services (d)**	**NA**	**NA**															
10	**Medical Nutritional Therapy/Nutritional Supplements**	**650**	**505**	**75%**	**24%**	**1%**	**40%**	**19%**	**4%**	**37%**	**0%**	**0%**	**1%**	**11%**	**17%**	**10%**	**48%**	**13%**
11	**Hospice Services (d)**	**NA**	**NA**															
12	**Outreach**	**700**	**880**	**74%**	**22%**	**4%**	**56%**	**13%**	**1%**	**30%**	**0%**	**1%**	**5%**	**34%**	**26%**	**11%**	**22%**	**2%**
13	**Non-Medical Case Management**	**7,045**	**6,155**															
13.a	Service Linkage Targeted to Youth	320	149	79%	19%	1%	55%	6%	1%	38%	0%	19%	81%	0%	0%	0%	0%	0%
13.b	Service Linkage at Testing Sites	260	79	76%	22%	3%	52%	4%	1%	43%	0%	0%	0%	61%	22%	3%	14%	1%
13.c	Service Linkage at Public Clinic Primary Care Program (a)	3,700	2,849	68%	31%	1%	54%	10%	2%	35%	0%	0%	0%	18%	24%	12%	39%	7%
13.d	Service Linkage at CBO Primary Care Programs (a)	2,765	3,078	74%	23%	3%	53%	13%	2%	32%	1%	1%	5%	28%	24%	10%	27%	3%
14	**Transportation**	**2,850**	**1,900**															
14.a	Transportation Services - Urban	170	606	70%	29%	1%	57%	9%	1%	33%	0%	0%	3%	27%	26%	11%	27%	5%
14.b	Transportation Services - Rural	130	216	67%	32%	1%	31%	34%	1%	33%	0%	0%	4%	17%	25%	15%	32%	7%
14.c	Transportation vouchering	2,550	1,078															
15	**Linguistic Services (d)**	**NA**	**NA**															
16	**Emergency Financial Assistance (e)**	**NA**	**763**	**71%**	**26%**	**3%**	**56%**	**9%**	**1%**	**34%**	**0%**	**0%**	**3%**	**26%**	**25%**	**12%**	**30%**	**3%**
17	**Referral for Health Care - Non Core Service (d)**	**NA**	**NA**															
Net unduplicated clients served - all categories*		**12,941**	**12,739**	**73%**	**24%**	**2%**	**50%**	**14%**	**2%**	**34%**	**0%**	**1%**	**4%**	**24%**	**24%**	**11%**	**30%**	**5%**
Living AIDS cases + estimated Living HIV non-AIDS (from FY19 App) (b)		**NA**	**28,225**	**60%**	**21%**		**39%**	**18%**	**3%**	**20%**	**0%**	**5%**		**15%**	**22%**	**25%**	**15%**	

Available Data As Of: 3/8/2022

Prepared by: Ryan White Grant Administration

FY 2021 Ryan White Part A and MAI Service Utilization Report

RW MAI Service Utilization Report - 3rd Quarter (03/01 -11/30)

Priority	Service Category MAI unduplicated served includes clients also served under Part A	Goal	Unduplicated MAI Clients Served YTD	Male	Female	Trans gender	AA (non-Hispanic)	White (non-Hispanic)	Other (non-Hispanic)	Hispanic	0-12	13-19	20-24	25-34	35-44	45-49	50-64	65 plus
	Outpatient/Ambulatory Primary Care (excluding Vision)																	
1.b	Primary Care - MAI CBO Targeted to AA (g)	1,060	1,496	**70%**	**27%**	**3%**	**99%**	**0%**	**1%**	**0%**	**0%**	**0%**	**7%**	**36%**	**27%**	**11%**	**18%**	**1%**
1.c	Primary Care - MAI CBO Targeted to Hispanic (g)	960	1,308	**82%**	**14%**	**4%**	**0%**	**0%**	**0%**	**100%**	**0%**	**0%**	**6%**	**30%**	**31%**	**13%**	**19%**	**1%**
2	**Medical Case Management (f)**																	
2.c	Med CM - Targeted to AA (a)	1,060	742	**76%**	**20%**	**4%**	**53%**	**10%**	**1%**	**35%**	**0%**	**1%**	**9%**	**39%**	**26%**	**9%**	**15%**	**1%**
2.d	Med CM - Targeted to H/L(a)	960	555	**73%**	**24%**	**3%**	**72%**	**10%**	**3%**	**15%**	**0%**	**1%**	**4%**	**38%**	**27%**	**14%**	**14%**	**1%**

RW Part A New Client Service Utilization Report - 3rd Quarter (03/01-11/30)
Report reflects the number & demographics of clients served during the report period who did not receive services during previous 12 months (3/1/20 - 2/28/21)

Priority	Service Category	Goal	Unduplicated New Clients Served YTD	Male	Female	Trans gender	AA (non-Hispanic)	White (non-Hispanic)	Other (non-Hispanic)	Hispanic	0-12	13-19	20-24	25-34	35-44	45-49	50-64	65 plus
1	**Primary Medical Care**	**2,100**	**1,373**	**80%**	**18%**	**3%**	**51%**	**11%**	**2%**	**35%**	**0%**	**1%**	**9%**	**40%**	**24%**	**8%**	**1%**	**16%**
2	**LPAP**	**1,200**	**536**	**76%**	**20%**	**4%**	**53%**	**10%**	**1%**	**35%**	**0%**	**1%**	**9%**	**39%**	**26%**	**9%**	**1%**	**15%**
3.a	Clinical Case Management	400	78	73%	24%	3%	72%	10%	3%	15%	0%	1%	4%	38%	**27%**	**14%**	1%	**14%**
3.b-3.h	Medical Case Management	1,600	798	77%	20%	4%	54%	14%	2%	30%	0%	2%	8%	37%	**25%**	**8%**	3%	**19%**
3.i	Medical Case Manangement - Targeted to Veterans	60	33	94%	6%	0%	85%	12%	0%	3%	0%	0%	0%	0%	**6%**	**9%**	39%	**45%**
4	**Oral Health**	**40**	**43**	**74%**	**26%**	0%	**49%**	**30%**	**0%**	**21%**	**0%**	**0%**	**2%**	**35%**	**23%**	**14%**	**5%**	**21%**
12.a. 12.c. 12.d.	**Non-Medical Case Management (Service Linkage)**	**3,700**	**1,393**	**74%**	**24%**	**2%**	**56%**	**13%**	**2%**	**29%**	**1%**	**2%**	**6%**	**31%**	**23%**	**9%**	**23%**	**5%**
12.b	**Service Linkage at Testing Sites**	**260**	**69**	**78%**	**17%**	**4%**	**54%**	**1%**	**3%**	**42%**	**0%**	**6%**	**16%**	**51%**	**12%**	**1%**	**13%**	**1%**

Footnotes:

(a) Bundled Category

(b) Age groups 13-19 and 20-24 combined together; Age groups 55-64 and 65+ combined together.

(d) Funded by Part B and/or State Services

(e) Total MCM served does not include Clinical Case Management

(f) CBO Pcare targeted to AA (1.b) and HL (1.c) goals represent combined Part A and MAI clients served

Available Data As Of: 3/8/2022

Part A Reflects "Decrease" Funding Scenario
MAI Reflects "Decrease" Funding Scenario

FY 2021 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**	**10,965,788**	**-75,776**	**1,415,641**	**60,600**	**0**	**12,366,253**	**51.76%**	**12,366,253**	**0**		**7,220,250**	**58%**	**92%**
1.a	Primary Care - Public Clinic (a)	3,927,300	-27,177				3,900,123	16.33%	3,900,123	0	3/1/2021	$1,624,811	42%	92%
1.b	Primary Care - CBO Targeted to AA (a) (e) (f)	1,064,576	-7,367	441,880	244,386		1,743,475	7.30%	1,743,475	0	3/1/2021	$1,383,479	79%	92%
1.c	Primary Care - CBO Targeted to Hispanic (a) (e)	910,551	-6,301	441,880	75,000		1,421,130	5.95%	1,421,130	0	3/1/2021	$1,182,227	83%	92%
1.d	Primary Care - CBO Targeted to White/MSM (a) (e)	1,147,924	-7,944	441,880			1,581,861	6.62%	1,581,861	0	3/1/2021	$611,515	39%	92%
1.e	Primary Care - CBO Targeted to Rural (a) (e)	1,100,000	-7,612		-75,000		1,017,388	4.26%	1,017,388	0	3/1/2021	$889,773	87%	92%
1.f	Primary Care - Women at Public Clinic (a)	2,100,000	-14,532				2,085,468	8.73%	2,085,468	0	3/1/2021	$1,156,539	55%	92%
1.g	Primary Care - Pediatric (a.1)	15,437					15,437	0.06%	15,437	0	3/1/2021	$3,600	23%	92%
1.h	Vision	500,000	-3,460	90,000	-85,000		501,540	2.10%	501,540	0	3/1/2021	$368,305	73%	92%
1.x	Primary Care Health Outcome Pilot	200,000	-1,384		-98,786		99,830	0.42%	99,830	0		$0	0%	92%
2	**Medical Case Management**	**1,730,000**	**-100,528**	**30,000**	**0**	**0**	**1,659,472**	**6.95%**	**1,659,472**	**0**		**1,303,825**	**79%**	**92%**
2.a	Clinical Case Management	488,656	-3,381	30,000			515,275	2.16%	515,275	0	3/1/2021	$321,267	62%	92%
2.b	Med CM - Public Clinic (a)	277,103	-1,918				275,185	1.15%	275,185	0	3/1/2021	$217,703	79%	92%
2.c	Med CM - Targeted to AA (a) (e)	169,009	-1,170				167,839	0.70%	167,839	0	3/1/2021	$223,684	133%	92%
2.d	Med CM - Targeted to H/L (a) (e)	169,011	-1,170				167,841	0.70%	167,841	0	3/1/2021	$118,776	71%	92%
2.e	Med CM - Targeted to W/MSM (a) (e)	61,186	-423				60,763	0.25%	60,763	0	3/1/2021	$75,679	125%	92%
2.f	Med CM - Targeted to Rural (a)	273,760	-1,894				271,866	1.14%	271,866	0	3/1/2021	$116,646	43%	92%
2.g	Med CM - Women at Public Clinic (a)	75,311	-521				74,790	0.31%	74,790	0	3/1/2021	$130,594	175%	92%
2.h	Med CM - Targeted to Pedi (a.1)	90,051	-90,051				0	0.00%	0	0	3/1/2021	$0	#DIV/0!	92%
2.i	Med CM - Targeted to Veterans	80,025	0				80,025	0.33%	80,025	0	3/1/2021	$58,009	72%	92%
2.j	Med CM - Targeted to Youth	45,888	0				45,888	0.19%	45,888	0	3/1/2021	$41,467	90%	92%
3	**Local Pharmacy Assistance Program**	**1,810,360**	**-12,528**	**22,920**	**0**	**0**	**1,820,752**	**7.62%**	**1,820,752**	**0**	3/1/2021	**$937,799**	**52%**	**92%**
3.a	Local Pharmacy Assistance Program-Public Clinic (a) (e)	310,360	-2,148				308,212	1.29%	308,212	0	3/1/2021	$260,442	85%	92%
3.b	Local Pharmacy Assistance Program-Untargeted (a) (e)	1,500,000	-10,380	22,920			1,512,540	6.33%	1,512,540	0	3/1/2021	$677,357	45%	92%
4	**Oral Health**	**166,404**	**-1,152**	**0**	**0**	**0**	**165,252**	**0.69%**	**165,252**	**0**	3/1/2021	**149,300**	**90%**	**92%**
4.a	Oral Health - Untargeted (c)	0					0	0.00%	0	0	N/A	$0	0%	**0%**
4.b	Oral Health - Targeted to Rural	166,404	-1,152		0		165,252	0.69%	165,252	0	3/1/2021	$149,300	90%	92%
5	**Health Insurance (c)**	**1,383,137**	**-9,571**	**300,000**	**0**	**0**	**1,673,566**	**7.01%**	**1,673,566**	**0**	3/1/2021	**$1,305,834**	**78%**	**92%**
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	**Medical Nutritional Therapy (supplements)**	**341,395**	**-2,362**		**55,000**		**394,033**	**1.65%**	**394,033**	**0**	**3/1/2021**	**$315,468**	**80%**	**92%**
9	**Home and Community-Based Services (c)**	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**	**NA**	**$0**	**0%**	**0%**
9.a	In-Home	0									N/A	$0	0%	0%
9.b	Facility Based	0									N/A	$0	0%	0%
10	**Substance Abuse Services - Outpatient**	**45,677**	**0**	**0**	**0**	**0**	**45,677**	**0.19%**	**45,677**	**0**	3/1/2021	**$25,150**	**55%**	**92%**
11	**Hospice Services**	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**	**NA**	**$0**	**0%**	**0%**
12	**Referral for Health Care and Support Services (c)**	**0**	**0**				**0**	**0.00%**	**0**	**0**	**NA**	**$0**	**0%**	**0%**
13	**Non-Medical Case Management**	**1,267,002**	**-8,768**	**40,000**	**-70,600**	**0**	**1,227,634**	**5.14%**	**1,227,634**	**0**	**3/1/2021**	**$958,125**	**78%**	**92%**
13.a	Service Linkage targeted to Youth	110,793	-767		-20,600		89,426	**0.37%**	89,426	0	3/1/2021	$79,723	89%	92%
13.b	Service Linkage targeted to Newly-Diagnosed/Not-in-Care	100,000	-692		-50,000		49,308	**0.21%**	49,308	0	3/1/2021	$56,791	115%	92%
13.c	Service Linkage at Public Clinic (a)	370,000	-2,560				367,440	**1.54%**	367,440	0	3/1/2021	$373,442	102%	92%
13.d	Service Linkage embedded in CBO Pcare (a) (e)	686,209	-4,749	40,000			721,460	**3.02%**	721,460	0	3/1/2021	$448,168	62%	92%
13.e	SLW-Substance Use	0	0				0	**0.00%**	0	0	NA	$0	0%	0%
14	**Medical Transportation**	**424,911**	**-2,940**	**0**	**0**	**0**	**421,971**	**1.77%**	**421,971**	**0**		**316,768**	**75%**	**92%**
14.a	Medical Transportation services targeted to Urban	252,680	-1,749				250,931	1.05%	250,931	0	3/1/2021	$235,244	94%	92%
14.b	Medical Transportation services targeted to Rural	97,185	-673				96,512	0.40%	96,512	0	3/1/2021	$81,524	84%	92%
14.c	Transportation vouchering (bus passes & gas cards)	75,046	-519				74,527	0.31%	74,527	0	3/1/2021	$0	0%	92%
15	**Emergency Financial Assistance**	**1,545,439**	**-10,694**	**0**	**-45,000**	**0**	**1,489,745**	**6.24%**	**1,489,745**	**0**		**986,085**	**66%**	**92%**
16.a	EFA - Pharmacy Assistance	1,305,439	-9,034		75,000		1,371,405	5.74%	1,371,405	0	3/1/2021	$913,437	67%	92%

Part A Reflects "Decrease" Funding Scenario
MAI Reflects "Decrease" Funding Scenario

FY 2021 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
16.b	EFA - Other	240,000	-1,661		-120,000		118,339	0.50%	118,339	0	3/1/2021	$72,648	61%	92%
16	**Linguistic Services (c)**	**0**	**0**				**0**	**0.00%**	**0**	**0**	**NA**	**$0**	**0%**	**0%**
17	**Outreach**	**420,000**	-2,906				**417,094**	**1.75%**	**417,094**	**0**	**3/1/2021**	**$259,504**	**0%**	**92%**
BEU27516	**Total Service Dollars**	**20,100,113**	**-227,226**	**1,808,561**	**0**	**0**	**21,681,448**	**90.75%**	**21,681,448**	**-1**		**13,778,108**	**64%**	**92%**
	Grant Administration	**1,795,958**	**0**	**0**	**0**	**0**	**1,795,958**	**7.52%**	**1,795,958**	0	**N/A**	**1,263,365**	**70%**	**92%**
BEU27517	HCPH/RWGA Section	1,271,050		0		0	1,271,050	5.32%	1,271,050	0	N/A	$896,759	71%	92%
PC	RWPC Support*	524,908			0	0	524,908	2.20%	524,908	0	N/A	366,606	70%	92%
BEU27521	**Quality Management**	**412,940**		**0**	**0**	**0**	**412,940**	**1.73%**	**412,940**	**0**	**N/A**	**$279,210**	**68%**	**92%**
		22,309,011	**-227,226**	**1,808,561**	**0**	**0**	**23,890,346**	**100.00%**	**23,890,346**	**-1**		**15,320,683**	**64%**	**92%**
								Unallocated	Unobligated					92%
	Part A Grant Award:	**22,171,816**	***Carry Over:***	**1,718,511**		***Total Part A:***	**23,890,327**	**-19**	**-1**					92%

		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)	**16,442,761**	**-201,918**	**1,768,561**	**115,600**	**0**	**18,125,004**	**83.60%**		
	Non-Core (may not exceed 25% of total service dollars)	**3,657,352**	**-25,309**	**40,000**	**-115,600**	**0**	**3,556,443**	**16.40%**		
	Total Service Dollars (does not include Admin and QM)	**20,100,113**	**-227,226**	**1,808,561**	**0**	**0**	**21,681,448**			
	Total Admin (must be ≤ 10% of total Part A + MAI)	**1,795,958**	**0**	**0**	**0**	**0**	**1,795,958**	**6.42%**		
	Total QM (must be ≤ 5% of total Part A + MAI)	**412,940**	**0**	**0**	**0**	**0**	**412,940**	**1.48%**		

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**	**2,002,860**	**-52,609**	**100,100**	**0**	**0**	**2,050,351**	**86.50%**	**2,050,351**	**0**		**1,627,450**	**79%**	**92%**
1.b (MAI)	Primary Care - CBO Targeted to African American	1,012,700	-26,601	50,050			1,036,149	43.71%	1,036,149	0	3/1/2021	$866,250	84%	92%
1.c (MAI)	Primary Care - CBO Targeted to Hispanic	990,160	-26,009	50,050			1,014,201	42.79%	1,014,201	0	3/1/2021	$761,200	75%	92%
2	**Medical Case Management**	**320,100**	**0**	**0**	**0**	**0**	**320,100**	**13.50%**	**320,100**	**0**		**$214,146**	**67%**	92%
2.c (MAI)	MCM - Targeted to African American	160,050					160,050	6.75%	160,050	0	3/1/2021	$119,733	75%	92%
2.d (MAI)	MCM - Targeted to Hispanic	160,050					160,050	6.75%	160,050	0	3/1/2021	$94,412	59%	92%
	Total MAI Service Funds	**2,322,960**	**-52,609**	**100,100**	**0**	**0**	**2,370,451**	**100.00%**	**2,370,451**	**0**		**1,841,596**	**78%**	**92%**
	Grant Administration	0	0	0	0	0	0	0.00%	0	0		0	0%	0%
	Quality Management	0	0	0	0	0	0	0.00%	0	0		0	0%	0%
	Total MAI Non-service Funds	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**		**0**	**0%**	**0%**
BEO 27516	**Total MAI Funds**	**2,322,960**	**-52,609**	**100,100**	**0**	**0**	**2,370,451**	**100.00%**	**2,370,451**	**0**		**1,841,596**	**78%**	**92%**
	MAI Grant Award	**3,175,710**	***Carry Over:***	**905,361**		***Total MAI:***	**4,081,071**							92%
	Combined Part A and MAI Orginial Allocation Total	**24,631,971**												

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.

Part A Reflects "Decrease" Funding Scenario
MAI Reflects "Decrease" Funding Scenario

FY 2021 Ryan White Part A and MAI
Procurement Report

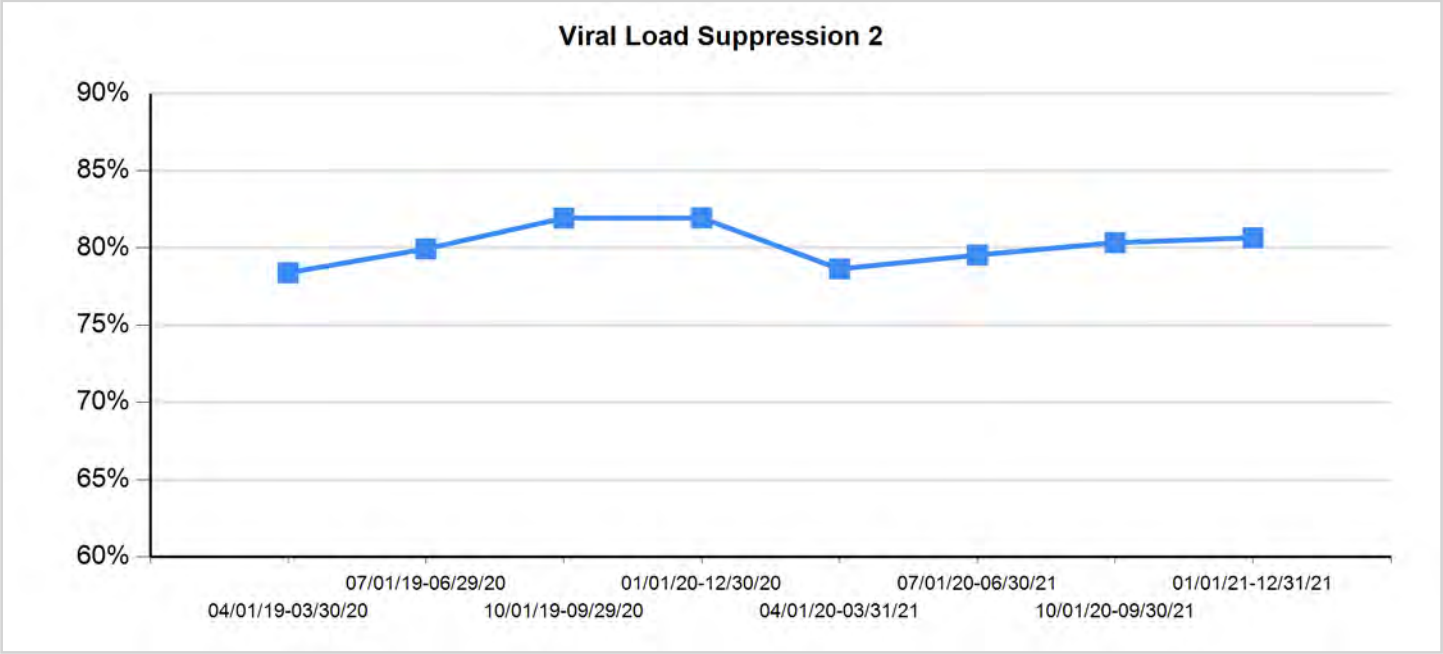
Priority	Service Category	Original Allocation *RWPC Approved Level Funding Scenario*	Award Reconcilation (b)	July Adjustments (carryover)	October Adjustments	Final Quarter Adjustments	Total Allocation	Percent of Grant Award	Amount Procured (a)	Procure-ment Balance	Original Date Procured	Expended YTD	Percent YTD	Percent Expected YTD
(c)	Funded under Part B and/or SS													
(d)	Not used at this time													
(e)	10% rule reallocations													

HARRIS COUNTY PUBLIC HEALTH AND ENVIRONMENTAL SERVICES - RWGA

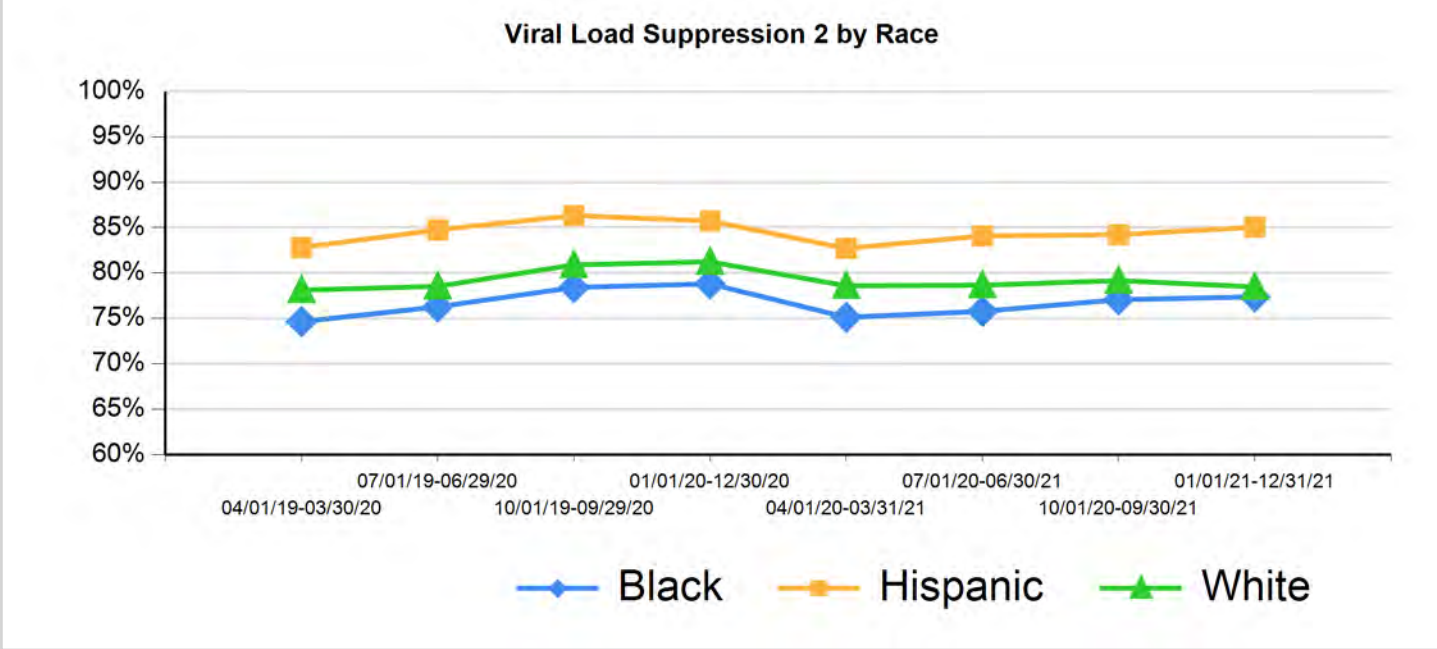
Clinical Quality Management Committee Quarterly Report

Last Quarter Start Date: **1/1/2021**

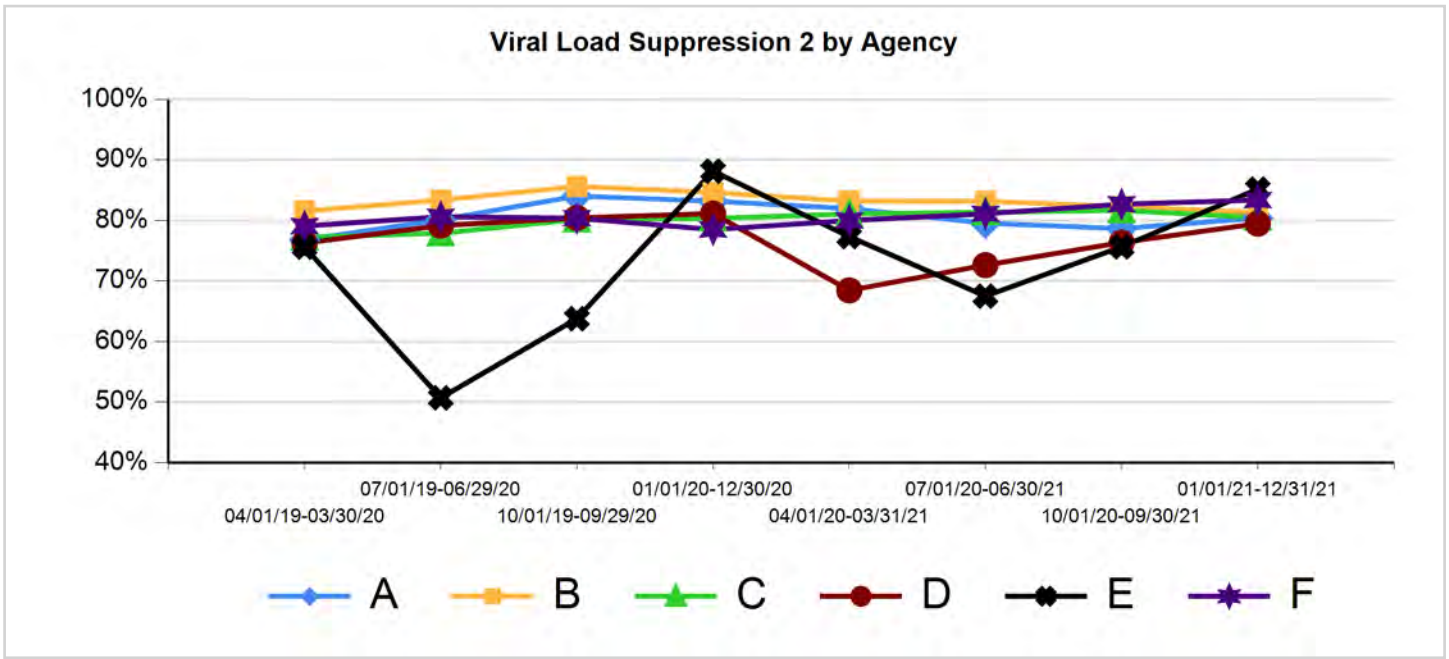
Viral Load Suppression 2- HAB Measure				
	04/01/20 - 03/31/21	07/01/20 - 06/30/21	10/01/20 - 09/30/21	01/01/21 - 12/31/21
Number of clients who have a viral load of <200 copies/ml during the measurement year	6,867	7,117	7,216	7,120
Number of clients who have had at least 1 medical visit with a provider with prescribing privileges	8,732	8,947	8,981	8,827
Percentage	78.6%	79.5%	80.3%	80.7%
Change from Previous Quarter Results	-3.3%	0.9%	0.8%	0.3%



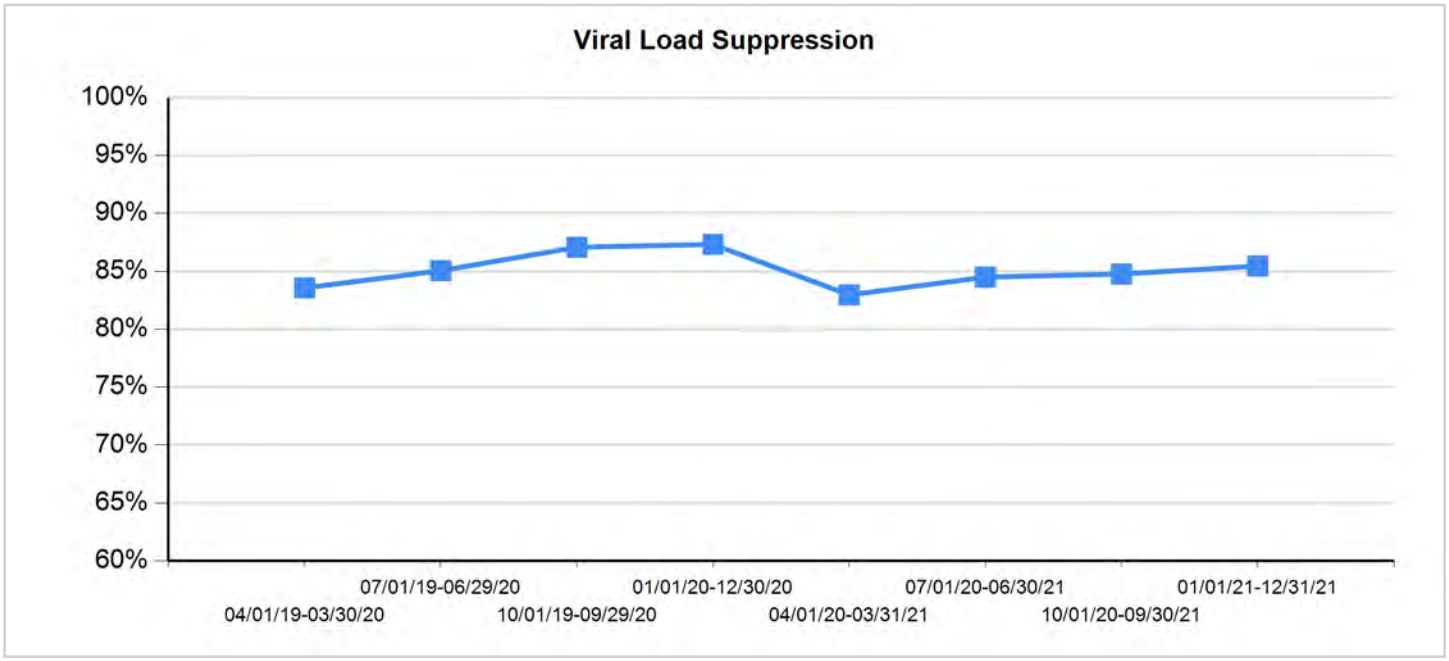
VL Suppression 2 by Race/Ethnicity									
	07/01/20 - 06/30/21			10/01/20 - 09/30/21			01/01/21 - 12/31/21		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of clients who have a viral load of <200 copies/ml during the measurement year	3,218	2,863	862	3,275	2,914	851	3,217	2,935	798
Number of clients who have had at least 1 medical visits with a provider with prescribing privileges and have been enrolled in care at least six month	4,247	3,405	1,096	4,250	3,460	1,075	4,158	3,451	1,017
Percentage	75.8%	84.1%	78.6%	77.1%	84.2%	79.2%	77.4%	85.0%	78.5%
Change from Previous Quarter Results	0.7%	1.4%	0.1%	1.3%	0.1%	0.5%	0.3%	0.8%	-0.7%



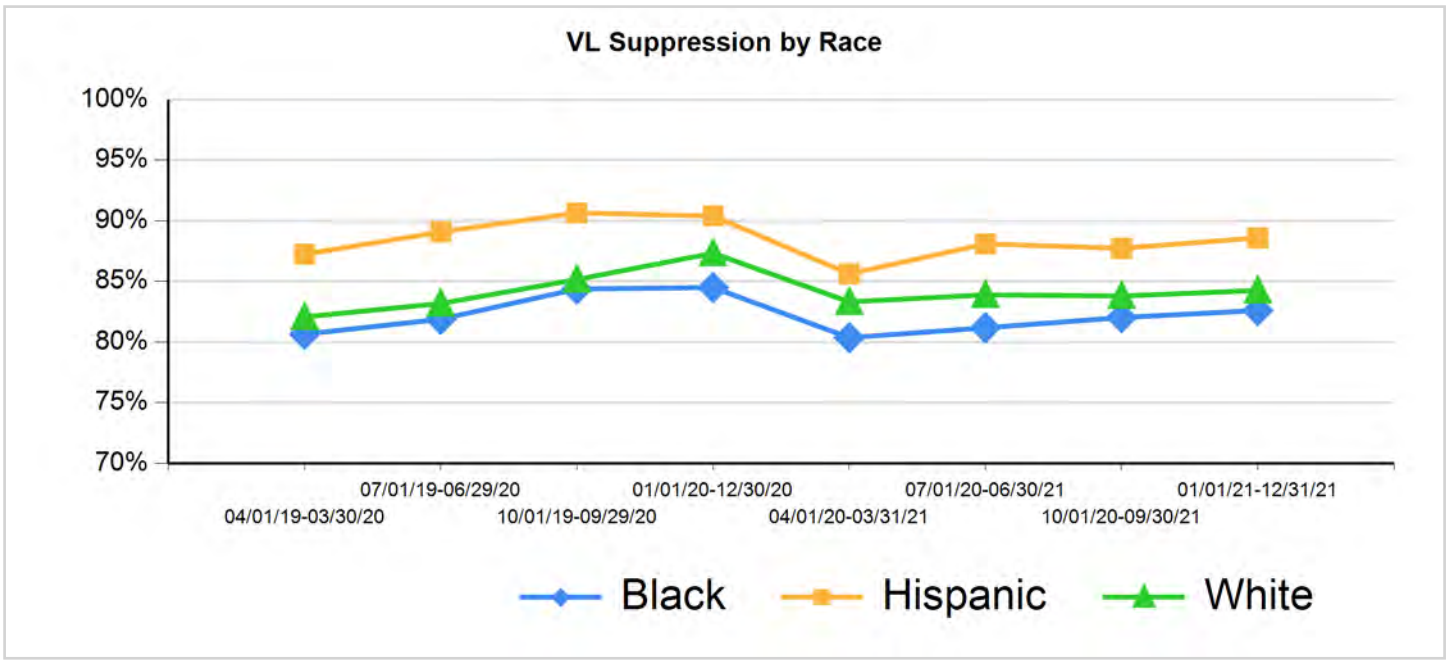
Viral Load 2 Suppression by Agency												
	10/01/20 - 09/30/21						01/01/21 - 12/31/21					
	A	B	C	D	E	F	A	B	C	D	E	F
Number of clients who have a viral load of <200 copies/ml during the measurement year	542	2,112	2,308	1,693	59	621	558	1,979	2,234	1,747	69	647
Number of clients who have had at least 1 medical visits with a provider with prescribing privileges and have been enrolled in care at least six month	689	2,566	2,826	2,217	78	751	694	2,434	2,776	2,198	81	776
Percentage	78.7%	82.3%	81.7%	76.4%	75.6%	82.7%	80.4%	81.3%	80.5%	79.5%	85.2%	83.4%
Change from Previous Quarter Results	-0.9%	-0.9%	0.3%	3.7%	8.1%	1.6%	1.7%	-1.0%	-1.2%	3.1%	9.5%	0.7%



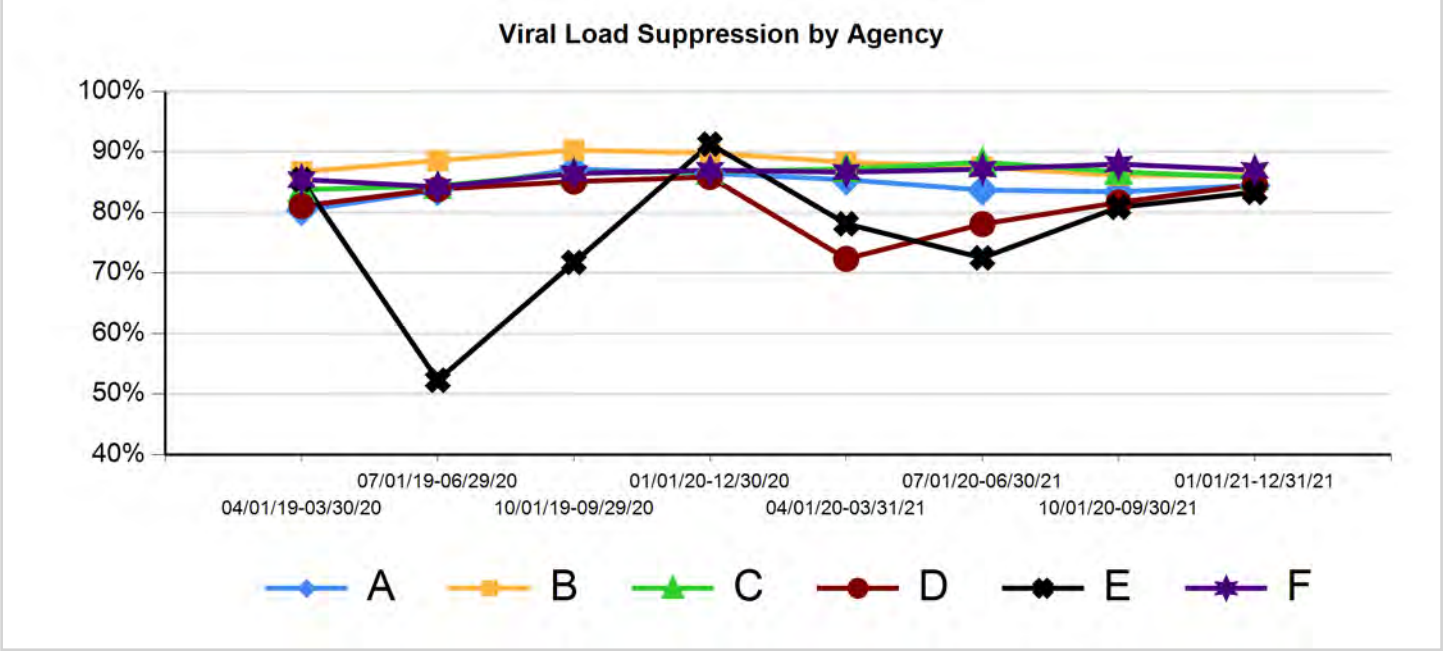
Viral Load Suppression				
	04/01/20 - 03/31/21	07/01/20 - 06/30/21	10/01/20 - 09/30/21	01/01/21 - 12/31/21
Number of clients who have a viral load of <200 copies/ml during the measurement year	5,074	5,243	5,275	5,244
Number of clients who have had at least 2 medical visits with a provider with prescribing privileges and have been enrolled in care at least six month	6,116	6,205	6,223	6,137
Percentage	83.0%	84.5%	84.8%	85.4%
Change from Previous Quarter Results	-4.4%	1.5%	0.3%	0.7%



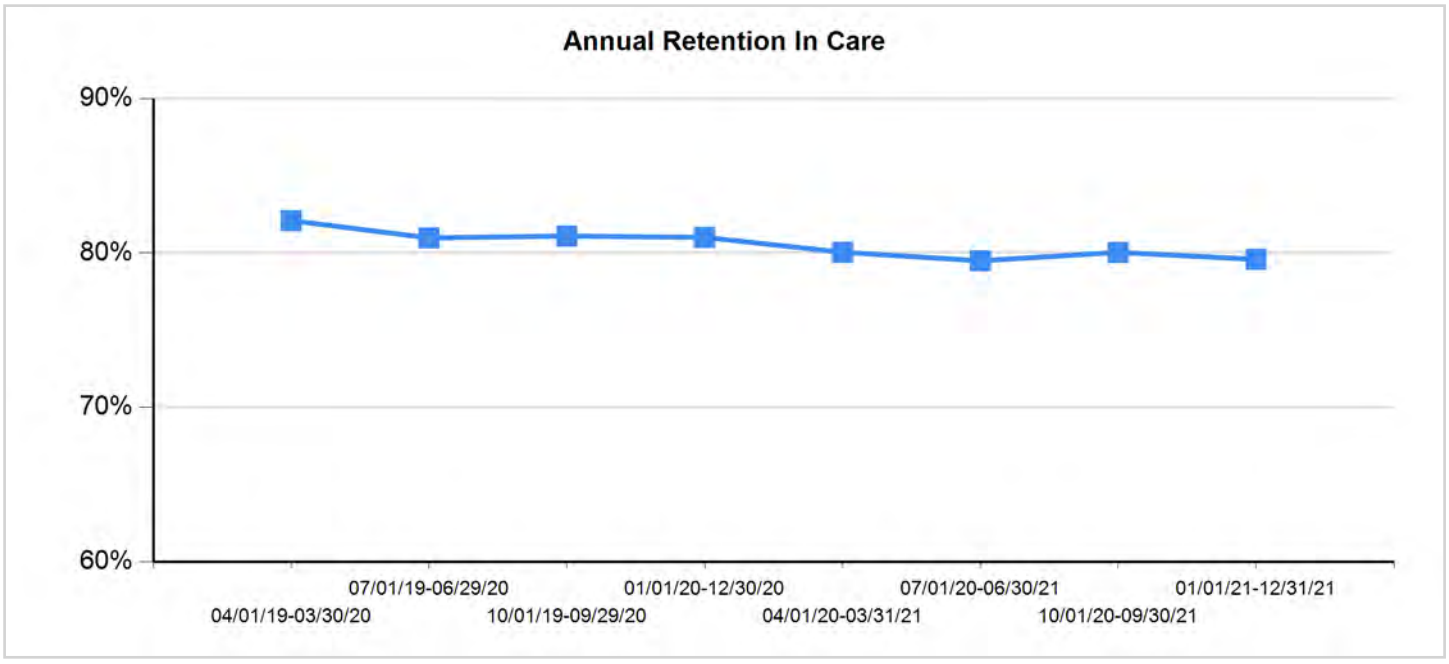
VL Suppression by Race/Ethnicity									
	07/01/20 - 06/30/21			10/01/20 - 09/30/21			01/01/21 - 12/31/21		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of clients who have a viral load of <200 copies/ml during the measurement year	2,311	2,205	604	2,335	2,203	605	2,288	2,244	583
Number of clients who have had at least 2 medical visits with a provider with prescribing privileges and have been enrolled in care at least six month	2,847	2,503	720	2,847	2,511	722	2,770	2,533	692
Percentage	81.2%	88.1%	83.9%	82.0%	87.7%	83.8%	82.6%	88.6%	84.2%
Change from Previous Quarter Results	0.8%	2.5%	0.6%	0.8%	-0.4%	-0.1%	0.6%	0.9%	0.5%



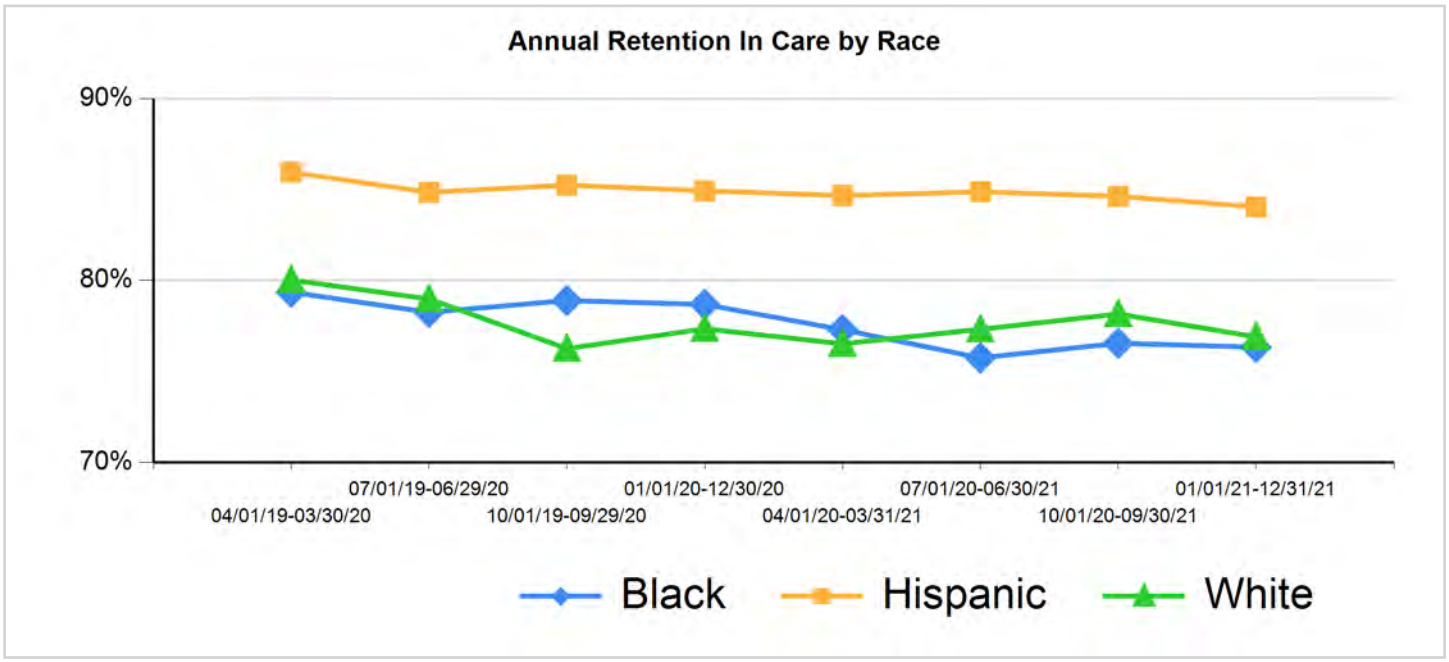
VL Suppression by Agency												
	10/01/20 - 09/30/21						01/01/21 - 12/31/21					
	A	B	C	D	E	F	A	B	C	D	E	F
Number of clients who have a viral load of <200 copies/ml during the measurement year	478	1,501	1,378	1,491	38	425	479	1,450	1,381	1,504	35	428
Number of clients who have had at least 2 medical visits with a provider with prescribing privileges and have been enrolled in care at least six month	573	1,743	1,589	1,826	47	483	567	1,683	1,610	1,777	42	492
Percentage	83.4%	86.1%	86.7%	81.7%	80.9%	88.0%	84.5%	86.2%	85.8%	84.6%	83.3%	87.0%
Change from Previous Quarter Results	-0.3%	-1.4%	-1.6%	3.6%	8.4%	0.8%	1.1%	0.0%	-0.9%	3.0%	2.5%	-1.0%



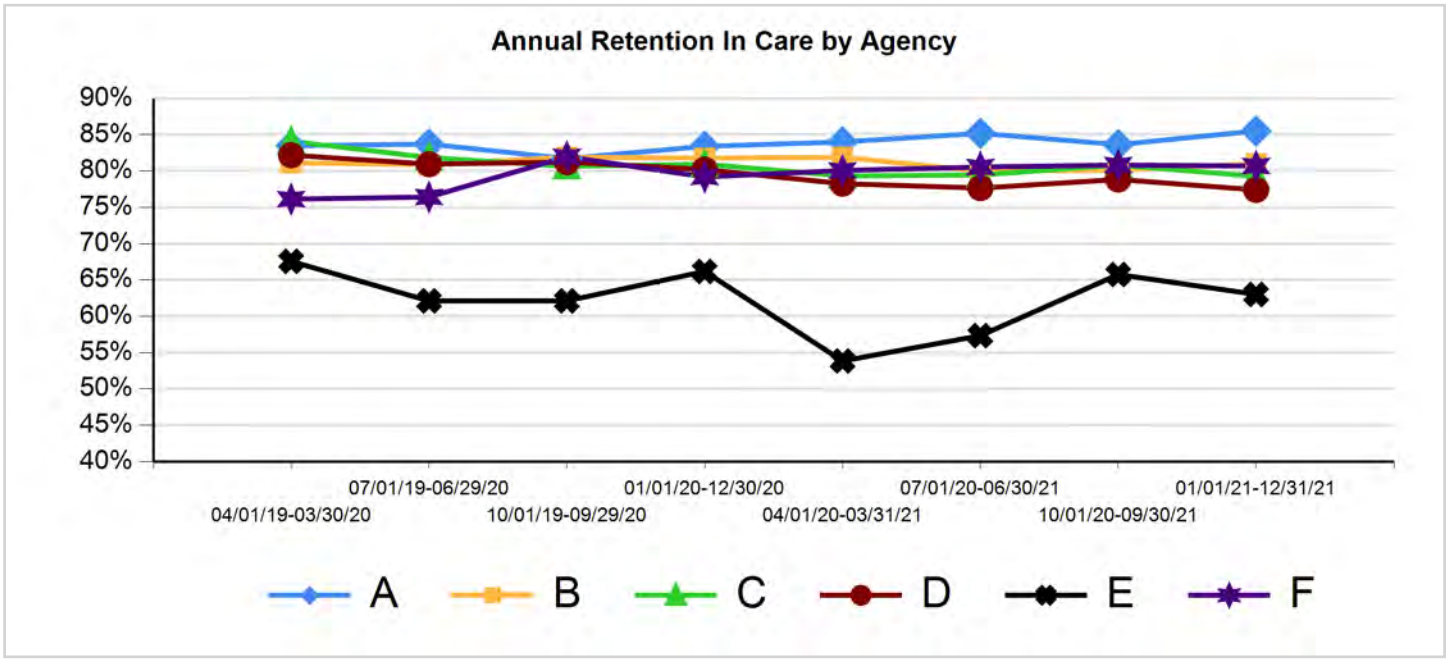
Annual Retention In Care				
Houston EMA Medical Visits Measure				
	04/01/20 - 03/31/21	07/01/20 - 06/30/21	10/01/20 - 09/30/21	01/01/21 - 12/31/21
Number of clients who had either of the following more than 90 days apart from 1st encounter: a) at least 1 VL test - b) a subsequent medical visit encounter with a provider with prescribing privileges - during the measurement year*	6,379	6,474	6,536	6,421
Number of clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year*	7,969	8,144	8,166	8,068
Percentage	80.0%	79.5%	80.0%	79.6%
Change from Previous Quarter Results	-1.0%	-0.6%	0.5%	-0.5%
* Not newly enrolled in care				



Annual Retention In Care by Race/Ethnicity									
	07/01/20 - 06/30/21			10/01/20 - 09/30/21			01/01/21 - 12/31/21		
	Black	Hisp	White	Black	Hisp	White	Black	Hisp	White
Number of clients who had either of the following more than 90 days apart from 1st encounter: a) at least 1 VL test - b) a subsequent medical visit encounter with a provider with prescribing privileges - during the measurement year	2,916	2,648	770	2,953	2,670	762	2,892	2,655	722
Number of clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year*	3,850	3,120	996	3,858	3,155	975	3,789	3,159	939
Percentage	75.7%	84.9%	77.3%	76.5%	84.6%	78.2%	76.3%	84.0%	76.9%
Change from Previous Quarter Results	-1.5%	0.2%	0.8%	0.8%	-0.2%	0.8%	-0.2%	-0.6%	-1.3%



Annual Retention In Care by Agency												
	10/01/20 - 09/30/21						01/01/21 - 12/31/21					
	A	B	C	D	E	F	A	B	C	D	E	F
Number of clients who had either of the following more than 90 days apart from 1st encounter: a) at least 1 VL test - b) a subsequent medical visit encounter with a provider with prescribing privileges - during the measurement year	542	1,908	2,054	1,625	48	468	555	1,834	2,011	1,587	46	489
Number of clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year*	648	2,381	2,541	2,061	73	579	649	2,264	2,537	2,050	73	606
Percentage	83.6%	80.1%	80.8%	78.8%	65.8%	80.8%	85.5%	81.0%	79.3%	77.4%	63.0%	80.7%
Change from Previous Quarter Results	-1.6%	0.1%	1.4%	1.2%	8.4%	0.3%	1.9%	0.9%	-1.6%	-1.4%	-2.7%	-0.1%



Houston Ryan White Health Insurance Assistance Service Utilization Report

Period Reported: 09/01/2021-01/31/2022

Revised: 3/9/2022

	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	532	$54,338.88	282			*0*
Medical Deductible	17	$7,945.33	14			*0*
Medical Premium	3061	$774,235.48	821			*0*
Pharmacy Co-Payment	10053	$531,425.36	1176			*0*
APTC Tax Liability	0	$0.00	0			*0*
Out of Network Out of Pocket	0	$0.00	0			*0*
ACA Premium Subsidy Repayment	4	$693.77	8	*NA*	*NA*	*NA*
Totals:	13667	$1,367,251.28	2301	0	$0.00	

Comments: This report represents services provided under all grants.

Completed By: S. Longoria