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
Titan Capri	*Deborah Somoye*
Tom Lindstrom	*Gloria Sierra*

Copy:

Carin Martin	Patrick Martin
Heather Keizman	Mackenzie A. Hudson
Mauricia Chatman	Diane Beck
Tiffany Shepherd	Ann Robison
Sha'Terra Johnson	Gary Grier

From: Tori Williams

Date: Tuesday, November 8, 2022

Re: Meeting Notice

We look forward to seeing you on Zoom for your last Quality Improvement Committee meeting in 2022. Please note that this is an important meeting because you will be reviewing recommendations on the FY23-24 Standards of Care. Details are as follows:

Quality Improvement Committee Meeting
2:00 p.m., Tuesday, November 15, 2022

To participate, click on this link:
https://us02web.zoom.us/j/81144509622?pwd=SFNBM1RScVFabHkzakVpaUZoeHhIdz09
Meeting ID: 811 4450 9622 Passcode: 125672

Or, call in by dialing: 346 248 7799

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:

Tana Pradia, 832 298-4248, tanapradia@gmail.com

We look forward to seeing you on Tuesday.

DRAFT

Houston Area HIV Services Ryan White Planning Council

Quality Improvement Committee Meeting
2:00 p.m., Tuesday, November 15, 2022

Join the meeting via Zoom
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

I. Call to Order — Daphne L. Jones and Denis Kelly, Co-Chairs
   A. Moment of Appreciation and Reflection
   B. Adoption of Agenda
   C. Approval of the Minutes:
      - June 14, 2022
      - September 1, 2022

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.

III. Reports from Ryan White Administrative Agents
   A. Ryan White Part A and MAI — Heather Keizman, RWGA*
      1. Clinical Quality Mgmt. Quarterly Report — Heather Keizman, RWGA*
      2. Other Reports
   B. Ryan White Part B and State Services (SS) — Patrick Martin, TRG**
      1.

IV. FY 2023 Standards of Care and Performance Measures
   A. Ryan White Part A and MAI — Mauricia Chatman, RWGA*
   B. Ryan White Part B and State Services (SS) — Patrick Martin, TRG**

V. Old Business
   A. 2023 Data Reports
   B. Committee Quarterly Report
   C. Appreciations

VI. Announcements

VII. Adjourn

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

Houston Area HIV Services Ryan White Planning Council

Quality Improvement Committee
2:00 p.m., Tuesday, June 14, 2022
Meeting Location: Zoom teleconference

Minutes

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

Call to Order: Daphne Jones, Co-Chair, called the meeting to order at 2:11 p.m. She then asked for a moment of reflection.

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

Approval of the Minutes: ***Motion #2****: it was moved and seconded (Kelly, Perez) to approve the May 3, 2022 committee meeting minutes.* **Motion carried**. Abstentions: Boyle, Rodriguez.

Public Comment: See attached email from A. Robison regarding the Mental Health service category.

Reports from the Administrative Agents
Ryan White Part A: See the attached reports:

- FY2022 Part A/MAI Procurement Report, reflecting the increase scenario, dated 06/01/22
- FY2021 Part A/MAI Procurement Report, dated 05/31/22
- FY2021 Part A/MAI Service Utilization Report, dated 06/01/22

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

- FY2021-22 Part B Procurement Report, dated 06/01/22
- FY2021-22 DSHS State Services Procurement Report, dated 10/27/21

FY 2023 How to Best Meet the Need - Mental Health Services: See attached public comment regarding this service definition. Shepherd said that they checked with DSHS and this is allowable under the service category. ***Motion #3****: it was moved and seconded (Rodriguez, Kelly) to update the Mental Health service definition to include the changes described in the public comment and leave it up to the Administrative Agent to work out the details.* **Motion carried.** Abstention: Sierra.

Checklist for the 2022 Assessment of the Part A Administrative Agency: See attached ***Motion #4****: it was moved and seconded (Sierra, Somoye) to use the 2021 checklist for the 2022 Assessments of the Ryan White Part A and Part B Administrative Mechanisms.* **Motion carried.**

Update on the Quality of Life workgroup meetings: The meetings have been very well attended and have outlined a number of strategies and activities, see attached chart. The last workgroup meeting for 2022 will be this afternoon at 4:00 p.m.. There is still time to register if you would like to attend on Zoom or in person.

Work Plan for the 2022 Integrated HIV Prevention and Care Services Plan: See attached. Williams said that meeting notices for the community meetings would be sent out soon.

Announcements: Please see the link to register for today's Quality of Life workgroup in the chat.

Adjourn: ***Motion:*** *it was moved and seconded (Rodriguez, Sierra) to adjourn the meeting at 2:39 p.m.* **Motion Carried.**

Submitted by: Approved by:

_____ _____

Tori Williams, Director Date Committee Chair Date

Scribe: D. Beck

2022 Quality Improvement Meeting Voting Record for Meeting Date 06/14/22

MEMBERS:	**Motion #1** Agenda				**Motion #2** Minutes				**Motion #3** Mental Health Service Definition				**Motion #4** Checklist for Assessment of the Admin Agents			
	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN
Daphne Jones, Co-Chair				**C**				**C**				**C**				**C**
Denis Kelly, Co-Chair		**X**				**X**				**X**				**X**		
Kevin Aloysius	**X**				**X**				**X**				**X**			
Veronica Ardoin	**X**				**X**				**X**				**X**			
Ardry “Skeet” Boyle		**X**						**X**		**X**				**X**		
Titan Capri	**X**				**X**				**X**				**X**			
Tom Lindstrom	**X**				**X**				**X**				**X**			
Nkechi Onyewuenyi	**X**				**X**				**X**				**X**			
Oscar Perez		**X**				**X**				**X**				**X**		
Tana Pradia		**X**				**X**				**X**				**X**		
Pete Rodriguez		**X**						**X**	**X**				**X**			
Andrew Wilson	**X**				**X**				**X**				**X**			
Gloria Sierra		**X**				**X**						**X**		**X**		
Deborah Somoye		**X**				**X**				**X**				**X**		

Houston Area HIV Services Ryan White Planning Council

Quality Improvement Committee
10:00 a.m., Thursday, September 1, 2022
Meeting Location: Zoom teleconference

Minutes

MEMBERS PRESENT	MEMBERS ABSENT	OTHERS PRESENT
Daphne Jones, Co-Chair	Kevin Aloysius	Crystal Starr, RWPC Chair
Denis Kelly, Co-Chair	Veronica Ardoin	Carin Martin, RWGA
Titan Capri	Ardry "Skeet" Boyle	Heather Keizman, RWGA
Tom Lindstrom	Andrew Wilson	Mauricia Chatman, RWGA
Oscar Perez		Sarah Ross, RWGA
Tana Pradia		Tiffany Shepherd, TRG
Pete Rodriguez		Tori Williams, Ofc of Support
Gloria Sierra		Mackenzie Hudson, Ofc of Support
Deborah Somoye		Diane Beck, Ofc of Support

Call to Order: Daphne Jones, Co-Chair, called the meeting to order at 10:10 a.m.. She then asked for a moment of reflection.

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

Public Comment: None.

Reports from the Administrative Agents
Ryan White Part A: Martin said that the new STARS process takes longer to approve invoices. All purchase orders are in place. The carryover request has been submitted to HRSA and contracts will be processed before it is received.

Ryan White Part B and State Services: No report.

2022 Assessment of the Part A Administrative Mechanism: See attached ***Motion #3****: it was moved and seconded (Kelly, Pradia) to accept the 2022 Assessment of the Ryan White Part A Administrative Mechanism with no corrective action needed.* **Motion carried.**

Announcements: Beck said that the second Community HIV Planning meeting will be today at 4:00 p.m.; Please register to receive the Zoom information: https://bit.ly/commHIVedu_Sept1

Adjourn: ***Motion:*** *it was moved and seconded (Rodriguez, Sierra) to adjourn the meeting at 10:30 a.m.* **Motion Carried.**

Submitted by: Approved by:

Tori Williams, Director Date Committee Chair Date

Scribe: D. Beck

JA = Just arrived at meeting
LR = Left room temporarily
LM = Left the meeting
C = Chaired the meeting

2022 Quality Improvement Meeting Voting Record for Meeting Date 09/01/22

MEMBERS:	**Motion #1** Agenda				**Motion #2** Assessment of the Part A Admin Mechanism			
	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN
Daphne Jones, Co-Chair				**C**				**C**
Denis Kelly, Co-Chair		**X**				**X**		
Kevin Aloysius	**X**				**X**			
Veronica Ardoin	**X**				**X**			
Ardry “Skeet” Boyle	**X**				**X**			
Titan Capri		**X**				**X**		
Tom Lindstrom		**X**				**X**		
Oscar Perez		**X**				**X**		
Tana Pradia		**X**				**X**		
Pete Rodriguez		**X**				**X**		
Andrew Wilson	**X**				**X**			
Gloria Sierra		**X**				**X**		
Deborah Somoye		**X**				**X**		

Prepared by: Ryan White Grant Administration

FY 2022 Ryan White Part A and MAI Service Utilization Report

RW PART A SUR- 2nd Quarter (3/1-8/31)																		
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**	**6,167**	**75%**	**23%**	**2%**	**43%**	**13%**	**3%**	**41%**	**0%**	**0%**	**4%**	**27%**	28%	12%	27%	2%
1.a	Primary Care - Public Clinic (a)	2,350	2,125	72%	27%	1%	40%	9%	2%	49%	0%	0%	2%	16%	27%	14%	38%	3%
1.b	Primary Care - CBO Targeted to AA (a)	1,060	1,659	70%	27%	3%	98%	0%	1%	0%	0%	0%	6%	37%	28%	10%	17%	1%
1.c	Primary Care - CBO Targeted to Hispanic (a)	960	1,384	82%	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	608	86%	13%	1%	0%	84%	16%	0%	0%	0%	3%	27%	26%	10%	33%	2%
1.e	Primary Care - CBO Targeted to Rural (a)	400	499	71%	28%	1%	42%	23%	2%	33%	0%	0%	2%	29%	30%	11%	26%	2%
1.f	Primary Care - Women at Public Clinic (a)	1,000	570	0%	99%	1%	49%	5%	1%	44%	0%	0%	2%	9%	26%	17%	42%	4%
1.g	Primary Care - Pediatric (a)	7	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!
1.h	Vision	1,600	1,524	74%	24%	2%	46%	13%	2%	39%	0%	0%	4%	23%	25%	12%	31%	5%
2	**Medical Case Management (f)**	**3,075**	**3,054**															
2.a	Clinical Case Management	600	572	74%	25%	1%	50%	13%	1%	35%	0%	0%	3%	22%	26%	13%	30%	6%
2.b	Med CM - Targeted to Public Clinic (a)	280	328	91%	7%	2%	51%	12%	2%	36%	0%	0%	2%	24%	26%	9%	34%	5%
2.c	Med CM - Targeted to AA (a)	550	882	67%	30%	3%	99%	0%	1%	0%	0%	0%	4%	29%	25%	11%	27%	4%
2.d	Med CM - Targeted to H/L(a)	550	408	78%	16%	6%	0%	0%	0%	100%	0%	1%	7%	28%	27%	11%	24%	2%
2.e	Med CM - Targeted to White and/or MSM (a)	260	294	84%	13%	3%	0%	91%	9%	0%	0%	0%	2%	19%	26%	11%	34%	8%
2.f	Med CM - Targeted to Rural (a)	150	310	68%	31%	1%	40%	32%	2%	26%	0%	0%	3%	24%	27%	11%	30%	5%
2.g	Med CM - Targeted to Women at Public Clinic (a)	240	134	0%	99%	1%	66%	11%	3%	20%	0%	0%	1%	22%	28%	12%	31%	7%
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	119	97%	3%	0%	71%	21%	1%	8%	0%	0%	0%	0%	3%	3%	46%	48%
2.j	Med CM - Targeted to Youth	120	7	86%	14%	0%	43%	29%	0%	29%	0%	0%	100%	0%	0%	0%	0%	0%
3	**Local Drug Reimbursement Program (a)**	**2,845**	**4,214**	**75%**	**22%**	**3%**	**45%**	**12%**	**3%**	**40%**	**0%**	**0%**	**3%**	**25%**	**29%**	**13%**	**27%**	**2%**
4	**Oral Health**	**200**	**226**	**70%**	**29%**	**1%**	**35%**	**29%**	**2%**	**34%**	**0%**	**0%**	**3%**	**20%**	**26%**	**15%**	**31%**	**5%**
4.a	Oral Health - Untargeted (d)	NA	NA															
4.b	Oral Health - Rural Target	200	226	70%	29%	**1%**	35%	29%	2%	34%	0%	0%	3%	20%	26%	15%	31%	5%
5	**Mental Health Services (d)**	**NA**	**NA**															
6	**Health Insurance**	**1,700**	**1,301**	**80%**	**19%**	**2%**	**41%**	**27%**	**3%**	**28%**	**0%**	**0%**	**1%**	**13%**	**16%**	**10%**	**43%**	**17%**
7	**Home and Community Based Services (d)**	**NA**	**NA**															
8	**Substance Abuse Treatment - Outpatient**	**40**	**7**	**100%**	**0%**	**0%**	**14%**	**57%**	**14%**	**14%**	**0%**	**14%**	**0%**	**29%**	**29%**	**0%**	**29%**	**0%**
9	**Early Medical Intervention Services (d)**	**NA**	**NA**															
10	**Medical Nutritional Therapy/Nutritional Supplements**	**650**	**375**	**74%**	**24%**	**1%**	**43%**	**20%**	**4%**	**33%**	**0%**	**0%**	**1%**	**7%**	**17%**	**9%**	**50%**	**15%**
11	**Hospice Services (d)**	**NA**	**NA**															
12	**Outreach**	**700**	**451**	**77%**	**19%**	**4%**	**59%**	**15%**	**0%**	**25%**	**0%**	**0%**	**4%**	**29%**	**27%**	**9%**	**26%**	**5%**
13	**Non-Medical Case Management**	**7,045**	**5,253**															
13.a	Service Linkage Targeted to Youth	320	126	76%	24%	0%	52%	4%	2%	42%	0%	16%	84%	0%	0%	0%	0%	0%
13.b	Service Linkage at Testing Sites	260	58	72%	26%	2%	57%	9%	5%	29%	0%	0%	0%	48%	34%	7%	10%	0%
13.c	Service Linkage at Public Clinic Primary Care Program (a)	3,700	2,226	69%	30%	1%	49%	9%	2%	40%	0%	0%	0%	18%	25%	13%	38%	6%
13.d	Service Linkage at CBO Primary Care Programs (a)	2,765	2,843	75%	22%	3%	54%	13%	3%	31%	0%	0%	4%	29%	24%	10%	28%	5%
14	**Transportation**	**2,850**	**1,409**															
14.a	Transportation Services - Urban	170	523	67%	31%	2%	60%	7%	3%	30%	0%	0%	5%	25%	24%	10%	30%	5%
14.b	Transportation Services - Rural	130	110	63%	35%	2%	29%	32%	2%	37%	0%	0%	5%	18%	18%	17%	32%	10%
14.c	Transportation vouchering	2,550	776															
15	**Linguistic Services (d)**	**NA**	**NA**															
16	**Emergency Financial Assistance (e)**	**NA**	**1,197**	**75%**	**23%**	**2%**	**46%**	**9%**	**2%**	**43%**	**0%**	**0%**	**3%**	**23%**	**28%**	**12%**	**30%**	**3%**
17	**Referral for Health Care - Non Core Service (d)**	**NA**	**NA**															
Net unduplicated clients served - all categories*		**12,941**	**11,569**	**74%**	**23%**	**2%**	**48%**	**14%**	**2%**	**36%**	**0%**	**0%**	**4%**	**24%**	**25%**	**11%**	**30%**	**6%**
Living AIDS cases + estimated Living HIV non-AIDS (from FY19 App) (b)		**NA**																

Available Data As Of: 10/14/2022

Prepared by: Ryan White Grant Administration

FY 2022 Ryan White Part A and MAI Service Utilization Report

RW MAI Service Utilization Report - 2nd Quarter (03/01 - 08/31)																		
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	1,310	**71%**	**25%**	**3%**	**99%**	**0%**	**1%**	**0%**	**0%**	**0%**	**6%**	**35%**	**28%**	**10%**	**19%**	**2%**
1.c	Primary Care - MAI CBO Targeted to Hispanic (g)	960	1,191	**82%**	**14%**	**4%**	**0%**	**0%**	**0%**	**100%**	**0%**	**0%**	**5%**	**32%**	**30%**	**13%**	**19%**	**1%**
2	**Medical Case Management (f)**																	
2.c	Med CM - Targeted to AA (a)	1,060	525	**80%**	**16%**	**3%**	**46%**	**16%**	**3%**	**35%**	**0%**	**0%**	**6%**	**35%**	**29%**	**10%**	**19%**	**1%**
2.d	Med CM - Targeted to H/L(a)	960	362	**69%**	**28%**	**3%**	**59%**	**13%**	**3%**	**26%**	**0%**	**3%**	**5%**	**21%**	**26%**	**13%**	**23%**	**10%**
RW Part A New Client Service Utilization Report - 2nd Quarter (03/01-08/31) **Report reflects the number & demographics of clients served during the report period who did not receive services during previous 12 months (3/1/22- 2/28/23)**																		
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**	**1,023**	**80%**	**18%**	**2%**	**46%**	**14%**	**3%**	**38%**	**0%**	**1%**	**8%**	**34%**	**28%**	**9%**	**2%**	**19%**
2	**LPAP**	**1,200**	**432**	**80%**	**16%**	**3%**	**46%**	**16%**	**3%**	**35%**	**0%**	**0%**	**6%**	**35%**	**29%**	**10%**	**1%**	**19%**
3.a	Clinical Case Management	400	39	69%	28%	3%	59%	13%	3%	26%	0%	3%	5%	21%	**26%**	**13%**	10%	**23%**
3.b-3.h	Medical Case Management	1,600	527	78%	20%	2%	47%	17%	2%	34%	0%	0%	7%	35%	**24%**	**8%**	4%	**22%**
3.i	Medical Case Manangement - Targeted to Veterans	60	12	100%	0%	0%	58%	25%	8%	8%	0%	0%	0%	0%	**8%**	**8%**	42%	**42%**
4	**Oral Health**	**40**	**19**	**63%**	**37%**	0%	**47%**	**26%**	**11%**	**16%**	**0%**	**0%**	**5%**	**32%**	**16%**	**11%**	**11%**	**26%**
12.a. 12.c. 12.d.	**Non-Medical Case Management (Service Linkage)**	**3,700**	**1,067**	**75%**	**24%**	**1%**	**52%**	**13%**	**3%**	**31%**	**0%**	**1%**	**6%**	**29%**	**25%**	**10%**	**24%**	**4%**
12.b	**Service Linkage at Testing Sites**	**260**	**50**	**76%**	**22%**	**2%**	**58%**	**10%**	**4%**	**28%**	**0%**	**4%**	**30%**	**26%**	**28%**	**6%**	**6%**	**0%**
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: 10/14/2022

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

FY 2022 Ryan White Part A and MAI
Procurement Report

Priority	Service Category	Original Allocation *RWPC Approved Level Funding Scenario*	Award Reconcilation	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**	**-15,437**	**0**	**0**	**0**	**10,950,351**	**45.46%**	**10,750,351**	**200,000**		**2,620,157**	**24%**	**42%**
1.a	Primary Care - Public Clinic (a)	3,927,300					3,927,300	16.30%	3,927,300	0	3/1/2022	$340,227	9%	42%
1.b	Primary Care - CBO Targeted to AA (a) (e) (f)	1,064,576					1,064,576	4.42%	1,064,576	0	3/1/2022	$587,788	55%	42%
1.c	Primary Care - CBO Targeted to Hispanic (a) (e)	910,551					910,551	3.78%	910,551	0	3/1/2022	$502,381	55%	42%
1.d	Primary Care - CBO Targeted to White/MSM (a) (e)	1,147,924					1,147,924	4.77%	1,147,924	0	3/1/2022	$296,939	26%	42%
1.e	Primary Care - CBO Targeted to Rural (a) (e)	1,100,000					1,100,000	4.57%	1,100,000	0	3/1/2022	$434,630	40%	42%
1.f	Primary Care - Women at Public Clinic (a)	2,100,000					2,100,000	8.72%	2,100,000	0	3/1/2022	$226,873	11%	42%
1.g	Primary Care - Pediatric (a.1)	15,437	-15,437				0	0.00%	0	0	3/1/2022	$0	0%	0%
1.h	Vision	500,000					500,000	2.08%	500,000	0	3/1/2022	$231,320	46%	42%
1.x	Primary Care Health Outcome Pilot	200,000					200,000	0.83%	0	200,000		$0	#DIV/0!	42%
2	**Medical Case Management**	**1,730,000**	**-90,051**	**0**	**0**	**0**	**1,639,949**	**6.81%**	**1,639,949**	**0**		**596,869**	**36%**	**42%**
2.a	Clinical Case Management	488,656					488,656	2.03%	488,656	0	3/1/2022	$284,114	58%	42%
2.b	Med CM - Public Clinic (a)	277,103					277,103	1.15%	277,103	0	3/1/2022	$42,689	15%	42%
2.c	Med CM - Targeted to AA (a) (e)	169,009					169,009	0.70%	169,009	0	3/1/2022	$96,404	57%	42%
2.d	Med CM - Targeted to H/L (a) (e)	169,011					169,011	0.70%	169,011	0	3/1/2022	$36,041	21%	42%
2.e	Med CM - Targeted to W/MSM (a) (e)	61,186					61,186	0.25%	61,186	0	3/1/2022	$34,524	56%	42%
2.f	Med CM - Targeted to Rural (a)	273,760					273,760	1.14%	273,760	0	3/1/2022	$52,828	19%	42%
2.g	Med CM - Women at Public Clinic (a)	75,311					75,311	0.31%	75,311	0	3/1/2022	$16,827	22%	42%
2.h	Med CM - Targeted to Pedi (a.1)	90,051	-90,051				0	0.00%	0	0	3/1/2022	$0	0%	0%
2.i	Med CM - Targeted to Veterans	80,025					80,025	0.33%	80,025	0	3/1/2022	$25,311	32%	42%
2.j	Med CM - Targeted to Youth	45,888					45,888	0.19%	45,888	0	3/1/2022	$8,131	18%	42%
3	**Local Pharmacy Assistance Program**	**1,810,360**	**200,000**	**0**	**0**	**0**	**2,010,360**	**8.35%**	**2,010,360**	**0**	3/1/2022	**$661,144**	**33%**	**42%**
3.a	Local Pharmacy Assistance Program-Public Clinic (a) (e)	310,360					310,360	1.29%	310,360	0	3/1/2022	$52,633	17%	42%
3.b	Local Pharmacy Assistance Program-Untargeted (a) (e)	1,500,000	200,000				1,700,000	7.06%	1,700,000	0	3/1/2022	$608,511	36%	42%
4	**Oral Health**	**166,404**	**0**	**0**	**0**	**0**	**166,404**	**0.69%**	**166,404**	**0**	3/1/2022	**97,750**	**59%**	**42%**
4.a	Oral Health - Untargeted (c)	0					0	0.00%	0	0	N/A	$0	0%	**0%**
4.b	Oral Health - Targeted to Rural	166,404					166,404	0.69%	166,404	0	3/1/2022	$97,750	59%	42%
5	**Health Insurance (c)**	**1,383,137**	**431,299**	**138,285**	**0**	**0**	**1,952,721**	**8.11%**	**1,952,721**	**0**	3/1/2022	**$789,381**	**40%**	**42%**
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**					**341,395**	**1.42%**	**341,395**	**0**	**3/1/2022**	**$166,896**	**49%**	**42%**
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 (c)**	**45,677**	**0**	**0**	**0**	**0**	**45,677**	**0.19%**	**45,677**	**0**	3/1/2022	**$2,081**	**5%**	**42%**
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**	**0**	**0**	**0**	**0**	**1,267,002**	**5.26%**	**1,267,002**	**0**	**3/1/2022**	**$507,721**	**40%**	**42%**
13.a	Service Linkage targeted to Youth	110,793					110,793	**0.46%**	110,793	0	3/1/2022	$30,994	28%	42%
13.b	Service Linkage targeted to Newly-Diagnosed/Not-in-Care	100,000					100,000	**0.42%**	100,000	0	3/1/2022	$49,511	50%	42%
13.c	Service Linkage at Public Clinic (a)	370,000					370,000	**1.54%**	370,000	0	3/1/2022	$89,013	24%	42%
13.d	Service Linkage embedded in CBO Pcare (a) (e)	686,209					686,209	**2.85%**	686,209	0	3/1/2022	$338,203	49%	42%
13.e	SLW-Substance Use	0					0	**0.00%**	0	0	NA	$0	0%	0%
14	**Medical Transportation**	**424,911**	**0**	**0**	**0**	**0**	**424,911**	**1.76%**	**424,911**	**0**		**172,052**	**40%**	**42%**
14.a	Medical Transportation services targeted to Urban	252,680					252,680	1.05%	252,680	0	3/1/2022	$138,698	55%	42%
14.b	Medical Transportation services targeted to Rural	97,185					97,185	0.40%	97,185	0	3/1/2022	$33,354	34%	42%
14.c	Transportation vouchering (bus passes & gas cards)	75,046					75,046	0.31%	75,046	0	3/1/2022	$0	0%	42%

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

FY 2022 Ryan White Part A and MAI
Procurement Report

Priority	Service Category	Original Allocation *RWPC Approved Level Funding Scenario*	Award Reconcilation	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
15	**Emergency Financial Assistance**	**1,545,439**	**189,168**	**750,000**	**0**	**0**	**2,484,607**	**10.32%**	**2,484,607**	**0**		**477,765**	**19%**	**42%**
16.a	EFA - Pharmacy Assistance	1,305,439	189,168	750,000			2,244,607	9.32%	2,244,607	0	3/1/2022	$425,101	19%	42%
16.b	EFA - Other	240,000					240,000	1.00%	240,000	0	3/1/2022	$52,664	22%	42%
16	**Linguistic Services (c)**	**0**	**0**				**0**	**0.00%**	**0**	**0**	**NA**	**$0**	**0%**	**0%**
17	**Outreach**	**420,000**					**420,000**	**1.74%**	**420,000**	**0**	**3/1/2022**	**$107,454**	**26%**	**42%**
BEU27516	**Total Service Dollars**	**20,100,113**	**714,979**	**888,285**	**0**	**0**	**21,703,377**	**90.10%**	**21,503,377**	**200,000**		**6,199,270**	**29%**	**42%**
	Grant Administration	**1,795,958**	**169,915**	**0**	**0**	**0**	**1,965,873**	**8.16%**	**1,965,873**	0	**N/A**	**791,144**	**40%**	**42%**
BEU27517	HCPH/RWGA Section	1,271,050	169,915	0		0	1,440,965	5.98%	1,440,965	0	N/A	$532,014	37%	42%
PC	RWPC Support*	524,908			0	0	524,908	2.18%	524,908	0	N/A	259,131	49%	42%
BEU27521	**Quality Management**	**412,940**		**0**	**0**	**0**	**412,940**	**1.71%**	**412,940**	**0**	**N/A**	**$150,588**	**36%**	**42%**
		22,309,011	**884,894**	**888,285**	**0**	**0**	**24,082,190**	**99.98%**	**23,882,190**	**200,000**		**7,141,003**	**30%**	**42%**
								Unallocated	Unobligated					42%
	Part A Grant Award:	**23,198,771**	***Carry Over:***	**888,285**		***Total Part A:***	**24,087,056**	**4,866**	**200,000**					42%

		Original Allocation	Award Reconcilation	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**	**525,811**	**138,285**	**0**	**0**	**17,106,857**	**78.82%**	**4,144,897**	**78.17%**
	Non-Core (may not exceed 25% of total service dollars)	**3,657,352**	**189,168**	**750,000**	**0**	**0**	**4,596,520**	**21.18%**	**1,157,538**	**21.83%**
	Total Service Dollars (does not include Admin and QM)	**20,100,113**	**714,979**	**888,285**	**0**	**0**	**21,703,377**		**5,302,436**	
	Total Admin (must be ≤ 10% of total Part A + MAI)	**1,795,958**	**169,915**	**0**	**0**	**0**	**1,965,873**	**7.41%**		
	Total QM (must be ≤ 5% of total Part A + MAI)	**412,940**	**0**	**0**	**0**	**0**	**412,940**	**1.56%**		

MAI Procurement Report

Priority	Service Category	Original Allocation *RWPC Approved Level Funding Scenario*	Award Reconcilation	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**	**104,950**	**0**	**0**	**0**	**2,107,810**	**86.82%**	**2,107,810**	**0**		**1,048,575**	**50%**	**42%**
1.b (MAI)	Primary Care - CBO Targeted to African American	1,012,700	53,065				1,065,765	43.90%	1,065,765	0	3/1/2022	$544,775	51%	42%
1.c (MAI)	Primary Care - CBO Targeted to Hispanic	990,160	51,884				1,042,044	42.92%	1,042,044	0	3/1/2022	$503,800	48%	42%
2	**Medical Case Management**	**320,100**	**0**	**0**	**0**	**0**	**320,100**	**13.18%**	**320,100**	**0**		**$105,236**	**33%**	42%
2.c (MAI)	MCM - Targeted to African American	160,050					160,050	6.59%	160,050	0	3/1/2022	$67,024	42%	42%
2.d (MAI)	MCM - Targeted to Hispanic	160,050					160,050	6.59%	160,050	0	3/1/2022	$38,212	24%	42%
	Total MAI Service Funds	**2,322,960**	**104,950**	**0**	**0**	**0**	**2,427,910**	**100.00%**	**2,427,910**	**0**		**1,153,811**	**48%**	**42%**
	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%**
	Total MAI Funds	**2,322,960**	**104,950**	**0**	**0**	**0**	**2,427,910**	**100.00%**	**2,427,910**	**0**		**1,153,811**	**48%**	**42%**
	MAI Grant Award	**2,427,918**	***Carry Over:***	**0**		***Total MAI:***	**2,427,918**							42%
	Combined Part A and MAI Orginial Allocation Total	**24,631,971**												

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

FY 2022 Ryan White Part A and MAI
Procurement Report

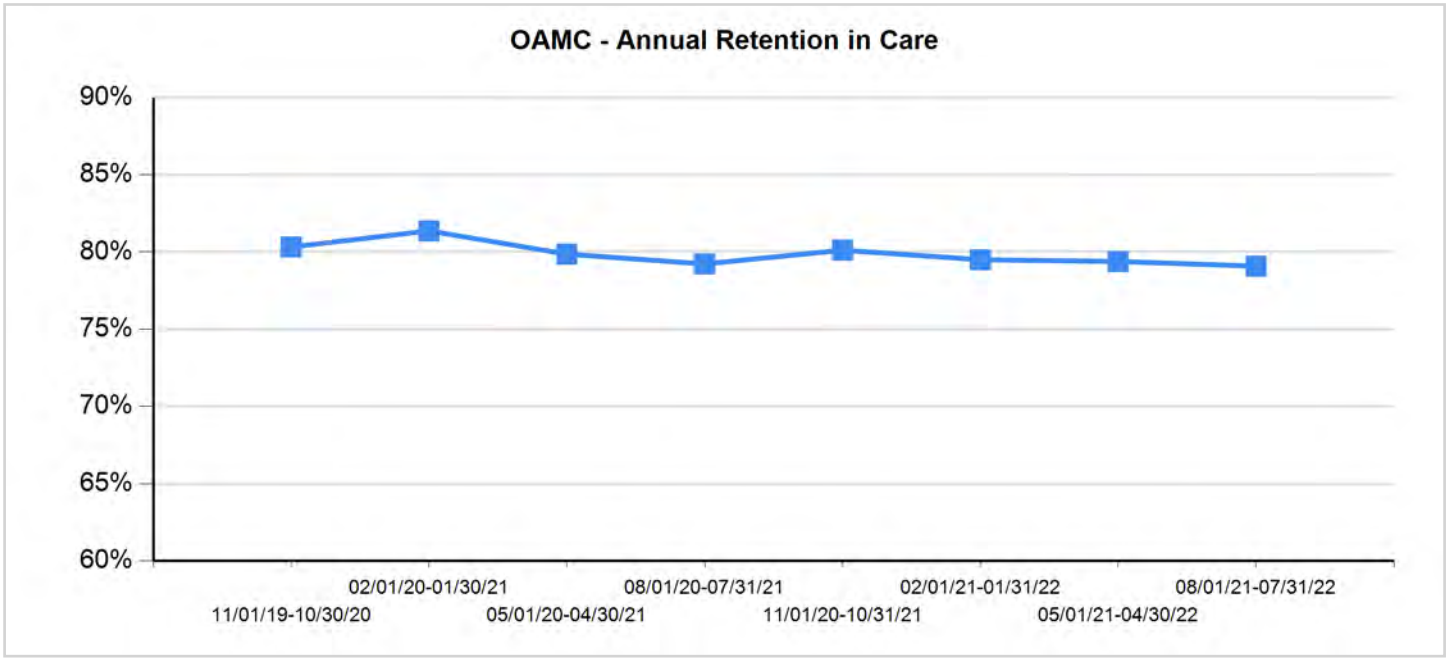
Priority	Service Category	Original Allocation *RWPC Approved Level Funding Scenario*	Award Reconcilation	July Adjustments (carryover)	October Adjustments	Final Quarter Adjustments	Total Allocation	Percent of Grant Award	Amount Procured (a)	Procure-ment Balance	Original Date Procured	Expended YTD	Percent YTD	Percent Expected YTD
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 multiple HRSA service categories. (1) does not include LPAP. Expenditures must be evaluated both by individual service category and by combined service categories.													
(c)	Funded under Part B and/or SS													
(e)	10% rule reallocations													

HARRIS COUNTY PUBLIC HEALTH AND ENVIRONMENTAL SERVICES - RWGA

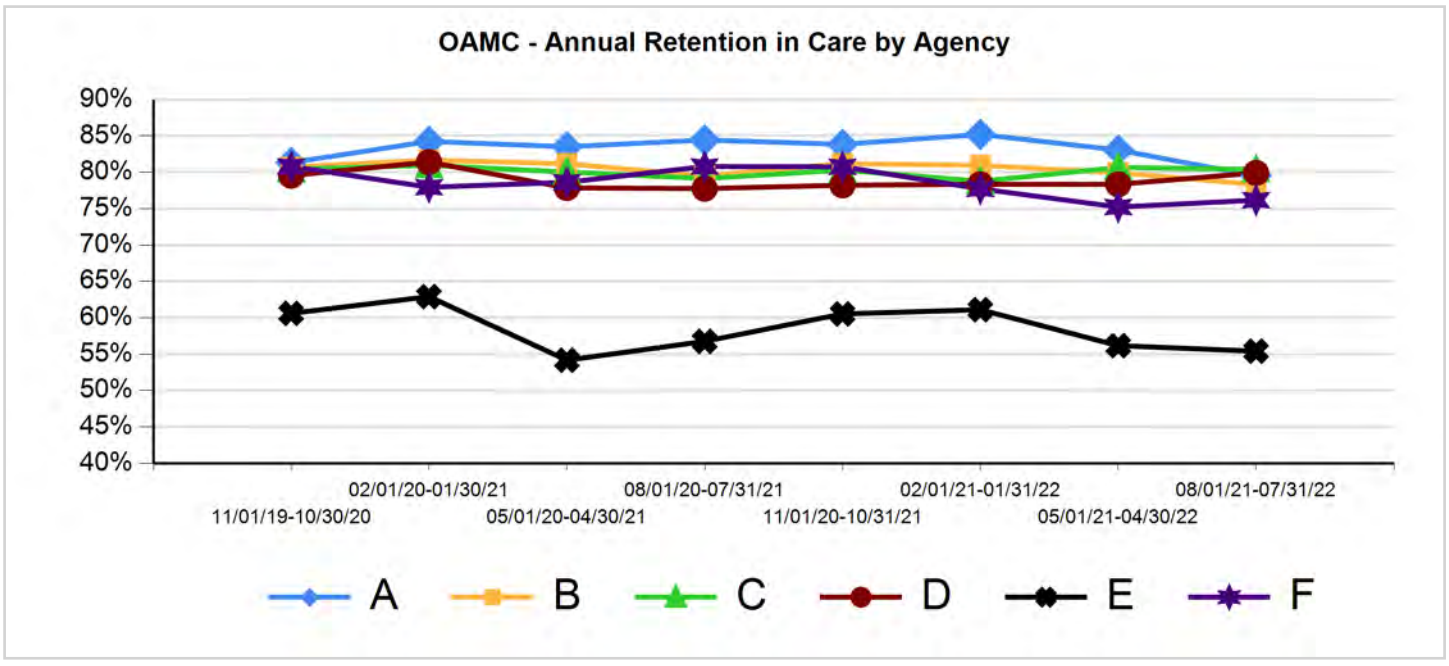
Clinical Quality Management Committee Quarterly Report

Last Quarter Start Date: **8/1/2021**

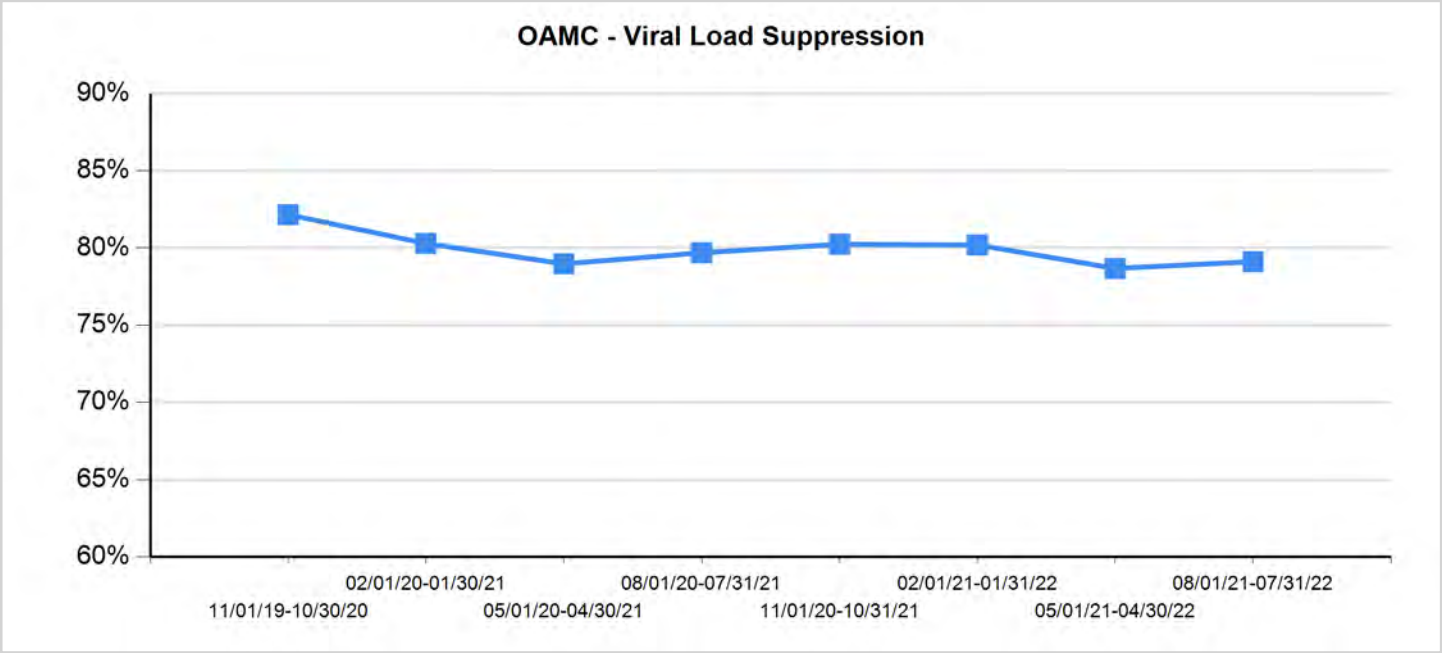
OAMC - Annual Retention in Care				
	11/01/20 - 10/31/21	02/01/21 - 01/31/22	05/01/21 - 04/30/22	08/01/21 - 07/31/22
Number of clients in the denominator who had at least two HIV medical care encounters at least 90 days apart within the measurement year	6,520	6,340	6,377	6,355
Number of clients living with HIV who had at least one HIV medical encounter within the measurement year	8,138	7,975	8,033	8,036
Percentage	80.1%	79.5%	79.4%	79.1%
Change from Previous Quarter Results	0.9%	-0.6%	-0.1%	-0.3%



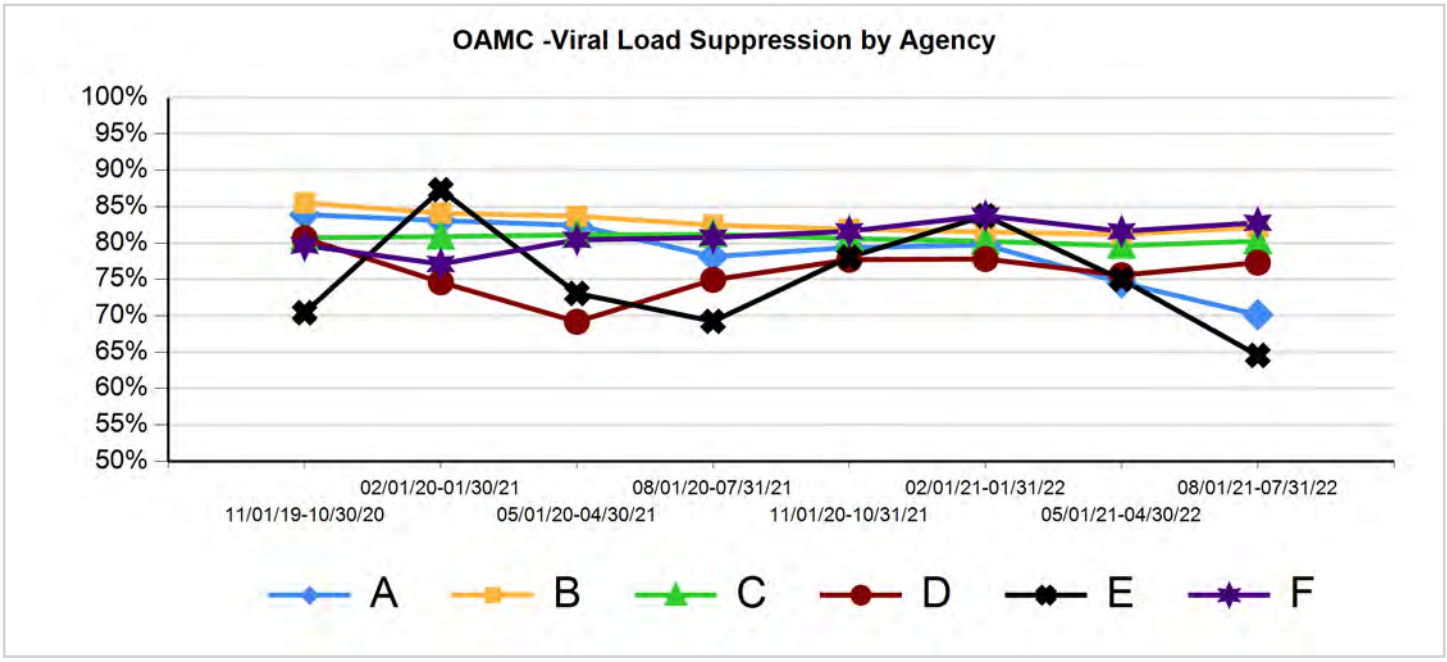
OAMC - Annual Retention in Care by Agency												
	05/01/21 - 04/30/22						08/01/21 - 07/31/22					
	A	B	C	D	E	F	A	B	C	D	E	F
Number of clients in the denominator who had at least two HIV medical care encounters at least 90 days apart within the measurement year	559	1,750	2,028	1,600	41	501	609	1,676	2,012	1,616	41	505
Number of clients living with HIV who had at least one HIV medical encounter within the measurement year	673	2,189	2,514	2,042	73	666	766	2,140	2,502	2,022	74	663
Percentage	83.1%	79.9%	80.7%	78.4%	56.2%	75.2%	79.5%	78.3%	80.4%	79.9%	55.4%	76.2%
Change from Previous Quarter Results	-2.2%	-1.0%	1.9%	0.0%	-4.9%	-2.5%	-3.6%	-1.6%	-0.3%	1.6%	-0.8%	0.9%



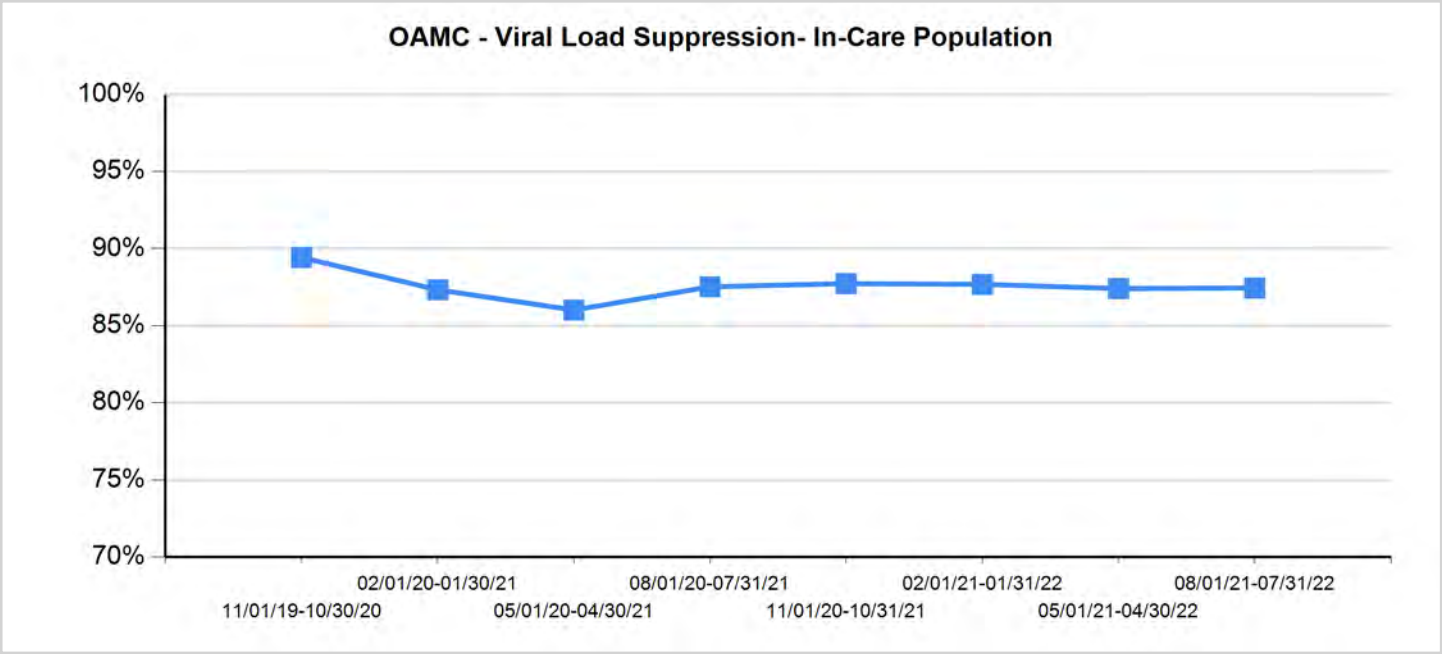
OAMC - Viral Load Suppression				
	11/01/20 - 10/31/21	02/01/21 - 01/31/22	05/01/21 - 04/30/22	08/01/21 - 07/31/22
Number of clients in the denominator with a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement year	7,155	6,970	6,907	7,000
Number of clients living with HIV, with at least one medical visit in the measurement year	8,917	8,691	8,779	8,848
Percentage	80.2%	80.2%	78.7%	79.1%
Change from Previous Quarter Results	0.6%	0.0%	-1.5%	0.4%



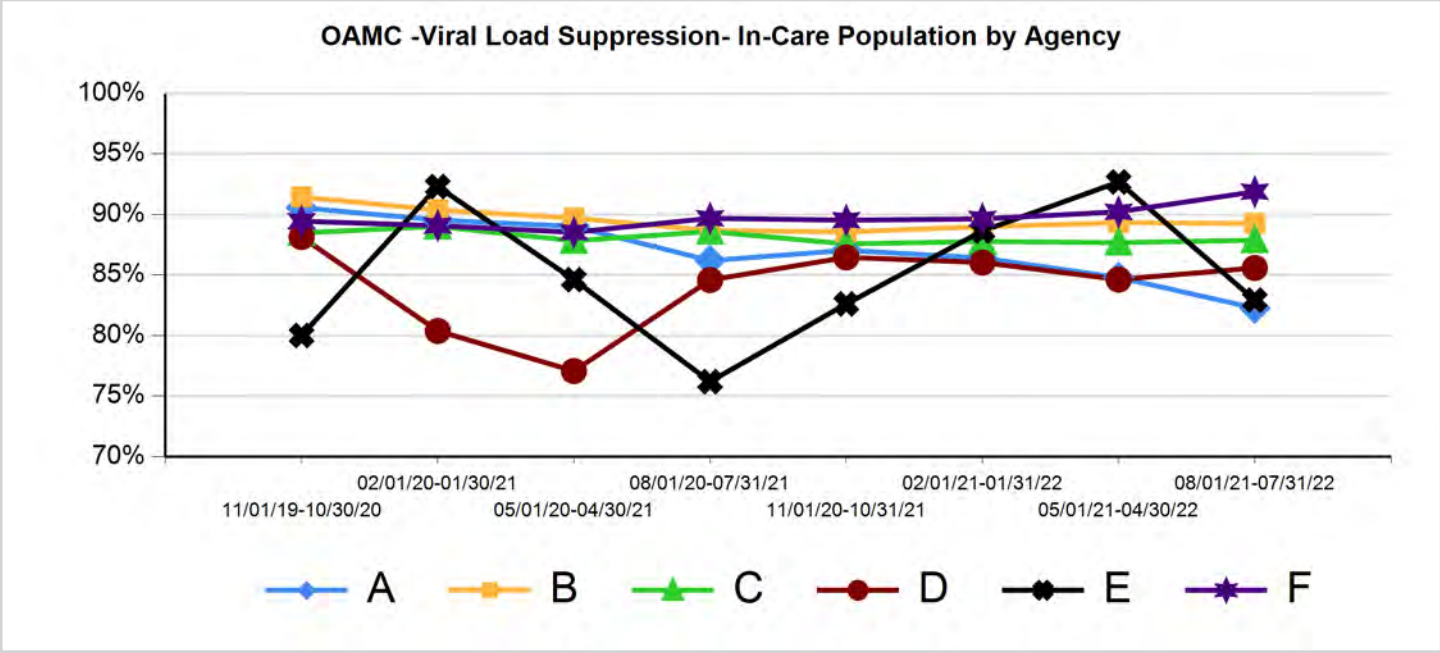
OAMC - Viral Load Suppression by Agency												
	05/01/21 - 04/30/22						08/01/21 - 07/31/22					
	A	B	C	D	E	F	A	B	C	D	E	F
Number of clients in the denominator with a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement year	533	1,895	2,194	1,659	60	675	580	1,880	2,221	1,673	51	712
Number of clients living with HIV, with at least one medical visit in the measurement year	715	2,334	2,755	2,195	80	827	827	2,288	2,767	2,164	79	860
Percentage	74.5%	81.2%	79.6%	75.6%	75.0%	81.6%	70.1%	82.2%	80.3%	77.3%	64.6%	82.8%
Change from Previous Quarter Results	-5.2%	-0.3%	-0.6%	-2.2%	-8.8%	-2.1%	-4.4%	1.0%	0.6%	1.7%	-10.4%	1.2%



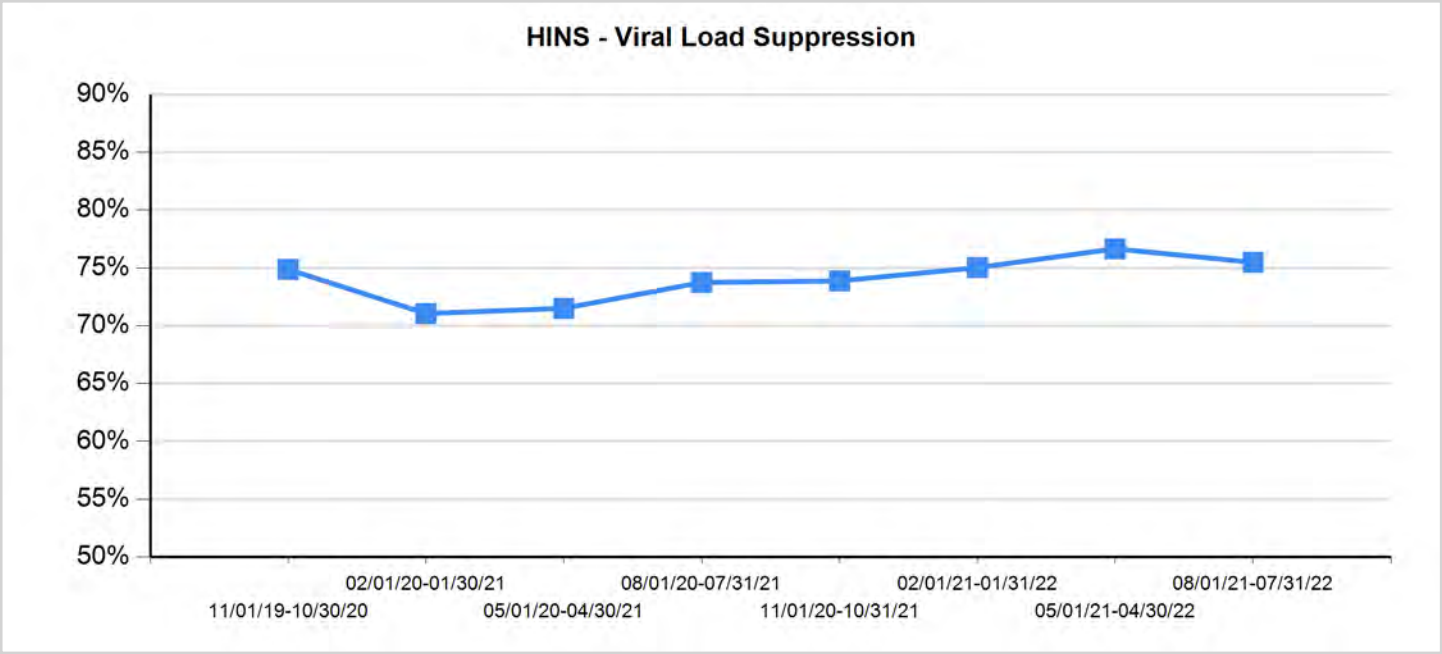
OAMC - Viral Load Suppression- In-Care Population				
	11/01/20 - 10/31/21	02/01/21 - 01/31/22	05/01/21 - 04/30/22	08/01/21 - 07/31/22
Number of clients in the denominator with a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement year	5,720	5,559	5,574	5,557
Number of clients living with HIV, with two or more medical encounters, 90 days apart, in an HIV care setting in the measurement year	6,520	6,340	6,377	6,355
Percentage	87.7%	87.7%	87.4%	87.4%
Change from Previous Quarter Results	0.2%	0.0%	-0.3%	0.0%



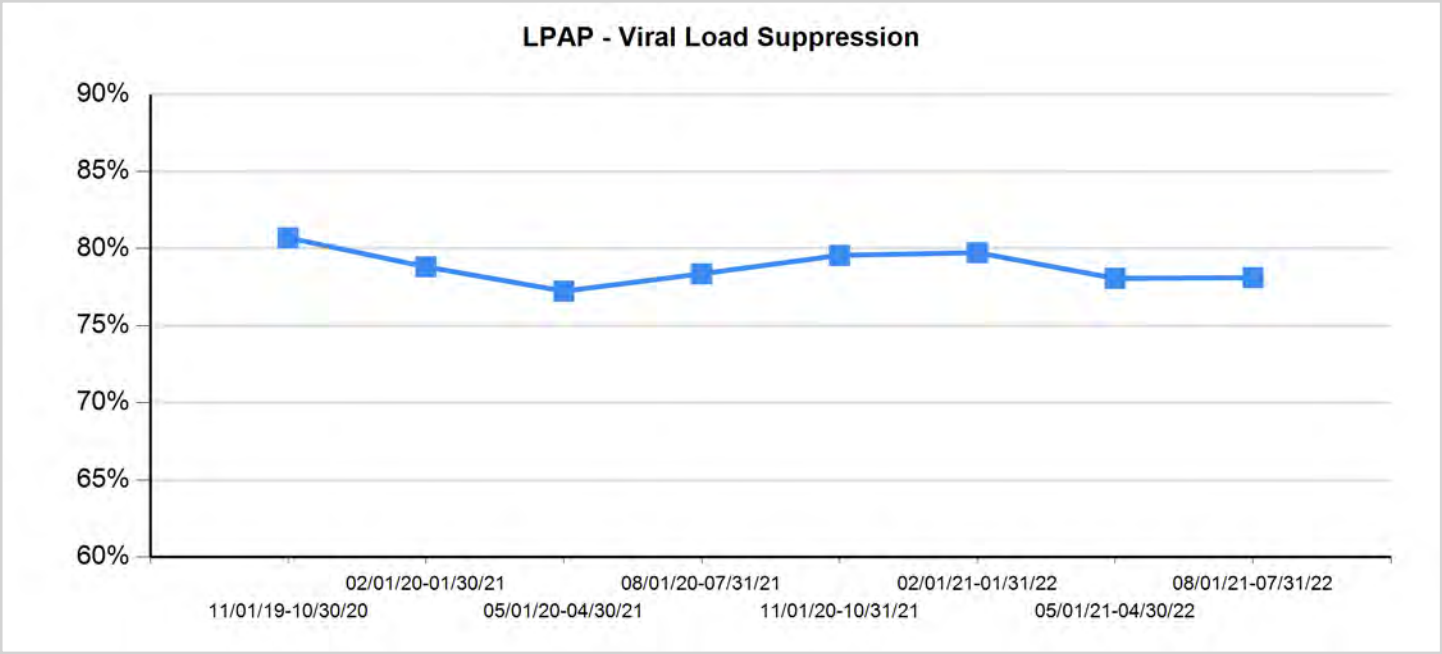
OAMC - Viral Load Suppression- In-Care Population by Agency												
	05/01/21 - 04/30/22						08/01/21 - 07/31/22					
	A	B	C	D	E	F	A	B	C	D	E	F
Number of clients in the denominator with a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement year	474	1,563	1,778	1,354	38	452	501	1,496	1,768	1,383	34	464
Number of clients living with HIV, with two or more medical encounters, 90 days apart, in an HIV care setting in the measurement year	559	1,750	2,028	1,600	41	501	609	1,676	2,012	1,616	41	505
Percentage	84.8%	89.3%	87.7%	84.6%	92.7%	90.2%	82.3%	89.3%	87.9%	85.6%	82.9%	91.9%
Change from Previous Quarter Results	-1.6%	0.3%	-0.1%	-1.4%	4.0%	0.6%	-2.5%	-0.1%	0.2%	1.0%	-9.8%	1.7%



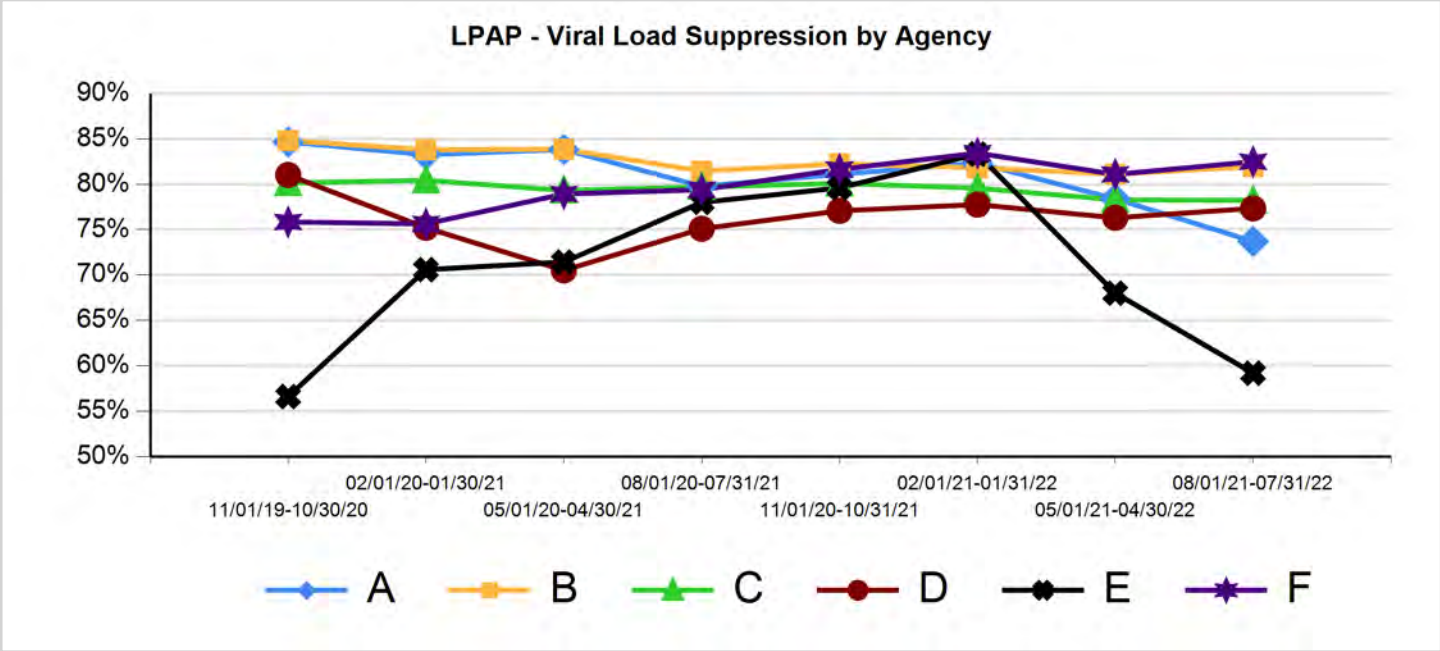
HINS - Viral Load Suppression				
	11/01/20 - 10/31/21	02/01/21 - 01/31/22	05/01/21 - 04/30/22	08/01/21 - 07/31/22
Number of clients in the denominator with a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement year	1,637	1,733	1,789	1,776
Number of clients living with HIV, with 1 or more Health Insurance Assistance encounters in the measurement year	2,216	2,310	2,334	2,353
Percentage	73.9%	75.0%	76.6%	75.5%
Change from Previous Quarter Results	0.1%	1.1%	1.6%	-1.2%



LPAP - Viral Load Suppression				
	11/01/20 - 10/31/21	02/01/21 - 01/31/22	05/01/21 - 04/30/22	08/01/21 - 07/31/22
Number of clients in the denominator with a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement year	4,773	4,797	4,845	4,950
Number of clients living with HIV, with 1 or more Local Pharmaceutical Assistance Program encounters in the measurement year	5,999	6,016	6,206	6,337
Percentage	79.6%	79.7%	78.1%	78.1%
Change from Previous Quarter Results	1.2%	0.2%	-1.7%	0.0%



LPAP - Viral Load Suppression by Agency												
	05/01/21 - 04/30/22						08/01/21 - 07/31/22					
	A	B	C	D	E	F	A	B	C	D	E	F
Number of clients in the denominator with a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement year	479	631	1,910	1,436	34	450	454	631	1,975	1,454	29	499
Number of clients living with HIV, with 1 or more Local Pharmaceutical Assistance Program encounters in the measurement year	611	778	2,440	1,882	50	555	616	770	2,525	1,880	49	605
Percentage	78.4%	81.1%	78.3%	76.3%	68.0%	81.1%	73.7%	81.9%	78.2%	77.3%	59.2%	82.5%
Change from Previous Quarter Results	-3.9%	-0.7%	-1.3%	-1.5%	-15.3%	-2.3%	-4.7%	0.8%	-0.1%	1.0%	-8.8%	1.4%



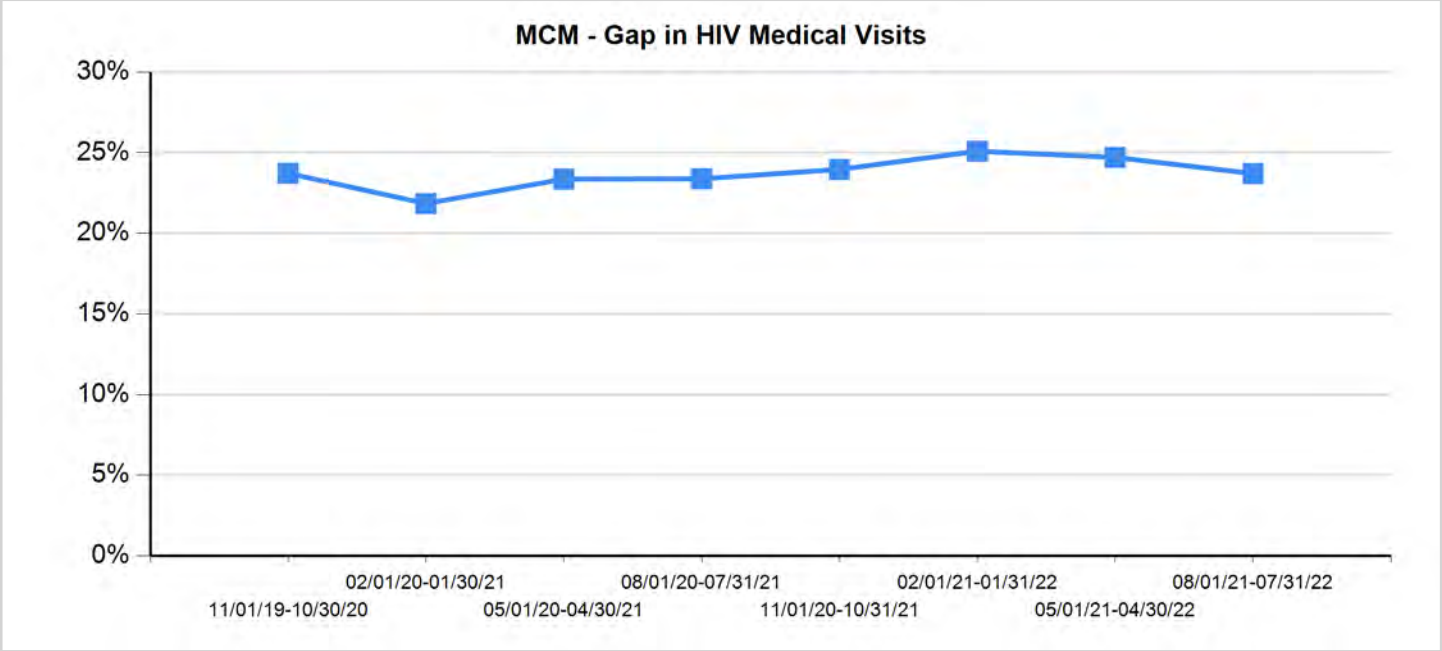
Footnotes:
1. Table/Chart data for this report run was taken from "ABR197 v1.1"

HARRIS COUNTY PUBLIC HEALTH AND ENVIRONMENTAL SERVICES - RWGA

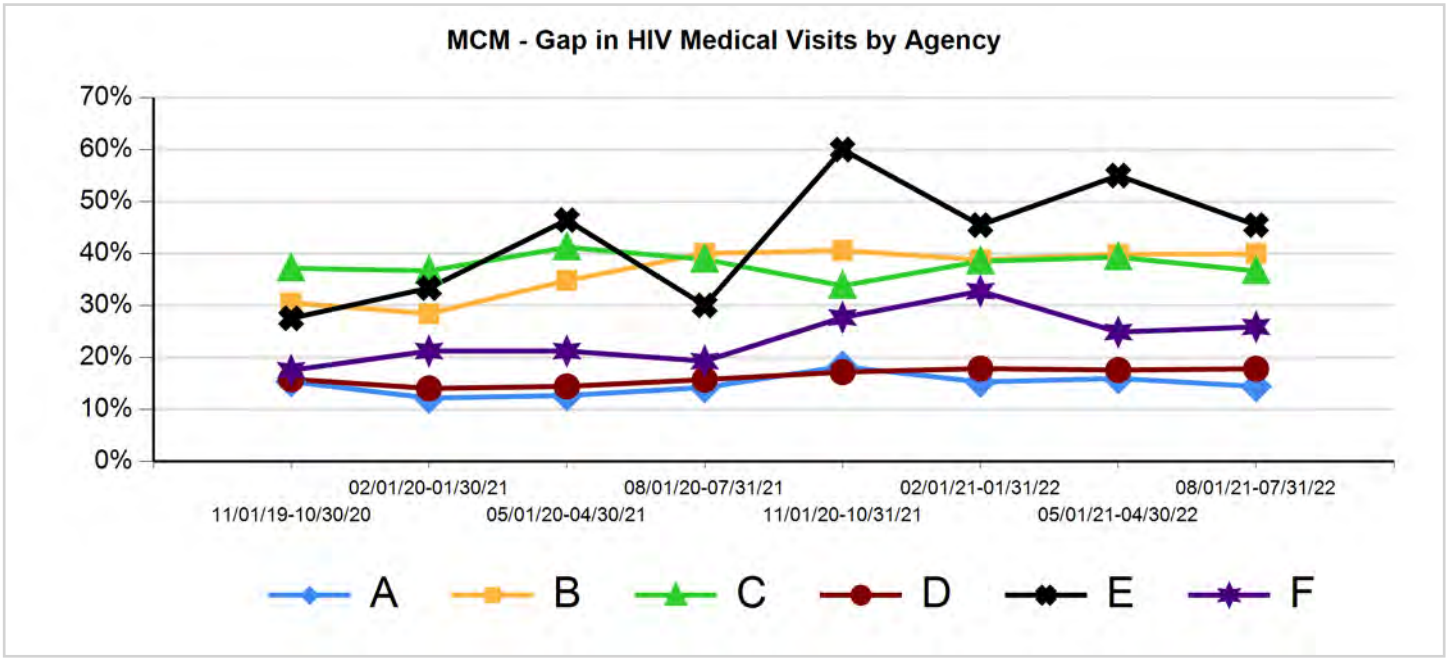
Clinical Quality Management Committee Quarterly Report

Last Quarter Start Date: **8/1/2021**

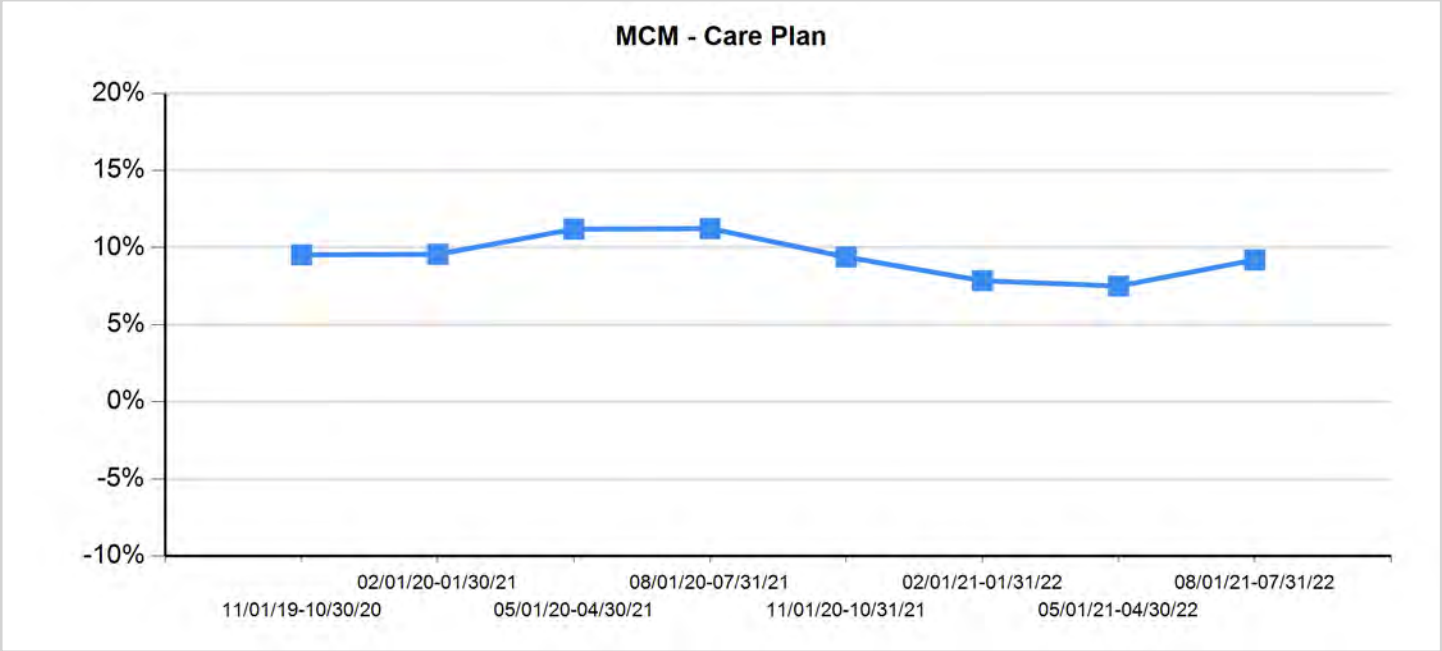
MCM - Gap in HIV Medical Visits				
	11/01/20 - 10/31/21	02/01/21 - 01/31/22	05/01/21 - 04/30/22	08/01/21 - 07/31/22
Number of clients in the denominator who did not have a medical visit in the last 6 months of the measurement year	681	700	673	588
Number of medical case management clients living with HIV who had at least one medical visit in the first 6 months of the measurement year	2,842	2,790	2,724	2,481
Percentage	24.0%	25.1%	24.7%	23.7%
Change from Previous Quarter Results	0.6%	1.1%	-0.4%	-1.0%



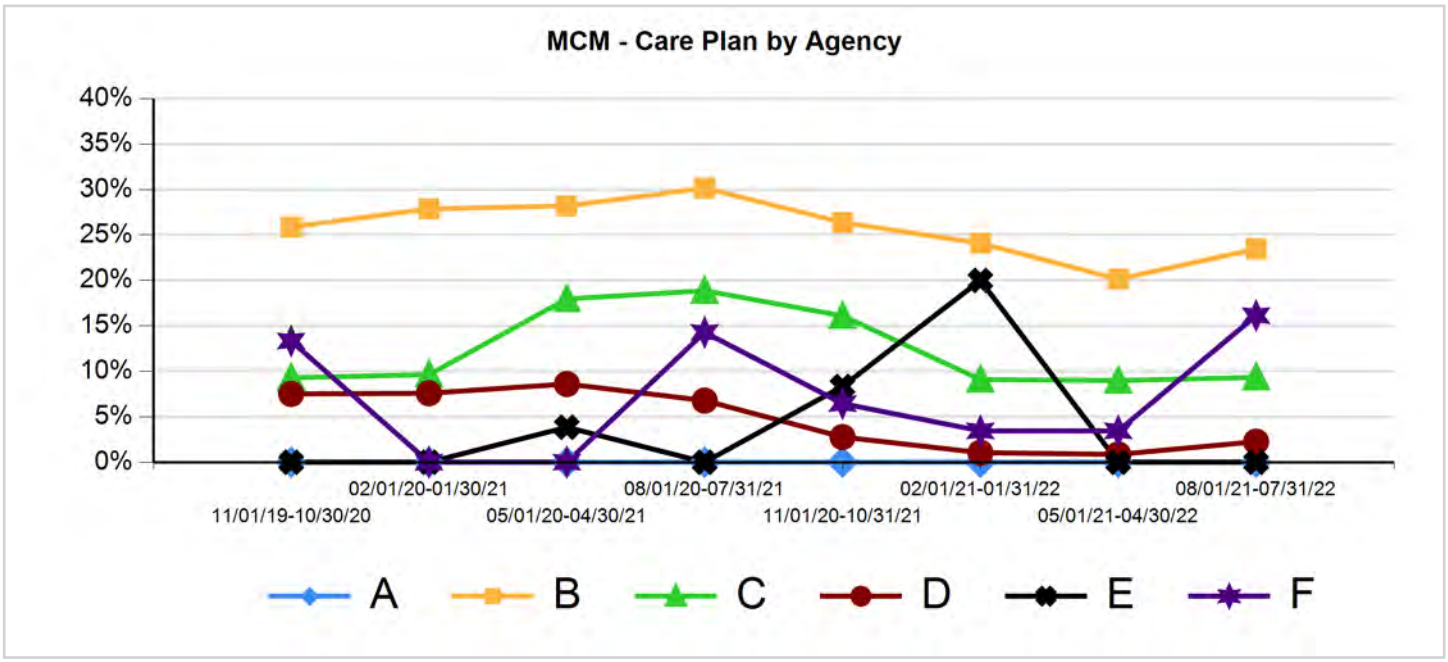
MCM - Gap in HIV Medical Visits by Agency												
	05/01/21 - 04/30/22						08/01/21 - 07/31/22					
	A	B	C	D	E	F	A	B	C	D	E	F
Number of clients in the denominator who did not have a medical visit in the last 6 months of the measurement year	61	151	172	232	11	45	53	137	126	218	10	45
Number of medical case management clients living with HIV who had at least one medical visit in the first 6 months of the measurement year	383	379	438	1,322	20	181	368	343	344	1,225	22	174
Percentage	15.9%	39.8%	39.3%	17.5%	55.0%	24.9%	14.4%	39.9%	36.6%	17.8%	45.5%	25.9%
Change from Previous Quarter Results	0.7%	1.1%	0.8%	-0.3%	9.5%	-7.9%	-1.5%	0.1%	-2.6%	0.2%	-9.5%	1.0%



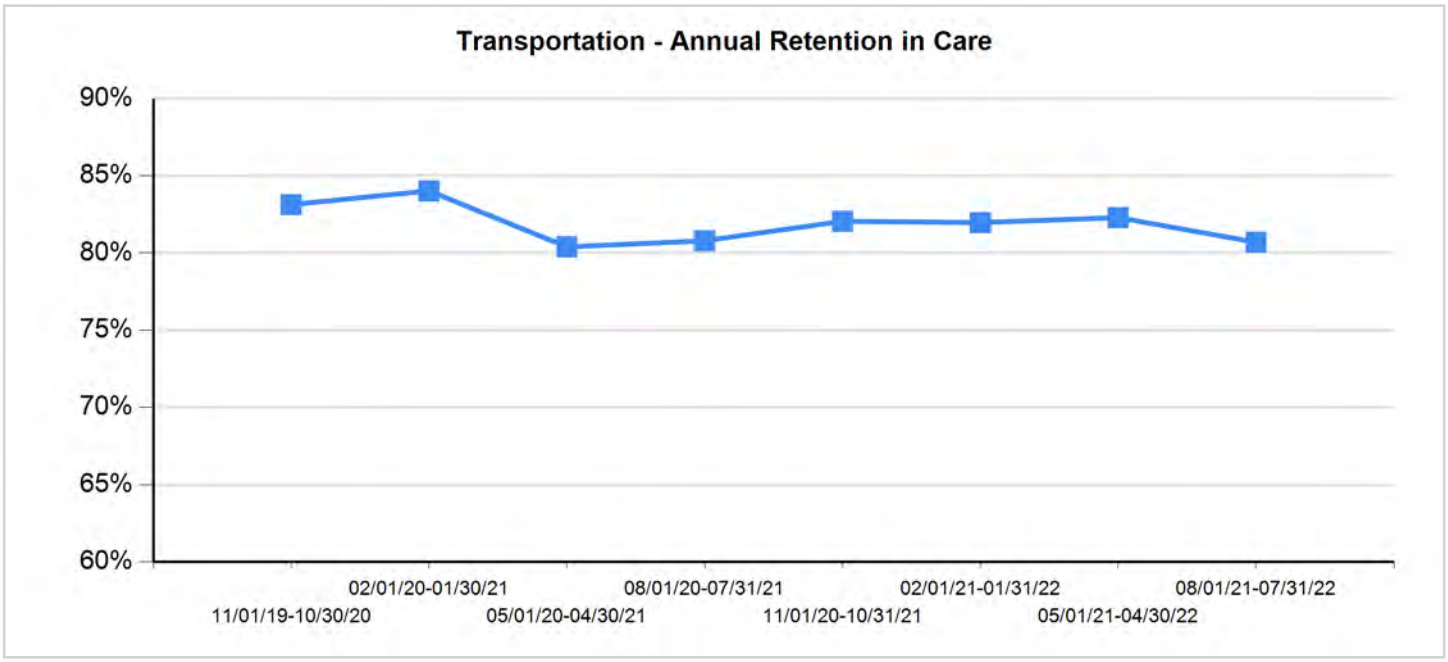
MCM - Care Plan				
	11/01/20 - 10/31/21	02/01/21 - 01/31/22	05/01/21 - 04/30/22	08/01/21 - 07/31/22
Number of clients in the denominator who had a medical case management care plan developed and/or updated two or more times at least three months apart in the measurement year	129	103	89	96
Number of medical case management clients living with HIV who had two or more medical case management encounters at least six months apart in the measurement year	1,374	1,312	1,186	1,043
Percentage	9.4%	7.9%	7.5%	9.2%
Change from Previous Quarter Results	-1.8%	-1.5%	-0.3%	1.7%



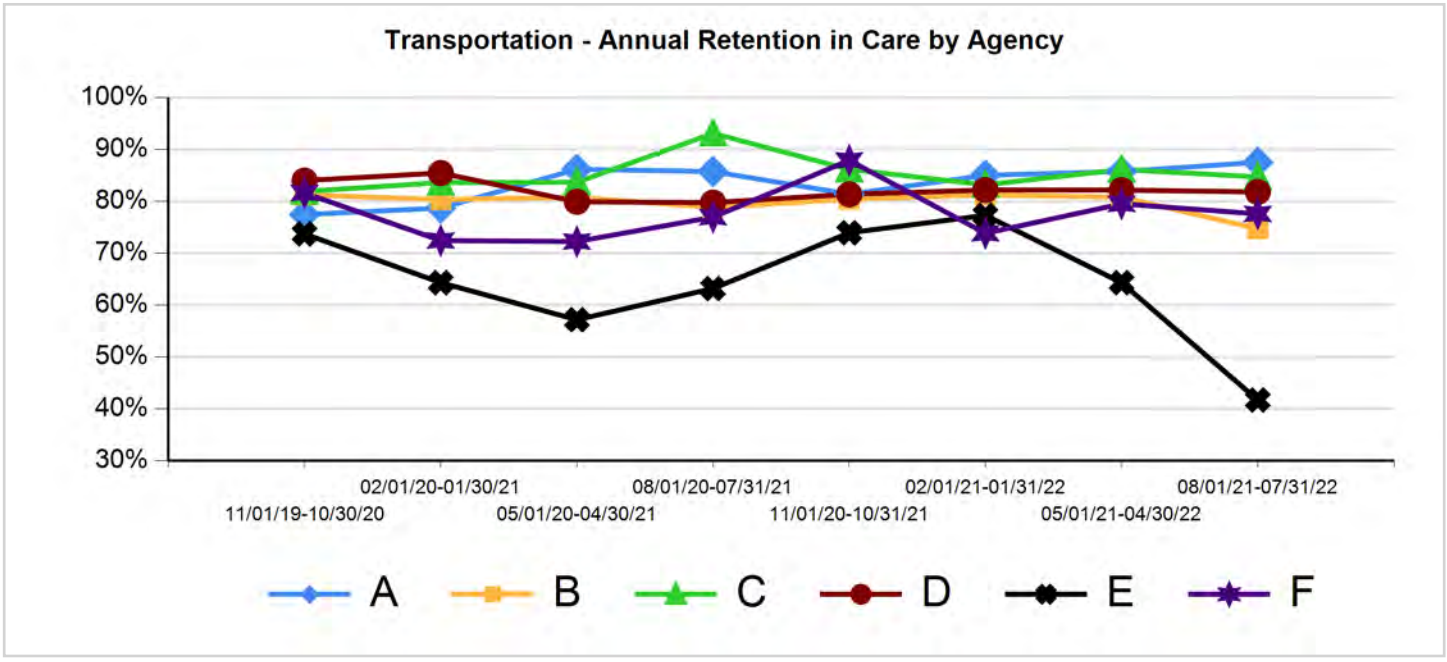
MCM - Care Plan by Agency												
	05/01/21 - 04/30/22						08/01/21 - 07/31/22					
	A	B	C	D	E	F	A	B	C	D	E	F
Number of clients in the denominator who had a medical case management care plan developed and/or updated two or more times at least three months apart in the measurement year	0	58	8	4	0	1	0	57	7	9	0	5
Number of medical case management clients living with HIV who had two or more medical case management encounters at least six months apart in the measurement year	116	288	89	466	4	29	98	243	75	398	5	31
Percentage	0.0%	20.1%	9.0%	0.9%	0.0%	3.4%	0.0%	23.5%	9.3%	2.3%	0.0%	16.1%
Change from Previous Quarter Results	0.0%	-3.9%	-0.1%	-0.2%	-20.0%	0.0%	0.0%	3.3%	0.3%	1.4%	0.0%	12.7%



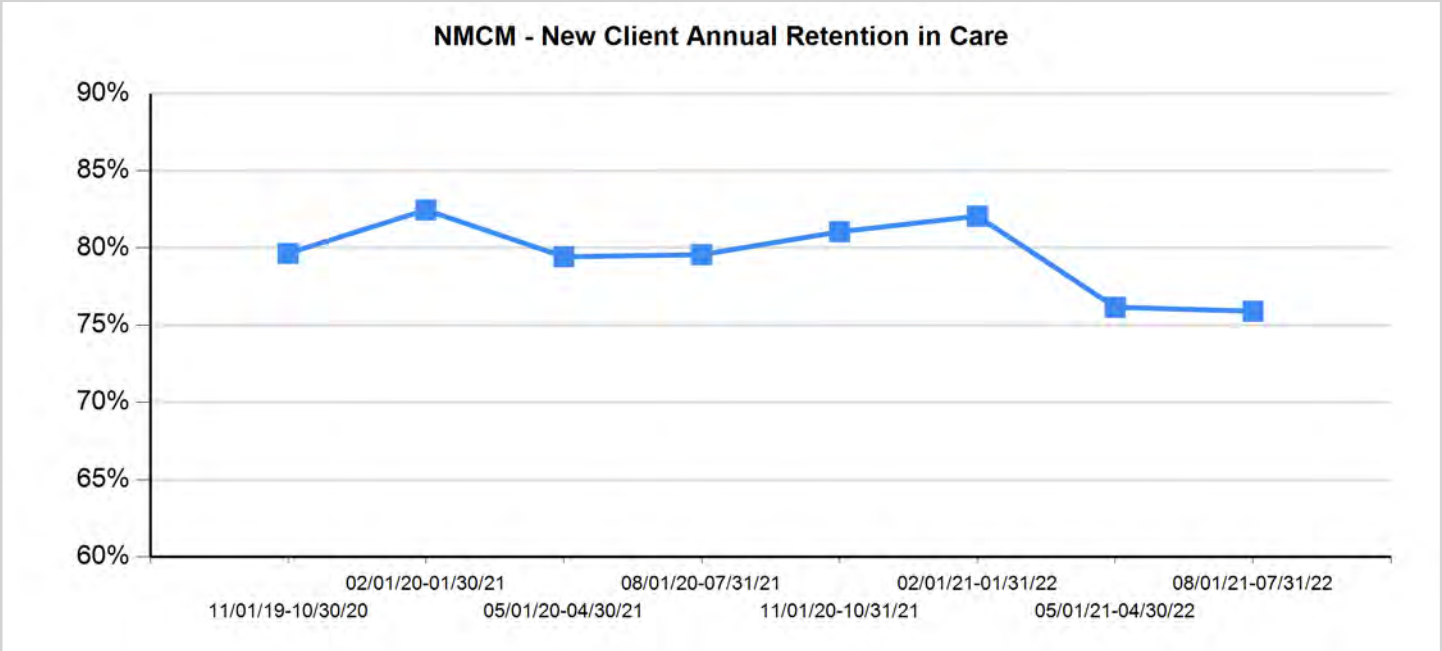
Transportation - Annual Retention in Care				
	11/01/20 - 10/31/21	02/01/21 - 01/31/22	05/01/21 - 04/30/22	08/01/21 - 07/31/22
Number of clients in the denominator who had at least two HIV medical care encounters at least 90 days apart within the measurement year	1,134	1,023	999	1,020
Number of medical transportation clients living with HIV[1] who had at least one HIV medical encounter within the measurement year	1,382	1,248	1,214	1,264
Percentage	82.1%	82.0%	82.3%	80.7%
Change from Previous Quarter Results	1.3%	-0.1%	0.3%	-1.6%



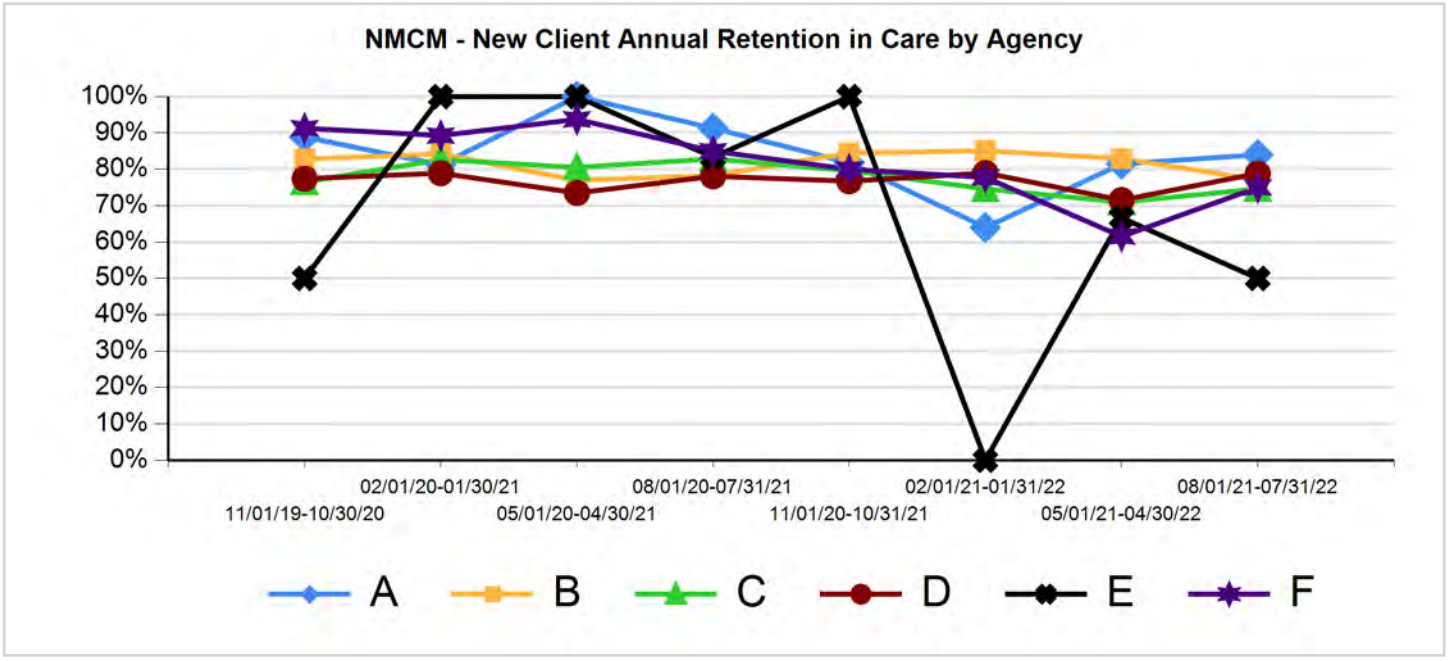
Transportation - Annual Retention in Care by Agency												
	05/01/21 - 04/30/22						08/01/21 - 07/31/22					
	A	B	C	D	E	F	A	B	C	D	E	F
Number of clients in the denominator who had at least two HIV medical care encounters at least 90 days apart within the measurement year	60	248	93	561	9	31	77	230	105	566	5	38
Number of medical transportation clients living with HIV[1] who had at least one HIV medical encounter within the measurement year	70	307	108	683	14	39	88	308	124	692	12	49
Percentage	85.7%	80.8%	86.1%	82.1%	64.3%	79.5%	87.5%	74.7%	84.7%	81.8%	41.7%	77.6%
Change from Previous Quarter Results	0.7%	-0.4%	3.0%	0.0%	-13.0%	5.7%	1.8%	-6.1%	-1.4%	-0.3%	-22.6%	-1.9%



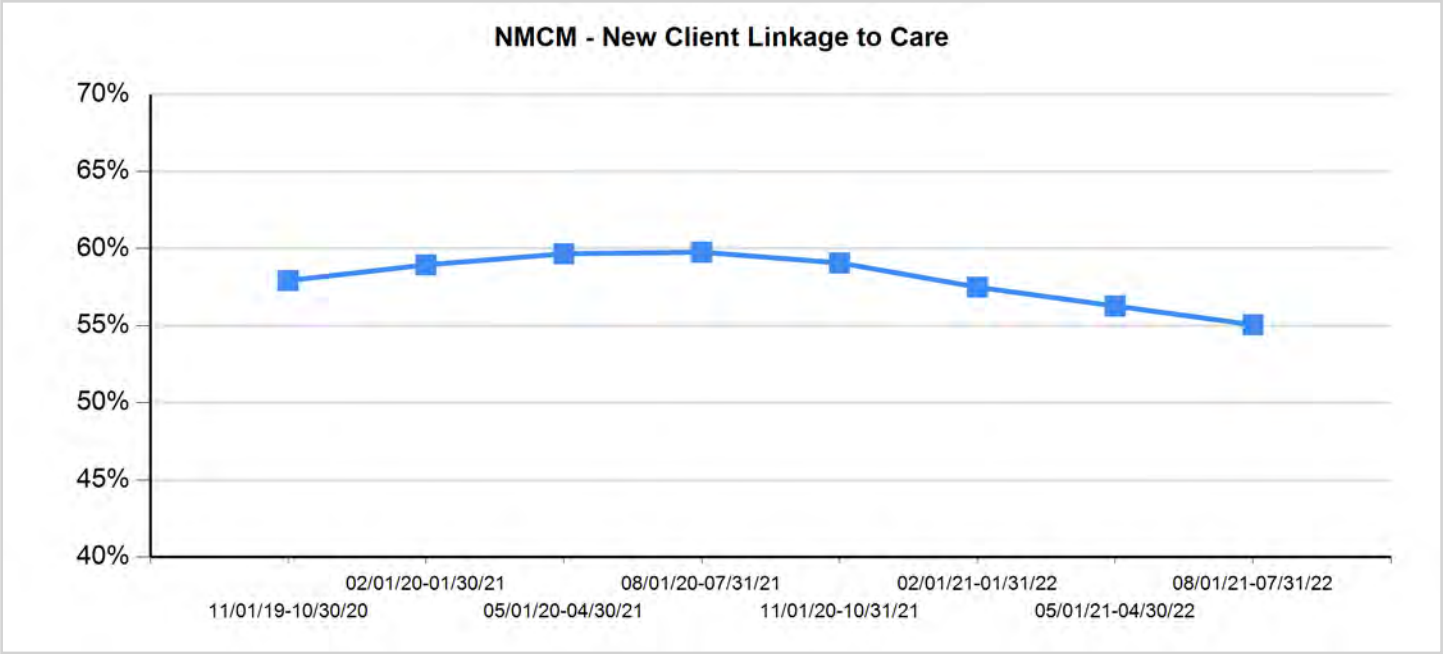
NMCM - New Client Annual Retention in Care				
	11/01/20 - 10/31/21	02/01/21 - 01/31/22	05/01/21 - 04/30/22	08/01/21 - 07/31/22
Number of clients in the denominator who had at least two HIV medical care encounters at least 90 days apart within the measurement year	278	302	262	252
Number of non-medical case management clients living with HIV who had their first HIV medical encounter within the first six months of the measurement year	343	368	344	332
Percentage	81.0%	82.1%	76.2%	75.9%
Change from Previous Quarter Results	1.5%	1.0%	-5.9%	-0.3%



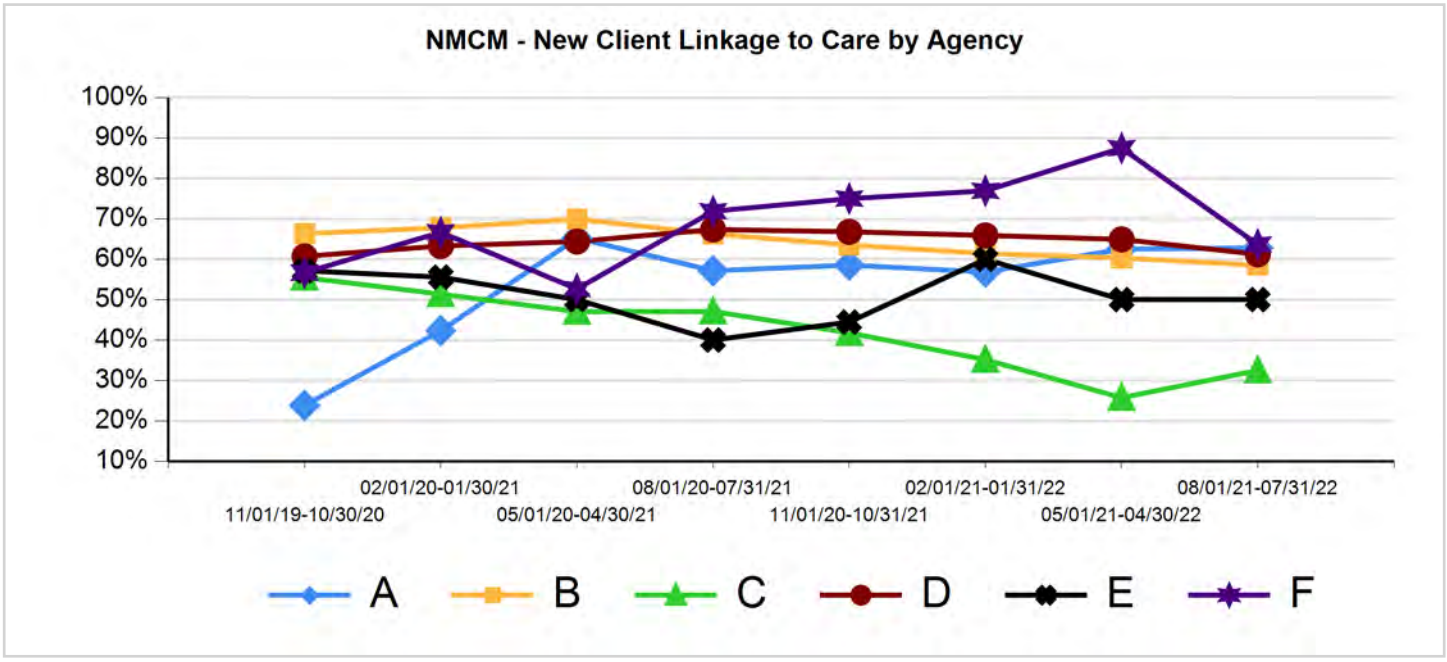
NMCM - New Client Annual Retention in Care by Agency												
	05/01/21 - 04/30/22						08/01/21 - 07/31/22					
	A	B	C	D	E	F	A	B	C	D	E	F
Number of clients in the denominator who had at least two HIV medical care encounters at least 90 days apart within the measurement year	22	107	44	93	2	8	21	91	50	97	1	12
Number of non-medical case management clients living with HIV who had their first HIV medical encounter within the first six months of the measurement year	27	129	62	130	3	13	25	118	67	123	2	16
Percentage	81.5%	82.9%	71.0%	71.5%	66.7%	61.5%	84.0%	77.1%	74.6%	78.9%	50.0%	75.0%
Change from Previous Quarter Results	17.5%	-2.2%	-3.6%	-7.4%	66.7%	-16.2%	2.5%	-5.8%	3.7%	7.3%	-16.7%	13.5%



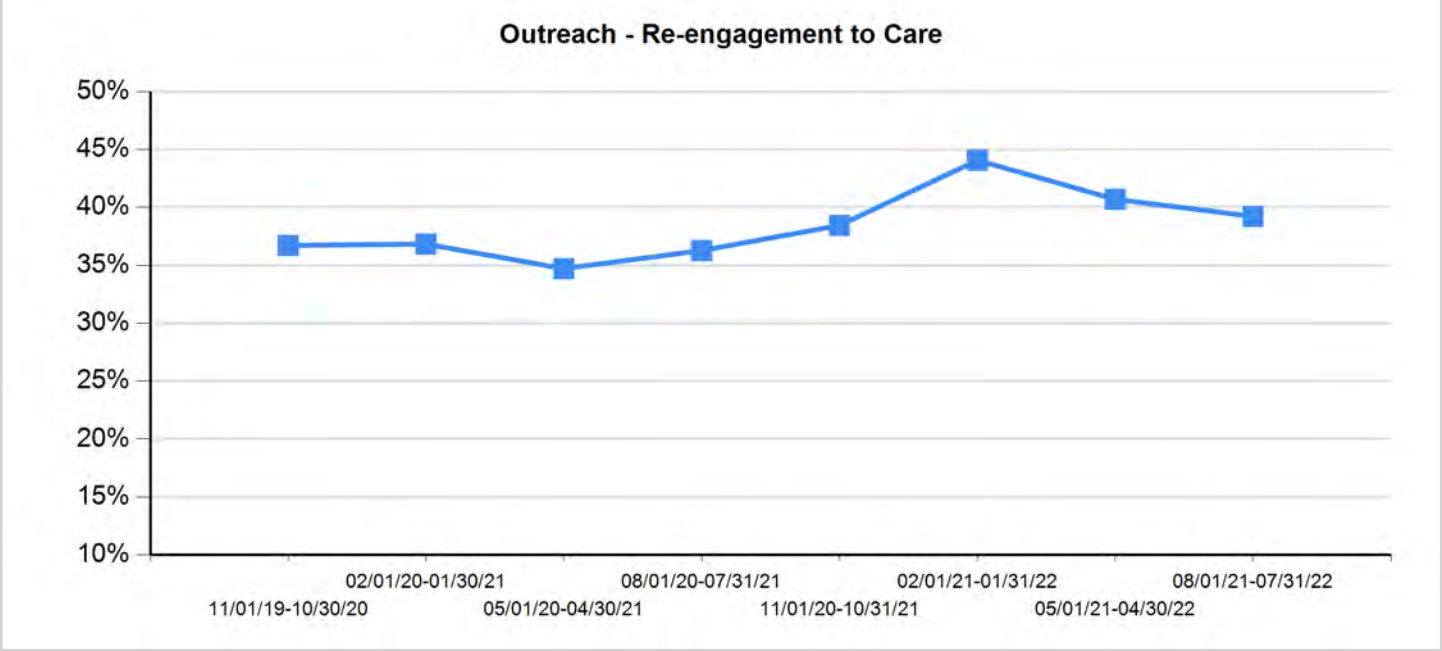
NMCM - New Client Linkage to Care				
	11/01/20 - 10/31/21	02/01/21 - 01/31/22	05/01/21 - 04/30/22	08/01/21 - 07/31/22
Number of clients in the denominator who attended a medical care visit within 30 days of a non-medical case management visit	472	441	426	419
Number of newly-enrolled clients living with HIV who had an initial non-medical case management encounter in the measurement year	799	767	757	761
Percentage	59.1%	57.5%	56.3%	55.1%
Change from Previous Quarter Results	-0.7%	-1.6%	-1.2%	-1.2%



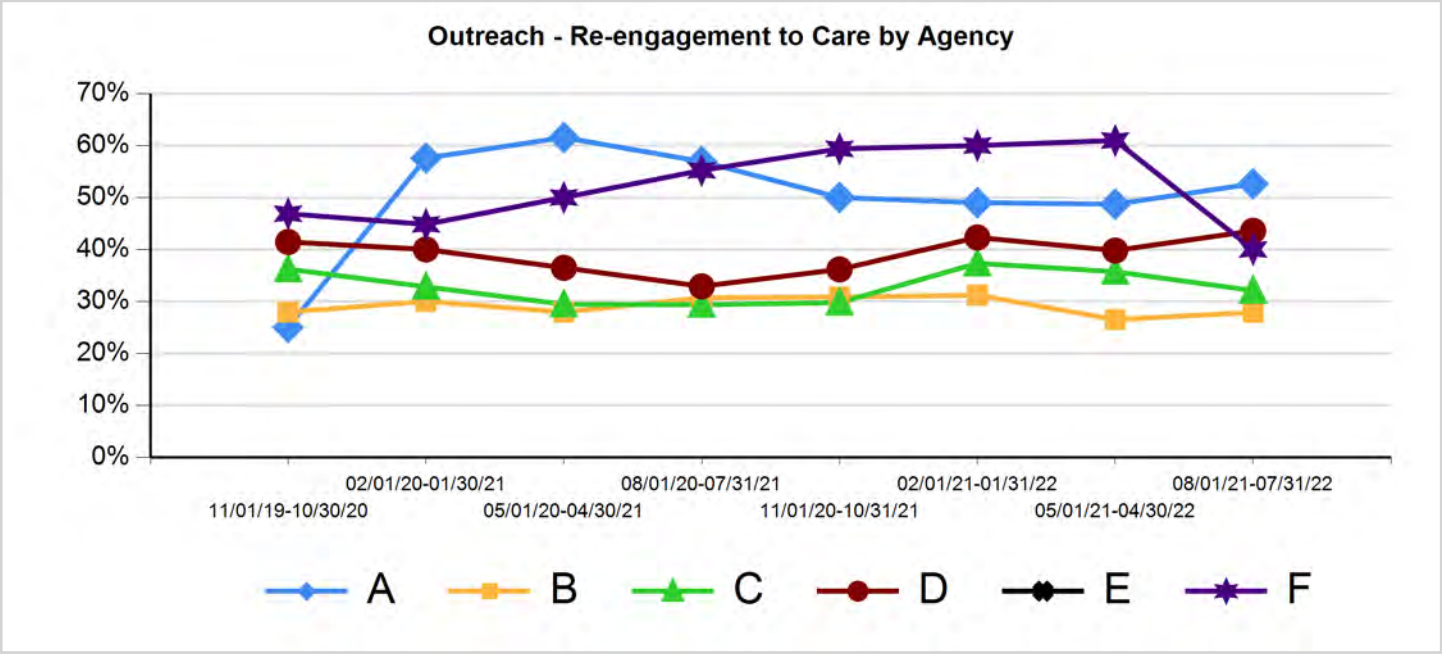
NMCM - New Client Linkage to Care by Agency												
	05/01/21 - 04/30/22						08/01/21 - 07/31/22					
	A	B	C	D	E	F	A	B	C	D	E	F
Number of clients in the denominator who attended a medical care visit within 30 days of a non-medical case management visit	25	196	18	172	3	14	27	189	25	161	2	14
Number of newly-enrolled clients living with HIV who had an initial non-medical case management encounter in the measurement year	40	325	70	265	6	16	43	323	77	263	4	22
Percentage	62.5%	60.3%	25.7%	64.9%	50.0%	87.5%	62.8%	58.5%	32.5%	61.2%	50.0%	63.6%
Change from Previous Quarter Results	5.7%	-1.1%	-9.4%	-1.0%	-10.0%	10.6%	0.3%	-1.8%	6.8%	-3.7%	0.0%	-23.9%



Outreach - Re-engagement to Care				
	11/01/20 - 10/31/21	02/01/21 - 01/31/22	05/01/21 - 04/30/22	08/01/21 - 07/31/22
Number of clients in the denominator who had at least one HIV medical care visit within 90 days of Outreach visit	336	379	350	313
Number of clients living with HIV who had at least one Outreach encounter within the measurement year	874	860	860	798
Percentage	38.4%	44.1%	40.7%	39.2%
Change from Previous Quarter Results	2.2%	5.6%	-3.4%	-1.5%



Outreach - Re-engagement to Care by Agency												
	05/01/21 - 04/30/22						08/01/21 - 07/31/22					
	A	B	C	D	E	F	A	B	C	D	E	F
Number of clients in the denominator who had at least one HIV medical care visit within 90 days of Outreach visit	76	22	140	76	0	25	80	17	137	68	0	2
Number of clients living with HIV who had at least one Outreach encounter within the measurement year	156	83	392	191	0	41	152	61	427	156	0	5
Percentage	48.7%	26.5%	35.7%	39.8%	NaN	61.0%	52.6%	27.9%	32.1%	43.6%	NaN	40.0%
Change from Previous Quarter Results	-0.3%	-4.7%	-1.6%	-2.5%	NaN	1.0%	3.9%	1.4%	-3.6%	3.8%	NaN	-21.0%



Footnotes:
1. Table/Chart data for this report run was taken from "ABR197 v1.1"

2021 - 2022 DSHS State Services Service Utilization Report

4/1/2022 thru 08/31/2022 Houston HSDA

4th Quarter

Revised 9/23/2022

	UDC		Gender				Race				Age Group							
Funded Service	***Goal***	**YTD**	**Male**	**Female**	**FTM**	**MTF**	**AA**	**White**	**Hisp**	**Other**	**0-12**	**13-19**	**20-24**	**25-34**	**35-44**	**45-49**	**50-64**	**65+**
Health Insurance Premiums	***2,300***	752	81.78%	17.55%	0.00%	0.67%	36.83%	27.12%	33.11%	2.94%	0.00%	0.00%	1.35%	17.28%	17.55%	26.59%	30.85%	6.38%
Mental Health Services	***250***	141	82.28%	15.60%	0.00%	2.12%	46.09%	24.11%	29.07%	0.73%	0.00%	0.00%	0.70%	29.78%	20.56%	19.85%	23.44%	5.67%
Hospice	***35***	17	82.36%	17.64%	0.00%	0.00%	52.94%	17.64%	29.42%	0.00%	0.00%	0.00%	0.00%	11.76%	11.76%	17.64%	47.08%	11.76%
Non Medical Case Management	***315***	97	83.50%	14.43%	0.00%	2.07%	44.33%	17.52%	37.11%	1.04%	0.00%	0.00%	1.03%	17.55%	21.64%	24.74%	28.86%	6.18%
Linguistic Services	***50***	45	46.66%	51.11%	0.00%	2.23%	53.33%	11.11%	4.44%	31.12%	0.00%	0.00%	0.00%	6.69%	24.44%	37.77%	22.22%	8.88%
Unduplicated Clients Served By State Services Funds:	*NA*	1,052	75.32%	23.27%	0.00%	1.41%	46.70%	19.50%	26.63%	7.17%	0.00%	0.00%	0.62%	16.61%	19.19%	25.32%	30.49%	7.77%

4-1-2022 State Services Start date to mirror and support the TRG Procurement Report

completed by: cvaguries

Houston Ryan White Health Insurance Assistance Service Utilization Report

Period Reported: 09/01/2021-08/31/2022

Revised: 9/28/2022

	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	1490	$184,247.72	523			*0*
Medical Deductible	137	$142,581.02	103			*0*
Medical Premium	8089	$2,290,085.35	918			*0*
Pharmacy Co-Payment	28931	$1,519,887.67	1714			*0*
APTC Tax Liability	1	$500.00	1			*0*
Out of Network Out of Pocket	0	$0.00	0			*0*
ACA Premium Subsidy Repayment		$18,046.03	33	*NA*	*NA*	*NA*
Totals:	38648	$4,119,255.73	3292	0	$0.00	

Comments: This report represents services provided under all grants.

The Houston Regional HIV/AIDS Resource Group, Inc.
FY 2122 Ryan White Part B
Procurement Report
April 1, 2022 - March 31, 2023

Reflects spending through August 2022

Spending Target: 43%

Revised 10/5/22

Priority	Service Category	Original Allocation per RWPC	% of Grant Award	Amendment*	Contractual Amount	Amendment	Contractual Amount	Date of Original Procurement	Expended YTD	Percent YTD
4	Oral Health Service	$1,658,878	48%	$0	$1,658,878	$0	$1,658,878	4/1/2021	$516,078	31%
4	Oral Health Service -Prosthodontics	$560,000	16%	$0	$560,000	$0	$560,000	4/1/2021	$248,958	44%
5	Health Insurance Premiums and Cost Sharing (1)	$1,107,702	32%	$0	$1,107,702	$0	$1,107,702	4/1/2021	$219,658	20%
9	Home and Community Based Health Services (2)	$113,315	3%	$0	$113,315	$0	$113,315	4/1/2021	$31,920	28%
		$0	0%	$0	$0					
	Total Houston HSDA	3,439,895	100%	0	3,439,895	$0	$3,439,895		1,016,613	30%

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

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

(2) Agency is behind on reporting

*Note TRG reallocated funds to avoid lapse in funds including reallocated funds from rural HSDAs.

The Houston Regional HIV/AIDS Resource Group, Inc.
FY 2122 DSHS State Services
Procurement Report
April 1, 2022 - August 31, 2022

Chart reflects spending through August 2022

Spending Target: 100%

Revised 10/5/2022

Priority	Service Category	Original Allocation per RWPC	% of Grant Award	Amendments per RWPC	Contractual Amount	Amendment	Contractual Amount	Date of Original Procurement	Expended YTD	Percent YTD
5	**Health Insurance Premiums and Cost Sharing**	$853,137	70%	**$0**	$853,137	$0	$853,137	9/1/2020	$890,785	104%
6	**Mental Health Services (1)**	$75,000	6%	**$0**	$75,000	$0	$75,000	9/1/2020	$54,400	73%
11	**Hospice (2)**	$108,000	9%	**$0**	$108,000	$0	$108,000	9/1/2020	$157,740	146%
13	**Non Medical Case Management (1)**	$135,000	11%	**$0**	$135,000	$0	$135,000	9/1/2020	$78,812	58%
16	**Linguistic Services (1)**	$40,000	3%	**$0**	$40,000	$0	$40,000	9/1/2020	$26,288	66%
	Total Houston HSDA	**1,211,137**	**100%**	**$0**	$1,211,137	$0	$1,211,137		1,208,024	100%

Note The five-month allocation is based on available funds and not 5/12 of budget

(1) Has had lower then expected serivce demand

(2) Service utilization is increasing

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Executive Director
2223 West Loop South | Houston, Texas 77027
Tel: (832) 927-7500 | Fax: (832) 927-0237

Harris County Public Health
Building a Healthy Community

Ericka Brown, MD, MBA, FACHE
Director Community Health and Wellness Division
2223 West Loop South| Houston, Texas 77027
Tel: (713) 408-0775 | Fax: (832) 927-0507

2023-2024 Houston EMA: RWGA Part A Standards of Care for HIV Services Ryan White Grant Administration Section SUMMARY OF CHANGES AS OF 11/07/2022

Location	2022-2023 (old)	2023-2024 (new)
General Standard 4.9b Accessibility	Not previously in SOC	HRSA US. A #2: **Provision of services regardless of an individual's ability to pay for the service.** Subgrantee billing and collection policies and procedures do not: • Deny services for non-payment • Deny payment for inability to produce income documentation • Require full payment prior to service • Include any other procedure that denies services for non-payment
General Standards 1.5 Staff Requirements	Agency must provide training on agency's policies and procedures for eligibility determination and sliding fee schedule for, but not limited to, case managers, and eligibility & intake staff annually. All new employees must complete within ninety (90) days of hire.	Agency must provide training on agency's policies and procedures for eligibility determination and sliding fee schedule for, but not limited to, case managers, and eligibility & intake staff annually. All staff applicable to this process must complete within ninety (90) days of hire.

Outreach Services	Outreach workers focus on locating clients who are on the cusp of falling out of care, for reengagement back into care. The Ryan White Part A Outreach Worker (OW) provides field-based services to clients based on criteria identified by each agency. These services include the provision of information, referrals, and assistance with linkage to medical, mental health, substance abuse and psychosocial services as needed and advocating on behalf of clients to decrease service gaps and remove barriers to services	Outreach workers focus on locating clients who are on the cusp of falling out of care, for reengagement and retention back into care. The Ryan White Part A Outreach Worker (OW) provides field-based services to clients based on criteria identified by each agency. These services include the provision of information, referrals, and assistance with linkage to medical, mental health, substance abuse and psychosocial services as needed and advocating on behalf of clients to decrease service gaps and remove barriers to services
Non-Medical Case Management 1.1 Staff Requirements	Service linkage workers must have a bachelor's degree from an accredited college or university with a major in social or behavioral sciences. Documented paid work experience in providing client services to PLWH may be substituted for the bachelor's degree requirement on a 1:1 basis (1 year of documented paid experience may be substituted for 1 year of college). Service linkage workers must have a minimum of 1-year paid work experience with PLWH	Service linkage workers must have a bachelor's degree from an accredited college or university with a major in social or behavioral sciences. Documented paid work experience in providing client services to PLWH may be substituted for the bachelor's degree requirement on a 1:1 basis (1 year of documented paid experience may be substituted for 1 year of college). Service linkage workers must have a minimum of 1-year work experience with PLWH

2022-2023 HOUSTON ELIGIBLE METROPOLITAN AREA: RYAN WHITE CARE ACT PART A
STANDARDS OF CARE FOR HIV SERVICES
RYAN WHITE GRANT ADMINISTRATION SECTION
HARRIS COUNTY PUBLIC HEALTH (HCPH)

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Introduction

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

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

Scope
The Houston EMA SOCs apply to Part A funded HRSA defined core and support services including the following services in FY 2021-2022:

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

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

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

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

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

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

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

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

GENERAL STANDARDS

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

	additional one (1) hour of HIV/Mental Health co-morbidity sensitivity training annually. All new employees must complete these within ninety (90) days of hire. All staff with greater than 5 years with their current employer must receive two (2) hours of cultural competency training and an additional one (1) hour of HIV/Mental Health co-morbidity sensitivity training annually.	
1.5	<u>Staff education on eligibility determination and fee schedule</u> Agency must provide training on agency's policies and procedures for eligibility determination and sliding fee schedule for, but not limited to, case managers, and eligibility & intake staff annually. All new employees must complete within ninety (90) days of hire.	• Documentation of training in employee's record
2.0	**Services utilize effective management practices such as cost effectiveness, human resources and quality improvement.**	
2.1	<u>Service Evaluation</u> Agency has a process in place for the evaluation of client services.	• Review of Agency's Policies and Procedures Manual indicates compliance • Staff interviews indicate compliance.
2.2	<u>Subcontractor Monitoring</u> Agency that utilizes a subcontractor in delivery of service, must have established policies and procedures on subcontractor monitoring that include: • Fiscal monitoring • Program • Quality of care • Compliance with guidelines and standards Reviewed Annually	• Documentation of subcontractor monitoring • Review of Agency's Policies and Procedures Manual indicates compliance
2.3	<u>Staff Guidelines</u> Agency develops written guidelines for staff, which include, at a minimum, agency-specific policies and procedures (staff selection, resignation and termination process, and position descriptions); client confidentiality; health and safety requirements; complaint and grievance procedures; emergency procedures; and statement of client rights; staff must review these guidelines annually	• Personnel file contains a signed statement acknowledging that staff guidelines were reviewed and that the employee understands agency policies and procedures

2.4	Work Conditions Staff/volunteers have the necessary tools, supplies, equipment and space to accomplish their work.	• Inspection of tools and/or equipment indicates that these are in good working order and in sufficient supply • Staff interviews indicate compliance
2.5	Staff Supervision Staff services are supervised by a paid coordinator or manager.	• Review of personnel files indicates compliance • Review of Agency's Policies and Procedures Manual indicates compliance
2.6	Professional Behavior Staff must comply with written standards of professional behavior.	• Staff guidelines include standards of professional behavior • Review of Agency's Policies and Procedures Manual indicates compliance • Review of personnel files indicates compliance • Review of agency's complaint and grievance files
2.7	Communication There are procedures in place regarding regular communication with staff about the program and general agency issues.	• Review of Agency's Policies and Procedures Manual indicates compliance • Documentation of regular staff meetings • Staff interviews indicate compliance
2.8	Accountability There is a system in place to document staff work time.	• Staff time sheets or other documentation indicate compliance
2.9	Staff Availability Staff are present to answer incoming calls during agency's normal operating hours.	• Published documentation of agency operating hours • Staff time sheets or other documentation indicate compliance

3.0	**Clients Rights and Responsibilities**	
3.1	Clients Rights and Responsibilities Agency reviews Client Rights and Responsibilities Statement with each client in a language and format the client understands. Agency provides client with written copy of client rights and responsibilities, including: • Informed consent • Confidentiality • Grievance procedures • Duty to warn or report certain behaviors • Scope of service • Criteria for end of services	• Documentation in client's record
3.2	Confidentiality Agency maintains Policy and Procedure regarding client confidentiality in accordance with RWGA site visit guidelines, local, state and federal laws. Providers must implement mechanisms to ensure protection of clients' confidentiality in all processes throughout the agency. There is a written policy statement regarding client confidentiality form signed by each employee and included in the personnel file.	• Review of Agency's Policies and Procedures Manual indicates compliance • Clients interview indicates compliance • Agency's structural layout and information management indicates compliance • Signed confidentiality statement in each employee's personnel file
3.3	Consents All consent forms comply with state and federal laws, are signed by an individual legally able to give consent and must include the Consent for Services form and a consent for release/exchange of information for every individual/agency to whom client identifying information is disclosed, regardless of whether or not HIV status is revealed.	• Agency Policy and Procedure and signed and dated consent forms in client record
3.4	Up to date Release of Information Agency obtains an informed written consent of the client or legally responsible person prior to the disclosure or exchange of certain information about client's case to another party (including family members) in accordance with the RWGA Site Visit Guidelines, local, state and federal laws. The release/exchange consent form must contain:	• Current Release of Information form with all the required elements signed by client or authorized person in client's record

	• Name of the person or entity permitted to make the disclosure • Name of the client • The purpose of the disclosure • The types of information to be disclosed • Entities to disclose to • Date on which the consent is signed • The expiration date of client authorization (or expiration event) no longer than two years • Signature of the client/or parent, guardian or person authorized to sign in lieu of the client. • Description of the *Release of Information*, its components, and ways the client can nullify it Release/exchange of information forms must be completed entirely in the presence of the client. Any unused lines must have a line crossed through the space.	
3.5	<u>Grievance Procedure</u> Agency has Policy and Procedure regarding client grievances that is reviewed with each client in a language and format the client can understand and a written copy of which is provided to each client. Grievance procedure includes but is not limited to: • to whom complaints can be made • steps necessary to complain • form of grievance, if any • timelines and steps taken by the agency to resolve the grievance • documentation by the agency of the process, including a standardized grievance/complaint form available in a language and format understandable to the client • all complaints or grievances initiated by clients are documented on the Agency's standardized form • resolution of each grievance/complaint is documented on the Standardized form and shared with client • confidentiality of grievance • addresses and phone numbers of licensing authorities and funding sources	• Signed receipt of agency Grievance Procedure, filed in client chart • Review of Agency's Policies and Procedures Manual indicates compliance • Review of Agency's Grievance file indicates compliance, • Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #2

	• language outlining that clients cannot be retaliated against for filing grievances	
3.6	<u>Conditions Under Which Discharge/Closure May Occur</u> A client may be discharged from Ryan White funded services for the following reasons. • Death of the client • At the client's or legal guardian request • Changes in client's need which indicates services from another agency • Fraudulent claims or documentation about HIV diagnosis by the client • Client actions put the agency, case manager or other clients at risk. Documented supervisory review is required when a client is terminated or suspended from services due to behavioral issues. • Client moves out of service area, enters jail or cannot be contacted for sixty (60) days. Agency must document three (3) attempts to contact clients by more than one method (e.g. phone, mail, email, text message, in person via home visit). • Client service plan is completed, and no additional needs are identified. Client must be provided a written notice prior to involuntary termination of services (e.g. due to dangerous behavior, fraudulent claims or documentation, etc.).	• Documentation in client record and in the Centralized Patient Care Data Management System • A copy of written notice and a certified mail receipt for involuntary termination
3.7	<u>Client Closure</u> A summary progress note is completed in accordance with Site Visit Guidelines within three (3) working days of closure, including: • Date and reason for discharge/closure • Summary of all services received by the client and the client's response to services • Referrals made and/or • Instructions given to the individual at discharge (when applicable)	• Documentation in client record and in the Centralized Patient Care Data Management System
3.8	<u>Client Feedback</u> In addition to the RWGA standardized client satisfaction survey conducted on an ongoing basis (no less than annually), Agency must have structured and ongoing efforts to obtain input from clients (or client caregivers, in cases where clients are unable to give feedback) in the design and delivery of services. Such efforts may	• Documentation of clients' evaluation of services is maintained • Documentation of CAB and public meeting minutes

	include client satisfaction surveys, focus groups and public meetings conducted at least annually. Agency may also maintain a visible suggestion box for clients' inputs. Analysis and use of results must be documented. Agency must maintain a file of materials documenting Consumer Advisory Board (CAB) membership and meeting materials (applicable only if agency has a CAB). • Agencies that serve an average of 100 or more unduplicated clients monthly under combined RW/A, MAI, RW/B and SS funding must implement a CAB. The CAB must meet regularly (at least 4 times per year) at a time and location conducive to consumer participation to gather, support and encourage client feedback, address issues which impact client satisfaction with services and provide Agency with recommendations to improve service delivery, including accessibility and retention in care.	• Documentation of existence and appropriateness of a suggestion box or other client input mechanism • Documentation of content, use, and confidentiality of a client satisfaction survey or focus groups conducted annually • Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #1
3.9	Patient Safety (Core Services Only) Agency shall establish mechanisms to implement National Patient Safety Goals (NPSG) modeled after the current Joint Commission accreditation *for Ambulatory Care* (www.jointcommission.org) to ensure patients' safety. The NPSG to be addressed include the following as applicable: • "Improve the accuracy of patient identification • Improve the safety of using medications • Reduce the risk of healthcare-associated infections • Accurately and completely reconcile medications across the continuum of care • Universal Protocol for preventing Wrong Site, Wrong Procedure and Wrong Person Surgery" (www.jointcommission.org)	• Review of Agency's Policies and Procedures Manual indicates compliance
3.10	Client Records Provider shall maintain all client records.	• Review of agency's policy and procedure for records administration indicates compliance
4.0	**Accessibility**	
4.1	Cultural Competence Agency demonstrates a commitment to provision of services that are culturally sensitive and language competent for Limited English Proficient (LEP) individuals and people of all gender identities and sexual orientations	• Agency has procedures for obtaining translation services • Client satisfaction survey indicates compliance

		• Policies and procedures demonstrate commitment to the community and culture of the clients • Availability of interpretive services, bilingual staff, and staff trained in cultural competence • Agency has vital documents including, but not limited to applications, consents, complaint forms, and notices of rights translated in client record • Agency has facilities available for consumers of all gender identities, including gender-neutral restrooms.
4.2	Client Education Agency demonstrates capacity for client education and provision of information on community resources	• Availability of the blue book and other educational materials • Documentation of educational needs assessment and client education in clients' records
4.3	Special Service Needs Agency demonstrates a commitment to assisting individuals with special needs	• Agency compliance with the Americans with Disabilities Act (ADA). • Review of Policies and Procedures indicates compliance • Environmental Review shows a facility that is handicapped accessible
4.4	Provision of Services for Low-Income Individuals Agency must ensure that facility is handicap accessible and is also accessible by public transportation (if in area served by METRO). Agency must have policies and procedures in place that ensures access to transportation services if facility is not accessible by public transportation. Agency should not have policies that dictate a dress code or conduct that may act as barrier to care for low income individuals.	• Facility is accessible by public transportation • Review of Agency's Policies and Procedures Manual indicates compliance • Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #4

4.5	Proof of HIV Diagnosis Documentation of the client's HIV status is obtained at or prior to the initiation of services or registration services. An anonymous test result may be used to document HIV status temporarily (up to sixty [60] days). It must contain enough information to ensure the identity of the subject with a reasonable amount of certainty.	• Documentation in client record as per RWGA site visit guidelines or TRG Policy SG-03 • Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #3
4.6	Provision of Services Regardless of Current or Past Health Condition Agency must have Policies and Procedures in place to ensure that clients living with HIV are not denied services due to current or pre-existing health condition or non-HIV related condition. A file must be maintained on all clients who are refused services and the reason for refusal.	• Review of Policies and Procedures indicates compliance • A file containing information on clients who have been refused services and the reasons for refusal • Source Citation: HAB Program Standards; Section D: #1
4.7	Client Eligibility In order to be eligible for services, individuals must meet the following: • HIV+ • Residence in the Houston EMA/ HSDA (With prior approval, clients can be served if they reside outside of the Houston EMA/HSDA.) • Income no greater than 300% of the Federal Poverty level (unless otherwise indicated) • Proof of identification • Ineligibility for third party reimbursement	• Documentation of HIV+ status, residence, identification and income in the client record • Documentation of ineligibility for third party reimbursement • Documentation of screening for Third Party Payers in accordance with RWGA site visit guidelines • Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section B: Eligibility Determination/Screening #1
4.8	Re-certification of Client Eligibility Appropriate documentation is required for changes in status and at least once a year (defined as a 12-month period) with renewed eligibility with the CPCDMS. At a minimum, agency confirms an individual's income, residency and re-screens, as appropriate, for third-party payers. Third party payers include State Children's Health Insurance Programs (SCHIP), Medicare (including Part D prescription drug benefit) and private insurance.	• Client record contains documentation of re-certification of client residence, income and rescreening for third party payers at least every twelve (12) months • Review of Policies and Procedures indicates compliance

	Agency must ensure that Ryan White is the Payer of last resort and must have policies and procedures addressing strategies to enroll all eligible uninsured clients into Medicare, Medicaid, private health insurance and other programs. Agency policy must also address coordination of benefits, billing and collection. Clients eligible for Department of Veterans Affairs (VA) benefits are duly eligible for Ryan White services and therefore exempted from the payer of last resort requirement. • Agency must verify 3rd party payment coverage for eligible services at every visit or monthly (whichever is less frequent)	• Information in client's files that includes proof of screening for insurance coverage (i.e. hard/scanned copy of results) • Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section B: Eligibility Determination/Screening #1 and #2 • Source Citation: HIV/AIDS Bureau (HAB) Policy Clarification Notice #13-02
4.9	<u>Charges for Services</u> Agency must institute Policies and Procedures for cost sharing including enrollment fees, premiums, deductibles, co-payments, co-insurance, sliding fee discount, etc. and an annual cap on these charges. Agency should not charge any of the above fees regardless of terminology to any Ryan White eligible patient whose gross income level (GIL)is ≤ 100% of the Federal Poverty Level (FPL) as documented in the CPCDMS for any services provided. Clients whose gross income is between 101-300% may be charged annual aggregate fees in accordance with the legislative mandate outlined below: • 101%-200% of FPL---5% or less of GIL • 201%-300% of FPL---7% or less of GIL • >300% of FPL ---------10% or less of GIL Additionally, agency must implement the following: • Six (6) month evaluation of clients to establish individual fees and cap (i.e. the six (6) month CPCDMS registration or registration update.) • Tracking of charges • A process for alerting the billing system when the cap is reached so client will not be charged for the rest of the calendar year. • Documentation of fees	• Review of Policies and Procedures indicates compliance • Review of system for tracking patient charges and payments indicate compliance • Review of charges and payments in client records indicate compliance with annual cap • Sliding fee application forms on client record is consistent with Federal guidelines
4.10	<u>Information on Program and Eligibility/Sliding Fee Schedule</u> Agency must provide broad-based dissemination of information regarding the availability of services. All clients accessing services must be provided with a clear description of their sliding fee charges in a simple understandable format at intake and annually at registration update.	• Agency has a written substantiated annual plan to targeted populations • Zip code data show provider is reaching clients throughout service

	Agency should maintain a file documenting promotion activity including copies of HIV program materials and information on eligibility requirements. Agency must proactively inform/educate clients when changes occur in the program design or process, client eligibility rules, fee schedule, facility layout or access to program or agency.	area (as applicable to specific service category). • Agency file containing informational materials about agency services and eligibility requirements including the following: Brochures Newsletters Posters Community bulletins any other types of promotional materials • Signed receipt for client education/ information regarding eligibility and sliding fees on client record • Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #5
4.11	<u>Linkage Into Core Services</u> Agency staff will provide out-of-care clients with individualized information and referral to connect them into ambulatory outpatient medical care and other core medical services.	• Documentation of client referral is present in client record • Review of agency's policies & procedures' manual indicates compliance
4.12	<u>Wait Lists</u> It is the expectation that clients will not be put on a Wait List nor will services be postponed or denied. Agency must notify the Administrative agency when funds for service are either low or exhausted for appropriate measures to be taken to ensure adequate funding is available. Should a wait list become required, the agency must, at a minimum, develop a policy that addresses how they will handle situations where service(s) cannot be immediately provided and a process by which client information will be obtained and maintained to ensure that all clients that requested service(s) are contacted after service provision resumes. A wait list is defined as a roster developed and maintained by providers of patients awaiting a particular service when a demand for a service exceeds available appointments used on a first come next serviced method.	• Review of Agency's Policies and Procedures Manual indicates compliance • Documentation that agency notified their Administrative Agency when funds for services were either low or exhausted

	The Agency will notify RWGA of the following information when a wait list must be created: An explanation for the cessation of service; and A plan for resumption of service. The Agency's plan must address: • Action steps to be taken Agency to resolve the service shortfall; and • Projected date that services will resume. The Agency will report to RWGA in writing on a monthly basis while a client wait list is required with the following information: • Number of clients on the wait list. • Progress toward completing the plan for resumption of service. • A revised plan for resumption of service, if necessary.	
4.13	<u>Intake</u> The agency conducts an intake to collect required data including, but not limited to, eligibility, appropriate consents and client identifiers for entry into CPCDMS. Intake process is flexible and responsive, accommodating disabilities and health conditions. In addition to office visits, client is provided alternatives such as conducting business by mail, online registration via the internet, or providing home visits, when necessary. Agency has established procedures for communicating with people with hearing impairments.	• Documentation in client record • Review of Agency's Policies and Procedures Manual indicates compliance
5.0	**Quality Management**	
5.1	<u>Continuous Quality Improvement (CQI)</u> Agency demonstrates capacity for an organized CQI program and has a CQI Committee in place to review procedures and to initiate Performance Improvement activities. The Agency shall maintain an up-to-date Quality Management (QM) Manual. The QM Manual will contain at a minimum: • The Agency's QM Plan • Meeting agendas and/or notes (if applicable) • Project specific CQI Plans • Root Cause Analysis & Improvement Plans • Data collection methods and analysis	• Review of Agency's Policies and Procedures Manual indicates compliance • Up-to-date QM Manual • Source Citation: HAB Universal Standards; Section F: #2

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

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

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

SERVICE SPECIFIC STANDARDS OF CARE

Case Management (All Case Management Categories)

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

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

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

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

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

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

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

Clinical Case Management Services

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

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

2.0	**Timeliness of Services/Documentation**	
2.1	<u>Client Eligibility</u> In addition to the general eligibility criteria, individuals must meet one or more of the following criteria in order to be eligible for clinical case management services: ● Individual living with HIV in mental health treatment/counseling and/or substance abuse treatment services or whose history or behavior may indicate the individual may need mental health and/or substance abuse treatment/counseling now or in the future. ● Clinical criteria for admission into clinical case management must include one of the following: ➢ Client is actively symptomatic with a DSM (most current, American Psychiatric Association approved) diagnosis, especially including substance-related disorders (abuse/dependence), mood disorders (Bipolar depression), depressive disorders, anxiety disorders, and other psychotic disorders; or DSM (most current, American Psychiatric Association approved) diagnosis personality disorders. ➢ Client has a mental health condition or substance abuse pattern that interferes with his/her ability to adhere to medical/medication regimen and needs motivated to access mental health or substance abuse treatment services. ➢ Client is in mental health counseling or chemical dependency treatment.	• Documentation of HIV+ status, mental health and substance abuse status, residence, identification, and income in the client record
2.2	<u>Discharge/Closure from Clinical Case Management Services</u> In addition to the general requirements, a client may be discharged from clinical case management services for the following reasons. • Client has achieved a sustainable level of stability and independence. ➢ Substance Abuse – Client has successfully completed an outpatient substance abuse treatment program. ➢ Mental Health – Client has successfully accessed and is engaged in mental health treatment and/or has completed mental health treatment plan objectives.	• Documentation in client record.

2. 3	Coordination with Primary Medical Care and Medical Case Management Provider Agency will have policies and procedures in place to ensure effective clinical coordination with Ryan White Part A funded Medical Case Management programs. Clinical Case Management services provided to clients accessing primary medical care from a Ryan White Part A funded primary medical care provider other than Agency will require Agency and Primary Medical Care/Medical Case Management provider to conduct regular multi-disciplinary case conferences to ensure effective coordination of clinical and psychosocial interventions. Case conferences must at a minimum include the clinical case manager; mental health/counselor and/or medical case manager and occur at least every six (6) months or more often if clinically indicated for the duration of Clinical Case Management services. Client refusal to provide consent for the clinical case manager to participate in multi-disciplinary case conferences with their Primary Medical Care provider must be documented in the client record.	• Review of Agency's Policies and Procedures Manual indicates compliance • Case conferences are documented in the client record
2.4	Assessment Assessment begins at intake. The case manager will provide client, and if appropriate, his/her support system information regarding the range of services offered by the case management program during intake/assessment. The comprehensive client assessment will include an evaluation of the client's medical and psychosocial needs, strengths, resources (including financial and medical coverage status), limitations, beliefs, concerns and projected barriers to service. Other areas of assessment include demographic information, health history, sexual history, mental history/status, substance abuse history, medication adherence and risk behavior practices, adult and child abuse (if applicable). A RWGA-approved comprehensive client assessment form must be completed within two weeks after initial contact. Clinical Case Management will use a RWGA-approved assessment tool. This tool may include Agency specific enhancements tailored to Agency's Mental Health and/or Substance Abuse treatment program(s).	• Documentation in client record on the comprehensive client assessment form, signed and dated, or agency's equivalent form. Updates to the information included in the assessment will be recorded in the comprehensive client assessment. • A completed DSHS checklist for screening of suspected sexual child abuse and reporting is evident in case management records, when appropriate
2.5	Reassessment Clients will be reassessed at six (6) month intervals following the initial assessment or more often if clinically indicated including when unanticipated events or major changes occur in the client's life (e.g. needing referral for services from other	• Documentation in client record on the comprehensive client reassessment form or agency's equivalent form signed and dated

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

Non-Medical Case Management Services (Service Linkage Worker)

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

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

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

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

Medical Case Management

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

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

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

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

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

Emergency Financial Assistance Program

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

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

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

Emergency Financial Assistance Program (OTHER)

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

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

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

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

Health Insurance Assistance

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

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

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

	• Update income information at Healthcare.gov every 6 months, at minimum, with one update required during annual Marketplace open enrollment or Marketplace renewal periods • Submit prior year tax information no later than May 31st. Tax information must include: o Federal Marketplace Form 1095-A o IRS Form 8962 o IRS Form 1040 (excludes 1040EZ) • Reconciliation of APTC credits or liabilities	
3.0	**Client Access**	
3.1	<u>Clients Referral and Tracking</u> Agency receives referrals from a broad range of HIV service providers and makes appropriate referrals out when necessary.	• Documentation of referrals received • Documentation of referrals out • Staff reports indicate compliance
3.2	<u>Prioritization of Service</u> Agency implements a system to utilize the RW Planning Council-approved prioritization of cost sharing assistance when limited funds warrant it. Agency use the Planning Council-approved consumer out-of-pocket methodology. **Priority Ranking of Cost Sharing Assistance (in descending order):** 1. HIV medication co-pays and deductibles (medications on the Texas ADAP formulary) 2. Non-HIV medication co-pays and deductibles (all other allowable HIV-related medications) 3. Doctor visit co-pays/deductibles (physician visit and/or lab copayments) Medicare Part D (Rx) premiums	• Review of agency's Policies & Procedures Manual indicates compliance. • Review of agency's monthly reimbursement indicates compliance
3.3	<u>Decreasing Barriers to Service</u> Agency establishes formal written agreements with all Houston HSDA Ryan White-funded (Part A, B, C, D) primary care, mental health and substance use provider agencies to enable clients of these agencies to enroll in Health Insurance assistance at his/her primary care, mental health or substance use provider site. (i.e. No need for client to physically present to Health Insurance provider.)	• Review of agency's Policies & Procedures Manual indicates compliance. • Review of client intake/assessment for service indicates compliance

Local Pharmacy Assistance Program

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

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

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

Medical Nutritional Therapy/Supplements

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

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

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

Oral Health

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

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

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

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

Outreach Services

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

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

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

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

Primary Medical Care

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

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

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

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

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

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

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

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

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

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

2.1	Psychiatric Guidelines Outpatient psychiatric care must be provided in accordance with the most current published treatment guidelines, including: Texas Society of Psychiatric Physicians guidelines (The Federation of Texas Psychiatry (txpsych.org) and the American Psychiatric Association (HIV Psychiatry) guidelines.	• Documentation in patient record
3.0	**In addition to demonstrating competency in the provision of HIV specific care, HIV clinical service programs must show evidence that their performance follows norms for ambulatory care.**	
3.1	Access to Care Primary care providers shall ensure all new referrals from testing sites are scheduled for a new patient appointment within 15 working days of referral. (All exceptions to this timeframe will be documented) Agency must assure the time-appropriate delivery of services, with 24 hour on-call coverage including: • Mechanisms for urgent care evaluation and/or triage • Mechanisms for in-patient care • Mechanisms for information/referral to: ➢ Medical sub-specialties: Gastroenterology, Neurology, Psychiatry, Ophthalmology, Dermatology, Obstetrics and Gynecology and Dentistry ➢ Social work and case management services ➢ Mental health services ➢ Substance abuse treatment services ➢ Anti-retroviral counseling/therapy for pregnant women ➢ Local federally funded hemophilia treatment center for persons with inherited coagulopathies ➢ Clinical investigations	• Agency Policy and Procedure regarding continuity of care.
3.2	Continuity with Referring Providers Agency must have a formal policy for coordinating referrals for inpatient care and exchanging patient information with inpatient care providers.	• Review of Agency's Policies and Procedures Manual indicates compliance
3.3	Clients Referral and Tracking Agency receives referrals from a broad range of sources and makes appropriate referrals out when necessary. Agencies must implement tracking systems to	• Documentation of referrals out • Staff interviews indicate compliance • Established tracking systems

	identify clients who are out of care and/or need health screenings (e.g. Hepatitis b & c, cervical cancer screening, etc., for follow-up).	
3.4	Client Notification of Service Provider Turnover Client must be provided notice of assigned service primary care provider's cessation of employment within 30 days of the employee's departure.	• Documentation in patient record
3.5	Recommended Format for Operational Standards Detailed standards and routines for program assessment are found in most recent Joint Commission performance standards.	• Ambulatory HIV clinical service should adopt and follow performance standards for ambulatory care as established by the Joint Commission
3.6	Client Accommodation for Same Day Provider Cancellations Agency must have a policy in place that outlines a timeline for client notification of provider cancellations, and a protocol for how patients will be accommodated when they do not receive notification in advance of arriving to the clinic.	• Review of Agency's Policies and Procedures Manual indicates compliance
3.7	Client Prescription Refill Policy Agency must have a policy in place that details short term prescription refill availability in when office visit is not feasible prior to patient depletion of medication.	• Review of Agency's Policies and Procedures Manual indicates compliance

Substance Use Services

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

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

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

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

Transportation Services

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

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

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

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

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

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

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

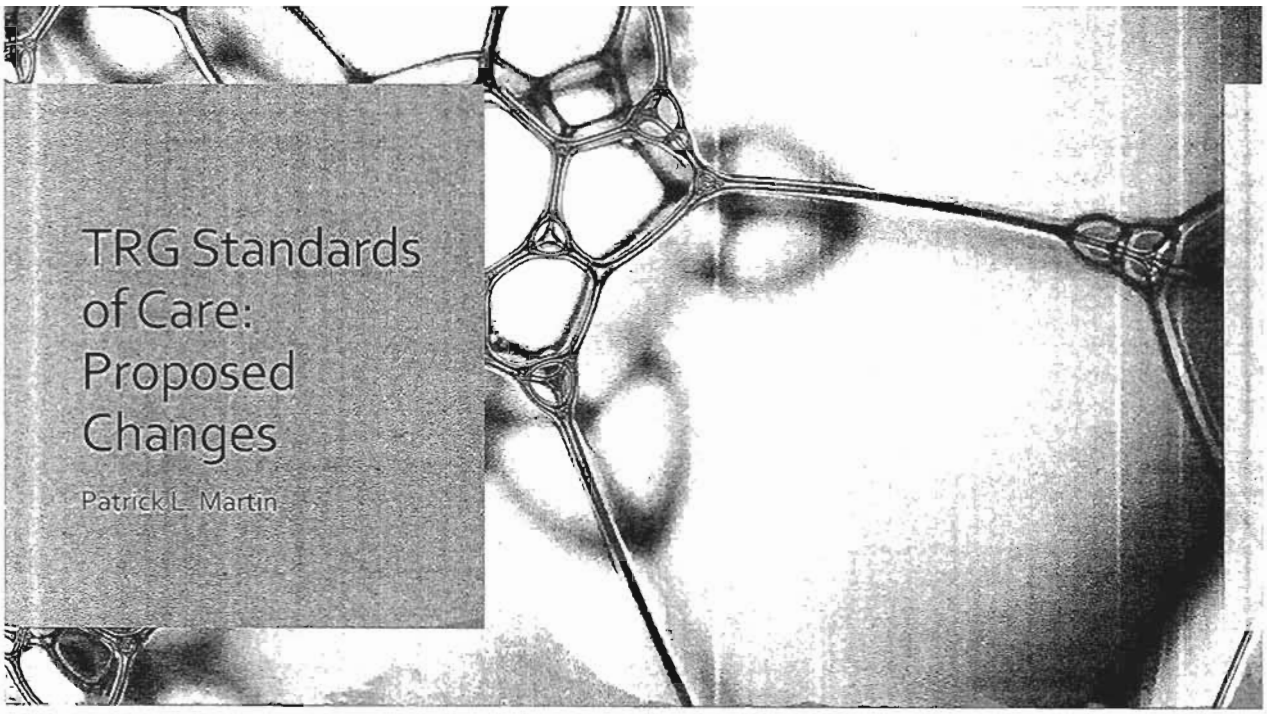
		• Log must contain driver's name, client's name or identification number, date, destinations, time of arrival, and type of appointment.
5.3	<u>Mileage Documentation</u> Agency must document the mileage between Trip Origin and Trip Destination (e.g. where client is transported to access eligible service)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

Vision Services

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

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

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



Today's Dialogue (Breakdown)

UNIFORM REVISION

EIS TO RFHC/IRR TRANSITION

SERVICE BY SERVICE REVIEW

Uniform Inserted Requirements

DSHS Updated Language

Language Accessibility Standard Insertion

2.6 Language Accessibility Language assistance must be provided to individuals who have limited English proficiency and/or other communication needs at no cost to them in order to facilitate timely access to all health care and services. Subrecipients must provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area to inform all individuals of the availability of language assistance services. All AAs and subrecipients must establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organizations' planning and operations.	▪ Language accessibility policies and documentation of training on policies are available for on-site review. ▪ Print and multimedia materials meet requirements.

1.7 Care Plan A written care plan is completed for each PLWH within seven (7) days of intake and updated at least every sixty (60) calendar days thereafter. Development of care plan incorporates a multidisciplinary team approach. The care plan will include: ▪ Current assessment and needs of the PLWH, including activities of daily living needs (personal hygiene care, basic assistance with cleaning, and cooking activities) ▪ Need for home and community-based health services ▪ Types, quantity, and length of time services are to be provided. ▪ Establish culturally and linguistically appropriate goals	▪ Completed care plan documented in the primary service record. ▪ Care plans updated documented in primary service record. ▪ Care plans completed and updated within established timeframes.

Care Plan / Treatment Plan/ Discharge Planning Standard Insertion Example

Early Intervention Services to Referral For Health Care Transition

Services Provided At Harris County Jail

Harris County Jail Medical Care Transition

- Earlier this year, Harris County Jail finally executed the contract with Harris Health System Correctional Health to provide healthcare to inmates in Harris County Jail.
  - Had been planned since before the pandemic.
- HCJ eliminated the EIS positions and terminated its direct contract with TRG.
- Contracts can not be transferred from one Subrecipient to another.
- TRG had to determine if the service needed to be competitively bid or sole sourced.
- Had to determine what services were unique and what was duplicative.

Stakeholder Meetings

- TRG met with various stakeholders that worked with the EIS Team in HCJ.
  - Assess the core functions of the EIS Team that were needed,
  - Incorporate the changes in the delivery of medical care,
  - Redesign the service to fit the need better, and
  - Find a HRSA-defined service category that better fit what was happening

What Is Referral For Health Care (RFHC)?

- HRSA Definition: Referral for Health Care and Support Services (RFHC) directs PLWH to needed core medical or support services in person or through telephone, written, or other type of communication. Activities provided under this service category may include referrals to assist HRSA Ryan White HIV/AIDS Program (RWHAP)-eligible PLWH to obtain access to other public or 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).

What Is RFHC targeting IRR?

- DSHS Definition: Referral for Health Care and Support Services includes benefits/entitlement counseling and referral to health care services to assist eligible PLWH to obtain access to other public and private programs for which they may be eligible.
- Benefits counseling: Services should facilitate PLWH's access to public/private health and disability benefits and programs. This service category works to maximize public funding by assisting PLWH in identifying all available health and disability benefits supported by funding streams other than RWHAP Part B and/or State Services funds. PLWH should be educated about and assisted with accessing and securing all available public and private benefits and entitlement programs.

What Is Referral For Health Care (RFHC)?

- RWHAP Part B and State Services funds can be used to provide transitional social services to establish or re-establish linkages to the community. Linking a soon-to-be-released inmate with primary care is an example of appropriate transitional social services.
- Transitional social services should NOT exceed 180 days. (Source: DSHS Policy 591.00 Limitations on Ryan White and State Service Funds for Incarcerated Persons in Community Facilities, Section 5.3).

What Is RFHC targeting IRR?

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

Local RFHC Targeting the IRR

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

Local RFHC Targeting the IRR

- Core Components (include but are not limited to)
  - Benefits Counseling (Assessment)
    - Screening for eligibility for healthcare coverage
    - Other community programs to resolve social determinants of health
  - Submission of expedited THMP applications through TCT
  - Referral to community partners and programs
  - Referral Education to ensure successful completion of referrals
  - Referral follow-up with community partners and programs to determine outcome of referral
  - Coordination of access to HCJ for community partners

Services By Service Review

Feedback and Comments

Home and Community Based Health Services

- Standard 1.7: Care Plan – Culturally and linguistically appropriate goals.
- Standard 2.6: Language Accessibility
- Both are DSHS revised language.

HCBHC Community Comments

- Definition of service provided.
- No questions/concerns raised.

Health Insurance Assistance

- Standard 2.7: Language Accessibility
- DSHS revised language

HIA Community Comments

- There were concerns about how lab bills were paid.
- There were questions about receiving or connecting to the service with or without case manager.
- There was a discussion that a PLWH could only access the service if the PLWH changed care to the facility with HIA.

Hospice Services

- Standard 1.5: Care Plan – Culturally and linguistically appropriate goals.
- Standard 2.9: Language Accessibility
- Both are DSHS revised language.

HS Community Comments

- Definition of service provided.
- No questions/concerns raised.

Linguistic Interpretive Services

- Standard 2.3: Language Accessibility
- DSHS revised language

LIS Community Comments

- No questions/concerns raised.

Mental Health Services

- Standard 1.3: Treatment Plan – Culturally and linguistically appropriate goals.
- Standard 2.10: Language Accessibility
- Both are DSHS revised language.

MHS Community Comments

- Question of how agencies outside of RW get funded to provide care to PLWH.
- Question about who is providing MHS in the service area.
- Discussion of PLWH wanting better access to MHS and how to promote MHS.

Non-Medical Case Management Targeting SUD Services

- Standard 1.3: Care Planning – Culturally and linguistically appropriate goals.
- Standard 2.8: Language Accessibility
- Both are DSHS revised language.

NMCM SUD Community Comments

- No questions/concerns raised.

Oral Health Care

- Standard 1.5: Treatment Plan – Culturally and linguistically appropriate goals.
- Standard 2.9: Language Accessibility
- Both are DSHS revised language.

OHC Community Comments

- There was concern about PLHW needing to understand getting bills in the mail.
- PLWH request better communication or education to understand the system and why they receive a bill.

Referral for Health Care: ADAP Enrollment

- Standards 1.1, 1.2, 1.3 – Culturally and linguistically appropriate provision of services and education
- Standard 1.7: ARIES Document Upload Process – Changed to TCT Electronic Application Process
- Standard 2.5: Language Accessibility

RFHC: AE Community Comments

- Group discussed the challenges of getting connected to ADAP.

Referral for Health Care: Incarcerated and Recently Released

- Service Definitions Updated to RFHC.
- Time Limitation for Service Provision Added.
- Discharge Planning Standards – Culturally and linguistically appropriate provision of services and education
- Standard 3.6 – Language Accessibility

RFHC: IRR Community Comments

- No questions/concerns raised.

Additional Written Comments Accepted through Noon on 11/4

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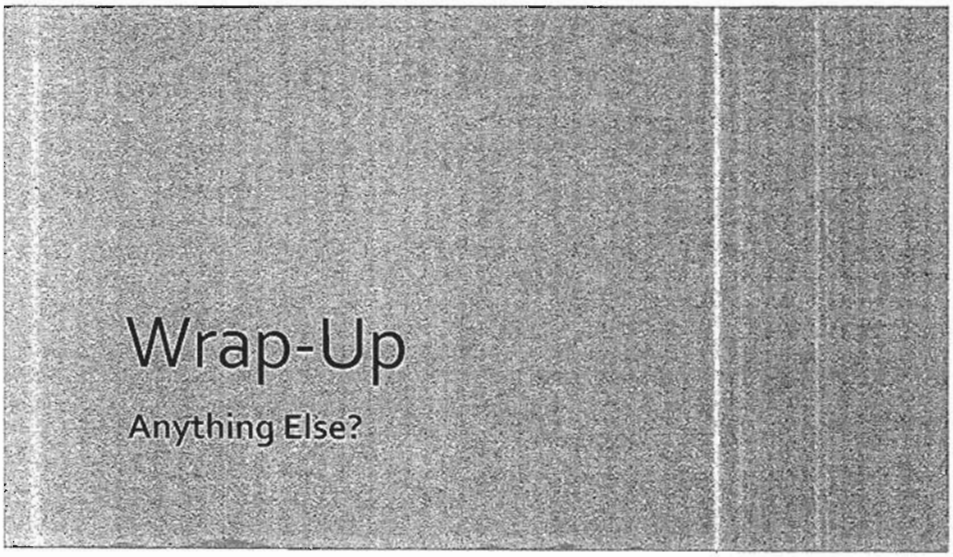
Wrap-Up
Anything Else?

RYAN WHITE PART B/DSHS STATE SERVICES
23-24 HOUSTON HSDA STANDARDS OF CARE
HEALTH INSURANCE ASSISTANCE

Effective Date: April 1, 2023/September 1, 2024

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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accountability, and infuse them throughout the organizations' planning and operations.	

References

- HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A April 2013. p. 33-36. Available at: https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringparta.pdf
- HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B April 2013. p. 31-35. Available at: https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringpartb.pdf
- HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Notices and Program Letters, Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) 16-02 (Revised 10/22/18). Available at: https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf
- HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Notices and Program Letters, Ryan White HIV/AIDS Program Services: Clarifications Regarding the use of Ryan White HIV/AIDS Program Funds for Health Care Coverage Premium and Cost Sharing Assistance Policy Clarification Notice (PCN) #18-01 (revised 08/30/2018). Available at: https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/18-01-use-of-rwhap-funds-for-premium-and-cost-sharing-assistance.pdf
- HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Notices and Program Letters, Policy Change Notice 14-01. Available at: https://hab.hrsa.gov/program-grants-management/policy-notices-and-program-letters
- HRSA/HAB, Ryan White Program & Grants Management, Recipient Resources. Policy Notices and Program Letters, Frequently Asked Questions (FAQ) for Standalone Dental Insurance. Available at: https://hab.hrsa.gov/sites/default/files/hab/program- grants-management/HAB_FAQs_on_Dental_Insurance.pdf
- Interim Guidance for the Use of Telemedicine and Telehealth for HIV Core and Support Services, March 2020. Available at: https://www.dshs.state.tx.us/hivstd/taxonomy/telemedguidance.shtm
- Interim Guidance for the Use of Telemedicine and Telehealth for HIV Core and Support Services – Users Guide and FAQs, March 2020. Available at: https://www.dshs.state.tx.us/hivstd/taxonomy/telemedguidance-faq.shtm
- TDSHS HIV/STD Ryan White Program Policies. DSHS Funds as Payment of Last Resort (Policy 590.001. Available at: http://www.dshs.texas.gov/hivstd/policy/policies.shtm

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RYAN WHITE PART B/DSHS STATE SERVICES
23-24 QUALITY ASSURANCE MEASURES
HEALTH INSURANCE ASSISTANCE

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

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RYAN WHITE PART B/DSHS STATE SERVICES
23-24 HOUSTON HSDA STANDARDS OF CARE
HOME AND COMMUNITY-BASED HEALTH SERVICES

Effective Date: April 1, 2023/September 1, 2023

HRSA Definition:
Home and Community-Based Health Services are provided to an eligible PLWH in an integrated setting appropriate to a PLWH'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,
- Home intravenous and aerosolized drug therapy (including prescription drugs administered as part of such therapy),
- Routine diagnostic testing, and
- Specialty care and vaccinations for hepatitis co-infection, provided by public and private entities.

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.

DSHS Definition:
Services: Home and Community-Based Health Services are therapeutic, nursing, supportive and/or compensatory health services provided by a licensed/certified home health agency in a licensed/certified home or community-based setting (e.g. adult daycare center) in accordance with a written, individualized plan of care established by a licensed physician. Home and Community-Based Health Services include the following:

- Para–professional care is the provision of services by a home health aide, personal caretaker, or attendant caretaker. This definition also includes non–medical, non–nursing assistance with cooking and cleaning activities to help PLWH remain in their homes.
- Professional care is the provision of services in the home by licensed providers for mental health, development health care, and/or rehabilitation services.

Home and Community-Based Health Providers work closely with the multidisciplinary care team that includes the case manager, primary care provider, and other appropriate health care professionals.

Local Definition:
Home and Community-based Health Services (facility-based) is defined as a day treatment program that includes Physician ordered therapeutic nursing, supportive and/or compensatory health services based on a written plan of care established by an interdisciplinary care team that includes appropriate healthcare professionals and paraprofessionals. Services include skilled nursing, nutritional counseling, evaluations and education, and additional therapeutic services and activities. Inpatient hospitals services, nursing home and other long-term care facilities are not included.

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Scope of Services:
Community-Based Health Services are designed to support the increased functioning and the return to self-sufficiency of PLWH through the provision of treatment and activities of daily living. Services will be available at least Monday through Friday for a minimum of 10 hours/day. Services must include:

- **Skilled Nursing** including medication administration, medication supervision, medication ordering, filling pill box, wound dressing changes, straight catheter insertion, education of family/significant others in patient care techniques, ongoing monitoring of patients' physical condition and communication with attending physician(s), personal care, and diagnostics testing,
- **Other Therapeutic Services** including recreational activities (fine/gross motor skills and cognitive development), replacement of durable medical equipment, information referral, peer support, and transportation,
- **Nutrition** including evaluation and counseling, supplemental nutrition, and daily nutritious meals, and
- **Education** including instructional workshops of HIV related topics and life skills.

Standard	Evidence
Program	
1.1 Doctor's Orders Community-based Health Services must be provided in accordance with doctor's orders. As part of the intake process, doctor's orders must be obtained to guide service provision to the PLWH.	• Doctor's order documented in the primary service record.
1.2 Refusal of Referral The home or community-based health service agency may refuse a referral for the following reasons only: • Based on the agency's perception of the PLWH's condition, the PLWH requires a higher level of care than would be considered reasonable in a home/community setting. • The agency has attempted to complete an initial assessment and the referred PLWH has been away from home on three occasions. • The home or current residence is determined to not be physically safe (if not residing in a community facility) before services can be offered or continued. The agency must document the situation in writing and immediately contact the PLWH's primary medical care provider.	• Refusal of referral documented in the primary service record. • Reason for refusal meets established criteria. • Primary medical care provider notification documented.
1.3 Initial Assessment A preliminary assessment will be conducted that includes services needed, perceived barriers to accessing services and/or medical care. PLWH will be contacted within one (1) business day of the referral, and services should be initiated at the	• Initial contact documented in the primary service record. • Initial contact attempted within established timeframe. • Completed initial assessment documented in the primary service record.

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time specified by the primary medical care provider, or within two (2) business days, whichever is earlier.	
1.4 Comprehensive Assessment A comprehensive PLWH assessment, including nursing, therapeutic, and educational is completed for each PLWH within seven (7) days of intake and every six (6) months thereafter. A measure of PLWH acuity will be incorporated into the assessment tool to track PLWH's increased functioning. A comprehensive evaluation of the PLWH's health, psychosocial status, functional status, and home environment should be completed to include: • Assessment of PLWH's access to primary care, adherence to therapies, disease progression, symptom management and prevention, and need for skilled nursing or rehabilitation services. • Information to determine PLWH's ability to perform activities of daily living and the level of attendant care assistance the PLWH needs to maintain living independently.	• Completed comprehensive assessment documented in the primary service record. • Comprehensive assessment completed within established timeframe. • Acuity level documented in comprehensive assessment.
1.5 Nutritional Evaluation Each PLWH shall receive a nutritional evaluation within fifteen (15) days of initiation of care. Nutritional evaluation updated as necessary.	• Nutritional evaluation documented in primary services record. • Nutritional evaluation updates documented in the primary service record. • Nutritional evaluation completed within established timeframes.
1.6 Meal Plans Staff will maintain signed and approved meal plans.	• Written documentation of plans is on file and posted in serving area.
1.7 Care Plan A written care plan is completed for each PLWH within seven (7) days of intake and updated at least every sixty (60) calendar days thereafter. Development of care plan incorporates a multidisciplinary team approach. The care plan will include: • Current assessment and needs of the PLWH, including activities of daily living needs (personal hygiene care, basic assistance with cleaning, and cooking activities) • Need for home and community-based health services • Types, quantity, and length of time services are to be provided. • Establish culturally and linguistically appropriate goals	• Completed care plan documented in the primary service record. • Care plans updated documented in primary service record. • Care plan completed and updated within established timeframes.

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1.8 Implementation of Care Plan In coordination with the medical care coordination team, professional staff will: • Provide nursing and rehabilitation therapy care under the supervision and orders of the PLWH's primary medical care provider. • Monitor the progress of the care plan by reviewing it regularly with the PLWH and revising it as necessary based on any changes in the PLWH's situation. • Advocate for the PLWH when necessary (e.g., advocating for the PLWH with a service agency to assist the PLWH in receiving necessary services). • Monitor changes in PLWH's physical and mental health, and level of functionality. • Work closely with PLWH's other health care providers and other members of the care team in order to effectively communicate and address PLWH service-related needs, challenges, and barriers. • Participate in the development of individualized care plan with members of the care team. • Participate in regularly scheduled case conferences that involve the multidisciplinary team and other service providers as appropriate. • Provide attendant care services which include taking vital signs if medically indicated • Assist with PLWH's self-administration of medication. • Promptly report any problems or questions regarding the PLWH's adherence to medication. • Report any changes in the PLWH's condition and needs.	• Service provision consistent with the care plan documented in the primary service record.
1.9 Provision of Service/Progress Notes Provides assurance that the services are provided in accordance with allowable modalities and locations under the definition of home and community-based health services. • Progress notes will be kept in the primary service record and must be written the day services are rendered. • Progress notes will then be entered into the PLWH record within (14) working days. • The agency will maintain ongoing communication with the multidisciplinary medical care team in compliance with Texas Medicaid and Medicare Guidelines.	• Completed progress notes documented in the primary service record. • Ongoing communication with primary medical care provider and care coordination team documented in the primary service record.

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The Home and Community-Based Provider will document in the primary service record progress notes throughout the course of the treatment, including evidence that the PLWH is not in need of acute care.	
1.10 Coordination of Services/Referrals If referrals are appropriate or deemed necessary, the agency will: • Ensure that service for PLWH will be provided in cooperation and in collaboration with other agency services and other community HIV service providers to avoid duplication of efforts and encouraging PLWH access to integrated health care. • Consistently report referral and coordination updates to the multidisciplinary medical care team. • Assist PLWH in making informed decisions on choices of available service providers and resources.	• Referrals to other services (as applicable) documented in the primary service record. • Referral follow-up documented in the primary service record. • Multidisciplinary team coordination documented in the primary service record.
1.11 Completion of Services/Discharge Services will end when one or more of the following takes place: • PLWH acuity indicates self-sufficiency and care plan goals completed, • PLWH expresses desire to discontinue/transfer services, • PLWH is not seen for ninety (90) days or more, • PLWH has been referred on to a higher level of care (such as assisted living or skilled nursing facility), • PLWH is unable or unwilling to adhere to agency policies, • PLWH relocates out of the service delivery area, and • When applicable, an employee of the agency has experienced a real or perceived threat to his/her safety during a visit to a PLWH's home, in the company of an escort or not. The agency may discontinue services or refuse the PLWH for as long as the threat is ongoing. Any assaults, verbal or physical, must be reported to the monitoring entity within one (1) business day and followed by a written report. A copy of the police report is sufficient, if applicable. All services discontinued under above circumstances (if applicable) must be accompanied by a referral to an appropriate service provider agency.	• Discharge documented in the primary service record. • Discharge/Transfer plan developed with PLWH documented in the primary service record, if applicable.

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Administrative	
2.1 Program Policies and/or Procedures Agency will develop and maintain policies and/or procedures that outline the delivery of service including, but not limited to, the marketing of the service to applicable community stakeholders and process of utilizing the HCBHS service. Agency will disseminate policies and/or procedures to providers seeking to utilize the service. Additionally, the agency will have policies and procedures that comply with applicable DSHS Universal Standards	• Program's Policies and Procedures document systems to comply with: ▪ DSHS Universal Standards ▪ TRG Contract and Attachments ▪ Standards of Care ▪ Collection of Performance Measures
2.2 Facility Licensure Agency must be licensed by the Texas Department of Aging and Disability Services (DADS) as an Adult Day Care provider. Agency maintains other certification for facilities and personnel, if applicable. Services are provided in accordance with Texas State regulations.	• License and/or certification available at the site(s) where services are provided. • License and/or certification posted in a highly visible place at site(s) where services are provided.
2.3 Services Requiring Licensed Personnel All services requiring licensed personnel shall be provided by Registered Nurses/Licensed Vocational Nurses or appropriate licensed personnel in accordance with State of Texas regulations. Other Therapeutic Services are provided by paraprofessionals, such as an activities coordinator, and counselors (LPC, LMSW, LMFTA). Nutritional Services are provided by a Registered Dietician and food managers. Education Services are provided by a health educator.	• License documented in the personnel file. • Staff interviews document compliance.
2.4 Staff Qualifications All personnel providing care shall have (or receive training) in the following minimum qualifications: • Ability to work with diverse populations in a non-judgmental way • Working knowledge of: ➢ HIV and its diverse manifestations ➢ HIV transmission and effective methods of reducing transmission ➢ current treatment modalities for HIV and co-morbidities ➢ HIV/AIDS continuum of care ➢ diverse learning and teaching styles ➢ the impacts of mental illness and substance use on behaviors and adherence to treatment ➢ crisis intervention skills	• Assessment of staff qualifications documented in personnel file. • Exceptions documented in personnel file. • Training to increase staff qualifications documented in personnel file.

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➢ the use of individualized plans of care in the provision of services and achievement of goals • Effective crisis management skills • Effective assessment skills	
2.5 Billing Requirement/Payment of Last Resort Home and Community Based Home Health agency must be able to bill Medicare, Medicaid, private insurance and/or other third-party payer sources.	• Third-Party payer screening documented in the primary service record. • Evidence of third-party billing
2.6 Language Accessibility Language assistance must be provided to individuals who have limited English proficiency and/or other communication needs at no cost to them in order to facilitate timely access to all health care and services. Subrecipients must provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area to inform all individuals of the availability of language assistance services. All AAs and subrecipients must establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organizations' planning and operations.	• Language accessibility policies and documentation of training on policies are available for on-site review. • Print and multimedia materials meet requirements.

References

- HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A April 2013, p. 14-16. Accessed on October 12, 2020 at: https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringparta.pdf
- HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B April 2013, p. 13-15. Accessed October 12, 2020 at: https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringpartb.pdf
- Massachusetts Department of Public Health Bureau of Infectious Disease Office of HIV/AIDS Standards of Care for HIV/AIDS Services 2009
- San Francisco EMA Home-Based Home Health Care Standards of Care February 2004
- Texas Administrative Code, Title 40, Part 1, Chapter 97, Subchapter B, Rule 97.211
- HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Notices and Program Letters, Policy Clarification Notice 16-02, https://hab.hrsa.gov/program-grants-management/policy-notices-and-program-letters Accessed on October 16, 2020.

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RYAN WHITE PART B/DSHS STATE SERVICES
23 -24 QUALITY ASSURANCE MEASURES
HOME AND COMMUNITY-BASED HEALTH SERVICES

1. Percentage of PLWH with documented evidence of agency refusal of services with detail on refusal in the primary service record **and** if applicable, documented evidence that a referral is provided for another home or community-based health agency.
2. Percentage of PLWH with documented evidence of needs assessment completed in the primary service record.
3. Percentage of PLWH with documented evidence of a comprehensive evaluation completed by the Home and Community-Based Health Agency Provider in the primary service record.
4. Percentage of PLWH with documented evidence of a care plan completed based on the primary medical care provider's order as indicated in the primary service record.
5. Percentage of PLWH with documented evidence of care plans reviewed and/or updated as necessary based on changes in the PLWH's situation at least every sixty (60) calendar days as evidenced in the primary service record.
6. Percentage of PLWH with documented evidence of completed progress notes in the primary service record.
7. Percentage of PLWH with documented evidence of ongoing communication with the primary medical care provider and care coordination team as indicated in the primary service record.
8. Percentage of PLWH accessing Home and Community-Based Health Services with documented evidence of referrals, as applicable, to other services as indicated in the primary service record.
9. Percentage of PLWH accessing Home and Community-Based Health Services have follow up documentation to the referral offered in the primary service record.
10. Percentage of PLWH with documented evidence, as applicable, of a transfer plan developed and documented with referral to an appropriate service provider agency as indicated in the primary service record.
11. Percentage of PLWH with documented evidence of a discharge plan developed with PLWH, as applicable, as indicated in the primary service record.

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RYAN WHITE PART B/DSHS STATE SERVICES
23-24 HOUSTON HSDA STANDARDS OF CARE
HOSPICE SERVICES

Effective Date: April 1, 2023/September 1, 2024

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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2.2 Services Requiring Licensed Personnel All services requiring licensed personnel shall be provided by appropriate licensed personnel in accordance with State of Texas regulations. Hospice services must be provided under the delegation of an attending physician and/or registered nurse.	• License documented in the personnel file. • Staff interviews document compliance.
2.3 Staff Education Agency shall employ staff who are trained and experienced in their area of practice and remain current in end of life issues as it relates to HIV. Staff shall maintain knowledge of psychosocial and end of life issues that may impact the needs of PLWH. Agency provides access to training activities, including but not limited to: • Updated HIV information, including current treatment methodologies and promising practices • In-service education • DSHS-sponsored trainings	• Agency documents the dissemination of HIV information and training activities relevant to the needs of PLWH to paid staff and volunteers. • Agency documents attendance at training activities. • Materials for training activities (agendas, handouts, etc.) are on file.
2.4 Ongoing Staff Training • Eight (8) hours of training in HIV and clinically related issues is required annually for licensed staff • One (1) hour of training in HIV/AIDS is required annually for all other staff.	• Completion of training requirements documented in personnel file • Materials for training and continuing education (agendas, handouts, etc.) are on file.
2.5 Staff Experience A minimum of one-year documented hospice and/or HIV work experience is preferred	• Work experience documented in personnel file with exceptions to work experience noted.
2.6 Staff Supervision Staff services are supervised by a paid coordinator or manager. Professional supervision shall be provided by a practitioner with at least two years' experience in hospice care of persons with HIV. All licensed personnel shall receive supervision consistent with the State of Texas licensure requirements. Supervisory, provider or advanced practice registered nurses will document supervision over other staff members	• Work experience for professional supervisory providers documented in personnel file. • Supervision consistent with licensure documented. • Supervision of other staff members by supervisory provider or advanced practice registered nurse documented.
2.7 Volunteer Assistance Volunteers cannot be used to substitute for required personnel. They may however provide	• Policy and/or procedure documents duties and activities conducted by volunteers and oversight.

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companionship and emotional/spiritual support to patients in hospice care. Volunteers providing patient care will: • Be provided with clearly defined roles and written job descriptions • Conform to policies and procedures	• Signed job descriptions documented in volunteer file. • Service provision by volunteers are documented in the primary service record.
2.8 Volunteer Training Volunteers may be recruited, screened, and trained in accordance with all applicable laws and guidelines. Unlicensed volunteers must have the appropriate State of Texas required training and orientation prior to providing direct patient care. Volunteer training must also address program-specific elements of hospice care and HIV. For volunteers who are licensed practitioners, training addresses documentation practices	• Trainings and education documented in volunteer file.
2.9 Language Accessibility Language assistance must be provided to individuals who have limited English proficiency and/or other communication needs at no cost to them in order to facilitate timely access to all health care and services. Subrecipients must provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area to inform all individuals of the availability of language assistance services. All AAs and subrecipients must establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organizations' planning and operations.	• Language accessibility policies and documentation of training on policies are available for on-site review. • Print and multimedia materials meet requirements.

References

- HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A April 2013, p. 16-18. Accessed on October 12, 2020 at: https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringparta.pdf
- HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B April 2013, p. 15-17. Accessed October 12, 2020 at: https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringpartb.pdf
- Texas Administrative code Title 40; Part 1; Chapter 97, Subchapter H Standards Specific to Agencies Licensed to Provide Hospice Services located at: https://hhs.texas.gov/laws-

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regulations/handbooks/texas-medicaid-hospice-program-standards-handbook/mhps- title-40-texas-administrative-code-chapter-30

- Texas Department of Aging and Disability Services Texas Medicaid Hospice Program Standards Handbook. Located at http://hhs.texas.gov/laws-regulations/handbooks/texas-medicaid-hospice-program-standards-handbook
- HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Notices and Program Letters, Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02 (Revised 10/22/18), https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf

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RYAN WHITE PART B/DSHS STATE SERVICES
23-24 QUALITY ASSURANCE MEASURES
HOSPICE SERVICES

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

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RYAN WHITE PART B/DSHS STATE SERVICES
23-24 HOUSTON HSDA STANDARDS OF CARE
LINGUISTIC INTERPRETIVE SERVICES

Effective Date: April 1, 2023/September 1, 2024

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

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

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

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

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

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

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

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

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

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

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

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

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Program will deliver services to the PLWH only to the extent that similar services are not available from another source (such as a translator employed by the clinic). This excludes use of family members of friends of the PLWH. Based on need, agency shall provide the following types of linguistic services in the PLWH's preferred language: • Oral interpretation • Written translation • Sign language	
1.2 Timeliness of Scheduling Program will schedule service within one (1) business day of the request.	• Request date documented. • Scheduling of service documented.
Administrative	

2.1 Program Policies and/or Procedures
Agency will develop and maintain policies and/or procedures that outline the delivery of service including, but not limited to, the marketing of the service to applicable community stakeholders, the scheduling of interpreters and process of utilizing the service. Agency will disseminate policies and/or procedures to providers seeking to utilize the service.
 	
Agency should have the ability to provide (or make arrangements for the provision of) translation services regardless of the language of the PLWH seeking assistance
 	
Agency will be able to provide interpretation/ translation in the languages needed based on the needs assessment for the area.
 	
Additionally, the agency will have policies and procedures that comply with applicable DSHS Universal Standards
	• Program's Policies and Procedures document systems to comply with:
	  • DSHS Universal Standards
	  • TRG contract and Attachments
	  • Standards of Care
	  • Collection of Performance Measures

2.2 Staff Qualifications and Training To ensure highest quality of communication: • Oral and written translators will be certified by the Certification Commission for Healthcare Interpreters (CCHI) or the National Board of	• Program Policies and Procedures will ensure the contracted agency complies with Legislation and Regulations: • (Americans with Disabilities Act (ADA), Section 504 of the

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Certification for Medical Interpreters (NBCMI). Where CCHI and NBCMI certification for a specific language do not exist, an equivalent certification (MasterWord, etc.) may be substituted for the CCHI and NBCMI certification. • Staff and volunteers who provide American Sign Language services must hold a certification from the Board of Evaluation of Interpreters (BEI), the Registry of Interpreters for the Deaf (RID), the National Interpreter Certification (NIC), or the State of Texas at a level recommended by the Texas Department of Assistive and Rehabilitative Services (DARS) Office for Deaf and Hard of Hearing Services. • Interpreter staff/agency will be trained and experienced in the health care setting.	Rehabilitation Act, Title VI of Civil Rights Act, Health Information Portability and Accountability Act (HIPAA), Health Information Technology for Economic and Clinical Health Act • Agency contracts with companies that maintain certified ASL interpreters on staff. • Agency scheduling documents appropriate levels of interpreters are requested.
2.6 Language Accessibility Language assistance must be provided to individuals who have limited English proficiency and/or other communication needs at no cost to them in order to facilitate timely access to all health care and services. Subrecipients must provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area to inform all individuals of the availability of language assistance services. All AAs and subrecipients must establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organizations' planning and operations.	• Language accessibility policies and documentation of training on policies are available for on-site review. • Print and multimedia materials meet requirements.

References

- HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A April 2013, p. 37-38. Accessed on October 12, 2020 at: https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringparta.pdf
- HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B April 2013, p. 37-38. Accessed October 12, 2020 at: https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringpartb.pdf

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- Title VI of the Civil Rights Act of 1964 with respect to individuals with limited English proficiency (LEP). Located at: http://www.hhs.gov/ocr/civilrights/resources/laws/summaryguidance.html
- HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Notices and Program Letters, Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02 (Revised 10/22/18), https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf
- Interim Guidance for the Use of Telemedicine and Telehealth for HIV Core and Support Services, March 2020. Available at: https://www.dshs.state.tx.us/hivstd/taxonomy/telemedguidance.shtm
- Interim Guidance for the Use of Telemedicine and Telehealth for HIV Core and Support Services – Users Guide and FAQs, March 2020. Available at: https://www.dshs.state.tx.us/hivstd/taxonomy/telemedguidance-faq.shtm
- National Culturally and Linguistically Appropriate Services (CLAS) Standards: https://thinkculturalhealth.hhs.gov/clas/standards

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RYAN WHITE PART B/DSHS STATE SERVICES
23 -24 QUALITY ASSURANCE MEASURES
LINGUISTIC INTERPRETIVE SERVICES

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

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RYAN WHITE PART B/DSHS STATE SERVICES
23-24 HOUSTON HSDA STANDARDS OF CARE
MENTAL HEALTH SERVICES

Effective Date: April 1, 2023/September 1, 2024

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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2.7 Substance Abuse Assessment Training Professional counselors must receive training in assessment of substance abuse with capacity to make appropriate referrals to licensed substance abuse treatment programs as indicated within 60 days of start of contract or hire date.	• Assessment documented in personnel file. • Training per assessment documented in personnel file.
2.8 Professional Liability Insurance Professional liability coverage of at least $300,000 for the individual or $1,000,000 for the agency is required.	• Professional Liability Insurance documented. • Annual Reviews documents compliance.
2.9 Clinical Supervision A minimum of bi-weekly supervision is provided to counselors licensed less than three years. A minimum of monthly supervision is provided to counselors licensed three years or more.	• Agency policy documents clinical supervision provided to staff. • Supervision of staff documented.
2.10 Language Accessibility Language assistance must be provided to individuals who have limited English proficiency and/or other communication needs at no cost to them in order to facilitate timely access to all health care and services. Subrecipients must provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area to inform all individuals of the availability of language assistance services. All AAs and subrecipients must establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organizations' planning and operations.	• Language accessibility policies and documentation of training on policies are available for on-site review. • Print and multimedia materials meet requirements.

References

- American Psychiatric Association. The Practice Guideline for Treatment of Patients with HIV/AIDS, Washington, DC, 2001. Available at: https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/hivaids.pdf
- American Psychiatric Association. Guideline Watch: Practice Guideline for the Treatment of Patients with HIV/AIDS, Washington, DC, 2006. Available at: https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/hivaids-watch.pdf
- HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A April 2013. p. 17-18. Available at: https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringparta.pdf
- HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B April 2013. p. 17-18. Available at: https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringpartb.pdf

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- HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Notices and Program Letters, Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02 (Revised 10/22/18). Available at: https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf
- Interim Guidance for the Use of Telemedicine and Telehealth for HIV Core and Support Services, March 2020. Available at: https://www.dshs.state.tx.us/hivstd/taxonomy/telemedguidance.shtm
- Interim Guidance for the Use of Telemedicine and Telehealth for HIV Core and Support Services – Users Guide and FAQs, March 2020. Available at: https://www.dshs.state.tx.us/hivstd/taxonomy/telemedguidance-faq.shtm
- New York State Department of Health, Mental Health Standards of Care, Delivery of Care. Available at: https://www.health.ny.gov/diseases/aids/providers/standards/mental_health/delivery_of_care.htm

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RYAN WHITE PART B/DSHS STATE SERVICES
23-24 QUALITY ASSURANCE MEASURES
MENTAL HEALTH SERVICES

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

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RYAN WHITE PART B/DSHS STATE SERVICES
23-24 HOUSTON HSDA STANDARDS OF CARE
NON-MEDICAL CASE MANAGEMENT TARGETING
SUBSTANCE USE DISORDERS

Effective Date: April 1, 2023/September 1, 2024

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

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

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

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

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

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

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

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

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

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

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

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

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

Key activities include:

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

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

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

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

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

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

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

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

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

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

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

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

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

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planning and operations.	

References:

- HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A April 2013. P. 25-26. Available at: https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringparta.pdf
- HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B April 2013. P. 24-26. Available at: https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringpartb.pdf
- HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Notices and Program Letters, Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02 (Revised 10/22/18), https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf
- Interim Guidance for the Use of Telemedicine and Telehealth for HIV Core and Support Services, March 2020. Available at: https://www.dshs.state.tx.us/hivstd/taxonomy/telemedguidance.shtm

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

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

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RYAN WHITE PART B/DSHS STATE SERVICES
23-24 HOUSTON HSDA STANDARDS OF CARE
ORAL HEALTH CARE

Effective Date: April 1, 2023/September 1, 2024

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

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

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

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

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

Limitations: Cosmetic dentistry for cosmetic purposes only is prohibited.

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

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

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

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

Limitations:
Cosmetic dentistry for cosmetic purposes only is prohibited.

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

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

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

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

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

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

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

2.2 Services Requiring Licensed Personnel	• License documented in the personnel file.

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

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All AAs and subrecipients must establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organizations' planning and operations.	

References

- HRSA/HAB Division of Service Systems Program Monitoring Standards – Part A April 2011, page 9-10. Accessed on October 12, 2020 at: https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringparta.pdf
- HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B April 2013, page 9-10. Accessed October 12, 2020 at: https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringpartb.pdf
- Texas Administrative Code. Title 22, Part 5 State Board of Dental Examiners. Chapter 108, Subchapter A, Rule §108.7 Minimal Standards of Care, General located at https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=22&pt=5&ch=108&rl=7
- Texas Administrative Code. Title 22, Part 5, State Board of Dental Examiners, Chapter 108, Subchapter A, Rule §108.8, Records of the Dentist located at: https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=22&pt=5&ch=108&rl=8
- Texas Health and Safety Code, Title 2, Subtitle D, Chapter 85. Acquired Immune Deficiency Syndrome and Human Immunodeficiency Virus Infection, located at https://statutes.capitol.texas.gov/Docs/HS/htm/HS.85.htm
- HRSA/HAB Clinical Care & Quality Management. HAB Oral Health Performance Measures located at https://hab.hrsa.gov/clinical-quality-management/performance-measure-portfolio Accessed January 11, 2018.
- HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Notices and Program Letters, Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02 (Revised 10/22/18), https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf
- New York State Department of Health AIDS Institute, Management of Periodontal Disease located at: https://www.hivguidelines.org/hiv-care/hiv-related-periodontal-disease/ Accessed October 14, 2020
- New York State Department of Health AIDS Institute, Oral Health Complications located at: https://www.hivguidelines.org/hiv-care/oral-health/. Accessed October 14, 2020
- HB2056: https://capitol.texas.gov/BillLookup/History.aspx?LegSess=87R&Bill=HB2056

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RYAN WHITE PART B/DSHS STATE SERVICES
22-23 QUALITY ASSURANCE MEASURES
ORAL HEALTH CARE

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

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RYAN WHITE PART B/DSHS STATE SERVICES
23-24 HOUSTON HSDA STANDARDS OF CARE
REFERRAL FOR HEALTH CARE
ADAP ENROLLMENT WORKERS

Effective Date: April 1, 2023/September 1, 2023

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

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

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

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

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

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

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

Local Definition:
AIDS Drug Assistance Program (ADAP) Enrollment Workers (AEWs) are co-located at Ryan-White funded clinics to ensure the efficient and accurate submission of ADAP applications to the Texas HIV Medication Program (THMP). AEWs will meet with all potential ADAP enrollees to explain ADAP program benefits and requirements and assist PLWHs with the submission of complete and accurate ADAP applications. AEWs will ensure benefits continuation through timely completion of annual re-certifications by the last day of the PLWH's birth month and attestations six months later to ensure there is no lapse in ADAP eligibility and/or loss of benefits. Other responsibilities will include:

- Track the ADAP application process to ensure submitted applications are processed as quick as possible, including prompt follow-up on pending applications to gather missing or questioned documentation as needed.
- Maintain ongoing communication with designated THMP staff to aid in resolution of PLWH inquires and questioned applications; and to ensure any issues affecting pending applications and/or PLWHs are mediated as quickly as possible.

AIDS Drug Assistance Program (ADAP) Enrollment Workers will be co-located at Ryan-White Part A funded primary care providers to ensure the efficient and accurate submission of ADAP applications to the Texas HIV Medication Program (THMP). AEWs must maintain relationships with the Ryan White ADAP Network (RWAN).

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

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

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

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Standard	Evidence
Program	
1.1 Provision of Service Staff will educate PLWH about available benefit programs, assess eligibility, assist with applications, provide advocacy with appeals and denials, assist with re-certifications and provide advocacy in other areas relevant to maintaining benefits/resources. ADAP Enrollment Workers (AEW) will meet with new potential and established ADAP enrollees to: 1. Explain ADAP program benefits and requirements 2. Assist PLWH and or staff with the submission of complete, accurate ADAP applications 3. Ensure there is no lapse in ADAP eligibility and loss of benefits, and 4. AEW will maintain relationships through the Ryan White ADAP Network (RWAN)	• Provision of service per established criteria documented in the primary service record.
1.2 Initial Provision of Education The initial education to PLWH regarding the THMP process should include, but not limited to: • Discussion of confidentiality, specific to the THMP process including that THMP regards all information in the application as confidential and the information cannot be released, except as allowed by law or as specifically designated by the PLWH. • Applicants should realize that their physician and pharmacist would also be aware of their diagnosis. • Discussion outlining that approved medication assistance through THMP may require a $5.00 co-payment fee per prescription to the participating pharmacy for each month's supply at the time the drug is dispensed and the availability of financial assistance for the dispensing fee. • Discussion outlining the recertification process, specific to THMP eligibility, including birth month recertification, half-birth month attestation and consequences of lapse.	• Initial education per established criteria documented in the primary service record. • Exceptions documented in the primary service record.
1.3 Benefits Counseling Activities should be individualized to the PLWH and facilitate access to and maintenance of health and disability benefits and services. It is the primary responsibility of staff to ensure PLWH are receiving all needed public	• Benefits counseling documented in the primary service record. • Completed applications as appropriate and per established timeframe documented in the primary service record.

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and/or private benefits and/or resources for which they are eligible. Staff will explore the following as possible options for PLWH, as appropriate: • AIDS Drug Assistance Program (ADAP) • Health Insurance Plans/Payment Options (CARE/HIPP, COBRA, OBRA, Health Insurance Assistance (HIA), Medicaid, Medicare, Private, ACA/ Marketplace) • SNAP • Pharmaceutical Patient Assistance Programs (PAPS) • Social Security Programs (SSI, SSDI, SDI) • Temporary Aid to Needy Families (TANF) • Veteran's Administration Benefits (VA) • Women, Infants and Children (WIC) • Other public/private benefits programs • Other professional services Staff will assist eligible PLWH with completion of benefits application(s) as appropriate within fourteen (14) business days of the eligibility determination date. Conduct a follow-up within ninety (90) days of completed application to determine if additional and/or ongoing needs are present.	• Follow-up per established timeframe and result(s) of application documented in the primary service record. • Exceptions documented in the primary service record.
<u>1.4 Healthcare Services</u> PLWH should be provided assistance in accessing health insurance or Marketplace plans to assist with engagement in the health care system and HIV Continuum of Care, including medication payment plans or programs. • Eligible PLWH will be referred to Health Insurance Premium and Cost-Sharing Assistance (HIA) to assist PLWH in accessing health insurance or Marketplace plans within one (1) week of the referral for health care and support services intake. Eligible PLWH should be referred to other core services (outside of a medical, MCM, or NMCM appointment), as applicable to the PLWH's needs, with education provided to the PLWH on how to access these services. • Eligible PLWH are referred to additional support services (outside of a medical, MCM, NMCM appointment), as applicable to the PLWH's needs, with education provided to the PLWH on how to access these services.	• Assistance accessing healthcare documented in the primary service record. • Referral education on how to access the service documented in the primary service record. • Follow-up for referrals per established timeframe documented in the primary service record. • Exceptions documented in the primary service record.

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Staff will follow-up within (10) business days of an applicable referral provided to HIA, any core or support service to ensure the PLWH accessed the service(s).	
1.5 THMP Intake Process Staff are expected to meet with new/potential PLWH to complete a comprehensive THMP intake including explanation of program benefits and requirements. The intake will also include the determination of PLWH eligibility for the ADAP program in accordance with the THMP eligibility policies including Modified Adjusted Gross Income (MAGI). Staff should identify and screen PLWH for third party payer and potential abuse Staff should obtain, maintain, and submit the required documentation for PLWH application including residency, income, and the THMP Medical Certification Form (MCF).	• THMP education to new/potential PLWH documented in the primary service record. • Completed THMP application and supporting documentation (including proof of residency, income and MCF) documented in the primary service record.
1.6 Benefits Continuation Process (ADAP) ADAP Enrollment Workers are expected to meet with new/potential and established ADAP enrollees; explain ADAP program benefits and requirements; and assist PLWH and or staff with the submission of complete, accurate ADAP applications. Birth Month/Recertification • Staff should conduct annual recertifications for enrolled PLWH in accordance with THMP policies. Recertification should include completion of the ADAP application, obtaining and verifying all eligibility documentation and timely submission to THMP for approval. • Recertification process should include screening PLWH for third party payer to avoid potential abuse. • Complete ADAP application includes proof of residency, proof of income, and the THMP Medical Certification Form (MCF). • Staff must ensure Birth Month/Recertifications are submitted by the last day of PLWH's birth month to ensure no lapse in program benefits. • Proactively contact ADAP enrollees 60-90 days prior to the enrollee's recertification deadline to ensure all	• Attempts to contact PLWH for attestations and recertifications per established timeframe documented in the primary service record. • Completed attestations and recertifications documented in the primary service record. • Lapse benefits due to non-completion of timely recertification/attestation documented in the primary service record. • Exceptions documented in the primary service record.

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necessary documentation is collected and accurate to complete the recertification process on or before the deadline. Half-Birth Month/6-month Self Attestation • Staff should conduct a 6-month half-birth month/self-attestation for all enrolled PLWH in accordance with THMP policies. Staff will obtain and submit the PLWH's self-attestation with any applicable updated eligibility documentation. • Proactively contact ADAP enrollees 60-90 days prior to the enrollee's attestation deadline to ensure all necessary documentation is collected and accurate to complete the attestation on or before the deadline. Half-birth/6-month self-attestations must be submitted by the last day of the PLWH's half-birth month to ensure no lapse in program benefits	
<u>1.7 TCT Application Process</u> The TakeChargeTexas (TCT) Application Process is the uniform practice for submission and approval of ADAP applications (with supportive documentation). This process ensures accurate submission and timely approvals, thereby expediting the ADAP application process. • ADAP Applications (with supportive documentation) must be completed through the TCT Application Process for THMP consideration. All uploaded applications must be reviewed and certified as "complete" prior to upload. • ADAP applications should be completed according to the THMP established guidelines and applicable guidelines as given by AA. • To ensure timely access to medications, all completed ADAP applications must be completed in TCT within one (1) business day of completion • To ensure receipt of the completed ADAP application by THMP, notification must be sent according to THMP guidelines within three (3) business days of the completed application in TCT. • Upload option is only available for ADAP applications; other benefits applications should be maintained separately and submitted according to instruction.	• Uploaded THMP application per established timeframe documented in ARIES. • Notification of THMP upload per established timeframe documented in primary service record.
<u>1.8 Tracking of THMP Application</u> Track the status of all pending applications and promptly follow-up with applicants regarding missing	• Tracking of application status documented.

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documentation or other needed information to ensure completed applications are submitted as quickly as feasible Maintain communication with designated THMP staff to quickly resolve any missing or questioned application information or documentation to ensure any issues affecting pending applications are resolved as quickly as possible	• Follow-up for missing or other information documented in primary service record.
1.9 Case Closure Summary PLWH who are no longer in need of assistance through Referral for Health Care and Support Services must have their cases closed with a case closure summary narrative documented in the primary service record. The case closure summary must include a brief synapsis of all services provided and the result of those services documented as 'completed' and/or 'not completed.' A supervisor must sign the case closure summary. Electronic signatures are acceptable.	• Case closure summary per established criteria documented in primary service record.
Administrative	
2.1 Program Policies and/or Procedures Program will develop and maintain policies and/or procedures that outline the delivery of service including, but not limited to, the marketing of the service to applicable community stakeholders and process of utilizing the AEW service. Program will disseminate policies and/or procedures to providers seeking to utilize the service. Additionally, Program will have policies and procedures that comply with applicable DSHS Universal Standards.	• Program's Policies and Procedures document systems to comply with: ▪ DSHS Universal Standards ▪ TRG Contract and Attachments ▪ Standards of Care ▪ Collection of Performance Measures
2.2 Staff Education Education can be defined locally, but must at minimum require a high school degree or equivalency	• Staff education documented in the personnel file.
2.3 Staff Qualifications All personnel providing care shall have (or receive training) in the following minimum qualifications: • Ability to work with diverse populations in a non-judgmental way • Working with Persons Living With HIV/AIDS or other chronic health conditions • Ability to (demonstrate) or learn health care insurance literacy, (Third Party Insurance and Affordable Care Act (ACA) Marketplace plans).	• Assessment of staff qualifications documented in personnel file. • Exceptions documented in personnel file. • Training to increase staff qualifications documented in personnel file.

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• Ability to perform intake/eligibility, referral/ linkage and/or basic assessments of PLWH needs preferred. ➢ Data Entry • Quickly establish rapport in respectable manner consistent with the health literacy, preferred language, and culture of prospective PLWH	
2.4 Staff Training AEWS must complete the following: • THMP Training Modules within 30 days of hire • Complete the DSHS ADAP Enrollment Worker (AEW) Regional update at earliest published date after hire • DSHS ARIES Document Upload Training (to include TRG upload observation module), completed no later than (45) days after completing ARIES certificate process • Data Security and Confidentiality Training • Complete all training required of Agency new hires, including any training required by DSHS HIV Care	• Completion of training requirements documented in personnel file. • Materials for training and continuing education (agendas, handouts, etc.) are on file.
2.6 Language Accessibility Language assistance must be provided to individuals who have limited English proficiency and/or other communication needs at no cost to them in order to facilitate timely access to all health care and services. Subrecipients must provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area to inform all individuals of the availability of language assistance services. All AAs and subrecipients must establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organizations' planning and operations.	• Language accessibility policies and documentation of training on policies are available for on-site review. • Print and multimedia materials meet requirements.

References

- HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A April 2013. p. 43-44. Accessed on October 12, 2020 at: https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringparta.pdf
- HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B April 2013. p. 42-43. Accessed October 12, 2020 at: https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringpartb.pdf
- HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Notices and Program Letters, Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02 (Revised 10/22/18),

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

- DSHS Policy 591.000, Section 5.3 regarding Transitional Social Service linkage.
- Interim Guidance for the Use of Telemedicine and Telehealth for HIV Core and Support Services, March 2020. Available at: https://www.dshs.state.tx.us/hivstd/taxonomy/telemedguidance.shtm

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RYAN WHITE PART B/DSHS STATE SERVICES
23-24 QUALITY ASSURANCE MEASURES
REFERRAL FOR HEALTH CARE
ADAP ENROLLMENT WORKERS

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

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RYAN WHITE PART B/DSHS STATE SERVICES 23-24 HOUSTON HSDA STANDARDS OF CARE REFERRAL FOR HEALTH CARE TARGETING THE INCARCERATED AND RECENTLY RELEASED

Effective Date: April 1, 2023/September 1, 2024

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

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

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

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

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

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

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

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

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

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

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

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

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

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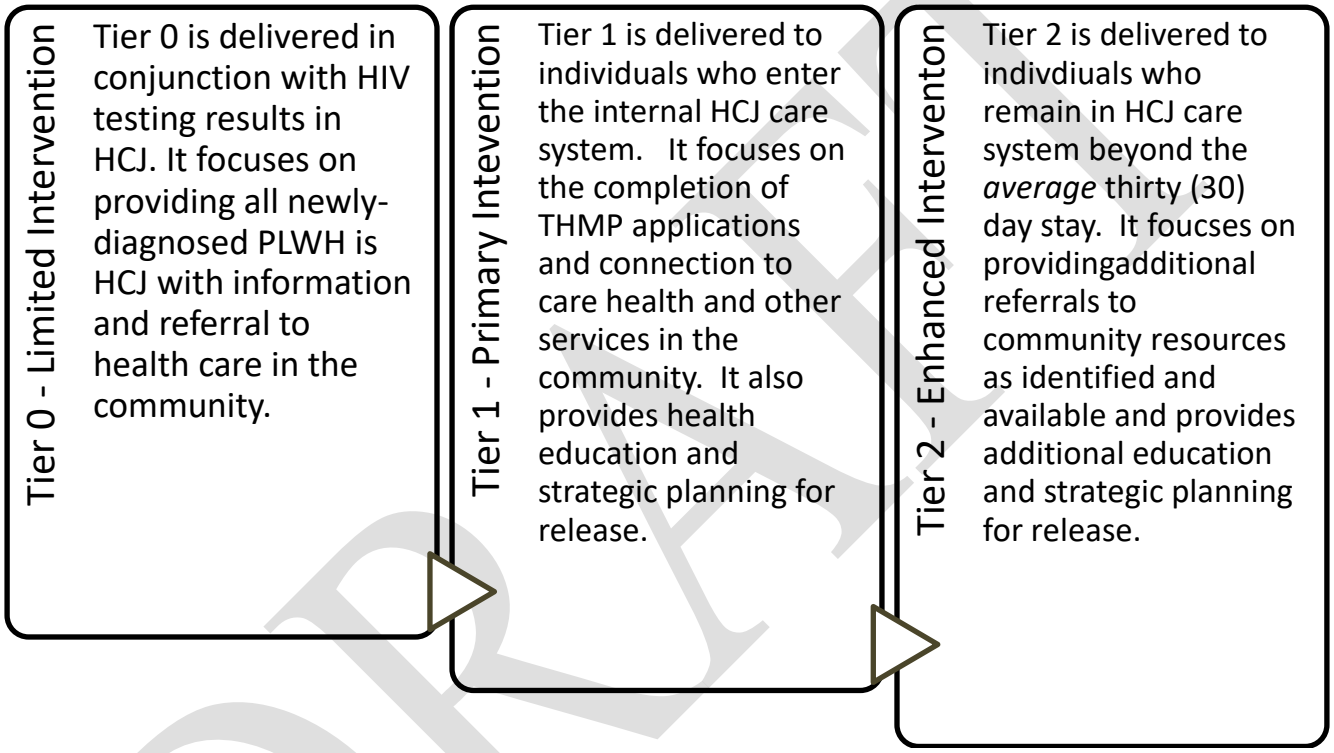
interactions to assure that certain benchmarks of service provision should be met. The length of stay in this tier is traditionally 15-30 days.

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

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



Guiding Principles for Intervention:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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at a minimum completeness and accuracy of records, compliance with standards, and effectiveness of service	
3.6 MOUs with Core Medical Services The Agency must maintain MOUs with a continuum of core medical service providers. MOUs should be targeted at increasing communication, simplifying referrals, and decreasing other barriers to successfully connecting PLWHs into ongoing care.	• Signed MOUs verified during annual quality compliance review. • Communication and referrals with agencies covered in MOUs documented in primary service record.
3.7 Language Accessibility Language assistance must be provided to individuals who have limited English proficiency and/or other communication needs at no cost to them in order to facilitate timely access to all health care and services. Subrecipients must provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area to inform all individuals of the availability of language assistance services. All AAs and subrecipients must establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organizations' planning and operations.	• Language accessibility policies and documentation of training on policies are available for on-site review. • Print and multimedia materials meet requirements.

References:

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

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RYAN WHITE PART B/DSHS STATE SERVICES
23-24 QUALITY ASSURANCE MEASURES
REFERRAL FOR HEALTH CARE TARGETING
THE INCARCERATED AND RECENTLY RELEASED

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

Intervention-Specific Performance Measures:

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

2022 Quarterly Report
Quality Improvement Committee
(November 2022)

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

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

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

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

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

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

Status of Tasks on the Timeline:

_____ _____

Committee Chairperson Date