University Health System Ryan White Program:

Part A, Part B, Part D,
Minority AIDS Initiative,
State Services and State Rebate

Standards of Care

Health Resources and Services Administration
&
Texas Department of State Health Services
funded HIV Core Medical and Supportive Health Services

The purpose of these service standards is to ensure that quality care and services are being provided to all persons living with HIV/AIDS in San Antonio Services Delivery Area

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STANDARDS OF CARE INTRODUCTION

Standards of Care are the requirements that Sub-Recipients (also referred to as Service Providers) are contractually obligated to meet when providing HIV/AIDS Core Medical and Supportive Health Services fund by University Health Center Ryan White Program.

Establishing the Standards of Care (SoC) will ensure the Ryan White Program Services:

- Provide services that improve health outcomes for people living with HIV along the HIV Care Continuum, with the ultimate goal being viral suppression;
- Provide clients with high quality care through experienced, trained, and qualified staff
- Have policies and procedures to protect clients' rights;
- Guarantee client confidentiality
- Protect client autonomy and ensure a fair process of client grievance review and advocacy;
- Provide services that are client centered, trauma informed, and culturally and linguistically appropriate;
- Comprehensively inform clients of services, establish client eligibility and provide equitable access to services;
- Provide coordinated care and referrals to needed services;
- Provide services to historically underserved populations, including but not limited to women, children, youth, transgender and gender non-conforming individuals and people of color; and
- Ensure clients apply and receive services that are free of discrimination based on race, color, sex, gender, ethnicity, national origin, religion, age, class, sexual orientation, housing status, and physical or mental ability.

The SoC are designed for HIV/AIDS Core Medical and Supportive Health Service Categories that are funded by Ryan White Part A, Ryan White Part B, Ryan White Part D, Minority AIDS Initiative (MAI), State Services and State Rebate in the following jurisdictions:

- Transitional Grant Area (TGA)
    - Include Health Resources and Services Administration (HRSA) funded grant programs
        - Ryan White Part A
        - Minority AIDS Initiative (MAI)
    - Comprises of the following counties for services:
        - Bexar
        - Comal
        - Guadalupe
        - Wilson

- Service Delivery Area (SDA)
  - Include Health Resources and Services Administration (HRSA) funded grant programs
    - Ryan White Part D
  - Comprises of the following counties for services:
    - Atascosa
    - Bandera
    - Bexar
    - Calhoun
    - Comal
    - Dewitt
    - Dimmit
    - Edwards
    - Frio
    - Gillespie
    - Goliad
    - Gonzales
    - Guadalupe
    - Jackson
    - Karnes
    - Kendall
    - Kerr
    - Kinney
    - La Salle
    - Lavaca
    - Maverick
    - Medina
    - Real
    - Uvalde
    - Val Verde
    - Victoria
    - Wilson
    - Zavala

- Health Service Delivery Area (HSDA)
  - Include Health Resources and Services Administration (HRSA) funded grant programs
    - Ryan White Part B
    - State Services
    - State Rebate
  - Comprises of the following counties for services:
    - Atascosa
    - Bandera
    - Bexar
    - Comal
    - Frio
    - Gillespie
    - Guadalupe
    - Karnes
    - Kendall
    - Kerr
    - Medina
    - Wilson

The SoC are designed to monitor and enhance the quality of care provided in the service delivery areas by setting goal-specific measurable outcomes. The service category standards include:

- HRSA Service Category Definition
- Services
- HRSA/DSHS Program Guidance
- Service Category Limitations
- Personnel Qualifications
- Service Standards and Performance Measures

It is important to note that the SoC are a living document and will evolve based on:

- Ryan White Legislation Updates, Changes, and/or Modifications,
- HRSA/DSHS Regulations Updates, Changes, and/or Modifications,
- HRSA/DSHS Policy Updates, Changes, and/or Modifications,
- The changing needs and realities of the persons living with HIV (PLWH) within the service delivery areas,
- The capacity of the service delivery areas.

The San Antonio Area HIV Health Services Planning Council, Planning Council Support Staff, Quality Management Committee, and Administrative Agency Staff continually monitor propose revisions and update the SOC as needed.

STANDARDS OF CARE MONITORING SNAPSHOT

Sampling Methodologies

For all service providers a random sampling of charts will be based on the HRSA sampling methodologies:

1. The HRSA Confidence Interval Sampling:
    a. 80% confidence level with a +/-8% confidence interval level.
    b. Will be used for the following service categories:
        i. Early Intervention Services (EIS)
        ii. Medical Case Management (MCM)
        iii. Non-Medical Case Management (NMCM)
        iv. Oral Health (OH)
        v. Outpatient Ambulatory Health Services (OAHS)
        vi. Referral for Health Care and Support Services
        vii. Universal Standards
2. The Tier System Methodology:
    a. For 1-24 Unduplicated ARIES IDs, 100% of client files will be reviewed.
    b. For 25-50 Unduplicated ARIES IDs, 25 random client files will be reviewed.
    c. For 51-100 Unduplicated ARIES IDs, 30 random client files will be reviewed.
    d. For more than 100 Unduplicated ARIES IDs, 40 random client files will be reviewed.
    e. Will be used for the following service categories:
        i. AIDS Pharmaceutical Assistance (Local) (LPAP)
        ii. Emergency Financial Assistance (EFA)
        iii. Food Bank/Home Delivered Meals
        iv. Health Education/Risk Reduction (HE/RR)
        v. Health Insurance Premium and Cost Sharing Assistance (HIPCSA)
        vi. Medical Nutrition Therapy
        vii. Medical Transportation Services
        viii. Mental Health Services
        ix. Outreach Services
        x. Psychosocial Services
        xi. Substance Abuse Outpatient Services

Corrective Action Plans (CAPs) & Plan-Do-Study Acts (PDSAs) Expectations

1. If there are deficient items with Universal Standards, a CAP will be **required** for each deficient item identified.
2. One (1) to three (3) PDSAs are **required** for the service categories of OAHS, HIPCSA, and MCM for any indicator (s) at or below 50% and HRSA/HAB measures **must** be priority.
3. One (1) CAP is **required** for the service categories of NMCM, LPAP, and EFA for any indicator (s) at or below 50% and HRSA/HAB measures **must** be priority.

CAPs and PDSAs **require** quarterly submission to the Administrative Agency demonstrating the results of ten (10) chart pulls per every thirty (30) days; for Universal Standards, this process **must** continue until the indicator reaches 100%.

DSHS TRAININGS / EDUCATION POLICY

The Value of an Employee Education Program

An employee education program is an excellent opportunity to promote understanding and prevention of HIV/AIDS as well as reducing fear and misinformation. An employee education program can also clarify issues about workplace rights and responsibilities related to HIV/AIDS.

A basic employee education program will:

1. give accurate answers to basic employee questions about HIV/AIDS transmission, risk and prevention;
2. discuss employer and employee rights and responsibilities, issues related to the Americans with Disabilities Act of 1990, medical confidentiality and reasonable accommodation;
3. help all employees understand they can work safely alongside persons living with the HIV disease;
4. promote a compassionate environment for employees living with HIV/AIDS by giving information about local resources, counseling, testing or support, and
5. provide up to date, continuing education about HIV/AIDS.

Information to Include in the Employee Education Program

1. How the HIV disease is transmitted
2. Misconceptions about HIV transmission
3. How HIV transmission can be prevented, or the risks reduced
4. Laws and regulations governing risky behaviors related to HIV/AIDS
5. Company or agency materials on policies and procedures for handling HIV/AIDS in the workplace
6. Confidentiality and privacy requirements and agreements
7. Lists of HIV/AIDS prevention or treatment resources in the company and the community

Training for Management and Supervisory Personnel

Management staff may be fearful, misinformed, or have widely varying knowledge about HIV; however, staff must be able to deal with employee concerns about HIV, and properly administer HIV/AIDS policies and procedures. A training program for managers should include:

1. current information about HIV transmission and prevention;
2. laws about confidentiality and related topics;
3. personnel management, including relevant policies;
4. development of staff problem-solving skills;
5. a plan for periodic training;
6. information for employee referrals for assistance, and
7. information, along with a demonstration, on the proper use of universal precautions.

Reference:

- DSHS Policy #035.001 "*Model Education Program for use by Employers to Educate Employees About the HIV Disease and its Progressive Stages*"
    - https://www.dshs.texas.gov/hivstd/policy/policies/035-001.shtm

REQUIRED TRAININGS / EDUCATION

All Staff:

1. Sexually Transmitted Infections
2. Specific HIV-Related Issues
3. Effective Communication
4. Confidentiality Training
5. Security Training
6. Texas Child Abuse Laws
7. Texas HIV Medication Program
8. Eligibility Training
    a. to include Ryan White and ADAP/THMP Eligibility
9. Health Literacy
10. Cultural Competency
    a. to include cultural awareness of youth and the aging population and/or relevant local priority populations based on epidemiological data and service priorities
11. ARIES Training (provided by the Administrative Agency)
12. Standards of Care
13. HIV Care Continuum

Case Management Staff: [1]

Initial Courses REQUIRED for all Case Managers (Medical and Non-medical):

1. Introduction to Cultural Competency and Title VI [Texas TRAIN: 1032904]
2. Texas HIV Medication Program Update 2013 [Texas TRAIN: 1033734]
3. HIV Case Management 2013 Update [Texas TRAIN: 1046992]
4. HIV Case Management 101: A Foundation Part Two modules:
    a. HIV Case Management 101: A Foundation Part Two – Behavioral Risk and HIV [Texas TRAIN: 1046842]
    b. HIV Case Management 101: A Foundation Part Two – Substance Use and HIV [Texas TRAIN: 1034579]
    c. HIV Case Management 101: A Foundation Part Two – Mental Health and HIV [Texas TRAIN: 1034578]

REQUIRED Medical Case Manager Training

Staff performing medical case management at agencies receiving Ryan White Part B or State Services case management funds must fulfill the **Texas DSHS HIV Program Medical Case Manager Competency Training Course** requirements. New Medical Case Managers must complete all components of the MCM Competency Training Course within 12 months of hire. It is preferred that staff complete training within nine months of hire.

The following two courses are the initial required courses for the MCM Competency Training Course. Additional trainings will be announced in the coming months.

1. STD Facts and Fallacies: Chlamydia, Gonorrhea, and Pelvic Inflammatory Disease (PID) [Texas TRAIN: 1030556]
2. STD Facts and Fallacies: Syphilis [Texas TRAIN: 1033232]

[1] https://www.dshs.texas.gov/hivstd/contractor/cm.shtm

Recommended Case Management Courses

1. HIV Service Categories Standards of Care: Case Management (Medical and Non-Medical) [Texas TRAIN: 1056173]
2. DSHS HIV Care: Payer of Last Resort [Texas TRAIN: 1028445]

Ongoing Courses REQUIRED for all Case Managers

In addition, all case managers (medical and non-medical) must complete a minimum of 12 hours of continuing education in relevant topics annually. Please see the Medical Case Management Standards and the Non-Medical Case Management Standards to learn more. Other topics not listed in the Case Management Standards of Care may be used to fulfill the requirement; however, courses must be approved by DSHS and should be submitted prior to attending training – this could include trainings taken to fulfill professional licensure requirements. Participants should submit a copy of the training agenda to the HIV Case Management Training Specialist for consideration.

Case Management tools (i.e. Intake Resources, Acuity Tools, Care Plan Tools, etc.) and other DSHS approved trainings here: https://www.dshs.texas.gov/hivstd/contractor/cm.shtm

Specific Training for Early Intervention Services (EIS) Staff:

Required initial training by EIS staff completed within three (3) months of hire and 12 additional hours annually

1. Education and Health Literacy training for clients to help them navigate the HIV care system
2. Training to document number of HIV tests (if applicable), number of referrals, and results of testing

Specific Training for Outreach Services Staff:

Within the first (3) months of hire, 16 hours of training for new staff and volunteers shall be given, which includes, but is not limited to:

1. Specific HIV-Related Issues
2. Substance Abuse and Treatment
3. Mental Health Issues
4. Domestic Violence
5. Sexually Transmitted Diseases
6. Partner Notification
7. Housing Services
8. Adolescent Health Issues
9. Commercial Sex Workers
10. Incarcerated/Recently Released
11. Gay/Lesbian/Bisexual/Transgender Concerns

Specific Training for Psychosocial Staff:

1. Staff conducting nutritional counseling will be trained to perform nutritional assessments.

UNIVERSAL STANDARDS

A. Access To Care	
Standard	**Performance Measure**
Structured and ongoing efforts to obtain input from clients in the design and delivery of services	1. Maintain file of materials documenting Consumer Advisory Board (CAB) membership and meetings, including minutes 2. Regularly implement client satisfaction survey tool, focus groups, and/or public meetings, with analysis and use of results documented 3. Maintain visible suggestion box or other client input mechanism
Provision of services regardless of an individual's ability to pay for the service	1. Have billing, collection, co-pay, and sliding fee policies that do not act as a barrier to providing services regardless of the client's ability to pay 2. Maintain file of individuals refused services with reasons for refusal specified; include in file any complaints from clients, with documentation of compliant review and decision reached
Provision of services regardless of the current or past health condition of the individual to be served	1. Maintain files of eligibility and clinical policies 2. Maintain file of individuals refused services
Provision of services in a setting accessible to low-income individuals with HIV disease	1. Comply with Americans with Disabilities Act (ADA) requirements 2. Ensure that the facility is accessible by public transportation or provide for transportation assistance
Efforts to inform low-income individuals of the availability of HIV-related services and how to access them	Maintain file documenting sub-recipient activities for the promotion of HIV services to low- income individuals, including copies of HIV program materials promoting services and explaining eligibility requirements

B. Eligibility Determination	
Standard	**Performance Measure**

Eligibility determination and reassessment of clients to determine eligibility as specified by the jurisdiction or ADAP	Clients must be screened for program eligibility every six months
	• **Initial Determination**
	  ○ Only needs to happen once initially, unless the birth month is 2+ months after initial date
	  ○ Required Documentation needed:
	  ▪ HIV/AIDS diagnosis
	  ▪ Proof of Residence
	  ▪ Low Income
	  ▪ Proof of Insurance
	• **6-month Self-Attestation**
	  ○ Must be completed no later than the last day of the clients' half birth month

	○ Required Documentation needed ▪ Proof of Residence ▪ Low Income ▪ Proof of Insurance • **12-month Recertification** ○ Must be completed no later than the last day of the clients' birth month ○ Required Documentation needed ▪ Proof of Residence ▪ Low Income ▪ Proof of Insurance Allowable Forms of Required Documentation • **HIV/AIDS diagnosis** ○ Only needed once at initial Determination ○ Documentation in client's file: ▪ HIV Lab result; or □ Positive result from HIV screening test (HIV 1/2 Combo Ab/Ag enzyme immunoassay [EIA]); □ Positive result from an HIV 1 RNA qualitative virologic test such as a HIV 1 Nucleic Acid Amplification Test (NAAT); or □ Detectable quantity from an HIV 1 RNA quantitative virologic test (e.g. viral load test) ▪ A signed statement from an entity with prescriptive authority attesting to the HIV-positive status of the person. Proof of residence • **Proof of Residence** ○ Documentation in client's file: ▪ Valid (unexpired) Texas Driver's License noting Texas address; ▪ Texas State identification card (including identification from criminal justice systems); ▪ IRS Tax Return Transcript, Verification of Non-Filing, W2, or 1099; ▪ Current employment records (pay stub); ▪ Benefits Award letter in name of client showing address; ▪ Voter registration; ▪ Mortgage or official rental lease agreement in the client's name; ▪ Rent or utility receipts for one month prior to the month of application in the client's name; ▪ Post office records;

	▪ official state mail; ▪ Letter of identification and verification of residency from a verifiable homeless shelter or community center serving homeless individuals; or ▪ Statement/attestation (does not require notarization) with client's signature declaring that client has no resources for housing or shelter. • **Low Income** o **Not more than 300% of FPL for Part A, D, and MAI** o **Not more than 500% of FPL for Part B, State Services, and State Rebate** o Documentation in client's file: ▪ Pay stubs (30 continuous days of payment within the last 60 days); ▪ Supporter statement; ▪ Employer statement; ▪ Agency letter; ▪ Social Security Income (SSI) Award Letter; ▪ Social Security Disability Income (SSDI) Award Letter; or ▪ Other income documentation ▪ Texas Workforce Commission unemployment benefits letter; or ▪ Prison release paper within 30 days of release date • **Proof of Insurance** o Uninsured or underinsured status (insurance verification as proof) o Determination of eligibility and enrollment in other third party insurance programs including Medicaid and Medicare o For underinsured, proof this service is not covered by other third party insurance programs including Medicaid and Medicare o Proof of compliance with eligibility determination as defined by the State or ADAP Document that the process and timelines for establishing initial client eligibility, assessment, and recertification takes place at a minimum of every six months Document that all staff involved in eligibility determination have participated in required training

	Sub-recipient client data reports are consistent with eligibility requirements specified by funder, which demonstrates eligible clients are receiving allowable services
Ensure military veterans with Department of Veterans Affairs (VA) benefits are deemed eligible for Ryan White services	Ensure that policies and procedures classify veterans receiving VA health benefits as uninsured, thus exempting these veterans from the "payer of last resort" requirement

C. Anti-Kickback Statute	
Standard	Performance Measure
Demonstrated structured and ongoing efforts to avoid fraud, waste, and abuse (mismanagement) in any federally funded program	Maintain and review file documentation of: • Corporate Compliance Plan (required by CMS if providing Medicare-or Medicaid-reimbursable services) • Personnel Policies • Code of Ethics or Standards of Conduct • Bylaws and Board policies • File documentation of any employee or Board Member violation of the Code of Ethics or Standards of Conduct • Documentation of any complaint of violation of the Code of Ethics or Standards of Conduct and its resolution For not-for-profit contractors/sub-recipient organizations, ensure documentation of sub-recipient Bylaws, Board Code of Ethics, and business conduct practices
Prohibition of employees (as individuals or entities), from soliciting or receiving payment in-kind or cash for the purchase, lease, ordering, or recommending the purchase, lease, or ordering, of any goods, facility services, or items.	Have adequate policies and procedures to discourage soliciting cash or in-kind payments for: • Awarding contracts • Referring clients • Purchasing goods or services, and/or • Submitting fraudulent billings Have employee policies that discourage: • The hiring of persons who have a criminal record relating to or are currently being investigated for Medicaid/Medicare fraud • Large signing bonuses

D. Recipient Accountability	
Standard	Performance Measure
Proper stewardship of all grant funds including compliance with programmatic requirements	Meet contracted programmatic and fiscal requirements, including: • Provide financial reports that specify expenditures by service category and use of Ryan White funds as specified by Recipient • Develop financial and sub-recipient Policies and Procedures Manual that meet federal and Ryan White program requirements • Closely monitor any sub-recipients/contractors • Commission an independent audit; for those meeting thresholds, an audit that meets A-133 requirements • Respond to audit requests initiated by Recipient
Recipient accountability for the expenditure of funds it shares with lead agencies (usually health departments), sub-recipients	Establish and implement: • Fiscal and general policies and procedures that include compliance with federal and Ryan White programmatic requirements • Flexible fiscal reporting systems that allow the tracking of unobligated balances and carryover funds and detail service reporting of funding sources • Timely submission of independent audits (A-133 audits if required) to the State Policies in place that ensure program income is documented per the Notice of Award using the 'additive' method. Program income must be used for the purposes for which the award was made, and may only be used for allowable costs under the award.
Business management systems that meet the requirements of the Office of Management and Budget code of federal regulations, programmatic expectations outlined in the Recipient assurances, and the Notice of Grant Award	Ensure that the following are in place: • Documented policies and procedures and fiscal/programmatic reports that provide effective control over and accountability for all funds in accordance with federal and Ryan White programmatic requirements
Responsibility for activities that are supported under the Ryan White Program as outlined by Office of Management and Budget, Code of Federal Regulations, HHS Grant Policy Statement Program Assurances, and Notice of Grant Award (NOA)	Ensure fiscal and programmatic policies and procedures are in place that comply with federal and Ryan White program requirements

E. Reporting	
Standard	Performance Measure
Submission of standard reports as required in circulars as well as program-specific reports, as outlined in the Notice of Grant Award (NOA)	Ensure: • Submission of timely sub-recipient reports • File documentation or data containing analysis of required reports to determine accuracy and any reconciliation with existing financial or programmatic data. Example: Test program income final FFR with calendar year RDR. • Submission of periodic financial reports that document the expenditure of Ryan White funds, positive and negative spending variances, and how funds have been reallocated to other line-items or service categories

F. Monitoring	
Standard	Performance Measure
Any recipient or sub-recipient or individual receiving federal funding is required to monitor for compliance with federal requirements and programmatic expectations	Participate in and provide all material necessary to carry out monitoring activities Monitor any service contractors for compliance with federal and programmatic requirements
Monitoring activities expected to include annual site visits of all Provider/Sub-recipients.	Establish policies and procedures to ensure compliance with federal and programmatic requirements Submit auditable reports Provide the recipient access to financial documentation
Performance of fiscal monitoring activities to ensure that Ryan White funding being used for approved purposes	Have documented evidence that federal funds have been used for allowable services and comply with Federal and Ryan White requirements
Salary Limit: HRSA funds may not be used to pay the salary of an individual at a rate in excess of the most current HRSA Executive Salary Level II.	Monitor staff salaries to determine whether the salary limit is being exceeded. Monitor prorated salaries to ensure that the salary when calculated at 100% does not exceed the HRSA Executive II Salary Limit Monitor staff salaries to determine that the salary limit is not exceeded when the aggregate salary funding from other federal sources including all parts of Ryan White do not exceed the limitation. Review payroll reports, payroll allocation journals, and employee contracts.
Salary Limit Fringe Benefits: If	Monitor to ensure that when an employee salary exceeds the

an individual is under the salary cap limitation, fringe is applied as usual. If an individual is over the salary cap limitation, fringe is calculated on the adjusted base salary.	salary limit, the fringe benefit contribution is limited to the percentage of the maximum allowable salary.
Corrective actions taken when sub-recipient outcomes do not meet program objectives and recipient expectations	Prepare and submit: • Timely and detailed response to monitoring findings • Timely progress reports on implementation of corrective action plan

G. Quality Management	
Standard	Performance Measure
Implementation of a Clinical Quality Management (CQM) Program	Participate in quality management activities as contractually required; at a minimum: • Compliance with relevant service category definitions • Collection and reporting of data for use in measuring performance

H. Other Service Requirements	
Standard	Performance Measure
Referral relationships with key points of entry: Requirement that service providers maintain appropriate referral relationships with entities that constitute key points of entry	Establish written referral relationships with specified points of entry Document referrals from these points of entry

I. Prohibition on Certain Activities	
Standard	Performance Measure
Drug Use and Sexual Activity: Ryan White funds cannot be used to support AIDS programs or materials designed to promote or directly encourage intravenous drug use or sexual activity, whether homosexual or heterosexual	Drug Use and Sexual Activity: Maintain a file with signed sub-recipient agreement, assurances, and/or certifications that specify unallowable activities Ensure that budgets and expenditures do not include unallowable activities Ensure that expenditures do not include unallowable activities Provide budgets and financial expense reports to the recipient with sufficient detail to document that they do not include unallowable costs or activities
Purchase of Vehicles without Approval: No use of Ryan White funds by recipients or sub-recipients for the purchase	Purchase of Vehicles without Approval: Maintain a file with signed sub-recipient agreement, assurances, and/or certifications that specify unallowable activities

of vehicles without written approval of HRSA Grants Management Officer (GMO)	If vehicle purchase is needed, seek recipient assistance in obtaining written GMO approval and maintain document in file
Broad Scope Awareness Activities: No use of Ryan White funds for broad scope awareness activities about HIV services that target the general public	Maintain a file with signed sub-recipient agreement, assurances, and/or certifications that specify unallowable activities Prepare a detailed program plan and budget narrative that describe planned use of any advertising or marketing activities
Lobbying Activities: Prohibition on the use of Ryan White funds for influencing or attempting to influence members of Congress and other Federal personnel	Broad Scope Awareness Activities: Maintain a file with signed sub-recipient agreement, assurances, and/or certifications that specify unallowable activities Include in personnel manual and employee orientation information on regulations that forbid lobbying with federal funds
Direct Cash Payments: No use of Ryan White program funds to make direct payments of cash to service recipients	Direct Cash Payments: Maintain a file with signed sub-recipient agreement, assurances, and/or certifications that specify unallowable activities Maintain documentation of policies that forbid use of Ryan White funds for cash payments to service recipients
Employment and Employment-Readiness Services: Prohibition on the use of Ryan White program funds to support employment, vocational, or employment-readiness services	Employment and Employment- Readiness Services: Maintain a file with signed sub-recipient agreement, assurances, and/or certifications that specify unallowable activities
Maintenance of Privately Owned Vehicle: No use of Ryan White funds for direct maintenance expenses (tires, repairs, etc.) of a privately owned vehicle or any other costs associated with a vehicle, such as lease or loan payments, insurance, or license and registration fees	Maintenance of Privately Owned Vehicle: Maintain a file with signed sub-recipient agreement, assurances, and/or certifications that specify unallowable activities
Syringe Services: No use of Ryan White funds shall be used to carry out any program of distributing sterile needles or syringes for the hypodermic injection of any illegal drugs.	Syringe Services: Maintain a file with signed sub-recipient agreement, assurances, and/or certifications that specify unallowable activities
Additional Prohibitions: No use of Ryan White Funds for	Additional Prohibitions: Maintain a file with signed sub-recipient agreement, assurances, and/or certifications that

the following activities or to purchase these items: • Clothing • Funeral, burial, cremation or related expenses • Local or State personal property taxes (for residential property, private automobiles, or any other personal property against which taxes may be levied) • Household appliances • Pet foods or other non-essential products • Off-premise social/recreational activities or payments for a client's gym membership • Purchase or improve land, or to purchase, construct, or permanently improve (other than minor remodeling) any building or other facility • Pre-exposure prophylaxis	specify unallowable activities

J. Data Reporting Requirements	
Standard	Performance Measure
Submission of the online service providers report of the Ryan White HIV/AIDS Program Services Report (RSR)	Report all the Ryan White Services the provider offers to clients during the funding year Submit both interim and final reports by the specified deadlines
Submission of the online client report	Maintain client-level data on each client served, including in each client record demographic status, HIV clinical information, HIV-care medical and support services received, and the client's Unique Client Identifier Submit this report online as an electronic file upload using the standard format Submit both interim and final reports by the specified deadlines

K. General HIV Policies And Procedures	
Standard	Performance Measure
Grievance Policies	Agency has a policy and/or procedure for handling client grievances
Delivery of Client Services	Agency has written procedures to deal with clients who may be disruptive or uncooperative. Agency has written procedures to deal with clients who are violent or exhibit threatening behavior.
Non-Discrimination Policy	Agency has comprehensive non-discrimination policies, which prohibits discrimination on the basis of race, color, national origin, religion, sex, sexual orientation, age, or disability, and any other non-discrimination provision in specific statures under which application for federal or state assistance is being made.
Payer of Last Resort	Recipients will develop and assure compliance with the Public Health Services Act, HRSA Policy, DSHS Policies and local policies, and monitor provider billing of third party payers to determine compliance with Payer of Last Resort requirements. Ensure that Ryan White Program (A, B, D, MAI, etc.) and State Services funds distributed are used as Payer of Last Resort for eligible services and eligible clients. Required by the Public Health Service Act
Confidentiality Regarding Patient Information	All staff, management, and volunteers have completed a signed confidentiality agreement affirming the individuals' responsibility for keeping client information and data confidential. All staff, management, and volunteers have successfully completed confidentiality and security training.
Breach of Confidentiality	Agency has detailed policies outlining how to address negligent or purposeful release of confidential client information in accordance with the Texas Health and Safety Code.
Child Abuse Reporting	Agency staff are trained on Texas child abuse reporting laws and suspected cases of child abuse are being reported as prescribed by Texas law.
Incarcerated Persons in Community Facilities	Agency has policies in place ensuring RWHAP and State Services funding is not utilized in paying for medical care or medications when incarcerated persons in community facilities are receiving services in local service provider locations.
Conflict of Interest Appendix A	Agency has written conflict of interest policies and procedures. All employees and board members of the agency have

	completed and signed a Conflict of Interest Disclosure Form.
Personnel Policies and Procedures	Agency has personnel policies and procedures that are in compliance with local, state, and federal program requirements.
Required Training	Agency maintains documented evidence of staff trainings, conferences, and meetings to ensure program compliance. Providers shall complete cultural competency training to include cultural awareness of youth and the aging population and/or relevant local priority populations based on epidemiological data and service priorities.
Code of Ethics	Agency has written policies and procedures on file for the following: • Provision of services without discrimination • Provision of services with confidentiality and respect • Provision of a grievance procedure
Consumer Rights and Responsibilities Appendix B & C	Documentation in client files of signed statement: • Provision of Statement of Consumer Rights and Responsibilities • Provision of informed consent

L. ARIES	
Standard	Performance Measure
ARIES Security Policy	Agency maintains policies and procedures to ensure ARIES information is protected and maintained to ensure patient confidentiality.
ARIES Data Managers Core Competencies	Agency has local policies and procedures in place relating to ARIES and the data collected through ARIES.

M. Additional Policies and Procedures: Core Services	
Standard	Performance Measure
Local AIDS Pharmaceutical Assistance Program (LPAP)	• Provide to the Recipient upon request, documentation that the LPAP program meets HRSA/HAB requirements. • Maintain documentation, and make available to the Recipient upon request, proof of client LPAP eligibility. • Only authorized personnel dispense/ provide prescription medication. • Medications and supplies are secured in a locked area and stored appropriately. • Agency has a system for drug therapy management. • Policy for timeliness of services. • MOUs ensuring cost efficient methods are in place • MOUs ensure dispensing fees are established and implemented. • Pharmacy technicians and other personnel authorized to dispense medications are under the supervision of a licensed pharmacist.

	• Active pharmacy license is onsite and is renewed every two years. • Documentation on file that pharmacy owner if not a Texas licensed pharmacist, is consulting with a pharmacist in charge (PIC) or with another licensed pharmacist.
Early Intervention Services (EIS)	• Ensure agencies have capacity and training to document number of tests (if applicable), number of referrals, and results of testing. • MOUs are in place with key points of entry into care • Establish linkage agreements with testing sites where Ryan White Program (A, B, D, MAI, etc.) and State Services funds are not used for testing but is funding referral and access to care • All four required EIS service components are documented in the Ryan White Program (A, B, D, MAI, etc.) and State Services EIS program policies both at local and regional systems of care • Agency has a policy that defines EIS that limits services to counseling and HIV testing, referral to appropriate services based on HIV status, linkage to care, and education and health literacy training for clients to help them navigate the HIV care system. • Document that HIV testing activities and methods meet CDC and state requirements, including licensure to conduct phlebotomy services where applicable. • Documentation that EIS program funds will supplement, not supplant, other funds available to the entity for the provision of providing EIS services in the fiscal year involved.
Health Insurance Premium and Cost Sharing Assistance (HIPCSA)	• Provide upon request: o Where premiums are covered by RW funds, provide proof that the insurance policy provides comprehensive primary care and a formulary with a full range of HIV medications o Maintain proof of low-income status o Provide documentation that demonstrates that funds were not used to cover costs associated with the creation, capitalization, or administration of a liability risk pool, or social security costs • Agency has policy that outlines caps on assistance/payment limits and adheres to DSHS Policy 270.001 (Calculation of Estimated Expenditures on Covered Clinical Services). • Agency has policy that details the expectation for client contribution and tracks these contributions under client charges. • Agency has policy that requires referral relationships with

	organizations or individuals who can provide expert assistance to clients on their health insurance coverage options and available cost reductions. • Agency has policies and procedures detailing process to make premium and out-of-pocket payments or IRS payments.
Medical Case Management (MCM) including Treatment Adherence	• Maintain documentation showing that MCM services are provided by trained professionals who are either medically credentialed or trained health care staff and operate as part of the clinical care team. • Maintain client records that include all required elements for compliance with contractual and RW programmatic requirements. • Policies and procedures are in place for conducting MCM services, including data collection procedures and forms, data reporting. • Staff Qualifications: o Minimum qualifications for Medical Case Management supervisors: ▪ degreed or licensed in the fields of health, social services, mental health or a related area (preferably Masters' level). ▪ Additionally, case manager supervisors must have 3 years' experience providing case management services, or other similar experience in a health or social services related field (preferably with 1 year of supervisory or clinical experience). • Supervision: o Core training of staff, using supportive supervision techniques (e.g. job shadowing, performance evaluation, and immediate (responsive) job counseling/training) should be provided on an ongoing basis -- frequency based on staff experience and performance -- by supervisors. o Supervisors should expect to expend more time than usual in providing such training to staff during their probationary period of employment. o During the probationary period, new case managers should be monitored for satisfactory completion of core, case management specific tasks (e.g. assessments, care planning and interventions). o These activities should be monitored in person by appropriate supervisory staff -- or qualified designees -- at least once weekly for the entire probationary period before the case manager is approved to provide services independently.

	• Required MCM trainings are documented in personnel files. • The agency shall have policies/procedures for: o Initial Comprehensive Assessment o MCM Case Management Acuity Level and Client contact o Care Planning o Viral Suppression/Treatment Adherence o Referral and Follow-up o Case Closure/Graduation o Caseload Management o Case Transfer (internal/external) o Probationary Period (new hire) o Staff Supervision o Staff Training, including agency specific training
Medical Nutrition Therapy	• Maintain and make available copies of the dietitian's license and registration • Staff has the knowledge, skills, and experience appropriate to providing food or nutritional counseling/education services. Personnel records/resumes/applications for employment will reflect requisite education, skills, and experience. • Licensed Registered Dietitians will maintain current professional education (CPE) units/hours, including HIV nutrition and other related medical topics approved by the Commission of Dietetic Registration. Documentation in personnel records of professional education. • Agency has a policy and procedure for determining frequency of contact with the licensed Registered Dietitian based on the level of care needed. • Agency has a policy and procedure on obtaining, tracking inventory, storing, and administering supplemental nutrition products, if applicable. • Agency has a policy and procedures on discharging a patient from medical nutrition therapy and the process for discharge/referral.
Mental Health Services	• Obtain and have on file and available for Recipient review appropriate and valid licensure and certification of mental health professionals, including supervision of licensed staff. • Maintain client records that include detailed treatment plans and documentation of services provided. • MOUs are available for referral needs. • Policies/procedures in place. • Agency has a policy for regular supervision of all licensed staff. • Policy stating agency staff will conduct monthly

	multidisciplinary discussions of selected clients. • Agency/Provider has a discharge policy and procedure.
Oral Health Care	• Maintain dental files for all clients. • Maintain, and provide to Recipient upon request, copies of professional licensure and certification. • X-rays are taken by dental assistants who are registered with the State Board of Dental Examiners. • Oral Health caps are documented at the regional level and are tracked for each client in the service area that receives Oral Health services. • If cost of dental care exceeded regional caps set, documentation of reason is in the client record.
Outpatient/Ambulatory Health Services (OAHS)	• Ensure that client medical records document services provided, the dates and frequency of services provided, that services are for the treatment of HIV infection. • Include clinician notes in patient records that are signed by the licensed provider of services. • Maintain professional certifications and licensure documents and make them available to the Recipient on request. • Peer Review for all levels of licensed/credentialed providers (i.e. MD, NP, PA) is completed and documented annually. • Standing Delegation Orders are available to staff and are reviewed annually • Service providers shall employ clinical staff who are experienced regarding their area of clinical practice as well as knowledgeable in the area of HIV/AIDS clinical practice. Personnel records/resumes/applications for employment will reflect requisite experience/education. • All staff without experience with HIV/AIDS shall be supervised by an employee with at least one (1) year of experience.
Substance Abuse Outpatient Care	• Maintain and provide: o Provider licensure or certifications as required by the State o Staffing structure showing supervision by a physician or other qualified personnel o Evidence that all services are provided on an outpatient basis o Program files and client records that include treatment plan • Facilities providing substance abuse treatment services will be licensed by the Texas Department of State Health Services (Department) or be registered as a faith-based exempt program.

	• Agency will have documentation on site that license is current for the physical location of the treatment facility.
	• Documentation of supervision during client interaction with Counselors In Training (CIT) or Interns as required by the Texas Department of State Health Services (DSHS).
	• Documentation of professional liability for all staff and agency.
	• Supervisors' files reflect notes of weekly supervisory conferences.
	• Agency shall have a policy and procedure to conduct Interdisciplinary Case Conferences held for each active client at least once every 6 months
	• Case Conference documentation, signed by the supervisor, in client record will include:
	  ○ Date, name of participants and name of client
	  ○ Issues and concerns
	  ○ Follow-up plan
	  ○ Clinical guidance provided
	  ○ Verification that guidance has been implemented
	• Provider agency must develop and implement policies and procedures for handling crisis situations and psychiatric emergencies, which include, but are not limited to, the following:
	  ○ Verbal Intervention
	  ○ Non-violent physical intervention
	  ○ Emergency medical contact information
	  ○ Incident reporting
	  ○ Voluntary and involuntary patient admission
	  ○ Follow-up contacts
	  ○ Continuity of services in the event of a facility emergency
	• Agency will have a policy and procedure for clients to follow if they need after-hours assistance.
	• There will be written policies and procedures for staff to follow in psychiatric or medical emergencies.
	• Policies and procedures define emergency situations, and the responsibilities of key staff are identified.

N. Additional Policies and Procedures: Support Services	
Standard	Performance Measure
Emergency Financial Assistance (EFA)	• Maintain client records that document client eligibility, types of EFA provided, dates of EFA, and method of providing EFA. • Maintain and provide documentation of assistance provided to clients. • Provide assurance to State that all EFA was for allowable

	types of assistance, was used where RW was payer of last resort, met State or local specified limitations on amount and frequency of assistance to an individual, and provided through allowable payment methods. • Policies include medication purchase limitations. • Agencies providing EFA medications must develop policies and procedures to pursue all feasible alternative revenues systems (e.g., pharmaceutical company patient assistance programs) before requesting reimbursement through EFA. • Agency may reimburse the pharmacy a minimal dispensing fee per prescription as outlined in a MOU.
Food Bank/Home-Delivered Meals	• Maintain documentation of: o Services provided by type o Amount and use of funds for purchase of non-food items o Compliance with all federal, state, and local laws regarding the provision of food bank, home-delivered meals and food voucher programs, including any required licensure and/or certifications. o Assurance that RW funds were used only for allowable purposes and RW was the payer of last resort. o Records of local health department food handling/food safety inspection are maintained on file. • Food pantry program will meet regulations on Food Service Sanitation as set forth by Texas Department of State Health Services, Regulatory Licensing Unit, and / or local city or county health regulating agencies. • Current license(s) will be on display at site. • Records of local health department food handling/food safety inspection are maintained on file. • Agency will be licensed for non-profit salvage by the Texas Department of State Health Services Regulatory Licensing Unit and/or local city or county health regulating agencies. • Food Pantry must display "And Justice for All" posters that inform people how to report discrimination. • There must be a method to regularly obtain client input about food preference and satisfaction. Such input shall be used to make program changes. • Director of meal program must complete and pass Service Safety certification every three (3) years. • An application form is completed for each volunteer. • Each staff and volunteer position has written job

	descriptions. • Staff/Volunteer Education- Personnel files reflect completion of applicable trainings and orientation.
Health Education/Risk Reduction	• Maintain records of services provided. • Document in client files client eligibility, information provided on available services, education about HIV transmission, counseling on how to improve their health status and reduce risk of HIV transmission. • Documentation that staff has visited collaborating service agencies/has knowledge of local resources. • Documentation that supervisors reviewed 10 percent of each HE/RR staff client records each month.
Medical Transportation Services	• Maintain program files. • Maintain documentation that the provider is meeting stated contract requirements with regard to methods of providing transportation. • Collection and maintenance of data documenting that funds are used only for transportation designed to help eligible individuals remain in medical care by enabling them to access medical and support services. • Obtain HRSA and State approval prior to purchasing or leasing a vehicle(s). • Maintains voucher or token system(s)
Non-Medical Case Management (NMCM)	• Maintain client records that include the required elements as detailed by the Recipient. • Provide assurances that any transitional case management for incarcerated persons meets contract requirements. • Policies and procedures are in place for conducting NMCM services. • Non-medical case managers will complete annual trainings per DSHS.
Outreach Services	• Document the design, implementation, target areas and populations, and outcomes of outreach activities. • Document and provide data showing that all RFP and contract requirements are being met with regard to program design, targeting, activities, and use of funds. • Provides financial and program data demonstrating that no outreach funds are being used to pay for HIV counseling and testing, to support broad-scope awareness activities, or to duplicate HIV prevention outreach efforts. • Within the first (3) months of hire, 16 hours of training for new staff and volunteers shall be given, which includes, but is not limited to: o Specific HIV-related issues o Substance abuse and treatment

	○ Mental health issues ○ Domestic violence ○ Sexually transmitted diseases ○ Partner notification ○ Housing Services ○ Adolescent health issues ○ Commercial sex workers ○ Incarcerated/recently released ○ Gay/lesbian/bisexual/transgender concerns • Each outreach supervisor, staff, and volunteer shall hold a valid Texas driver's license and proof of liability insurance, if needed, to carry out work responsibilities.
Psychosocial Support Services	• Documentation of the provision of psychosocial support services. • Maintains documentation that demonstrates funds are used for allowable services only, no funds are used for provision of nutritional supplements, and any pastoral care/counseling services meet all stated requirements. • Program staff conducting nutritional counseling will be trained to perform nutritional assessments. • All non-professional staff delivering support group facilitation must be supervised by a licensed professional.
Referral for Health Care/Supportive Services	• Maintains program files. • Maintains client records that include required elements as detailed by the State. • Maintains documentation demonstrating that services and circumstances of referral services meet contract requirements.

References:

- Public Health Service Act, 42 U.S.C.
  - https://legcounsel.house.gov/Comps/PHSA-merged.pdf
- Public Health Service Act, 42 U.S.C. Title XXVI—HIV Healthcare Services Program
  - https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/legislationtitlexxvi.pdf
- HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A
  - 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
  - https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringpartb.pdf
- HRSA/HAB Ryan White & Global HIV/AIDS Programs, Program & Grants Management, Policy Notices and Program Letters, Policy Clarification Notice 16-02
  - https://hab.hrsa.gov/program-grants-management/policy-notices-and-program-letters
- DSHS HIV Core and Support Service Categories
  - https://www.dshs.texas.gov/hivstd/taxonomy/
- DSHS Monitoring Tools
  - https://www.dshs.texas.gov/hivstd/taxonomy/#section7
- DSHS HIV/STD Policy #220.001 "*Eligibility to Receive HIV Services*"
  - https://www.dshs.texas.gov/hivstd/policy/policies/220-001.shtm
- DSHS HIV/STD Policy #270.001 "*Calculation of Estimated Expenditures on Covered Clinical Services*"
  - https://www.dshs.texas.gov/hivstd/policy/policies/270-001.shtm

AIDS PHARMACEUTICAL ASSISTANCE (LOCAL) {LPAP}

HRSA Service Category Definition:

LPAP is operated by a Ryan White Program (A, B, D, MAI, etc.) and State Services recipient or sub-recipient as a supplemental means of providing medication assistance when an ADAP has a restricted formulary, waiting list, and/or restricted financial eligibility criteria.

Services:

RWHAP recipients using the LPAP service category must establish the following:

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

HRSA/DSHS Program Guidance:

An LPAP is a program to ensure that clients receive medications when other means to procure medications are unavailable or insufficient. As such, LPAPs are meant to serve as an ongoing means of providing medications for a period of time. Only RWHAP Part B Base award or Part A grant funds may be used to support an LPAP. ADAP funds may not be used for LPAP support. LPAP funds are not to be used for Emergency Financial Assistance. Emergency Financial Assistance may assist with medications not covered by the LPAP.

Statement of Need: The Texas ADAP (TX ADAP) has a limited formulary and currently limits income eligibility to 200% of the Federal Poverty Limit (FPL), with a spend-down adjustment to account for the cost of HIV medications. Providers must first use patient and/or pharmaceutical assistance programs (PAP) prior to the use of LPAP. However, these programs may not fully meet the needs of clients with HIV-related medication needs because the full spectrum of HIV and HIV-related medications that may be prescribed to improve health outcomes may not be affordable or available via a PAP. The LPAP is needed to assist clients that have incomes above 200% of FPL, after spend down adjustment. LPAP is further needed to assist clients requiring long-term HIV and HIV-related medications that cannot be obtained through the TX ADAP program or PAPs.

The TX ADAP must be accessed by eligible clients prior to using the LPAP.

- The LPAP may not duplicate services available through the TX ADAP program.
- Clients needing long-term assistance with prescription medications shall be assisted with completing a TX ADAP application and, when applicable, PAP applications.
- If the medication is not on the TX ADAP formulary and is not available through assistance programs, the client may be served with LPAP funds if the medication is on the LPAP formulary.

- If short-term medication assistance is required and a client is eligible, this need may be met with Emergency Financial Assistance funds.
- Clients with insurance and other third-party payer sources are not eligible for LPAP assistance unless there is documentation on file that the medication is not covered by their prescription benefits.

Purchase of pharmaceuticals must be directly linked to the management of HIV disease that is:

- Consistent with the most current HIV/AIDS Treatment Guidelines;
- Coordinated with the State's Part B Texas HIV Medication Program (THMP) of which the TX ADAP is part of; and/or

Implemented in accordance with requirements of the 340B Drug Pricing Program and the Prime Vendor Program. LPAP shall, to the extent allocations permit, provide eligible clients with medications on the local area's LPAP formulary that have been prescribed by a qualified, prescribing medical provider. Patients denied enrollment into the THMP may access medications on the ADAP formulary via LPAP only if other payer sources have been exhausted and the medication is on the local area's LPAP formulary.

LPAP medications must be purchased at the lowest possible cost, such as 340B Program pricing. Clients must obtain their medications through a 340B covered entity or pharmacy OR a comparable medication discount program. Contracts/Memorandums of Understanding (MOU) must be set up to purchase medications at wholesale or another below retail price.

All LPAP programs will use the statement of need and available standards of care to inform their services and will operate in accordance with legal and ethical standards. The importance of maintaining confidentiality is critical and all programs must comply with the Health Insurance Portability and Accountability Act (HIPAA) standards.

Prescribed Over-the-Counter (OTC) medications may be purchased with LPAP funds if the medication is listed on the LPAP formulary and the provider has deemed that the medication is needed for prevention and treatment of opportunistic infections or to prevent the serious deterioration of health. All OTC medications purchased with LPAP funds must be FDA approved.

Medications not included in the LPAP formulary cannot be purchased. All medications purchased with LPAP funds must be FDA-approved. The provider wishing to prescribe a medication not on the formulary shall make a request to the LPAP Board for approval.

Service Category Limitations:

State AIDS Drug Assistance Program (ADAP) funds may not be used for LPAP support. LPAP funds are not emergency financial assistance for medications.

- Local pharmacy assistance programs are not funded with ADAP earmark funding.
- LPAPs are not to take the place of the ADAP program.
- Clients cannot be enrolled in another medication assistance program for the same medication, excluding co-payment discounts.
- Funds may not be used to make direct payments of cash/vouchers to a client.

- No charges may be imposed on clients with incomes below 100% of the Federal Poverty Level (FPL).

- Local AIDS Pharmacy Assistance Programs (LPAP) do not dispense medications as:
  - A result or component of a primary medical visit;
  - A single occurrence of short duration (an emergency);
  - Vouchers to clients on an emergency basis.

Note:: Emergency Financial Assistance service category funds should be used for the above situations

Program/Clinical Quality Management Standard and Performance Measure:
The following Standards and Performance Measures are guides to improving healthcare outcomes for PLWH throughout the San Antonio Service Area within the Ryan White Part A, Part B, Part D, State Services, and State Rebate Programs.

A. Program Requirements	
Standard	Performance Measure
Elements of the LPAP Program must include: • A client enrollment and eligibility determination process for Ryan White/state services funding that includes screening/applying for ADAP. Additional LPAP eligibility (i.e. financial criteria) if applicable • A LPAP advisory board • Uniform benefits for all enrolled clients throughout the region • Compliance with Ryan White requirement of payer of last resort • A recordkeeping system for distributed medications • A drug distribution system that includes a drug formulary approved by the LPAP Board or a subcommittee of a Planning Council/ADAP - Advisory Board • All medications have to be FDA approved • A system for drug therapy management	Documentation on File

B. Agency Requirements	
Standard	Performance Measure
Medication Deductibles, and/or Dispensing Fee Agencies may use funding to assist eligible clients with purchasing medications that are over the Medicaid monthly allotment or that the TMHP program does not cover. • Agencies may charge clients with a FPL above 100% a co-payment for medication based on an established sliding fee scale. • Agencies may charge a dispensing fee.	Documentation on File

C. Policies and Procedures	
Standard	Performance Measure
Timeliness of Service Agencies will develop policies/procedures to: • Provide access to its system of drug reimbursement for clients with HIV/AIDS through Memorandums of Understanding (MOUs) or Memorandums of Agreement (MOAs) with local pharmacies • Implement a system for clients to access prescriptions twenty-four (24) hours/day if feasible • Provide mechanisms for urgent and/or emergency care. • Determine amount of time between ordering of the medication by the provider and prescription availability to the client.	Documentation on File

D. Documentation	
Standard	Performance Measure
Agency shall provide and maintain accurate program record keeping, including medication inventory control.	Documentation on File
Eligibility determination will be kept on file in the primary client record system.	Documented in Client Chart and ARIES
Copies of receipt(s) for payment will be kept on file.	Documented in Client Chart and ARIES
Documentation in the client's primary record must include the attempts made to access client assistance programs with pharmaceutical	Documented in Client Chart and ARIES

companies, private or public insurance programs the client may have and other community resources	

E. Chart Review	
Standard	Performance Measure
LPAP Prescriptions Providers may use funding to assist eligible clients with purchasing medications that are over the Medicaid monthly allotment or that the THMP program does not cover. A copy of the client's prescription from the prescribing provider is on file with the agency. The prescription must include: • Name of the client • Date of Birth • Medication • Dose • Signature of prescribing medical provider	Percentage of client charts that have the documented prescriptions funded through LPAP assistance with: name of client; date of birth; medication; dose; and signature of prescribing medical provider.
Timeliness of Service Agencies must have a system for clients to access prescriptions. Prescriptions should be available and approved for LPAP assistance within two (2) business days. Otherwise eligible clients shall have ongoing access to medications prescribed by a qualified prescribing medical provider through the local area's LPAP program so long as the medication is on the LPAP formulary and allocations permit.	Percentage of clients accessing services under LPAP have access to their prescribed medication(s) that are not on the State Formulary within two (2) business days of approved LPAP-funding.
Prescribed Over the Counter (OTC) medications LPAP can assist clients with their OTC medications if the provider has prescribed the medication and has deemed the medication is needed for prevention and treatment of opportunistic infections (OI) or to prevent the serious deterioration of the client's health AND the medication is on the LPAP formulary.	Percentage of client files with prescribed OTC medications paid through LPAP funding have documented evidence from prescribing provider of medical necessity.

Provider must issue a prescription for the over-the- counter medication or a signed document approving use by the patient.	
Medication Adherence Counseling Clients are offered counseling on medication adherence when assistance is requested.	Percentage of clients who have documented evidence of adherence counseling offered at the time of assistance request.
Viral Suppression Clients who access HIV medications for long-term assistance (more than 60 days) have documentation in their files of viral suppression.	Percentage of clients accessing HIV medication assistance for long-term (more than 60 days) have documented evidence of viral suppression within the measurement year.

References:

- Public Health Service Act, 42 U.S.C.
  - https://legcounsel.house.gov/Comps/PHSA-merged.pdf
- Public Health Service Act, 42 U.S.C. Title XXVI—HIV Healthcare Services Program
  - https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/legislationtitlexxvi.pdf
- HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A
  - 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
  - https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringpartb.pdf
- HRSA/HAB Ryan White & Global HIV/AIDS Programs, Program & Grants Management, Policy Notices and Program Letters, Policy Clarification Notice 16-02
  - https://hab.hrsa.gov/program-grants-management/policy-notices-and-program-letters
- Texas Administrative Code: TAC 22, Chapter 15, 291.6.
  - https://texreg.sos.state.tx.us/public/
- DSHS HIV Core and Support Service Categories
  - https://www.dshs.texas.gov/hivstd/taxonomy/
- DSHS HIV/STD Policy #590.001 "*Payer of Last Resort*"
  - https://www.dshs.texas.gov/hivstd/policy/policies/590-001.shtm
- DSHS HIV/STD Policy #220.101 "*Purchasing Prescription or Over-The-Counter Medications and Vitamins not Covered by a Third-Party Payer*"
  - https://www.dshs.texas.gov/hivstd/policy/policies/220-101.shtm
- DSHS HIV/STD Policy #700.003 "*HIV/STD Medication Program Pharmacy Eligibility Criteria*"
  - https://www.dshs.texas.gov/hivstd/policy/policies/700-003.shtm
- DSHS Monitoring Tools
  - https://www.dshs.texas.gov/hivstd/taxonomy/#section7
- For a list of 340B eligible entity types
  - https://www.hrsa.gov/opa/eligibilityandregistration/index.html.
  - Ryan White HIV/AIDS Program Recipients and Sub-recipients are eligible entities.

EARLY INTERVENTION SERVICES (EIS)

HRSA Service Category Definition:

Early Intervention Services (EIS) include identification of individuals at points of entry and access to services and provision of:

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

Note: All four components must be present in the EIS program.

Services:

EIS services 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 clients to help them navigate the HIV care system. EIS services require coordination with providers of prevention services and should be provided at specific points of entry.

Counseling, testing, and referral activities are designed to bring individuals with HIV into Outpatient/Ambulatory Health Services (OAHS). The goal of EIS is to decrease the number of underserved individuals with HIV by increasing access to care. EIS also provides the added benefit of educating and motivating clients on the importance and benefits of getting into care. Individuals found to be HIV-negative should be referred to appropriate prevention services.

HRSA/DSHS Program Guidance:

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

RWHAP EIS services must include the following four components:

- Targeted HIV testing to help the unaware learn of their HIV status and receive referral to HIV care and treatment services if found to be living with HIV;
    - Recipients must coordinate these testing services with other HIV prevention and testing programs to avoid duplication of efforts.
    - HIV testing paid for by EIS cannot supplant testing efforts paid for by other sources.
- Referral services to improve HIV care and treatment services at key points of entry;
- Access and linkage to HIV care and treatment services such as HIV OAHS, Medical Case Management (MCM), and Substance Use Care; and

- Outreach Services and Health Education/Risk Reduction related to HIV diagnosis.

Service Category Limitations:

Ryan White HIV/AIDS Program (RWHAP) Part A, Part B, Part D, State Services, and State Rebate funds are used for HIV testing only where existing federal, state, and local funds are not adequate and RWHAP funds will supplement, **not supplant**, existing funds for testing. RWHAP Part A, Part B, Part D, State Services, and State Rebate funds cannot be used to purchase at-home testing kits.

Program/Clinical Quality Management Standard and Performance Measure:

The following Standards and Performance Measures are guides to improving healthcare outcomes for PLWH throughout the San Antonio Service Area within the Ryan White Part A, Part B, Part D, State Services, and State Rebate Programs.

A. Agency Requirements	
Standard	Performance Measure
Agency is licensed or certified by Texas Department of State Health Services for the provision of HIV Early Intervention Services.	Documentation on File
Agency is licensed to conduct phlebotomy services.	Documentation on File

B. Policies and Procedures	
Standard	Performance Measure
Agency has policies/procedures in place for each of the following: • Patient rights and responsibilities, including confidentiality guidelines • Patient grievance policies and procedures • Patient eligibility requirements • Data collection procedures and forms, including data reporting • Guidelines for language accessibility	Documentation on File
Agency has a policy that defines EIS that limits services to counseling and HIV testing, referral to appropriate services based on HIV status, linkage to care, and education and health literacy training for clients to help them navigate the HIV care system	Documentation on File
Agency has a policy that specifies points of entry and has established Memoranda of Understanding with those facilities.	Documentation on File
Agency has a policy that outlines monitoring and reporting of HIV tests conducted	Documentation on File
Agency has a method to document results of testing.	Documentation on File
Agency has a method that tracks the number of	Documentation on File

referrals and entry into medical care.	
Agency is using an approved health education and literacy training curriculum that includes components of education concerning the HIV disease process, risk reduction, and maintenance of the immune system and literacy training to help clients navigate the HIV care system.	Documentation on File
Agency has documentation that Ryan White Part A, Part B, Part D, State Services, and State Rebate funds are only being used for HIV testing to supplement existing funding.	Documentation on File
Agency has a policy outlining process for referral for both HIV positives and HIV negatives to appropriate resources.	Documentation on File

C. Staff Requirements	
Standard	Performance Measure
Documentation of advanced training/related work experience for all staff.	Documentation on File
Documentation of required initial training by EIS staff completed within three (3) months of hire	Documentation on File
Documentation of a minimum of 12 additional hours annually for EIS staff.	Documentation on File

D. Staff Supervision Requirements	
Standard	Performance Measure
Documentation that supervisors reviewed 10 percent of each EIS employee's client records each month.	Documentation on File
Documentation that supervisors have held a supervisory meeting with each staff once a month.	Documentation on File

E. Documentation	
Standard	Performance Measure
Documentation of numbers of HIV tests and positives, as well as where and when Ryan White Program (A, B, D, MAI, etc.) and State Services funded HIV testing occurred	Documentation on File
Documentation of all HIV testing activities and what methods were used to meet CDC and state requirements	Documentation on File
Documentation of the number of referrals from key points of entry to EIS program	Documentation on File
Documentation of the number of referrals for	Documentation on File

health care and supportive services	
Documentation of training and education sessions held to help individuals navigate and understand the HIV system of care.	Documentation on File
Documentation of date the HIV positive client was first seen by a medical provider.	Documentation on File

F. Chart Review	
Standard	Performance Measure
Eligibility Determination Eligibility documentation is filed in the client's record.	Documented in Client Chart and ARIES
HIV Testing and Targeted Counseling Documentation that client received appropriate testing	Documented in Client Chart and ARIES
Linkage Documentation that client testing positive was linked to a medical provider and obtained an appointment.	Documented in Client Chart and ARIES
Linkage Documentation that client was referred for preventive services that may include clinician who may be able to prescribe Pre-exposure prophylaxis, or PrEP using non-Ryan White/State Services funds.	Documented in Client Chart and ARIES
Referral and Follow-Up Documentation that staff conducted follow-up with client/medical provider to ensure that client attended a routine HIV medical care visit within three (3) months of HIV diagnosis.	Documented in Client Chart and ARIES

G. HIV Testing	
Standards	Performance Measure
Agencies providing HIV testing will ensure the following: • At a minimum, ensure that HIV testing is performed through the use of blood samples (either finger stick or venipuncture); • Maintain records of number of HIV tests conducted in each measurement year; and • Maintain records of test results with documentation that indicates whether the client was informed of their status. • Staff will be familiar with the DSHS HIV/STD Policy 2013.02	Percentage of HIV positive tests in the measurement year. (HRSA HAB Measure)
	Percentage of individuals who test positive for HIV who are given their HIV-antibody test results in the measurement year. (HRSA HAB Measure)

H. Results Counseling	
Standards	**Performance Measure**
Results counseling will be offered to all clients regardless of the result of the HIV test performed. Results counseling will include discussion of risk reduction education and general health education provided to the client. Results counseling for people living with HIV will include: • Health education regarding HIV • Risk Reduction counseling • Maintenance of immune system • Disclosure to partners and support systems • Importance of accessing medical care and medications. Results counseling for HIV-negative individuals will include: • Health education • Risk Reduction • Referral to HIV prevention services	Percentage of clients offered results counseling as documented in the primary client record.

I. Linkage to Care	
Standards	**Performance Measure**
Clients testing positive for HIV through preliminary testing will be linked to and assisted in scheduling an appointment with a medical provider of the client's choosing. Successful linkage to outpatient/ambulatory health services is measured as attendance to the actual medical appointment with a prescribing provider.	Percentage of clients who tested positive who were linked to outpatient/ambulatory health services in the measurement year.
	Percentage of people living with HIV, regardless of age, who attended a routine HIV medical care visit within 1 month of HIV diagnosis. (HRSA HAB Measure)
	Percentage of people living with HIV, who were homeless or unstably housed in the measurement period, who attended a routine HIV medical care visit within three (3) months of HIV diagnosis. (HRSA HAB Measure)

J. EIS Care Planning	
Standards	Performance Measure

Persons living with HIV will have care plans developed during the time they are receiving services through EIS programs. Care plans will include:
• Problem Statement (Need)
• Goal(s) – suggest no more than 3 goals
• Intervention
  ○ Task(s)
  ○ Referral(s)
  ○ Service Deliveries
• Individuals responsible for the activity (EIS staff, client, family)
• Anticipated time for each task
 	
The care plan is updated with outcomes and revised or amended in response to changes in the client's life circumstances or goals.
 	
As EIS programs are centered to assist clients in engaging in medical care rapidly after testing positive, care plans should be updated at least monthly, or more often as goals are achieved.
	Percentage of clients accessing EIS services that have a care plan developed as documented in the primary client record.
	
	Percentage of clients accessing EIS services that have a care plan updated and/or revised as documented in the primary client record.

K. Progress Notes	
Standards	Performance Measure
Progress notes will be maintained in each client's primary record with documentation of the assistance the EIS staff provided to the client to help achieve the goal of a successful linkage to OAHS services.	Percentage of clients accessing EIS services that have documented progress notes showing assistance provided to the client in the primary client record.

L. Referrals and Follow-up	
Standards	Performance Measure
EIS staff will assist the clients with referrals to necessary services to achieve successful linkage to care. Referrals will be documented in the client's primary record and, at a minimum, should	Percentage of clients accessing EIS services with documented referrals in the primary client record initiated in a timely manner with client agreed participation upon identification of client needs.

<table>
<tr><td rowspan="2">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 clients engage in their medical care

All referrals made will have documentation of follow-up to the referral in the client's primary record. Follow-up documentation should include the result of the referral made (successful or otherwise) and any additional assistance the EIS staff offered to the client</td><td>Percentage of clients with documented referrals declined by the client in the primary client record.</td></tr>
<tr><td>Percentage of clients accessing EIS services that have documentation of follow-up to the referral including appointment attended and the result of the referral in the primary client record.</td></tr>
</table>

<table>
<tr><th colspan="2">M. Transition/Case Closure</th></tr>
<tr><th>Standards</th><th>Performance Measure</th></tr>
<tr><td>Clients who are successfully linked to active MCM services and/or OAHS must have their cases closed with a case closure summary narrative documented on the criteria and protocol outlined below.

Common reasons for case closure, as applicable, include:
• Client is referred and successfully linked to MCM services;
• Client relocates outside of the service area;
• Client chooses to terminate services;
• Client is lost to care or does not engage in services;
• Client incarceration is greater than six (6) months in a correctional facility;
• Client death.</td><td>Percentage of EIS clients with closed cases that include documentation stating the reason for closure and a closure summary (brief narrative in progress notes and formal case closure/graduation summary) in the primary client record system.</td></tr>
</table>

Transition criteria: • Client has completed EIS goals and has been successfully linked to MCM services • Client is no longer in need of EIS services (client declines EIS assistance). Client is considered non-adherent with care if three (3) attempts to contact client (via phone, text, home visit, e-mail, and/or written correspondence) are unsuccessful and the client has been given 30 days from initial contact to respond. Case closure proceedings should be initiated by the agency 30 days following the 3rd attempt. Make sure appropriate Releases of Information and consents are signed by the client and meet requirements of Texas Medical Record Privacy Act HB 300 regarding electronic dissemination of protected health information (PHI). Staff should utilize multiple methods of contact (phone, text, e-mail, certified letter) when trying to re-engage a client, as appropriate. Agencies must ensure that they have releases of information and consent forms that meet the requirements of Texas Medical Record Privacy Act HB 300 regarding the electronic dissemination of PHI.	Percentage of closed cases with documentation of supervisor signature/approval on closure summary (electronic review is acceptable).

Note: After three unsuccessful attempts are made to contact and re-engage the client, EIS staff should work with their local Disease Intervention Specialist (DIS) workers.

References:

- HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A
  - 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
  - https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringpartb.pdf
- HRSA/HAB Ryan White & Global HIV/AIDS Programs, Program & Grants Management, Policy Notices and Program Letters, Policy Clarification Notice 16-02
  - https://hab.hrsa.gov/program-grants-management/policy-notices-and-program-letters
- DSHS HIV Core and Support Service Categories
  - https://www.dshs.texas.gov/hivstd/taxonomy/
- DSHS Monitoring Tools
  - https://www.dshs.texas.gov/hivstd/taxonomy/#section7
- DSHS HIV/STD Policy #2013.02, *"The Use of Testing Technology to Detect HIV Infection"*
  - http://www.dshs.texas.gov/hivstd/policy/policies/2013-02.shtml

EMERGENCY FINANCIAL ASSISTANCE (EFA)

HRSA Service Category Definition:

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

Services:

Ryan White HIV/AIDS/State Services funds may be used to provide services in the following categories:

1. ADAP eligibility determination period;
2. Dispensing fee for ADAP medications; and/or
3. Emergency Financial Assistance (EFA).

EFA is an allowable support service with an $800/year/client cap.

- 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.
- Limitations on the provision of emergency assistance to eligible individuals/households should be delineated and consistently applied to all clients. It is expected that all other sources of funding in the community for emergency assistance will be effectively used and that any allocation of EFA funding for these purposes will be the payer-of-last-resort, and for limited amounts, limited use, and limited periods of time.

EFA can be used during the ADAP eligibility determination period. Initial medications purchased for this use are not subject to the $800/client/year cap.

EFA can be used to reimburse dispensing fees associated with purchased medications. Dispensing fees are not subject to the $800/client/year cap.

EFA provides funding through:

- Short-term payments to agencies
- Establishment of voucher programs

EFA to individual clients is provided with limited frequency and for a limited period of time, with specified frequency and duration of assistance. Emergent need must be documented each time funds are used.

- Assistance is provided only for the following essential services/subcategories:
    - Utilities such as household utilities including gas, electricity, propane, water, and all required fees
    - Housing such as rent or temporary shelter. EFA can only be used if HOPWA assistance isn't available
    - Food such as groceries and food vouchers

- Prescription medication assistance such as short term, one-time assistance for any medication and associated dispensing fee as a result or component of a primary medical visit (not to exceed a 30-day supply)

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

Service Category Limitations:
Direct cash payments to clients are not permitted. No funds may be used for any expenses associated with the ownership or maintenance of a privately owned motor vehicle.

Program/Clinical Quality Management Standard and Performance Measure:
The following Standards and Performance Measures are guides to improving healthcare outcomes for PLWH throughout the San Antonio Service Area within the Ryan White Part A, Part B, Part D, State Services, and State Rebate Programs.

A. Assisting Clients	
Standards	**Performance Measure**
Assisting Clients during ADAP eligibility determination period HIV+ clients with documented evidence of emergency need of HIV medications are able to receive short-term medication assistance (30-day supply) with limited use of EFA for no more than 60 days (2 months or less).	Percentage of clients that have documented evidence in the client primary record of short-term HIV medication assistance provided during ADAP application period.
Assisting Clients with Short-Term Medications HIV+ clients with documented evidence of pending health insurance medication plan approval are able to receive short-term HIV medication assistance through EFA.	Percentage of clients that have documented evidence in the client primary record of short-term HIV medication copay assistance provided during health insurance application period.

B. Client Determination for Emergency Financial Assistance	
Standards	**Performance Measure**
Applicants must demonstrate an emergent need resulting in their inability to pay their utility bills or prescriptions without assistance and risk disconnection of service due to one or more of the following: • A significant increase in bills • A recent decrease in income • High unexpected expenses on essential	Percentage of clients with documented evidence of determination of EFA need noted in client's primary record.

items • They are unable to provide for basic needs and shelter • A failure to provide EFA will result in danger to the physical health of client or dependent children • Other emergency needs as deemed appropriate by the agency • Agency staff will conduct an assessment of the presenting problems/needs of the client with emergency financial issue. A service plan will be developed documenting client's emergent need resulting in their inability to pay bills/prescriptions without assistance, and other resources pursued noted prior to using EFA funding for assistance. 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. Resolution of the emergency status will be documented in the client record.	Percentage of clients with documented service plan for EFA in the client's primary record that indicates emergent need, other resources pursued, and outcome of EFA provided. Percentage of clients with documented evidence of resolution of the emergency status and referrals made (as applicable) with outcome results in client's primary record.

C. Emergency Financial Assistance Provided	
Standards	Performance Measure
Short-term assistance will only be provided for: • Utilities • Housing • Food (groceries and food vouchers) • Prescription medication assistance All completed requests for assistance shall be approved or denied within three (3) business days. Assistance shall be issued in response to an essential need (as identified by the staff person providing EFA) within three (3) business days of approval of request. Payment for assistance made to service providers will protect client confidentiality.	Percentage of clients with documented evidence of payments made by agency for resolution of emergency status. (copies of checks/vouchers available)

Use of checks and envelopes that de-identify agency as an HIV/AIDS provider to protect client confidentiality.	

References:

- Public Health Service Act, 42 U.S.C.
  - https://legcounsel.house.gov/Comps/PHSA-merged.pdf
- Public Health Service Act, 42 U.S.C. Title XXVI—HIV Healthcare Services Program
  - https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/legislationtitlexxvi.pdf
- HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A
  - 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
  - https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringpartb.pdf
- HRSA/HAB Ryan White & Global HIV/AIDS Programs, Program & Grants Management, Policy Notices and Program Letters, Policy Clarification Notice 16-02
  - https://hab.hrsa.gov/program-grants-management/policy-notices-and-program-letters
- DSHS HIV Core and Support Service Categories
  - https://www.dshs.texas.gov/hivstd/taxonomy/
- DSHS Monitoring Tools
  - https://www.dshs.texas.gov/hivstd/taxonomy/#section7
- DSHS HIV/STD Policy #220.001 "*Eligibility to Receive HIV Services*"
  - https://www.dshs.texas.gov/hivstd/policy/policies/220-001.shtm
- DSHS HIV/STD Policy #590.001 "*Payer of Last Resort*"
  - https://www.dshs.texas.gov/hivstd/policy/policies/590-001.shtm

FOOD BANK /HOME-DELIVERED MEALS

HRSA Service Category Definition:

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

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

Services:

This category includes the provision of actual food, prepared meals, or food vouchers to purchase prepared meals. This category also includes the provision of fruit, vegetables, dairy, canned meat, staples, and personal care products in a food bank setting.

Food Bank: Food Bank services are the provision of actual food and personal care items in a food bank setting.

On-site/Home-Delivered Meals: On-site/Home-Delivered Meals are the provision of prepared meals or food vouchers for prepared meals, in either a congregate dining setting or delivered to clients who are homebound and cannot shop for or prepare their own food. This service includes the provision of both frozen and hot meals.

HRSA/DSHS Program Guidance:

Unallowable costs include household appliances, pet foods, and other non-essential products. Nutritional services and nutritional supplements provided by a registered dietitian are considered a core medical service under the RWHAP and if offered, should be funded under Medical Nutritional Therapy.

Service Category Limitations:

Food vouchers/gift cards are to be restricted from the purchase of tobacco or alcohol products. No direct payment to clients is allowed.

Program/Clinical Quality Management Standard and Performance Measure:

The following Standards and Performance Measures are guides to improving healthcare outcomes for PLWH throughout the San Antonio Service Area within the Ryan White Part A, Part B, Part D, State Services, and State Rebate Programs.

A. Provision of Services	
Standards	**Performance Measure**
Food Distribution: Clients referred to, **or otherwise accessing food bank without a referral**, must be screened for other eligible resources such as SNAP as evidence in their primary record.	Percentage of clients with documentation in the client's primary record of other food resources accessed prior to clients accessing food bank.

Clients accessing food bank have documentation in the client primary record of reason/need assessed. Assessment of client's immediate or ongoing need for food bank services is documented in the client's primary record.	Percentage of clients with documentation in the client's primary record of the assessment of need for food resources.

B. Dietary Guidance	
Standards	**Performance Measure**
A Registered Dietician (RD) must be consulted in the development of a dietary/nutritional policy that lists specific food items that may be offered in the food bank/pantry or prepared for home-delivered meals. There is an agency plan to address the needs of clients' special diets. As applicable, clients are referred to an RD for specific dietary issues. Clients are offered counseling, if requested, to help with meal planning and food appropriateness.	Percentage of clients accessing food bank are referred, as applicable, to a RD for specific dietary issues as documentation in the client primary record.
Program must ensure that available foods are selected taking into account special nutritional needs (incorporating generally accepted nutritional standards), religious requirements, and ethnic food preferences, as appropriate. Attempts must be made on a regular basis to provide choices on food items that meet individual dietary needs of persons with HIV infection, including the foods that fall into the recognized food categories for good diet identified in the Food and Drug Administration or American Dietetic Association standards.	Percentage of clients accessing food bank that are offered counseling for meal planning and food appropriateness.

C. Home-Cooked/Hot Meals	
Standards	**Performance Measure**
Clients assessed for food security and offered home-cooked meals/hot meal programs have evidence of the need documented in the client's primary record. Clients provided vouchers for hot meal programs have an increase in food security.	Percentage of clients accessing hot meal programs, have documented evidence of assessment of need in the client's primary record.
	Percentage of clients accessing hot meal programs have increase in food security as documented in the client's primary record. *(Pilot)*

D. Discharge/Termination	
Standards	Performance Measure
Agency will develop discharge/termination for cause criteria and procedures.	Percentage of clients discharged from food bank/home-delivered meals have documentation of reason of discharge in the client's primary record.

References:

- Public Health Service Act, 42 U.S.C.
  - https://legcounsel.house.gov/Comps/PHSA-merged.pdf
- Public Health Service Act, 42 U.S.C. Title XXVI—HIV Healthcare Services Program
  - https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/legislationtitlexxvi.pdf
- HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A
  - 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
  - https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringpartb.pdf
- HRSA/HAB Ryan White & Global HIV/AIDS Programs, Program & Grants Management, Policy Notices and Program Letters, Policy Clarification Notice 16-02
  - https://hab.hrsa.gov/program-grants-management/policy-notices-and-program-letters
- DSHS HIV Core and Support Service Categories
  - https://www.dshs.texas.gov/hivstd/taxonomy/
- DSHS Monitoring Tools
  - https://www.dshs.texas.gov/hivstd/taxonomy/#section7
- DSHS HIV/STD Policy #220.001 "*Eligibility to Receive HIV Services*"
  - https://www.dshs.texas.gov/hivstd/policy/policies/220-001.shtm
- Texas Department of State Health Services HIV Food Services Standards located within the Program Operating Policies, Chapter 13.

HEALTH EDUCATION / RISK REDUCTION (HE/RR)

HRSA Service Category Definition:

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

Education on risk reduction strategies to reduce transmission such as pre-exposure prophylaxis (PrEP) for clients' partners and treatment as prevention;

- Education on health care coverage options (e.g., qualified health plans through the Marketplace, Medicaid coverage, Medicare coverage);
- Health literacy; and
- Treatment adherence education.

Services:

This service category includes the provision of information dissemination about medical and psychosocial support services and counseling to help clients with HIV improve their health status.

Activities of Health Education/Risk Reduction include, but are not limited to:

- Provision of information about available medical services, psychosocial support, and counseling services;
- Education on HIV transmission and how to reduce the risk of transmission; and
- Risk reduction counseling on how to improve their health status and reduce the risk of HIV transmission to others.

Service Category Limitations:

Health Education/Risk Reduction services cannot be delivered anonymously.

Program/Clinical Quality Management Standard and Performance Measure:

The following Standards and Performance Measures are guides to improving healthcare outcomes for PLWH throughout the San Antonio Service Area within the Ryan White Part A, Part B, Part D, State Services, and State Rebate Programs.

A. Health Educational Assessment and Service Plan	
Standards	**Performance Measure**
HE/RR staff will complete a health/HIV educational evaluation and plan that will indicate how the client's educational needs will be met. Plan must address: • Methods of HIV transmission	Percentage of clients with documented evidence in the client's primary record of a completed health/HIV education evaluation and plan.

• How to reduce risk of HIV transmission ○ Medication adherence • Available resources to meet needs for recently incarcerated • Available resources to meet client needs • Health literacy	Percentage of clients with documented evidence in the client's primary record of a completed plan addressing methods of HIV transmission, risk reduction education, and resources available to meet client's needs.

B. Health Education/Risk Reduction	
Standards	Performance Measure
HE/RR staff will provide health education/risk reduction curriculum regarding: • Methods of HIV transmission and how to reduce the risk of transmission	Percentage of clients with documented evidence in the client's primary record of HE/RR curriculum regarding methods of HIV transmission and how to reduce risk of transmission.
HE/RR staff will provide health education/risk reduction counseling regarding: • How to improve their health status and reduce their risk of transmission to others.	Percentage of clients with documented evidence in the client's primary record of HE/RR counseling regarding how to improve health status and reduce risk of transmission.

C. Resource	
Standards	Performance Measure
HE/RR staff will provide information regarding available medical and psychosocial support services to reduce barriers to care.	Percentage of clients with documented evidence in the client's primary record of HE/RR education provided regarding available medical and support services in the community.

D. Evaluation of Health Education/Risk Reduction Counseling	
Standards	Performance Measure
HE/RR staff will administer pre-post test to each client to assess changes in knowledge/attitudes as a result of the health education/risk reduction counseling.	Percentage of clients with documented evidence in the client's primary record of a pre-test to assess client's understanding of disease process.
	Percentage of clients with documented evidence in the client's primary record of a post-test to assess client's understanding of disease process.
HE/RR Staff will ask each client to complete a brief program evaluation after each completion of a course/service plan to assess effectiveness of program.	Percentage of clients with documented evidence in the client's primary record of increased knowledge of disease process and risk reduction methods.
	Percentage of clients with documented evidence of participation in course/service plan satisfaction survey.

References:

- Public Health Service Act, 42 U.S.C.
  - https://legcounsel.house.gov/Comps/PHSA-merged.pdf
- Public Health Service Act, 42 U.S.C. Title XXVI—HIV Healthcare Services Program
  - https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/legislationtitlexxvi.pdf
- HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A
  - 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
  - https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringpartb.pdf
- HRSA/HAB Ryan White & Global HIV/AIDS Programs, Program & Grants Management, Policy Notices and Program Letters, Policy Clarification Notice 16-02
  - https://hab.hrsa.gov/program-grants-management/policy-notices-and-program-letters
- DSHS HIV Core and Support Service Categories
  - https://www.dshs.texas.gov/hivstd/taxonomy/
- DSHS Monitoring Tools
  - https://www.dshs.texas.gov/hivstd/taxonomy/#section7
- DSHS HIV/STD Policy #220.001 "*Eligibility to Receive HIV Services*"
  - https://www.dshs.texas.gov/hivstd/policy/policies/220-001.shtm

HEALTH INSURANCE PREMIUM AND COST SHARING ASSISTANCE (HIPCSA)

HRSA Service Category Definition:

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

- RWHAP Part recipients must ensure that clients are buying health coverage that, at a minimum, includes at least one drug in each class of core antiretroviral therapeutics from the Department of Health and Human Services (HHS) treatment guidelines along with appropriate HIV outpatient/ambulatory health services;
- RWHAP Part recipients must assess and compare the aggregate cost of paying for the health coverage option versus paying for the aggregate full cost for medications and other appropriate HIV outpatient/ambulatory health services, and allocate funding to HIPCSA only when determined to be cost effective.

Services:

The provision of financial assistance for eligible individuals living with HIV 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).

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, as long as the primary purpose of the supplemental policy is to assist with HIV-related outpatient care.

Funds may be used for:

- Purchasing health insurance (both job or employer-related plans and plans on the individual and group market) that provides comprehensive primary care and pharmacy benefits for clients that provide a full range of HIV medications;
- Standalone dental insurance premiums when cost effective and/or cost sharing assistance when provided in compliance with requirements described in HRSA Policy Clarification Notice (PCN) 16-02, including the FAQ;
- Paying co-pays (including co-pays for prescription eyewear for conditions related to HIV infection), deductibles, and co-insurance for medical and dental plans on behalf of the client;

- Providing funds to contribute to a client's Medicare Part D true out-of-pocket (TrOOP) costs; and/or
- Certain tax liabilities

HRSA/DSHS Program Guidance:

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

- HRSA/HAB Ryan White & Global HIV/AIDS Programs, Program & Grants Management, Policy Notices and Program Letters, Policy Clarification Notice 07-05
  - https://hab.hrsa.gov/sites/default/files/hab/Global/partbadapfundspn0705.pdf
- HRSA/HAB Ryan White & Global HIV/AIDS Programs, Program & Grants Management, Policy Notices and Program Letters, Policy Clarification Notice 13-06
  - https://hab.hrsa.gov/sites/default/files/hab/Global/pcn1306medicaidpremiumcostsharing.pdf
- HRSA/HAB Ryan White & Global HIV/AIDS Programs, Program & Grants Management, Policy Notices and Program Letters, Policy Clarification Notice14-01
  - https://hab.hrsa.gov/sites/default/files/hab/Global/1401policyclarification.pdf
- HRSA/HAB Ryan White & Global HIV/AIDS Programs, Program & Grants Management, Policy Notices and Program Letters, Policy Clarification Notice 16-02
  - https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf
- HRSA/HAB Ryan White & Global HIV/AIDS Programs, Program & Grants Management, Policy Notices and Program Letters, Policy Clarification Notice 18-01
  - https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/18-01-use-of-rwhap-funds-for-premium-and-cost-sharing-assistance.pdf
- DSHS HIV Core and Support Service Categories
  - https://www.dshs.texas.gov/hivstd/taxonomy/
- DSHS Monitoring Tools
  - https://www.dshs.texas.gov/hivstd/taxonomy/#section7
- DSHS HIV/STD Policy #220.001 "*Eligibility to Receive HIV Services*"
  - https://www.dshs.texas.gov/hivstd/policy/policies/220-001.shtm
- DSHS HIV/STD Policy #270.001 "*Calculation of Estimated Expenditures on Covered Clinical Services*"
  - https://www.dshs.texas.gov/hivstd/policy/policies/270-001.shtm
- DSHS HIV/STD Policy #260.002 "*Health Insurance Assistance*"
  - https://www.dshs.texas.gov/hivstd/policy/policies/260-002.shtm
- DSHS HIV/STD "*HIV Core and Support Service Categories, Section 4. Health Insurance Program (HIP)*"
  - https://www.dshs.texas.gov/hivstd/taxonomy/#section4

Service Category Limitations:

HIPCSA cannot be in the form of direct cash payments to clients.

HIPCSA excludes plans that do not cover HIV-treatment drugs; specifically, the 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.

Any cost associated with liability risk pools cannot be funded by RWHAP.

RWHAP funds cannot be used to cover costs associated with Social Security.

HIPCSA funds may not be used to pay fines or tax obligations incurred by clients for not maintaining health insurance coverage required by the Affordable Care Act (ACA).

HIPCSA funds may not be used to make out-of-pocket payments for inpatient hospitalization and emergency department care.

HIPCSA funds may not be used to support plans that offer only catastrophic coverage or supplemental insurance that assists only with hospitalization.

HIPCSA must not be extended for Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage if a client is eligible for other coverage that provides the required minimal level of coverage at a cost-effective price.

Program/Clinical Quality Management Standard and Performance Measure:

The following Standards and Performance Measures are guides to improving healthcare outcomes for PLWH throughout the San Antonio Service Area within the Ryan White Part A, Part B, Part D, State Services, and State Rebate Programs.

A. Health Insurance Plans	
Standards	**Performance Measure**
The agency must ensure that clients are buying health coverage that, at a minimum, includes at least one drug in each class of core anti-retro viral treatment (ART) from the HHS treatment guidelines along with Outpatient/Ambulatory Health Services (OAHS) that meet the requirements of the ACA law for essential health benefits. This must be documented in the client's primary record.	Percentage of clients 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 services that meet the requirements of the ACA law for essential health benefits as indicated in the client's primary record.

B. Co-payments, Premiums, Deductibles, and Co-insurance	
Standards	**Performance Measure**
Otherwise eligible clients with job or employer-based insurance coverage, Qualified Health Plans (QHP), or Medicaid plans, can be provided assistance to offset any cost-sharing programs may impose. Clients must be educated on the cost and their responsibilities to maintaining medical adherence.	Percentage of clients 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 client's primary record.

Education must be provided to clients 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. Agencies will ensure payments are made directly to the health or dental insurance vendor within five (5) business days of approved request.	Percentage of clients with documented evidence of insurance payments made to the vendor within five (5) business days of the approved request.

C. Cost Sharing Education	
Standards	Performance Measure
Education is provided to clients, as applicable, regarding cost-sharing reductions to lower their out-of-pocket expenses. It must be evidenced in the client's primary record that the individual must receive a premium tax credit and enroll in a silver level plan offered in the Marketplace. Clients who are not eligible for cost-sharing reductions (those under 100% FPL in Texas; those with incomes above 400% FPL; clients 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 client's health care needs.	Percentage of clients with documented evidence of education provided regarding cost sharing reductions as applicable, as indicated in the client's primary record.

D. Premium Tax Credits Education	
Standards	Performance Measure
Agencies have documented evidence in the client's primary record of the enrollment in a QHP in the Marketplace, as applicable to the individual (clients that are between 100-400% FPL without access to minimum essential coverage). Education provided to the client regarding tax credits and the requirement to file income tax returns must be documented in the client's primary record. Clients must be provided education on the	Percentage of clients with documented evidence of education provided regarding premium tax credits as indicated in the client's primary record.

importance of reconciling any Advanced Premium Tax Credit (APTC) well before the IRS tax filing deadline.	

E. Prescription Eyewear	
Standards	Performance Measure
Agency must keep documentation from physician stating that the eye condition is related to the client's HIV infection when HIPCSA funds are used to cover co-pays for prescription eyewear.	Percentage of client files with documented evidence, as applicable, of prescribing physician's order relating eye condition warranting prescription eyewear is medically related to the client's HIV infection as indicated in the client's primary record.

F. Medical Visits	
Standards	Performance Measure
Clients accessing health insurance premium and cost sharing assistance services are adherent with their HIV medical care and have documented evidence of attendance of HIV medical appointments in the client's primary record. Note: For clients who use HIPCSA to enable their use of medical care outside of the RW system: HIA providers are required to maintain documentation of client's adherence to Primary Medical Care (e.g. proof of MD visits) during the previous 12 months.	For clients with applicable data in ARIES or other data system used at the provider location[2], percentage of clients, 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) OR For clients who use HIPCSA to enable their use of medical care outside of the RWHAP system: Percentage of clients with documentation of client's adherence to Primary Medical Care (e.g. proof of MD visits, insurance Explanation of Benefits, MD bill/invoice) during the previous 12 months.

G. Viral Suppression	
Standards	Performance Measure
Clients receiving Health Insurance Premium and Cost-Sharing Assistance services have evidence of viral suppression as documented in viral load testing.	For clients with applicable data in ARIES or other data system used at the provider location, percentage of clients, 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. (HRSA HAB Measure)

[2] ~~For clients who use HIPCSA for OAHS at RWHAP-funded providers and therefore have visit and lab data in ARIES or other data system~~

References:

- Public Health Service Act, 42 U.S.C.
  - https://legcounsel.house.gov/Comps/PHSA-merged.pdf
- Public Health Service Act, 42 U.S.C. Title XXVI—HIV Healthcare Services Program
  - https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/legislationtitlexxvi.pdf
- HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A
  - 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
  - https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringpartb.pdf
- HRSA/HAB Ryan White & Global HIV/AIDS Programs, Program & Grants Management, Policy Notices and Program Letters, Policy Clarification Notice 07-05
  - https://hab.hrsa.gov/sites/default/files/hab/Global/partbadapfundspn0705.pdf
- HRSA/HAB Ryan White & Global HIV/AIDS Programs, Program & Grants Management, Policy Notices and Program Letters, Policy Clarification Notice 13-06
  - https://hab.hrsa.gov/sites/default/files/hab/Global/pcn1306medicaidpremiumcostsharing.pdf
- HRSA/HAB Ryan White & Global HIV/AIDS Programs, Program & Grants Management, Policy Notices and Program Letters, Policy Clarification Notice14-01
  - https://hab.hrsa.gov/sites/default/files/hab/Global/1401policyclarification.pdf
- HRSA/HAB Ryan White & Global HIV/AIDS Programs, Program & Grants Management, Policy Notices and Program Letters, Policy Clarification Notice 16-02
  - https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf
- HRSA/HAB Ryan White & Global HIV/AIDS Programs, Program & Grants Management, Policy Notices and Program Letters, Policy Clarification Notice 18-01
  - https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/18-01-use-of-rwhap-funds-for-premium-and-cost-sharing-assistance.pdf
- DSHS HIV Core and Support Service Categories
  - https://www.dshs.texas.gov/hivstd/taxonomy/
- DSHS Monitoring Tools
  - https://www.dshs.texas.gov/hivstd/taxonomy/#section7
- DSHS HIV/STD Policy #220.001 "*Eligibility to Receive HIV Services*"
  - https://www.dshs.texas.gov/hivstd/policy/policies/220-001.shtm
- DSHS HIV/STD Policy #270.001 "*Calculation of Estimated Expenditures on Covered Clinical Services*"
  - https://www.dshs.texas.gov/hivstd/policy/policies/270-001.shtm
- DSHS HIV/STD Policy #260.002 "*Health Insurance Assistance*"
  - https://www.dshs.texas.gov/hivstd/policy/policies/260-002.shtm
- DSHS HIV/STD "*HIV Core and Support Service Categories, Section 4. Health Insurance Program (HIP)*"
  - https://www.dshs.texas.gov/hivstd/taxonomy/#section4

MEDICAL CASE MANAGEMENT (MCM)

HRSA Service Category Definition:

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

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

Services:

Medical Case Managers act as part of a multidisciplinary medical care team, with a specific role of assisting clients in following their medical treatment plan and assisting in the coordination and follow-up of the client's medical care between multiple providers. The goals of this service are 1) the development of knowledge and skills that allow clients to adhere to the medical treatment plan without the support and assistance of the staff providing Medical Case Management services and 2) to address needs for concrete services such as health care, public benefits and assistance, housing, and nutrition, as well as develop the relationship necessary to assist the client in addressing other issues including substance use, mental health, and domestic violence in the context of their family/close support system. Core components of Medical Case Management services are:

1. Coordination of Medical Care – scheduling appointments for various treatments and referrals including labs, screenings, medical specialist appointments, mental health, oral health care and substance abuse treatment
2. Follow-up of Medical Treatments – includes either accompanying client to medical appointments, calling, emailing, texting or writing letters to clients with respect to various treatments to ensure appointments were kept or rescheduled as needed. Additionally, follow-up also includes ensuring clients have appropriate documentation, transportation, and understanding of procedures. MCM staff must also encourage and enable open dialogue with medical healthcare professionals.
3. Treatment Adherence – the provision of counseling or special programs to ensure readiness for, and adherence to, HIV/AIDS treatments.

Key activities include:

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

- Treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments
- Client-specific advocacy and/or review of utilization of services

HRSA/DSHS Program Guidance:
The HAB performance measures for Medical Case Management Services can be located on the HRSA website with the following link: https://hab.hrsa.gov/clinical-quality-management/performance-measure-portfolio

Service Category Limitations:
Medical Case Management is a service based on need, and is not appropriate or necessary for every client accessing services. Medical Case Management is designed to serve individuals who have complex needs related to their ability to access and maintain HIV medical care. **Medical Case Management should not be used as the only access point for medical care and other agency services.** Clients who do not need Medical Case Management services to access and maintain medical care should not be enrolled in Medical Case Management services. When clients are able to maintain their medical care, clients should be graduated. Clients with ongoing existing need for Treatment Adherence support due to mental illness or other documented behavioral disorders meet the criteria for Medical Case Management services.

Medical Case Management services have as their objective ***improving health care outcomes*** whereas Non-Medical Case Management Services have as their objective providing ***guidance and assistance in improving access to needed services***. Visits to ensure readiness for, and adherence to, complex HIV treatments shall be considered Medical Case Management or Outpatient/Ambulatory Health Services. Treatment Adherence Services provided during a Medical Case Management visit should be reported in the Medical Case Management service category whereas Treatment Adherence services provided during an Outpatient/Ambulatory Health Service visit should be reported under the Outpatient/Ambulatory Health Services category.

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

Program/Clinical Quality Management Standard and Performance Measure:
The following Standards and Performance Measures are guides to improving healthcare outcomes for PLWH throughout the San Antonio Service Area within the Ryan White Part A, Part B, Part D, State Services, and State Rebate Programs.

<table>
<tr><th colspan="2">A. Initial Comprehensive Assessment</th></tr>
<tr><th>Standards</th><th>Performance Measure</th></tr>
<tr><td rowspan="4">Initial Comprehensive Assessment must be completed within 30 calendar days of the first appointment to access MCM services and includes at a minimum:
1. Client health history, health status and health-related needs, including but not limited to:
• HIV disease progression
• Tuberculosis
• Hepatitis
• STI history and/or history of screening
• Other medical conditions
• OB/GYN as appropriate, including pregnancy status
• Routine health maintenance (ex. Well women exams, pap smears)
• Medications and adherence
• Allergies to medications
• Complementary therapy
• Current health care providers; engagement in and barriers to care
• Oral health care
• Vision care
• Home health care and community-based services
• Substance Use (validated and reliable substance use disorder screening tool must be used. See website for SAMISS)
• Mental Health (validated and reliable substance use disorder screening tool must be used. See website for SAMISS)
• Medical Nutritional Therapy
• Clinical trials
• Family Violence
• Sexual health assessment and risk reduction counseling

2. Additional information
• Client strengths and resources</td><td>Percentage of clients who access MCM services that have a completed initial comprehensive assessment within 30 calendar days of the first appointment to access MCM services and includes all required documentation in the primary client record system.</td></tr>
<tr><td>Percentage of clients that received at least one face-to-face meeting with the MCM staff that conducted the initial comprehensive assessment.</td></tr>
<tr><td>Percentage of clients with documentation of case closure due to non-responsiveness. (See case closure)</td></tr>
<tr><td>Percentage of MCM clients with documented education on basic HIV information as needed (newly diagnosed, return to care), including explanation of viral load and viral suppression.</td></tr>
</table>

• Other agencies that serve client and household • Progress note of assessment session(s) • Supervisor signature and date, signifying review and approval, for medical case management staff during their probationary period *NOTE*: The MCM team has the discretion to (1) determine priority need clients that should be enrolled in MCM and (2) enroll clients who have low acuity scores, but are high need and/or high-risk clients for disengaging in care. Clear and detailed documentation must be present in the client's primary record.	Percentage of MCM clients with documented evidence of sexual health literacy and education provided on harm reduction, as needed.

B. Medical Case Management Acuity Level and Client Contact	
Standards	Performance Measure
MCM clients have a documented acuity level using an approved acuity scoring tool with the comprehensive assessment. Each interaction with a client has the potential to change acuity scores in specific categories. Any changes in a client's acuity should be documented appropriately. Acuity and frequency of contact is documented in the primary client record system.	Percentage of clients who have a completed acuity level documented using an approved acuity scale with the comprehensive assessment and documented in the client primary record system.
	Percentage of clients with acuity that have documented evidence of review of acuity, minimum every three (3) months, to ensure acuity is still appropriate level for the client's needs.
	Percentage of clients with documented decreased acuity during the measurement year
	Percentage of clients with documented evidence of acuity and frequency of contact by MCM matches acuity level in the primary client record system.

<table>
<tr><th colspan="2">C. Care Planning</th></tr>
<tr><th>Standards</th><th>Performance Measure</th></tr>
<tr><td rowspan="2">The client and the case manager will actively work together to develop and implement the care plan. Care plans include at a minimum:
Problem Statement (Need)
Goal(s) – suggest no more than three goals
Intervention
Task(s)
Referral(s)
Service Deliveries
Individuals responsible for the activity (medical case management staff, client, other team member, family)
Anticipated time for each task
The care plan is updated with outcomes and revised or amended in response to changes in client life circumstances or goals, at a minimum, every six (6) months. Tasks, referrals and services should be updated as they are identified or completed – not at set intervals.</td><td>Percentage of medical case management patients, regardless of age, with a diagnosis of HIV who had a medical case management care plan developed and/or updated two or more times in the measurement year. (HRSA HAB Measure)</td></tr>
<tr><td>Percentage of client records with documented issues noted in the care plans that have ongoing case notes that match the stated need and the progress towards meeting the goal identified, as indicated in the primary client record system.</td></tr>
</table>

<table>
<tr><th colspan="2">D. Viral Suppression/Treatment Adherence</th></tr>
<tr><th>Standards</th><th>Performance Measure</th></tr>
<tr><td rowspan="2">An assessment of treatment adherence support needs and client education should begin as soon as clients enter MCM services and should continue as long as a client remains in MCM services.

Medical Case Management services should involve an individually tailored adherence intervention program, and staff providing medical case management should reinforce treatment adherence at every contact whether it is during face-to-face contact or telephone contact.

The following criteria are recommendations that can help medical case management staff</td><td>Percentage of MCM clients with documented education about the goals of ARV therapy.</td></tr>
<tr><td>Percentage of MCM clients who were provided medication adherence counseling as indicated for those clients that are non-compliant (not taking their medications as prescribed, missing doses) with education documented in the primary client record system.</td></tr>
</table>

and clients examine the client's current and historical adherence to both medical care and treatment regimens: **Medication Adherence**: Relates to current level of adherence to ARV medication regimen and client ability to take medications as prescribed. MCM staff will use any available treatment adherence tool to promote adherence. **Appointments**: Relates to current level of completion of appointments for core medical services and understanding of the importance of regular attendance at medical and non-medical appointments in order to achieve positive health outcomes. **ARV Medication Side Effects**: Relates to adverse side effects associated with ARV treatment and the impact on functioning and adherence. MCM staff will discuss side effects of medications as challenges and barriers to treatment adherence, including diarrhea, nausea, rash, headache, vomiting, swallowing and problems due to thrush. **Knowledge of HIV Medications**: Relates to client understanding of prescribed ARV regimen, the role of medications in achieving positive health outcomes and techniques to manage side effects. **Treatment Support**: Relates to client relationship with family, friends, and/or community support systems, which may either promote or hinder client adherence to treatment protocols.	Percentage of MCM clients who were provided education on treatment adherence as determined necessary for non-compliant clients and education is documented in the primary client record system. Percentage of MCM patients, regardless of age, with a diagnosis of HIV who did not have a medical visit in the last 6 months of the measurement year (that is documented in the medical case management record). (HRSA HAB measure) Percentage of MCM patients, 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) Percentage of MCM patients, 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.

E. Referral and Follow-Up	
Standards	Performance Measure
Medical case management staff will work with the client to determine barriers to referrals and facilitate access to referrals.	Percentage of MCM clients with documented referrals initiated immediately with client agreed participation upon identification of client needs.
Medical case management staff will ensure that clients are accessing needed referrals and services, and will identify and resolve any	Percentage of MCM clients with documented referrals declined by the client in the primary client record system.

barriers clients may have in following through with their Care Plan. When clients are referred for services elsewhere, case notes include documentation of the completed referral with outcome of the referral in the primary client record system.	Percentage of MCM clients with referrals that have documentation of follow up to the referral including appointment attended and the result of the referral.
	Percentage of MCM agencies with documented evidence of a referral tracking mechanism to monitor completion of all medical case management referrals.

F. Case Closure/Graduation	
Standards	Performance Measure
Clients who are no longer engaged in active medical case management services should have their cases closed with case closure summary narrative documented based on the criteria and protocol outlined below. Common reasons for case closure, as applicable, include: • Client is referred to another medical case management program • Client relocates outside of service area • Client chooses to terminate services • Client is no longer eligible for services due to not meeting eligibility requirements • Client is lost to care or does not engage in service • Client incarceration greater than six (6) months in a correctional facility • Provider initiated termination due to behavioral violations, per agency's policy and/or procedures • Client death Graduation criteria: • Client completed medical case management goals • Client is no longer in need of medical case management services (e.g. client is capable of resolving needs independent of medical case management assistance) Client is considered non-compliant with care if three (3) attempts to contact client (via phone, e-mail and/or written correspondence) are	Percentage of MCM clients with closed cases that include documentation stating the reason for closure and a closure summary (brief narrative in progress notes and formal case closure/graduation summary) in the primary client record system.
	Percentage of closed cases with documentation of supervisor signature/approval on closure summary (electronic review is acceptable).
	Percentage of clients notified (through face-to-face meeting, telephone conversation or letter) of plans for case closure of the client's file from medical case management services.
	Percentage of clients with written documentation explaining the reason(s) for case closure/graduation and the process to be followed if client elects to appeal the case closure/graduation from service.

<table>
<tr><td rowspan="2">unsuccessful and the client has been given 30 days from initial contact to respond. Case closure proceedings should be initiated by agency 30 days following the 3rd attempt. Make sure appropriate Releases of Information and consents are signed by the client and meet requirements of HB 300 regarding electronic dissemination of protected health information (PHI).

Staff should utilize multiple methods of contact (phone, text, e-mail, certified letter) when trying to re-engage a client, as appropriate. Agencies must ensure that they have releases of information and consent forms that meet the requirements of HB 300 regarding the electric dissemination of protected health information (PHI).</td><td>Percentage of MCM closed files that have documentation that other service providers are notified and this is documented in the client's chart.</td></tr>
<tr><td>Percentage of clients that are provided with contact information and process for reestablishment as documented in primary client record system.</td></tr>
</table>

Note: See Appendix B for the Case Management Chart; courtesy of DSHS

References:

- Public Health Service Act, 42 U.S.C.
  - https://legcounsel.house.gov/Comps/PHSA-merged.pdf
- Public Health Service Act, 42 U.S.C. Title XXVI—HIV Healthcare Services Program
  - https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/legislationtitlexxvi.pdf
- HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A
  - 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
  - https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringpartb.pdf
- HRSA/HAB Ryan White & Global HIV/AIDS Programs, Program & Grants Management, Policy Notices and Program Letters, Policy Clarification Notice 16-02
  - https://hab.hrsa.gov/program-grants-management/policy-notices-and-program-letters
- DSHS HIV Core and Support Service Categories
  - https://www.dshs.texas.gov/hivstd/taxonomy/
- DSHS Monitoring Tools
  - https://www.dshs.texas.gov/hivstd/taxonomy/#section7

MEDICAL NUTRITION THERAPY

HRSA Service Category Definition:

Medical Nutrition Therapy includes:

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

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

Services:

The application of Medical Nutrition Therapy as a part of the Nutrition Care Process is an integral component of the medical treatment for management of specific disease states and conditions and should be the initial step in the management of these situations. Efforts to optimize nutritional status through individualized medical nutrition therapy, assurance of food and nutrition security, and nutrition education are essential to the total system of health care available to people with human immunodeficiency virus (HIV) infection through the continuum of care.

Medical Nutrition Therapy is individualized dietary instruction that incorporates diet therapy counseling for a nutrition-related problem. This level of specialized instruction is above basic nutrition counseling and includes an individualized dietary assessment performed by an RD. Medical Nutrition Therapy services can be provided via telehealth subject to federal guidelines, Texas State Law, and DSHS policy.

Services include providing nutritional supplements and food provisions based on the medical care provider's recommendation:

- Nutritional supplements include medical nutritional formula, vitamins, and herbs;
- Food provisions consist of recommending significant change in daily food intake based on a deficiency, which may directly affect HIV/co-morbidities.

HRSA/DSHS Program Guidance:

plan developed by the registered dietitian or other licensed nutrition professional. Services not provided by a registered/licensed dietitian should be considered Psychosocial Support Services under the RWHAP.

Note: In the State of Texas, the only allowable nutrition professional recognized for this service category is a licensed Registered Dietitian (RD).

Service Category Limitations:

Services must be provided by a licensed RD or other licensed nutrition professional pursuant to a medical provider's written referral. Nutritional services and nutritional supplements not provided by an RD shall be considered a support service under Psychosocial Support Services under the RWHAP.

Food provisions and nutritional supplements not provided pursuant to a physician's recommendation **and** a nutritional plan developed by an RD also shall be considered a support service under Food Bank/Home-Delivered Meals.

Program/Clinical Quality Management Standard and Performance Measure:
The following Standards and Performance Measures are guides to improving healthcare outcomes for PLWH throughout the San Antonio Service Area within the Ryan White Part A, Part B, Part D, State Services, and State Rebate Programs.

<table>
<tr><th colspan="2">A. Medical Nutrition Therapy Assessment</th></tr>
<tr><th>Standards</th><th>Performance Measure</th></tr>
<tr><td rowspan="2">An initial Medical Nutrition Therapy assessment will be conducted by an RD pursuant to a medical provider’s referral.

Medical Nutrition Therapy provider will contact the patient for the initial nutritional assessment within five (5) business days of the referral.

The initial Medical Nutrition Therapy assessment must be completed within ten (10) business days of the initial appointment with the RD.

Medical Nutrition Therapy provider obtains and documents HIV primary medical care provider contact information for each patient. Medical Nutrition Therapy services must be provided in consultation with the medical care provider for medical coordination.

Medical Nutrition Therapy provider collects and documents assessment history information with updates as medically appropriate prior to providing care. This information must be based on the Academy of Nutrition & Dietetics (AND) Evidence Based Guidelines that include, but not be limited to:
• Anthropometrics: height and weight; pre-illness usual weight and goal weight; and body muscle and fat.
• Clinical data: medical history.
• Dietary data: individual’s food preferences including ethnic and cultural food preferences and practices; information about allergies, food intolerances, and food</td><td>Percentage of clients accessing Medical Nutrition Therapy with documentation of the medical provider’s referral to Medical Nutrition Therapy in the client’s primary record.</td></tr>
<tr><td>Percentage of clients accessing Medical Nutrition Therapy with a documented completed Medical Nutrition Therapy assessment conducted by an RD in the client’s primary record.</td></tr>
</table>

avoidances; exercise frequency; food security. • **Biochemical**: lab data from the primary medical care provider.	

B. Nutrition Plan	
Standards	Performance Measure
A nutritional plan will be developed appropriate for the client's health status, financial status, and individual preference. A Nutritional Plan is completed within ten (10) business days of Nutrition Assessment and includes, but is not limited to: • Nutritional diagnosis • Measurable goal • Date service is to be initiated • Recommended services and course of medical nutrition therapy to be provided to include the planned number and frequency of sessions • Types and amounts of nutritional supplements and food provisions. The plan will be signed by the RD developing the plan. The Nutrition Plan will be updated as necessary, but no less than at least twice per year, and will be shared with the client, the client's primary care provider, and other authorized personnel involved in the client's care.	Percentage of clients accessing Medical Nutrition Therapy services have a documented nutrition plan developed in the client's primary record. Percentage of clients accessing Medical Nutrition Therapy services have an updated nutrition plan at least twice per year as documented in the client's primary record.

C. Services Provided	
Standards	Performance Measure
According to the American Dietetic Association's HIV-related protocols in Medical Nutrition Therapy Across the Continuum of Care nutritional services will be provided. The frequency of contact with the RD will be based on the level of care needed	Percentage of clients accessing Medical Nutrition Therapy services that have documentation in the client's primary record of frequency of contact with the RD to review the nutritional plan and goals as indicated in the initial assessment.

per the initial assessment. Nutritional intervention will focus on set standards of medical nutrition therapy that targets measurable goals, recommended services, and course of medical nutrition therapy as outlined in the Nutrition Plan. Emerging problems such as lipodystrophy syndrome will be addressed and added to the nutrition plan as needed. Services will be documented in the patient's chart and signed by the RD providing care at each visit.	Percentage of clients accessing Medical Nutrition Therapy services with RD notes documented in the client's primary record of nutritional interventions and recommendations.
	Percentage of clients accessing Medical Nutrition Therapy services show improvement in issues identified in the initial assessment as documented by the RD in the client's primary record.

D. Provision of Nutritional Supplements and Food Provisions	
Standards	Performance Measure
Nutritional supplements and food provisions deemed medically necessary may be provided per written orders from a prescribing physician. Upon receipt of the written referral by the primary medical care provider to the RD, clients may receive up to a 90-day supply of nutritional supplements at one time in accordance with their Medical Nutrition Therapy developed nutritional plan. Nutritional supplements and food provisions must be outlined in the written nutrition plan by the RD. The written nutritional plan must be communicated with the primary HIV prescribing provider.	Percentage of clients accessing Medical Nutrition Therapy services that are prescribed nutritional supplements in accordance with the nutritional plan developed by the RD have documented evidence of supplements provided to the client in the client's primary record.

E. Nutrition Education	
Standards	Performance Measure
Patient nutritional health education will be offered to each patient a minimum of once a year that includes, but is not limited to: • Benefits of good nutrition • Special dietary needs of people with HIV/AIDS • Supplementation • Coping with complications	Percentage of clients accessing Medical Nutrition Therapy services with documented evidence of nutritional health education provided in the client's primary record.

F. Referrals	
Standards	**Performance Measure**
At a minimum, patients will receive referrals to specialized health care providers/services as needed to augment Medical Nutrition Therapy that includes, but is not limited to: • Other medical professionals such as social workers, mental health providers, or case managers • Community resources such as food pantries; SNAP/food stamps; Women, Infants and Children Supplemental Food Program (WIC), etc. • Nutrition classes • Exercise facilities • Other education and economic resource groups Medical Nutrition Therapy provider will document referral and outcome in the client's record.	Percentage of clients accessing Medical Nutrition Therapy services that had documentation of referrals to other services as indicated in the client's primary record. Percentage of clients accessing Medical Nutrition Therapy services have follow up documentation to the referral offered in the client's primary record.

G. Discharge	
Standards	**Performance Measure**
An individual is deemed no longer to be in need of Medical Nutrition Therapy if one or more of these criteria is met: • Patient's medical condition improves and Medical Nutrition Therapy services are no longer necessary • Patient deceased • Patient moves out of the service area Date of discharge, reason, and any recommendations for follow up shall be documented in the patient's record and the primary medical provider notified.	Percentage of clients accessing Medical Nutrition Therapy with documentation of discharge noted in the client's primary record as applicable.

References:

- Public Health Service Act, 42 U.S.C.
  - https://legcounsel.house.gov/Comps/PHSA-merged.pdf
- Public Health Service Act, 42 U.S.C. Title XXVI—HIV Healthcare Services Program
  - https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/legislationtitlexxvi.pdf
- HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A
  - 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
  - https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringpartb.pdf

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    - https://hab.hrsa.gov/program-grants-management/policy-notices-and-program-letters
- DSHS HIV Core and Support Service Categories
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- DSHS Monitoring Tools
    - https://www.dshs.texas.gov/hivstd/taxonomy/#section7
- DSHS HIV/STD Policy #220.001 "*Eligibility to Receive HIV Services*"
    - https://www.dshs.texas.gov/hivstd/policy/policies/220-001.shtm
- Academy of Nutrition and Dietetics Nutrition Guides for Practice and Other Resources
- Agency for Healthcare Research and Quality. HIV/AIDS evidence-based nutrition practice guideline
- Guidelines for Implementing HIV/AIDS Medical Nutrition Therapy Protocols, September, 1999
- Living well with HIV/AIDS. A manual on nutritional care and support for people living with HIV/AIDS
- The American Dietetic Association. Medical Nutrition Therapy Across the Continuum of Care, Second Edition, October, 1998.
- The American Dietetic Association. HIV/AIDS evidence-based nutrition practice guideline. Chicago (IL): American Dietetic Association; December, 2010.
- Texas Medicaid & Healthcare Partnership. *Texas Medicaid Provider Procedures Manual, volume 2*, August 2017.

MEDICAL TRANSPORTATION SERVICES

HRSA Service Category Definition:

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

Services:

Services include transportation to public and private outpatient medical care and physician services, case management, substance abuse and mental health services, pharmacies, and other services where eligible clients receive Ryan White/State Services-defined Core or Support Services, and/or medical and health-related care services, including clinical trials, essential to their well-being.

All drivers must have a valid Texas Driver's License. The contractor must ensure that each driver has or is covered by automobile liability insurance for the vehicle operated as required by the State of Texas and that all vehicles have a current Texas State Registration.

Medical Transportation must be reported as a Support Service in all cases, regardless of whether the client is transported to a Core or Support service.

HRSA/DSHS Program Guidance:

Medical Transportation may be provided through:

- Contracts with providers of transportation services, including ride share service providers;
- Mileage reimbursement (through a non-cash system) that enables clients to travel to needed medical or other support services, but should not in any case exceed the established rates for federal Programs (Federal Joint Travel Regulations provide further guidance on this subject);
- Purchase or lease of organizational vehicles for client transportation programs, provided the recipient receives prior approval for the purchase of a vehicle from DSHS first and HRSA/HAB as applicable;
- Organization and use of volunteer drivers (through programs with insurance and other liability issues specifically addressed); and/or
- Voucher or token systems.

Service Category Limitations:

Unallowable costs include:

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

Medical Transportation cannot be used to transport a client in need of emergency medical care.

Program/Clinical Quality Management Standard and Performance Measure:

The following Standards and Performance Measures are guides to improving healthcare outcomes for PLWH throughout the San Antonio Service Area within the Ryan White Part A, Part B, Part D, State Services, and State Rebate Programs.

A. Client Education Regarding Services Available and Limitations	
Standards	**Performance Measure**
Clients are provided with information on transportation services and instructions on how to access the services. • General transportation service hours should correspond with the business hours of local core medical and support services that clients access. • Clients must be able to confirm their transportation arrangements to core or support service appointments at least two business days in advance for medical transportation services offered via van, ride share, or volunteer-operated vehicles. This does not apply to transportation solutions relying on fare media (e.g., bus passes, bus tokens, taxi vouchers). The agency provides clients with information on transportation limitations, clients' responsibilities for accessing the receiving transportation, and the agency's responsibilities for providing transportation.	Percentage of clients accessing Medical Transportation services that have documented evidence of education provided regarding services available and limitations in the primary client record.

B. Screening for Other Transportation Resources:	
Standards	**Performance Measure**
Client shall be screened for other transportation resources (e.g., Medicaid-eligible clients using DSHS Medicaid transportation program). Sub-recipients must enforce Payor of Last Resort requirements for transportation. Clients eligible for Medicaid Transportation cannot be billed to RW unless there is documentation in the client file that the Medicaid Transportation program cannot meet the need for the needed transportation event (e.g., not available for the date and time of the scheduled OAHS appointment).	Percentage of clients accessing Medical Transportation services that have documented evidence of screening completed of other resources for transportation services in the primary client record.

C. Client Signed Statement	
Standards	Performance Measure
A signed statement from the client consenting to transportation services and agreeing to safe and proper conduct in any vehicle is documented in the client's primary record. This statement is to include the consequences of violating the agreement such as removal, suspension, and/or possible termination of transportation services (not applicable to fare media-supported services such as bus passes or tokens).	Percentage of clients accessing Medical Transportation services that have documented evidence of a signed statement agreeing to safe and proper conduct in the primary client record.

D. Use of Agency Vehicles	
Standards	Performance Measure
When Agency Conveyance is used for medical transportation, clients and agencies are made aware of problems immediately (e.g. vehicle breakdown) and notification documented. The Agency shall ensure that the transportation program has the capability to provide alternate transportation (e.g. taxi, ride share) to eligible clients in, at a minimum, the following situations: • Service is unavailable due to primary transportation vehicle breakdown, driver unavailability, or inclement weather; • Client's non-emergency medical need requires immediate transport; • Scheduling conflicts; and/or • Other locally determined events where missing an appointment may impose significant hardship upon a client (e.g. missing a Social Security Disability hearing).	Percentage of clients accessing Medical Transportation services that have documented evidence, as applicable, of issue reported to the client and other arrangements are made to accommodate the client need in the primary client record.

E. Documentation of "No Shows"	
Standards	Performance Measure
Client "no shows" are documented in either a transportation log and/or the client's primary record where an agency's conveyance or contracted transportation service provider (such as taxi services, ride share providers, etc.) is transporting clients from their home to necessary Core and/or Support Services.	Percentage of clients accessing Medical Transportation services that have documented evidence where a client does not show for an agency conveyance or contracted service scheduled appointment.

Core medical and support service providers are promptly notified by the Medical Transportation agency regarding client "no shows."	

F. Access to Care	
Standards	Performance Measure
Clients accessing Medical Transportation services have evidence of attendance to their Core and/or Support Services where Medical Transportation services were required to access and retain a client in care.	Percentage of clients who access Medical Transportation services have documentation of evidence of access and retention in medical care, other Core Services, and/or Support Services in the primary client record.

References:

- Public Health Service Act, 42 U.S.C.
  - https://legcounsel.house.gov/Comps/PHSA-merged.pdf
- Public Health Service Act, 42 U.S.C. Title XXVI—HIV Healthcare Services Program
  - https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/legislationtitlexxvi.pdf
- HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A
  - 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
  - https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringpartb.pdf
- HRSA/HAB Ryan White & Global HIV/AIDS Programs, Program & Grants Management, Policy Notices and Program Letters, Policy Clarification Notice 16-02
  - https://hab.hrsa.gov/program-grants-management/policy-notices-and-program-letters
- DSHS HIV Core and Support Service Categories
  - https://www.dshs.texas.gov/hivstd/taxonomy/
- DSHS Monitoring Tools
  - https://www.dshs.texas.gov/hivstd/taxonomy/#section7
- DSHS HIV/STD Policy #220.001 "*Eligibility to Receive HIV Services*"
  - https://www.dshs.texas.gov/hivstd/policy/policies/220-001.shtm
- American with Disabilities Act (ADA)
- State of Texas Transportation Code Title 7, Subtitle C, Chapter 545. Operation and movement of Vehicles.
- Texas Department of Public Safety. Classes of Drivers Licenses.

MENTAL HEALTH SERVICES

HRSA Service Category Definition:

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

Services:

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 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) information.

Mental health services can be delivered via telehealth subject to federal guidelines, Texas State law, and DSHS policy.

Service Category Limitations:

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

Program/Clinical Quality Management Standard and Performance Measure:

The following Standards and Performance Measures are guides to improving healthcare outcomes for PLWH throughout the San Antonio Service Area within the Ryan White Part A, Part B, Part D, State Services, and State Rebate Programs.

A. Policies and Procedures	
Standards	Performance Measure
Orientation is provided to all new clients to introduce them to program services, to ensure their understanding of the need of continuous care, and to empower them in accessing services. Orientation includes written or verbal information provided to the client on the following: • Services available • Clinic hours and procedures for after-hours emergency and non-life-threatening urgent situations • How to reach staff member(s) as appropriate • Scheduling appointments • Client responsibilities for receiving program services and the agency's responsibilities for delivering them • Patient rights including the grievance process	Percentage of new clients with documented evidence of orientation to services available in the client's primary record.

B. Mental Health Assessment	
Standards	Performance Measure
All clients referred to the program will receive a Mental Health Assessment by licensed mental health professionals. A mental health assessment should be completed no later than the third counseling session and should include, at a minimum, the following as guided by licensure requirements: • Presenting problems • Completed mental status evaluation (including appearance and behavior, self-attitude, speech, psychomotor activity, mood, insight, judgment, suicidal ideation, homicidal ideation, perceptual disturbances, obsessions/compulsions, phobias, panic attacks) • Cognitive assessment (level of consciousness, orientation, memory, and language) • Current risk of danger to self and others • Living Situation • Social support and family relationships, including client strengths/weaknesses,	Percentage of clients with documented mental health assessment completed by the 3rd counseling session, unless otherwise noted, in the client's primary record.

coping mechanisms and self-help strategies
• Medical history
• Current Medications
• Substance use history
• Psychosocial history to include:
  ○ Education and employment history, including military service
  ○ Sexual and relationship history and status
  ○ Physical, emotional, and/or sexual abuse history
  ○ Domestic violence assessment
  ○ Trauma assessment
  ○ Legal history
  ○ Leisure and recreational activities
 	
Clients are assessed for care coordination needs, and referrals are made to case management programs as appropriate. If pressing mental health needs emerge during the mental health assessment requiring immediate attention that results in the assessment not being finalized by the third session, this must be documented in the client's primary record.	

C. Treatment Plan	
Standards	Performance Measure
All eligible client files should have documented evidence of a detailed treatment plan and documentation of services provided within the client's primary record. A treatment plan shall be completed within 30 days from the Mental Health Assessment. The treatment plan should include: • Diagnosed mental health issue • Goals and objectives • Treatment type (individual, group) • Start date for mental health services • Recommended number of sessions • Date for reassessment • Projected treatment end date (estimated) • Any recommendations for follow up Treatment, as clinically appropriate, should include counseling regarding:	Percentage of clients with documented detailed treatment plan and documentation of services provided within the client's primary record.

• Risk reduction and health promotion • Substance use disorder • Treatment adherence • Development of social support systems • Community resources • Maximizing social and adaptive functioning • The role of spirituality and religion in a client's life, disability, death and dying and exploration of future goals The treatment plan must be signed by the mental health professional rendering service and developed in conjunction with the client. 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. Percentage of clients with documented detailed treatment plan and documentation of services provided within the client's primary record. Percentage of clients with treatment plans completed and signed by the licensed mental health professional rendering services in the client's primary record. Percentage of clients 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 client's primary record.	Percentage of clients with treatment plans completed and signed by the licensed mental health professional rendering services in the client's primary record. Percentage of clients 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 client's primary record.

D. Psychiatric Referral	
Standards	Performance Measure
Clients are evaluated for psychiatric intervention and appropriate referrals are initiated as documented in the client's primary record.	Percentage of clients with documented need for psychiatric intervention are referred to services as evidenced in the client's primary record.

E. Psychotropic Medication Management	
Standards	**Performance Measure**
Psychotropic medication management services are available for all clients either directly or through referral as appropriate. Pharm Ds can provide psychotropic medication management services. Mental health professional will discuss the client's concerns with the client about prescribed medications (side effects, dosage, interactions with HIV medications, etc.). Mental health professional will encourage the client to discuss concerns about prescribed medications with their HIV-prescribing clinician (if the mental health 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*	Percentage of clients accessing medication management services with documented evidence in the client's primary record of education regarding medications. Percentage of clients with changes to psychotropic/psychoactive medications with documented evidence of this change shared with the HIV-prescribing provider, as permitted by the client's signed consent to share information, in the client's primary record.

F. Provision of Services	
Standards	**Performance Measure**
Services will be provided according to the individual's treatment plan and documented in the client's primary record. Progress notes are completed according to the agency's standardized format for each session and will include: • Client name • Session date • Focus of session • Interventions • Progress on treatment goals • Newly identified issues/goals • Counselor signature and authentication (credentials). 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 client to another organization that can	Percentage of client's with documented evidence of progress notes completed and signed in accordance with the individual's treatment plan in the client's primary record.

provide the services. The referral must be made within one (1) business day for urgent, non-life threatening situation(s).	

G. Coordination of Care	
Standards	Performance Measure
Care will be coordinated across the mental health care coordination team members. The client is involved in the decision to initiate or defer treatments. The mental health professional will involve the entire care team in educating the client, providing support, and monitoring mental health treatment adherence. Problem solving strategies or referrals are in place for clients 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.	Percentage of agencies who have documented evidence in the client's primary record or care coordination, as permissible, of shared MH treatment adherence with the client's prescribing provider.

H. Referrals	
Standards	Performance Measure
As needed, mental health providers will refer clients to full range of medical/mental health services including: • Psychiatric evaluation • Pharmacist for psychotropic medication management • Neuropsychological testing • Day treatment programs • In-patient hospitalization • Family/Couples therapy for relationship issues unrelated to the client's HIV diagnosis	Percentage of clients with documented referrals, as applicable, for other medical/mental health services in the client's primary record.

I. Discharge Planning	
Standards	Performance Measure
Discharge planning will be done with each client when treatment goals are met or when client has discontinued therapy as evidenced by non-attendance of scheduled appointments, as applicable. Documentation for discharge planning will include, as applicable: • Circumstances of discharge	Percentage of clients with documentation of discharge planning when treatment goals being met as evidenced in the client's primary record.

• Summary of needs at admission • Summary of services provided • Goals and objectives completed during counseling • Discharge plan • Counselor authentication, in accordance with current licensure requirements	Percentage of clients with documentation of case closure per agency non-attendance policy as evidenced in the client's primary record.

References:

- Public Health Service Act, 42 U.S.C.
  - https://legcounsel.house.gov/Comps/PHSA-merged.pdf
- Public Health Service Act, 42 U.S.C. Title XXVI—HIV Healthcare Services Program
  - https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/legislationtitlexxvi.pdf
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  - https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringpartb.pdf
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- DSHS HIV/STD Policy #220.001 "*Eligibility to Receive HIV Services*"
  - https://www.dshs.texas.gov/hivstd/policy/policies/220-001.shtm
- DSHS HIV/STD Policy #270.001 "*Calculation of Estimated Expenditures on Covered Clinical Services*"
  - https://www.dshs.texas.gov/hivstd/policy/policies/270-001.shtm
- American Psychiatric Association. The Practice Guideline for Treatment of Patients with HIV/AIDS, Washington, DC, 2001.
- New York State Mental Health Standards of Care

NON-MEDICAL CASE MANAGEMENT (NMCM)

HRSA Service Category Definition:

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

Services:

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

Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Continuous client monitoring to assess the efficacy of the care plan
- Re-evaluation of the care plan at least every six (6) months with adaptations as necessary
- Ongoing assessment of the client'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 clients in obtaining access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, and insurance plans through the health insurance Marketplaces/Exchanges).

Service Category Limitations:

Non-Medical Case Management services do not involve coordination and follow up of medical treatments.

Non-Medical Case Management is a service based on need, and is not appropriate or necessary for every client 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. Clients who do not need guidance and assistance in improving/gaining access to needed services should not be enrolled in NMCM services. When clients are able to maintain their care, clients should be graduated. Clients 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.

Program/Clinical Quality Management Standard and Performance Measure:

The following Standards and Performance Measures are guides to improving healthcare outcomes for PLWH throughout the San Antonio Service Area within the Ryan White Part A, Part B, Part D, State Services, and State Rebate Programs.

<table>
<tr><th colspan="2">A. Initial Assessment</th></tr>
<tr><th>Standards</th><th>Performance Measure</th></tr>
<tr><td rowspan="2">The Initial Assessment is required for clients 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 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:
1. Client’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</td><td>Percentage of clients who access NMCM services that have a completed assessment within 30 calendar days of the first appointment to access NMCM services and includes all required documentation.</td></tr>
<tr><td>Percentage of clients that received at least one face-to-face meeting with the NMCM staff that conducted the initial assessment.</td></tr>
</table>

• 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 2. Additional information • Client strengths and resources • Other agencies that serve client and household • Brief narrative summary of assessment session(s)	Percentage of clients who have documented Initial Assessment in the primary client record system.

B. Care Planning	
Standards	**Performance Measure**

The client and the case manager will actively work together to develop and implement the care plan. Care plans include at a minimum:
 	
• Problem Statement (Need)
• Goal(s) – suggest no more than three goals
• Intervention
  ○ Task(s)
  ○ Assistance in accessing services (types of assistance)
  ○ Service Deliveries
• Individuals responsible for the activity (case management staff, client, other team member, family)
• Anticipated time for each task
• Client 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.
	Percentage of NMCM clients, 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. (DSHS Performance Measure)
	
	Percentage of client records with documented follow up for issues presented in the care plan.
	
	Percentage of Care Plans documented in the primary client record system.

C. Assistance in Accessing Services and Follow-Up	
Standards	**Performance Measure**
Case management staff will work with the client to determine barriers to accessing services and will provide assistance in accessing needed services. Case management staff will ensure that clients are accessing needed services, and will identify and resolve any barriers clients may have in following through with their Care Plan. When clients are provided assistance for services elsewhere, case notes include documentation of follow-up.	Percentage of NMCM clients with documented types of assistance provided that was initiated upon identification of client needs and with the agreement of the client. Assistance denied by the client should also be documented in the primary client record system
	Percentage of NMCM clients with assistance provided have documentation of follow up to the type of assistance provided.

D. Case Closure/Graduation	
Standards	**Performance Measure**
Clients who are no longer engaged in active case management services should have their cases closed based on the criteria and protocol outlined below. Common reasons for case closure include: • Client is referred to another case management program • Client relocates outside of service area • Client chooses to terminate services • Client is no longer eligible for services due to not meeting eligibility requirements • Client is lost to care or does not engage in service • Client incarceration greater than six (6) months in a correctional facility • Provider initiated termination due to behavioral violations • Client death	Percentage of client with written documentation explaining the reason(s) for discharge and the process to be followed if client elects to appeal the discharge from service
	Percentage of clients with information about reestablishment shared with the client and documented in primary client record system.

<table>
<tr>
<td rowspan="2">Graduation criteria:
• Client completed case management goals for increased access to services/care needs
• Client is no longer in need of case management services (e.g. client is capable of resolving needs independent of case management assistance)

Client is considered non-compliant with care if three (3) attempts to contact client (via phone, e-mail and/or written correspondence) are unsuccessful and the client has been given 30 days from initial contact to respond. Discharge proceedings should be initiated by agency 30 days following the 3rd attempt. Make sure appropriate Releases of Information and consents are signed by the client and meet requirements of HB 300 regarding electronic dissemination of protected health information (PHI).

Staff should utilize multiple methods of contact (phone, text, e-mail, certified letter) when trying to re-engage a client, as appropriate. Agencies must ensure that they have releases of information and consent forms that meet the requirements of HB 300 regarding the electronic dissemination of protected health information (PHI).</td>
<td>Percentage of clients provided with contact information and process for reestablishment as documented in primary client record system.</td>
</tr>
<tr>
<td>Percentage of clients with documented Case Closure/Graduation in the primary client record system.</td>
</tr>
</table>

Note: See Appendix B for the Case Management Chart; courtesy of DSHS

References:

- Public Health Service Act, 42 U.S.C.
  - https://legcounsel.house.gov/Comps/PHSA-merged.pdf
- Public Health Service Act, 42 U.S.C. Title XXVI—HIV Healthcare Services Program
  - https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/legislationtitlexxvi.pdf
- HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A
  - 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
  - https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringpartb.pdf
- HRSA/HAB Ryan White & Global HIV/AIDS Programs, Program & Grants Management, Policy Notices and Program Letters, Policy Clarification Notice 16-02
  - https://hab.hrsa.gov/program-grants-management/policy-notices-and-program-letters
- DSHS HIV Core and Support Service Categories
  - https://www.dshs.texas.gov/hivstd/taxonomy/
- DSHS Monitoring Tools
  - https://www.dshs.texas.gov/hivstd/taxonomy/#section7

ORAL HEALTH CARE

HRSA Service Category 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.

Services:

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 client's annual benefit balance.

Oral health services are an allowable core service with an expenditure cap of $3,000/client 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.

Service Category Limitations:

Cosmetic dentistry for cosmetic purposes only is prohibited.

Program/Clinical Quality Management Standard and Performance Measure:

The following Standards and Performance Measures are guides to improving healthcare outcomes for PLWH throughout the San Antonio Service Area within the Ryan White Part A, Part B, Part D, State Services, and State Rebate Programs.

A. Dental and Medical History	
Standard	Performance Measure
To develop an appropriate treatment plan, the oral health care provider shall obtain complete information about the patient's health and medication status. This information shall include, but not be limited to, the following: The client's HIV-prescribing primary medical care provider name and phone number; • Pregnancy status as applicable;	Percentage of oral health patients who had a dental and medical health history (initial or updated) at least once in the measurement year. (HRSA HAB Measure)

• A baseline current CBC laboratory test; • Current CD4 and Viral Load laboratory test results; • 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; • Patient's chief complaint; • Current Medications, including any osteoporotic medications; • 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; • Date of last dental examination; and • Any predisposing conditions that may affect the prognosis, progression, and management of oral health condition. All lab results documented in the medical and dental history must align with current treatment guidelines.	

B. Limited Physical Examination	
Standard	Performance Measure
The oral health provider is responsible for completing an initial limited physical examination in accordance with the Texas Board of Dental Examiners that shall include, but not be limited to: • Blood Pressure; • Pulse/Heart Rate; and • Basic vital signs. • Dental practitioner shall 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 patient's vital signs, the dental practitioner	Percentage of oral health patients with a documented limited physical examination completed in the primary client oral health record.

must document in the patient's oral health care record why the attempt to obtain vital signs was unsuccessful	

C. Oral Examination	
Standard	Performance Measure
Clinical oral evaluations include evaluation, diagnosis and treatment planning. Patient must have either an initial comprehensive oral exam or a periodic recall oral evaluation once per year such as: • Comprehensive oral evaluation, to include bitewing x-rays, new or established patient; • Periodic Oral Evaluation to include bitewing x-rays, established patient; • Detailed and Extensive Oral Evaluation, problem focused by report; • Re-evaluation, limited, problem focused (established patient; not post-operative visit); or • Comprehensive Periodontal Evaluation, new or established patient. Source: http://ada.org Please reference Dental Practice Parameters on the above website.	Percentage of oral health patients with a documented oral examination completed within the measurement year in the client's primary oral health record.

D. Periodontal Screening or Examination	
Standard	Performance Measure
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. A comprehensive periodontal examination includes: • Evaluation of periodontal conditions; • Evaluation and recording of dental caries; • Evaluation and recording of missing or unerupted teeth; • Evaluation and recording of restorations; • Evaluation and recording of occlusal relationships;	Percentage of oral health patients who had a periodontal screen or examination as least once in the measurement year. (HRSA HAB Measure)

• Evaluation of oral cancer; • Probing and charting; • Evaluation and recording of the patient's dental and medical history; and • General health assessment. Some forms of periodontal disease may be more severe in individuals affected with immune system disorders. Patients with HIV may have especially severe forms of periodontal disease. The incidence of necrotizing periodontal diseases may increase with patients with acquired immune deficiency syndrome.	

E. Dental Treatment Plan	
Standard	**Performance Measure**
A dental treatment plan that includes preventive care, maintenance, and elimination of oral pathology shall be developed and discussed with the patient. Various treatment options shall be discussed and developed in collaboration with the patient. A treatment plan appropriate for the patient's health status, financial status, and individual preference must 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)[3]; • Dental treatment plan will be signed by the	Percentage of oral health patients who had a dental treatment plan developed and/or updated at least once in the measurement year. (HRSA HAB Measure)

[3] https://www.ada.org/en/member-center/oral-health-topics/antibiotic-prophylaxis. Source: https://www.ncbi.nlm.nih.gov/pubmed/10875698 and www.hivguidelines.org.

oral care health professional providing the services. (Electronic signatures are acceptable)	

F. Phase 1 Treatment Plan	
Standard	Performance Measure
Phase 1 treatment includes prevention, maintenance, and/or elimination of oral pathology that results from dental caries or periodontal disease. This includes: • Restorative treatment; • Basic periodontal therapy (nonsurgical); • Basic oral surgery that includes extractions and biopsy; • Non-surgical endodontic therapy; and • Space maintenance and tooth eruption guidance for transitional dentition. A Phase 1 treatment plan will be established and updated annually to include diagnostic, preventative, and therapeutic services that will be provided. The Phase 1 treatment plan, if the care was completed on schedule, is completed within 12 months of initiating treatment.	Percentage of oral health patients with a Phase 1 treatment plan that is completed within 12 months. (HRSA HAB Measure)

G. Oral Health Education	
Standard	Performance Measure
Oral health education must be provided and can be documented by either a licensed dentist, dental hygienist, dental assistant, or dental case manager and shall include: • Oral hygiene instruction; • 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 patient. If deemed appropriate, the reason is stated in the patient's oral health record; and • Smoking/tobacco cessation counseling as indicated. Additional areas for instruction may include Nutrition.	Percentage of oral health patients who received oral health education at least once in the measurement year. (HRSA HAB Measure)

For pediatric patients, oral health education shall be provided to parents and caregivers and be age-appropriate for pediatric patients. *Source*: http://ada.org Please reference Dental Practice Parameters on the above website.	

H. Referrals	
Standard	Performance Measure
Referrals for other services must be documented in the patient's oral health care chart. Any referrals provided by the oral health provider must have documented evidence of outcomes of the referral and/or follow-up documentation regarding the referral.	Percentage of oral health patients with documented referrals provided have outcomes and/or follow-up documentation in the primary oral health care record.

References:

- Public Health Service Act, 42 U.S.C.
  - https://legcounsel.house.gov/Comps/PHSA-merged.pdf
- Public Health Service Act, 42 U.S.C. Title XXVI—HIV Healthcare Services Program
  - https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/legislationtitlexxvi.pdf
- HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A
  - 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
  - https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringpartb.pdf
- HRSA/HAB Ryan White & Global HIV/AIDS Programs, Program & Grants Management, Policy Notices and Program Letters, Policy Clarification Notice 16-02
  - https://hab.hrsa.gov/program-grants-management/policy-notices-and-program-letters
- DSHS HIV Core and Support Service Categories
  - https://www.dshs.texas.gov/hivstd/taxonomy/
- DSHS Monitoring Tools
  - https://www.dshs.texas.gov/hivstd/taxonomy/#section7
- DSHS HIV/STD Policy #220.001 "*Eligibility to Receive HIV Services*"
  - https://www.dshs.texas.gov/hivstd/policy/policies/220-001.shtm
- DSHS HIV/STD Policy #270.001 "*Calculation of Estimated Expenditures on Covered Clinical Services*"
  - https://www.dshs.texas.gov/hivstd/policy/policies/270-001.shtm
- American Dental Association. Dental Practice Parameters. Patients requiring a comprehensive oral evaluation
- Texas Administrative Code. Title 22, Part 5 State Board of Dental Examiners. Chapter 108, Rule 7. Minimal Standards of Care
- Texas Health and Safety Code, Title 2, Subtitle D, Chapter 85. Acquired Immune Deficiency Syndrome and Human Immunodeficiency Virus Infection
- HRSA/HAB Clinical Care & Quality Management. HAB Oral Health Performance Measures

OUTPATIENT/AMBULATORY HEALTH SERVICES (OAHS)

HRSA Service Category Definition:

Outpatient/Ambulatory Health Services (OAHS) are diagnostic and therapeutic services provided directly to a client by a licensed healthcare provider in an outpatient medical setting. Outpatient medical settings include clinics, medical offices, and mobile vans where clients do not stay overnight.

Services:

Allowable activities include:

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

Care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies (ART).

Diagnostic Laboratory Testing includes all indicated medical diagnostic testing, including all tests considered integral to treatment of HIV and related complications (e.g., viral Load, CD4 counts, and genotype assays). Funded tests must meet the following conditions:

- Tests must be consistent with medical and laboratory standards as established by scientific evidence and supported by professional panels, associations, or organizations;
- Tests must be (1) approved by the U.S. Food and Drug Administration (FDA), when required under the FDA Medical Devices Act; and/or (2) performed in an approved Clinical Laboratory Improvement Amendments of 1988 (CLIA)-certified laboratory or State-exempt laboratory; and
- Tests must be (1) ordered by a registered, certified, or licensed medical provider, and (2) necessary and appropriate based on established clinical practice standards and professional clinical judgment.

Telemedicine is an acceptable means of providing OAHS but must conform to the Texas Medical Board (TMB) guidelines for providing telemedicine, Texas Administrative Code, Texas Medical Board, Rules, Title 22, Part 9, Chapter 174, RULE §174.1 to §174.12 and the February 2018 Texas Medicaid Provider Telecommunication Services Handbook, Volume 2.

Service Category Limitations:

Emergency room, urgent care services, or ambulance services are NOT considered outpatient settings; therefore, services cannot be reimbursed.

Program/Clinical Quality Management Standard and Performance Measure:

The following Standards and Performance Measures are guides to improving healthcare outcomes for PLWH throughout the San Antonio Service Area within the Ryan White Part A, Part B, Part D, State Services, and State Rebate Programs. The most current U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), Guide for HIV/AIDS Clinical Care – 2014 Edition are sources cited throughout the Standards for additional reference materials for direct care service providers.

A. Medical Evaluation/Assessment	
Standard	**Performance Measure**
All HIV patients receiving medical care shall have a completed initial comprehensive medical evaluation/assessment and physical examination that adheres to the current HHS guidelines within one (1) month of HIV diagnosis[4] or within 15 business days of initial contact with patient who has been in care. Primary medical care for the treatment of HIV includes the provision of care that is consistent with the most current HHS treatment guidelines	Percentage of patients who attended a routine HIV medical care visit within one (1) month of HIV diagnosis. (HRSA HAB Measure – Linkage to Care) Percentage of existing patients (returning to care and those in current medical care for more than one year) with a documented comprehensive assessment/evaluation completed by the MD, NP, CNS, or PA within 15 business days of initial contact with patient in accordance with professional and established HIV practice guidelines.
Source: Page 61, https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/2014guide.pdf	

B. Comprehensive HIV-Related History	
Standard	**Performance Measure**
Primary medical care for the treatment of HIV includes the provision of care that is consistent with the most current HHS treatment guidelines. History shall consist of, at a minimum, general medical history, a comprehensive HIV related history, and psychosocial history to include: • Documented past medical and surgical history with regard to chronic diseases such as diabetes, high blood pressure, heart disease, cholesterol, asthma or emphysema, sickle cell disease, etc. per HHS guidelines. • Psychosocial history to include socio-cultural assessment, occupational history, hobbies (as applicable), travel history, mental health, and housing status.	Percentage of new patients with a documented comprehensive HIV-related history that is inclusive of all components listed in the OAHS Standard as referenced in the HHS guidelines.

[4] HRSA/HAB Performance Measure: https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/systemlevelmeasures-part1.pdf

• Lifestyle including tobacco use, alcohol use, illicit substance use, exercise, travel history. • Sexual Health including partners, practices, past sexually transmitted infections (STIs), contraception use (past and present). • HIV-related health history including most recent CD4 and Viral Load results, current ART (if applicable), previous adverse ART drug reactions, history of HIV-related illness and infections, HIV treatment history and staging. Physical examination will include the documentation from the complete review of systems as indicated within the comprehensive medical history. This can be completed during the initial visit or divided over the course of two or three early visits.	Percentage of existing patients with a documented comprehensive HIV-related history that is inclusive of all components listed in the OAHS Standard as referenced in the HHS guidelines.
Source: Page 61-70; https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/2014guide.pdf	

C. Physical Examination	
Standard	Performance Measure
Primary medical care for the treatment of HIV includes the provision of care that is consistent with the most current HHS treatment guidelines. Providers should perform a baseline and annual comprehensive physical examination, with particular attention to areas potentially affected by HIV. Examination of the oral cavity should be included in both the initial and interim physical examination of all HIV patients.	Percentage of new patients with a documented annual physical examination.
	Percentage of new patients with a diagnosis of HIV who received an oral cavity exam during the physical exam as documented in the patient's primary record.
	Percentage of existing patients with a documented annual physical examination.
	Percentage of existing patients with a diagnosis of HIV who received an oral cavity exam during the physical exam as documented in the patient's primary record.
Source: Page 73-77; https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/2014guide.pdf.	

<table>
<tr><th colspan="2">D. Initial Laboratory Tests, as Clinically Indicated by Licensed Provider[5]</th></tr>
<tr><th>Standard</th><th>Performance Measure</th></tr>
<tr><td rowspan="8">Tests will include as clinically indicated:
• HIV Antibody, if not documented previously;
• CD4 Count and/or CD4 Percentage
• Quantitative Plasma HIV RNA (HIV Viral Load)
• Standard genotypic drug-resistance testing ***Refer to Table 3 in the "Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents Living with HIV" for guidance on other scenarios where genotype testing is recommended***
• Co-receptor Tropism Test (if considering use of CCR5 co-receptor antagonist or for patients who exhibit virologic failure on a CCR5 antagonist)
• HLA-B*5701 testing (only before initiating abacavir-containing regimen per guidelines)
• Complete Blood Count (CBC) with Differential and Platelets
• Chemistry Profile: Electrolytes, Creatinine, Blood Urea Nitrogen (BUN)
• Liver Transaminases, Bilirubin (Total and Direct)
• Urinalysis with Urine Protein and Creatinine
• Quantitative HCV RNA viral load testing (for Hepatitis C (HCV)-positive patients who are candidates for treatment)
• Hepatitis A antibody, Hepatitis B surface antigen, core Ab, and surface antibody & Hepatitis C antibody screens at initial intake (providers should screen all HIV-infected patients for anti-HCV antibodies at baseline)
• Lipid Profile (Total Cholesterol, LDL, HDL, Triglycerides); fasting
• Glucose (preferably fasting) or hemoglobin A1C</td><td>Percentage of new patients with documented initial laboratory tests completed according the OAHS Standard and HHS treatment guidelines.</td></tr>
<tr><td>Percentage of new patients with documented CD4 count (absolute).</td></tr>
<tr><td>Percentage of new patients with documented HIV-RNA viral load. (HRSA HAB Measure)</td></tr>
<tr><td>Percentage of new patients with documented drug resistance testing, as applicable.</td></tr>
<tr><td>Percentage of new patients with a diagnosis of HIV at risk for STIs who had a test for chlamydia within the measurement year. (HRSA HAB Measure)</td></tr>
<tr><td>Percentage of new patients with a diagnosis of HIV at risk for STIs who had a test for gonorrhea within the measurement year. (HRSA HAB Measure)</td></tr>
<tr><td>Percentage of new adult patients with a diagnosis of HIV who had a test for syphilis performed within the measurement year. (HRSA HAB Measure)</td></tr>
<tr><td>Hepatitis B screening was performed at least once since the diagnosis of HIV or for whom there is documented infection or immunity. (HRSA HAB Measure)</td></tr>
</table>

[5] Initial Laboratory Tests: https://aidsinfo.nih.gov/guidelines/htmltables/1/5570, see Table 3.

• Pregnancy Test (for female clients of childbearing potential) • RPR or treponemal antibody (Syphilis Screening) • Gonorrhea (GC) and Chlamydia (CT) Testing • Toxoplasma gondii IgG • Trichomoniasis Testing Primary medical care for the treatment of HIV includes the provision of care that is consistent with the most current HHS treatment guidelines.	Percentage of new patients for whom HCV screening was performed at least once since the diagnosis of HIV. (HRSA HAB Measure)
Source: Page 79-89; https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/2014guide.pdf.	

E. Other diagnostic testing	
Standard	Performance Measure
Primary medical care for the treatment of HIV includes the provision of care that is consistent with the most current HHS treatment guidelines. Chest x-ray will be completed if pulmonary symptoms are present; if positive LTBI test (either TST or Interferon Gamma Release Assay (IGRA)); or if prior evidence of LTBI or pulmonary TB (perform annually).	Percentage of new or existing patients with documented chest x-ray completed if pulmonary symptoms were present, after an initial positive QTF, after initial positive TST, or annually if prior evidence of LTBI or pulmonary TB.
Source: Page 85: https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/2014guide.pdf.	

F. Initial Screenings/Assessments	
Standards	Performance Measure
Primary medical care for the treatment of HIV includes the provision of care that is consistent with the most current HHS treatment guidelines. Patients should receive screening for opportunistic infections and assessment of psychosocial needs initially and annually according to the most current HHS guidelines. Screening should include at a minimum: • Mental health assessment that includes screening for clinical depression (PHQ 2 at	Percentage of new patients with documented initial medical screenings and assessments as indicated in the OAHS Standard and in accordance with HHS guidelines.

a minimum) • Psychosocial assessment, including domestic violence and housing status[6] • Substance use and abuse screening • Tobacco use screening • Pediatric patients (14 years and younger) will be screened for child abuse as defined in Chapter 261 of the Texas Family Code and DSHS policy. Consider screening youth 14-17 for child abuse. • Oral health exam and assessment • Tuberculosis (TB) Screening • Cervical Cancer Screen (following the most current clinical recommendations)[7] ○ **Women Aged <30 Years with HIV**: ▪ If younger than age 21, known to have HIV or newly diagnosed with HIV, and sexually active, Pap test should be performed within one (1) year of onset of sexual activity regardless of mode of HIV transmission. ○ **Women Aged >30 Years with HIV**: ▪ Pap Testing Only: □ Pap test should be done at baseline and every 12 months □ If results of three (3) consecutive Pap tests are normal, follow-up Pap tests can be performed every three (3) years Additional screenings as medically indicated include: • Dilated eye exam every 6 to 12 months if the CD4<50 by an ophthalmologist **Anal Cancer (Dysplasia) Screening** The Anal Cancer (Dysplasia) Screening Guidelines recommend, at a minimum, annual	Percentage of new female patients with a diagnosis of HIV who were screened for cervical cancer in the last three years. (HRSA HAB Measure) Percentage of new patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen. (HRSA HAB Measure) Percentage of new patients with documented initial psychosocial assessment to include domestic violence and housing status. Percentage of new patients with a diagnosis of HIV who have been screened for substance use (alcohol & drugs) in the measurement year. (HRSA HAB Measure) Percentage of new patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user. (HRSA HAB Measure) Percentage of new patients, if applicable, with completed child abuse assessment (completed if patient aged 14 years and younger).

[6] Recommended: Psychosocial Assessment Questions: page 65. https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/2014guide.pdf

[7] Cervical Cancer Screen guidelines for <30 and over 3 years of age: https://aidsinfo.nih.gov/guidelines/html/4/adult-and-adolescent-opportunistic-infection/343/hpv

digital examination to detect masses on palpation that could be anal cancer. However, performing the digital exam alone as a screening procedure for anal dysplasia or cancer will miss many lesions. Anal cancer screening using a Pap test can improve sensitivity for detecting anal dysplasia or cancer. Cytology combined with high-resolution anoscopy (HRA) is considered the best strategy for screening of precancerous lesions. If anal Pap is performed, clinicians should refer patients with abnormal anal cytology for HRA. In communities where HRA is not available, clinicians should consider referring patients with abnormal anal cytology to a surgeon for evaluation.	Percentage of new patients aged three months and older with a diagnosis of HIV, for whom there was documentation that a tuberculosis (TB) screening test was performed and results interpreted (for TB skin tests) as least once since the diagnosis of HIV. (HRSA HAB Measure)
Source: Page 6-7, 83-89, 127, https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/2014guide.pdf	

G. Immunizations	
Standards	Performance Measure
Primary medical care for the treatment of HIV includes the provision of care that is consistent with the most current HHS treatment guidelines. Immunizations/vaccinations will be given according to the most current HHS guidelines and the CDC's "2017 Adult Vaccination Schedule." Providers will initiate prophylaxis for specific opportunistic infections. Patients will be offered vaccinations for the following: • Tetanus, Diphtheria, and Pertussis (Tdap) per recommended treatment guidelines for immunizations[8] • Measles, Mumps, Rubella (MMR) per recommended treatment guidelines for immunizations.[9] ***Adults and adolescents with a CD4 cell count <200 cells/uL should not receive MMR.*** • Influenza (inactivated vaccine)- annually during flu season October 1st - March 31st • Pneumococcal is recommended for all patients, two separate vaccines are recommended; • Receive a dose of PCV13, (Prevnar 13), followed by a dose of PPV23 (Pneumovax) at least eig*ht (8) weeks later*. For specific guidance on doses and frequency	Percentage of patients with Tetanus, Diphtheria, and Pertussis current within 10 years, Td booster doses every 10 years thereafter, or documentation of refusal. Percentage of patients aged six months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization. (HRSA HAB Measure)

[8] Tdap vaccination guidelines: https://aidsinfo.nih.gov/guidelines/html/4/adult-and-adolescent-opportunistic-infection/365/figure--immunization
[9] ~~MMR vaccination guidelines: https://aidsinfo.nih.gov/guidelines/html/4/adult-and-adolescent-opportunistic-infection/65/figure--immunization~~

see: https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/pneumo.html • Completion of Hepatitis B (HBV) vaccines series, unless otherwise documented as immune, *vaccinated patients should be tested for HBsAb response 1–2 months or at the next scheduled clinic visits after the third dose see:* https://aidsinfo.nih.gov/guidelines/html/4/adult-and-adolescent-opportunistic-infection/365/figure--immunization • Completion of Hepatitis A (HAV) vaccines series, unless otherwise documented as immune. • Varicella-Zoster (VZV): Please reference current treatment guidelines for VZV.[10] ***This vaccination is contraindicated in persons with HIV and CD4 count <200***. *HPV vaccine: The 2017 ACIP recommends and DHHS states: "because of the potential benefit in preventing HPV-associated disease and cancer in this population, HPV vaccination is recommended for HIV infected males and females aged 13 through 26". • For providers who need vaccine to provide their patients at no cost to the provider, please reference: https://www.dshs.texas.gov/immunize/ASN/providers.aspx • For providers who want to refer their patients out for vaccines that are offered at no cost or reduced cost, please reference: https://www.dshs.texas.gov/immunize/ASN/public.aspx	Percentage of patients with a diagnosis of HIV who completed the vaccination series for Hepatitis B. (HRSA HAB Measure) Percentage of patients with a diagnosis of HIV who ever received pneumococcal vaccine. (HRSA HAB Measure) Percentage of patients with a diagnosis of HIV who completed the vaccination series for Hepatitis A.

H. Antibiotic Treatment (Recommend Prophylactic Antibiotic Treatment)	
Standards	Performance Measure
Antibiotic prophylaxis for opportunistic infections will be initiated if active infection has been ruled out and the following conditions are met: • Mycobacterium avium complex (MAC): if CD4 <50 • Toxoplasmosis: if CD4 <100 and toxoplasma IgG is positive • PCP Prophylaxis will be completed adhering to the current HHS Guidelines.	Percentage of patients, regardless of age, who are offered MAC Prophylaxis as medically indicated.

[10] VZV guidelines: https://aidsinfo.nih.gov/guidelines/html/4/adult-and-adolescent-opportunistic-infections/365/figure--immunization

○ *Preventing 1st Episode of PCP (Primary Prophylaxis) Indications for Initiating Primary Prophylaxis*: ▪ CD4 count <200 cells/mm3 or ▪ CD4% <14% of total lymphocyte count or ▪ CD4 count >200 but <250 cells/mm3, if ART cannot be initiated, and if CD4 cell count monitoring (e.g., every 3 months) is not possible[11]	Patients aged six weeks or older with a diagnosed of HIV, with CD4 counts of less than 200 cells/µL or a CD4 percentage below 15%, will be prescribed PCP prophylaxis. (HRSA HAB Measure)

I. Anti-retroviral Therapy (ART)	
Standards	Performance Measure
Primary medical care for the treatment of HIV includes the provision of care that is consistent with the most current HHS treatment guidelines. ART will be prescribed in accordance with the HHS established guidelines. Patients who meet current guidelines for ART are offered and/or prescribed ART.	Percentage of patients, regardless of age, with a diagnosis of HIV are prescribed ART for the treatment of HIV during the measurement year. (HRSA HAB Measure)
Source: (ARV) Page 207-220; https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/2014guide.pdf	

J. Drug Resistance Testing	
Standards	Performance Measure
Primary medical care for the treatment of HIV includes the provision of care that is consistent with the most current HHS treatment guidelines. "HIV drug-resistance testing is recommended for persons with HIV infection at entry into care. Genotypic testing is recommended as the preferred resistance testing to guide therapy in ARV-naïve patients." Panel on Opportunistic Infections in HIV-Infected Adults and Adolescents. Guidelines for the prevention and treatment of opportunistic infections in HIV-	Percentage of patients, regardless of age, with a diagnosis of HIV who had an HIV drug resistance test performed before initiation of HIV ART if therapy started during the measurement year. (HRSA HAB Measure)

[11] Panel on Opportunistic Infections in HIV-Infected Adults and Adolescents. Guidelines for the prevention and treatment of opportunistic infections in HIV-infected adults and adolescents: recommendations from the Centers for Disease Control and Prevention, the National Institutes of Health, and the HIV Medicine Association of the Infectious Disease Society of America. Available at: ~~http://aidsinfo.nih.gov/contentfiles/lvguidelines/adult_oi.pdf.1/8/2018~~, page ~~B-8.~~

infected adults and adolescents: recommendations from the Centers for Disease Control and Prevention, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. Available at http://aidsinfo.nih.gov/contentfiles/lvguidelines/adult_oi.pdf. Accessed 11/8/17. C1-5, Table 3 ***https://aidsinfo.nih.gov/contentfiles/lvguidelines/adultandadolescentgl.pdf*** Drug resistance testing must follow most recent, established resistance testing guidelines, including genotypic testing on all ARV-naïve patients. Counseling and education about drug resistance testing must be provided by the patient's medical practitioner, registered nurse and/or other appropriate licensed healthcare provider (if designated by the practitioner). ***Drug-Resistance Assay Not Usually Recommended*** • *After therapy is discontinued: Drug-resistance testing is not usually recommended more than 4 weeks after ARV drugs are discontinued* • *In patients with low HIV RNA levels: Drug-resistance testing is not usually recommended in patients with a plasma viral load of <500 copies/mL*	
Source: Page 81; https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/2014guide.pdf	

K. Health Education/Risk Reduction	
Standards	Performance Measure
Health education will adhere to the most current HHS guidelines. Providers will provide routine HIV risk-reduction counseling and behavioral health counseling for HIV-infected patients. Since patients' behaviors change over time as the course of their disease changes and their social situations vary, health education	Percentage of patients with a diagnosis of HIV who received HIV risk counseling in the measurement year. (HRSA HAB Measure)
	Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user. (HRSA HAB Measure)

<table>
<tr><td rowspan="3">providers will tailor routine risk-reduction counseling and behavioral health counseling not only to the individual patient but also to the particular point in time in the patient's life.

The following will be conducted initially and as needed:

• Providers should discuss safer sexual practices so to decrease risk of transmitting HIV.
• Providers should counsel HIV-infected patients about the risk of acquiring syphilis and other STIs from unprotected sexual contact, including all sites of possible transmission, such as anus, cervix, vagina, urethra, and oropharynx.
• Providers should discuss family planning with patients
• Contraception counseling/hormonal contraception
• Drug interaction counseling
• Providers should counsel patients on tobacco cessation annually for those patients that were screened and positive for smoking (or document decline of tobacco use)
• When current alcohol or other substance use is identified, providers should discuss the possible effects of such use on the patient's general health and HIV medications, as well as options for treatment if indicated
• Providers should routinely discuss with patients the importance of disclosure to partners. Patients should be educated about the options for voluntary partner notification.
• When HIV patients are diagnosed with early syphilis (primary, secondary, or early latent), providers should intensify risk-reduction counseling, including discussions about the importance of condom use.
• Nutritional Counseling regarding:
o Quality and quantity of daily food and liquid intake
o Exercise (as medically indicated)</td><td>Percentage of patients with documented counseling about family planning method appropriate to patient's status, as applicable.</td></tr>
<tr><td>Percentage of patients with documented instruction regarding new medications, as appropriate.</td></tr>
<tr><td>Percentage of patients with documented counseling regarding the importance of disclosure to partners.</td></tr>
</table>

Source: (Smoking Cessation) page 189-196; https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/2014guide.pdf.
Source: (Patient Education) Page 57-59, 89, 102, 107, 111, 126, 143-154; https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/2014guide.pdf.
Source: (Nutrition) page 197-202; https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/2014guide.pdf.

L. Treatment Adherence	
Standards	Performance Measure
Assessment of treatment adherence and counseling will be provided that adheres to current HHS guidelines. Patients are assessed for treatment adherence and counseling at a minimum of twice a year. Those who are prescribed on-going ART regimen must receive adherence assessment and counseling on every HIV-related clinical encounter. If adherence issue is identified by another member of the healthcare team (MCM, MA, LVN, RN), there is documented evidence of adherence counseling and follow-up action. This adherence counseling documentation must be evident in the patient's medical record and clearly indicated that the prescribing provider was made aware of the adherence issue.	Percentage of patients with documented assessment for treatment adherence two or more times within the measurement year if patient is on ART. Percentage of patients with documented adherence issues who received counseling for treatment adherence two or more times within the measurement year.
Source: Page 273; https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/2014guide.pdf.	

M. Referrals	
Standards	Performance Measure
Providers will refer to specialty care in accordance with current HHS guidelines. At a minimum, patients should receive referrals to specialized health care/providers/services ***as needed or medically indicated*** to augment medical care: • If CD4 count below 50, should be referred for examination by an ophthalmologist. • AIDS Drug Assistance Program (ADAP) • Medication Assistance Programs • Medical care coordination • Medical specialties • Mental health and substance use services -	Percentage of patients, as medically indicated, who had documentation of referrals for: • Mental Health and/or Substance Use • Oral Health • Ophthalmological services • Child abuse if suspected abuse • Disease intervention specialist • Other specialty services.

Treatment education services
• Partner counseling and referral
• Annual oral hygiene and intraoral examinations, including dental caries and soft-tissue examinations.
• Medical Nutrition Therapy (MNT)
• Health maintenance, as medically indicated, such as:
  ○ Cervical Cancer Screening
  ○ Family Planning
  ○ Colorectal cancer screening
• Breast cancer screening
• Specialty medical care for any preexisting chronic diseases
• Case Management Services or a Disease Investigation Specialist (DIS) for follow-up if missing appointments.
 	
Providers/staff are expected to follow-up on each referral to assess attendance and outcomes.
 	
For specific details regarding screening modalities and timeframes see: see the United States Preventive Services Task Force (www.ahrq.gov/clinic/USpstfix.htm).
 	
Percentage of patients, as medically indicated, who had documentation of referrals for:
• Mental Health and/or Substance Use
• Oral Health
• Ophthalmological services
• Child abuse if suspected abuse
• Disease intervention specialist
• Other specialty services.
 	
Percentage of patients with a documented referral in the measurement year, has a progress note in the patient's chart regarding attendance, and outcomes of the referral.
	Percentage of patients with a documented referral in the measurement year, has a progress note in the patient's chart regarding attendance, and outcomes of the referral.

Source: Page 73; https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/2014guide.pdf.	

N. Follow-up Visits	
Standards	Performance Measure
Outpatient Medical Care will adhere to the current HHS guidelines for on-going health care. Reassessment/reevaluation of health history, comprehensive physical examination, and annual laboratory testing should be documented in patient medical record. All HIV patients should have the following lab tests documented: Annually: urinalysis, with urine protein and creatinine; fasting lipid profile; syphilis screening; and gonorrhea and chlamydia testing (screen all sites of possible exposure). These tests may need to be performed more frequently, if clinically indicated. Every 3-6 months[12]: HIV-RNA viral load; CBC with differential; chemistry profile (to include electrolytes, BUN, creatinine, HCO3, estimated GFR); liver function tests (to include transaminases, total and direct bilirubin); and glucose[13] (preferably fasting) or hemoglobin A1c. These tests may need to be performed more frequently, if clinically indicated. Providers will continually evaluate patients for adverse outcomes and documents actions taken, outcomes, and follow-up.	Percentage of existing patients with documented initial medical screenings and assessments as indicated in the OAHS Standard and in accordance with HHS guidelines. Percentage of patients, 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) Percentage of patients, regardless of age, with a diagnosis of HIV who did not have a medical visit in the last 6 months of the measurement year. (HRSA HAB Measure) Percentage of patients, 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. (HRSA HAB Measure) Percentage of existing female patients with a diagnosis of HIV who were screened for cervical cancer in the last three years. (HRSA HAB Measure) Percentage of existing patients with a diagnosis of HIV at risk for STIs who had a test for chlamydia within the measurement year. (HRSA HAB Measure) Percentage of existing patients with a diagnosis of HIV at risk for STIs who had a test for gonorrhea within the measurement year. (HRSA HAB Measure) Percentage of existing adult patients with a diagnosis of HIV who had a test for syphilis performed within the measurement year. (HRSA HAB Measure) Percentage of existing patients aged 12 years and older screened for clinical depression (annually) on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up

[12] Please reference Table 3.

[13] ~~Fasting Glucose or Hemoglobin A1c Annually and only every 2-6 months if the last measurement was abnormal,~~ see Table 3.

	plan is documented on the date of the positive screen. (HRSA HAB Measure)
	Percentage of existing patients with documented annual psychosocial assessment to include domestic violence and housing status.
	Percentage of existing patients with a diagnosis of HIV who have been screened for substance use (alcohol & drugs) in the measurement year. (HRSA HAB Measure)
	Percentage of existing patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user. (HRSA HAB Measure)
	Percentage of existing patients, if applicable, with completed child abuse assessment (completed if patient aged 14 years and younger).
	Percentage of existing patients aged three (3) months and older with a diagnosis of HIV, for whom there was documentation that a tuberculosis (TB) screening test was performed and results interpreted (for TB skin tests) as least once since the diagnosis of HIV. (HRSA HAB Measure)
	Percentage of existing patients, regardless of age, for whom Hepatitis B screening was performed at least once since the diagnosis of HIV or for whom there is documented infection or immunity. (HRSA HAB Measure)
	Percentage of existing patients for whom HCV screening was performed at least once since the diagnosis of HIV. (HRSA HAB Measure)
	Percentage of patients, regardless of age, with a diagnosis of HIV who were prescribed HIV ART and who had a fasting lipid panel during the measurement year. (HRSA HAB Measure)
Source: (Adverse Outcomes) Page 527; https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/2014guide.pdf.	

O. Documentation in Patients' Medical Chart	
Standards	Performance Measure
Primary medical care for the treatment of HIV includes the provision of care that is consistent with the most current HHS treatment	Percentage of patient medical records with signed clinician entries.

guidelines. Clinicians will develop/update plan of care at each visit. If a patient refuses a treatment, such as vaccinations, documentation of denial will be written in the patient's medical chart. The provider developing the plan will sign each entry.	Percentage of flow sheets present and updated in the patient medical records. Percentage of problem lists present and updated in the patient medical records. Percentage of medication lists present and updated in the patient medical records.
Source: See Section 2, Page77; https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/2014guide.pdf.	

P. Documentation of Missed Patient Appointments and Efforts to Bring the Patient into Care	
Standards	Performance Measure
Provider and/or staff will conduct the following: • Contact patients who have missed 3 consecutive appointments, using at least 3 different forms of contact (email, phone, mail, emergency contact, phone call, referral to DIS for home visit) prior to determining they are lost to follow-up; • Address any specific barriers to accessing services; • Document number of missed patient appointments and efforts to bring the patient into care.	Percentage of patient medical records with documentation of any specific barriers and efforts made to address missed appointments.
Source: Page 1; https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/2014guide.pdf.	

References:

- Public Health Service Act, 42 U.S.C.
  - https://legcounsel.house.gov/Comps/PHSA-merged.pdf
- Public Health Service Act, 42 U.S.C. Title XXVI—HIV Healthcare Services Program
  - https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/legislationtitlexxvi.pdf
- HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A
  - 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
  - https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringpartb.pdf
- HRSA/HAB Ryan White & Global HIV/AIDS Programs, Program & Grants Management, Policy Notices and Program Letters, Policy Clarification Notice 16-02
  - https://hab.hrsa.gov/program-grants-management/policy-notices-and-program-letters
- DSHS HIV Core and Support Service Categories
  - https://www.dshs.texas.gov/hivstd/taxonomy/
- DSHS Monitoring Tools
  - https://www.dshs.texas.gov/hivstd/taxonomy/#section7
- DSHS HIV/STD Policy #220.001 "*Eligibility to Receive HIV Services*"
  - https://www.dshs.texas.gov/hivstd/policy/policies/220-001.shtm

- DSHS HIV/STD Policy #270.001 "*Calculation of Estimated Expenditures on Covered Clinical Services*"
  - https://www.dshs.texas.gov/hivstd/policy/policies/270-001.shtm
- American College of Obstetricians and Gynecologists (ACOG); 2011 Aug. 11 p. (ACOG practice bulletin; no. 122)
- Centers for Disease Control and Prevention. Guidelines for the Prevention and Treatment of Opportunistic Infections Among HIV-Exposed and HIV-Infected Children. MMWR 2009; 58 (No. RR-11): 47 (PDF) *Accessed July 25, 2013.*
- Commission on HIV. (2010). *Medical Outpatient Standards of Care*, Department of Health Services, Los Angeles
- HIV Clinical Resource (2011). *Primary Care Approach to the HIV-Infected Patient* . Office of the Medical Director New York State Department of Health AIDS Institute
- MMWR (January 31, 2014 / 63(04); 69-72) CDC Grand Rounds: Reducing the Burden of HPV-Associated Cancer and Disease
- New York AIDS Institute Clinical Guidelines, Best Practices, *Promoting Adherence to HIV Antiretroviral Therapies*, pp. 9-10.
- New York State Recommendations on Anal Pap Smears
- Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents. Department of Health and Human Services
- Panel on Antiretroviral Therapy and Medical Management of HIV-Infected Children. Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Infection (PDF) *Accessed July 25, 2013.*
- Panel on Opportunistic Infections in HIV-Infected Adults and Adolescents. Guidelines for the prevention and treatment of opportunistic infections in HIV-infected adults and adolescents: recommendations from the Centers for Disease Control and Prevention, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. *Accessed November 9, 2017*
- Preexposure prophylaxis for the prevention of HIV infection (2014). Department of Health and Human Services
- Texas Administrative Code Title 22; Part 9; Chapter 193; Rule § 193.1
- U.S. Department of Health and Human Services, Health Resources and Services. *A Guide to the Clinical Care of Women with HIV – 2013 Edition*. Rockville, Maryland: U.S. Department of Health and Human Services, 2013
- U.S. Department of Health and Human Services *Guide for HIV/AIDS Clinical Care-2014 Edition.* Rockville, Maryland: U.S. Department of Health and Human Services, 2014
- Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents Living with HIV. Department of Health and Human Services. *Accessed November 30, 2017, C-1-5; C-12, Tables: 3 & 5.*
- U.S. Department of Health and Human Services, Health Resources and Services Administration, Guide for HIV/AIDS Clinical Care – 2014 Edition. Rockville, MD: U.S. Department of Health and Human Services, page 81.
- Primary Care Guidelines for Management of HIV. CID 2014:58 (1 January).
- 2014 HRSA HIV Care Guide, page 85.
- Recommended Immunization Schedule for Adults Aged 19 Years or Older. United States. 2017 Advisory Commission on Immunization Practices, Figure 2.
- Guidelines for the prevention and treatment of opportunistic infections in HIV-infected adults and adolescents. DHHS, 2017.

OUTREACH SERVICES

HRSA Service Category Definition:

Outreach Services include the provision of the following three activities:

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

Services:

Outreach Services may include both case finding and consumer recruitment through street outreach. Outreach Services activities supported with Ryan White HIV/AIDS Program funds must continue to be:

- Planned and delivered in coordination with State and local HIV Prevention Programs to avoid duplication of effort;
- Targeted to populations known through local epidemiologic data to be at disproportionate risk for HIV infection;
- Targeted to communities or local establishments that are frequented by individuals exhibiting high risk behaviors;
- Conducted at times and in places where there is a high probability that individuals with HIV infection will be reached;
- Designed with quantified program reporting that will accommodate local effectiveness evaluation.

Activities should be conducted in such a manner as to reach those known to have delayed seeking care.

HRSA/DSHS Program Guidance:

Please reference PCN 16-02 and PCN 12-01.

Service Category Limitations:

Funds may not be used to pay for HIV counseling or testing under this service category. Funds cannot be used to pay for outreach activities with exclusive promotion of HIV prevention education. Outreach services cannot be delivered anonymously as personally identifiable information is needed from clients for program reporting (per Policy Change Notice 12-01 (PDF)). Broad activities such as providing “leaflets at a subway stop” or “a poster at a bus stop” do not meet the intent of the law.

Program/Clinical Quality Management Standard and Performance Measure:

The following Standards and Performance Measures are guides to improving healthcare outcomes for PLWH throughout the San Antonio Service Area within the Ryan White Part A, Part B, Part D, State Services, and State Rebate Programs.

A. Referral	
Standards	**Performance Measure**
Identified HIV positive individuals will be referred to Early Intervention Services or Medical Case Management Services to facilitate transition and linkage to Outpatient/Ambulatory Health Services. Outreach providers will follow-up with referrals to EIS and/or MCM to ensure HIV+ individuals attended EIS and/or MCM appointment for linkage to OAHS.	Percentage of clients identified as HIV+ have documented evidence of referrals made to EIS and/or MCM services in the Outreach provider primary record. Percentage of referrals to EIS and/or MCM services with documented evidence of follow-up to determine PLWH linkage to OAHS in the Outreach provider primary record.

References:

- Public Health Service Act, 42 U.S.C.
  - https://legcounsel.house.gov/Comps/PHSA-merged.pdf
- Public Health Service Act, 42 U.S.C. Title XXVI—HIV Healthcare Services Program
  - https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/legislationtitlexxvi.pdf
- HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A
  - 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
  - https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringpartb.pdf
- HRSA/HAB Ryan White & Global HIV/AIDS Programs, Program & Grants Management, Policy Notices and Program Letters, Policy Clarification Notice 16-02
  - https://hab.hrsa.gov/program-grants-management/policy-notices-and-program-letters
- HRSA/HAB Ryan White & Global HIV/AIDS Programs, Program & Grants Management, Policy Notices and Program Letters, Policy Clarification Notice 12-02
  - https://hab.hrsa.gov/sites/default/files/hab/Global/outreachpolicy2012.pdf
- DSHS HIV Core and Support Service Categories
  - https://www.dshs.texas.gov/hivstd/taxonomy/
- DSHS Monitoring Tools
  - https://www.dshs.texas.gov/hivstd/taxonomy/#section7
- DSHS HIV/STD Policy #220.001 "*Eligibility to Receive HIV Services*"
  - https://www.dshs.texas.gov/hivstd/policy/policies/220-001.shtm

PSYCHOSOCIAL SUPPORT SERVICES

HRSA Service Category Definition:

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

- Bereavement counseling
- Child abuse and neglect counseling
- HIV support groups
- Nutrition counseling provided by a non-registered dietitian
- Pastoral Care/counseling

Services:

Psychosocial services may include providing support, either individually or through group settings, for eligible clients to assist PLWH in addressing behaviors that will enhance a continuity in medical care and address physical health concerns. Psychosocial Support Services may also include individual and group counseling for child abuse and neglect, bereavement counseling, and associated HIV problems.

Pastoral care/counseling services must be:

- Provided by an institutional pastoral care program (e.g. components of AIDS interfaith networks, separately incorporated pastoral care and counseling centers, components of services provided by a licensed provider such as a home care or hospice provider)
- Provided by a licensed or accredited provider wherever such licensure or accreditation is either required or available; and
- Available to all individuals eligible for Ryan White services, regardless of their religious denominational affiliation.

Nutrition Counseling provides nutritional education, assessment, and counseling by a non-registered dietitian to persons living with HIV to assist clients in:

- Maintaining treatment regimens;
- Remaining in primary medical care; and/or
- Improving overall client wellness and quality of life.

This service is meant to help clients use food products in the best way possible to maintain or improve health and to maximize health benefits.

Note: A nutritional plan cannot be developed by a registered dietitian under this service category.

Service Category Limitations:

Funds under this service category may not be used to provide nutritional supplements (nutritional supplements may be allowable under Food Bank/Home Delivered Meals and/or Medical Nutrition Therapy). RWHAP-funded pastoral counseling must be available to all eligible clients regardless of their religious denominational affiliation. Funds may not be used for social/recreational activities or to pay for a client's gym membership.

Program/Clinical Quality Management Standard and Performance Measure:

The following Standards and Performance Measures are guides to improving healthcare outcomes for PLWH throughout the San Antonio Service Area within the Ryan White Part A, Part B, Part D, State Services, and State Rebate Programs.

A. Assessment/Plan of Care for Counseling Services

Standards	Performance Measure
Clients are assessed within thirty (30) business days of initial session for • Support system and psychosocial support needs • History of accessing primary care and other services and barriers to access—noting psychosocial support barriers in particular.	Percentage of clients with documented evidence in the client's primary record of a completed assessment within 30 business days of referral for counseling.
Staff explains to the client during the first encounter what services are available at the agency based on the client's identified needs. Within thirty (30) business days after the assessment, a service plan will be developed and agreed upon by the client and provider outlining service goals, objectives, and interventions. This should include client identified needs as well as plans for continuity of primary medical care and support services.	Percentage of clients with documented evidence in the client's primary record of a service plan developed within 30 business days of the completed assessment.
Client needs and service plan are reviewed and revised a minimum of every six (6) months.	Percentage of clients with documented evidence in the client's primary record of service plans reviewed and/or revised every six (6) months, at a minimum.

B. Support Group Service Plans

Standards	Performance Measure
Within thirty (30) business days of first attendance, a client primary record should be established for all clients attending support groups only. Attendance and topic discussed should be documented in the progress notes with goals for the client outlined.	Percentage of clients attending group sessions will have documented evidence in the client's primary record of attendance and topic discussed in progress notes with goals for the client outlined.

C. Provision of Services - Counseling

Standards	Performance Measure
Staff may provide counseling related to: Child abuse and neglect counseling Bereavement counseling Topics that should be covered in individual	Percentage of clients with documented evidence, as applicable, in the client's primary record of counseling provided for child abuse and neglect.

counseling sessions by non-professional staff include: • Treatment adherence (non-clinical, supportive discussion to reiterate importance of retention in care) • Access and engagement in primary care • Assess and engagement in case management if appropriate Psychosocial support staff will make appropriate referrals	Percentage of clients with documented evidence, as applicable, in the client's primary record of counseling provided for bereavement. Percentage of clients with documented evidence in the client's primary record of discussion regarding retention in care regardless of type of counseling provided.

D. Provision of Service - Support Groups	
Standards	Performance Measure
HIV support groups provide discussion of topics relevant to the PLWH needs in the community through group facilitation. Staff or volunteers providing psychosocial support through group facilitation will include discussions on: • Treatment adherence (non-clinical, supportive discussion to reiterate importance of retention in care) • Access and engagement in primary care • Assess and engagement in case management if appropriate Evidence of client progress toward meeting established goals through documentation of activity including sign-in sheets, progress notes, group curricula, etc.	Percentage of clients engaged in HIV support group services with documented evidence, as applicable, in the client's primary record of client progression in meeting established goals.

E. Provision of Service - Pastoral Counseling/Care	
Standards	Performance Measure
If pastoral counseling/care is needed, may be provided by the agency either: • Directly if by a licensed healthcare services provider such as a home care or hospice provider; • Through referral to AIDS interfaith networks, separately incorporated pastoral care and counseling center, and/or a home care or hospice licensed provider ○ If client referred to another agency, referral and follow-up regarding	Percentage of clients with documented evidence, in the client's primary record, of pastoral care provided through progress notes. Percentage of clients with documented referral, as applicable, in the client's primary record to an eligible pastoral care program (as outlined in standard).

outcome must be documented Must be available either directly or through referral to all individuals eligible to receive Ryan White services regardless of their religious denominational affiliation.	Percentage of clients accessing pastoral care/counseling through referral with documented outcomes in client's primary record.

F. Provision of Service – Nutrition Counseling	
Standards	**Performance Measure**
Nutritional education and counseling provided under Psychosocial Support Services are by a non-registered dietitian and must be based on a client-specific nutritional assessment and plan that has been developed by a registered dietitian or other licensed nutrition professional (see Medical Nutrition Therapy Service Standard). Progress notes will be kept in the client primary record system and will include progress toward meeting objectives outlined in the nutritional plan.	Percentage of clients with documented evidence in the client's primary record of nutritional education and counseling provided based on a client-specific nutritional assessment and plan developed by a RD or other licensed nutrition professional. Percentage of clients with documented evidence in the client's primary record of an individualized nutritional plan based on the assessment. Percentage of clients with documented evidence in the client's primary record of progress notes indicating client's progression toward meeting objectives outlined in the nutritional plan.

G. Closure	
Standards	**Performance Measure**
An individual is deemed no longer to be in need of psychosocial support services and can be deemed inactive/case closed if one or more of these criteria is met: • Client deceased; • Client's medical condition improves and counseling/group attendance is no longer necessary; • Client elects to discontinue participation and/or • Client demonstrates non-attendance, as defined by agency policy and procedure	Percentage of clients with documented evidence in client's primary record of case closure documented as applicable.

References:

- Public Health Service Act, 42 U.S.C.
  - https://legcounsel.house.gov/Comps/PHSA-merged.pdf
- Public Health Service Act, 42 U.S.C. Title XXVI—HIV Healthcare Services Program
  - https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/legislationtitlexxvi.pdf
- HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A

- 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
  - https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringpartb.pdf
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- DSHS HIV Core and Support Service Categories
  - https://www.dshs.texas.gov/hivstd/taxonomy/
- DSHS Monitoring Tools
  - https://www.dshs.texas.gov/hivstd/taxonomy/#section7
- DSHS HIV/STD Policy #220.001 "*Eligibility to Receive HIV Services*"
  - https://www.dshs.texas.gov/hivstd/policy/policies/220-001.shtm

REFERRAL FOR HEALTH CARE AND SUPPORT SERVICES

HRSA Service Category Definition:

Referral for Health Care and Support Services directs a client to needed core medical or support services in person or through telephone, written, or other type of communication. This service may include referrals to assist eligible clients to obtain access to other public 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).

Services:

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

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

Health Care Services: Clients 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 client's entry into and movement through the care service delivery network such that RWHAP and/or State Services funds are payer of last resort.

HRSA/DSHS Program Guidance:

Referrals for Health Care and Support Services provided by outpatient/ambulatory health care professionals should be reported under Outpatient/Ambulatory Health Services (OAHS) category.

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

RWHAP Part B and State Services funds can be used to provide transitional social services to establish or re-establish linkages to the community. Case management that links 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 590.000, Section 5.3)

Service Category Limitations:

Funds cannot be used to duplicate referral services provided through other service categories. Please reference the HRSA Program Guidance above.

Program/Clinical Quality Management Standard and Performance Measure:

The following Standards and Performance Measures are guides to improving healthcare outcomes for PLWH throughout the San Antonio Service Area within the Ryan White Part A, Part B, Part D, State Services, and State Rebate Programs.

A. Benefits Counseling

Standards	Performance Measure
Activities should be client-centered facilitating access to and maintenance of health and disability benefits and services. It is the primary responsibility of staff to ensure clients are receiving all needed public and/or private benefits and/or resources for which they are eligible. Staff will educate clients 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. Staff will explore the following as possible options for clients, 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	Percentage of clients with documented evidence of education provided on other public and/or private benefit programs in the primary client record. Percentage of clients 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 client record. Percentage of eligible clients with documented evidence of the follow-up and result(s) to a completed benefit application in the primary client record.

B. Health Care Services	
Standards	Performance Measure
Clients 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 clients are referred to Health Insurance Premium and Cost-Sharing Assistance (HIA) to assist clients in accessing health insurance or Marketplace plans within one (1) week of the referral for health care and support services intake. Eligible clients are referred to other core services (outside of a medical, MCM, or NMCM appointment), as applicable to the client's needs, with education provided to the client on how to access these services. Eligible clients are referred to additional support services (outside of a medical, MCM, NMCM appointment), as applicable to the client's needs, with education provided to the client on how to access these services. Staff will follow-up within 10 business days of a referral provided to HIA to determine if the client accessed HIA services. Staff will follow-up within 10 business days of a referral provided to any core services to ensure the client accessed the service. Staff will follow up within 10 business days of a referral provided to support services to ensure the client accessed the service.	Percentage of clients with documented evidence of assistance provided to access health insurance or Marketplace plans in the primary client record. Percentage of clients 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 client record. Percentage of clients 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 client record. Percentage of clients with documented evidence of referrals provided for HIA assistance that had follow-up documentation within 10 business days of the referral in the primary client record. Percentage of clients 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 client record. Percentage of clients 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 client record.

C. Case Closure Summary	
Standards	**Performance Measure**
Clients 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 client primary 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.	Percentage of clients 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 client record.

Note: See Appendix B for the Case Management Chart; courtesy of DSHS

References:

- Public Health Service Act, 42 U.S.C.
  - https://legcounsel.house.gov/Comps/PHSA-merged.pdf
- Public Health Service Act, 42 U.S.C. Title XXVI—HIV Healthcare Services Program
  - https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/legislationtitlexxvi.pdf
- HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A
  - 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
  - https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringpartb.pdf
- HRSA/HAB Ryan White & Global HIV/AIDS Programs, Program & Grants Management, Policy Notices and Program Letters, Policy Clarification Notice 16-02
  - https://hab.hrsa.gov/program-grants-management/policy-notices-and-program-letters
- DSHS HIV Core and Support Service Categories
  - https://www.dshs.texas.gov/hivstd/taxonomy/
- DSHS Monitoring Tools
  - https://www.dshs.texas.gov/hivstd/taxonomy/#section7
- DSHS HIV/STD Policy #590.000 "*HIV/STD Prevention and Care Branch Limitations on Ryan White and State Services Funds for Incarcerated Persons in Community Facilities Policy*"
  - https://www.dshs.texas.gov/hivstd/policy/policies/591-000.shtm
- DSHS HIV/STD Policy #270.001 "*Calculation of Estimated Expenditures on Covered Clinical Services*"
  - https://www.dshs.texas.gov/hivstd/policy/policies/270-001.shtm

SUBSTANCE ABUSE OUTPATIENT CARE

HRSA Service Category Definition:

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

Services:

Services include:

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

HRSA/DSHS Program Guidance:

Acupuncture therapy may be allowable under this service category only when, as part of a substance use disorder treatment program funded under the RWHAP, is included in a documented plan. For RWHAP Part B funded providers, acupuncturists must be licensed and therapeutic treatments provided involve the use of sterile, disposable acupuncture needles.

Services will be provided in accordance with Texas Health and Safety code, title 6, Subtitle B, Chapter 464. Counseling and education will be completed in accordance with Texas Health and Safety Code for Substance Abuse Programs.

Service Category Limitations:

Services limited to the services below as stated in the HRSA National Monitoring Standards. No use of RWHAP funds shall be used to carry out any program of distributing sterile needles or syringes for the hypodermic injection of any illegal drugs. Please reference the Texas Health and Safety Code, Title 6, Subtitle C, Chapter 481, Subchapter A General Provisions.

Program/Clinical Quality Management Standard and Performance Measure:

The following Standards and Performance Measures are guides to improving healthcare outcomes for PLWH throughout the San Antonio Service Area within the Ryan White Part A, Part B, Part D, State Services, and State Rebate Programs.

A. Initial Appointment/Screening	
Standards	Performance Measure
Face to face client orientation is provided to all new clients to introduce them to program services, to ensure their understanding of the need of continuous care, and to empower them in accessing services. In accordance with Texas Administrative Code (TAC), clients will be informed of opportunities for family to be involved in the client's treatment. An appointment will be scheduled within a reasonable amount of time but not greater than 10 business days from a client's request for substance use services. The agency may provide written orientation materials to the client that supports the above information and is culturally sensitive and linguistically appropriate.	Percentage of client charts with documentation of an appointment scheduled, after request (referral) for substance use outpatient services.
In urgent, non-life-threatening emergency circumstances, an appointment will be made as soon as possible but no later than within one (1) business day, subject to licensure requirements. If an agency cannot provide the needed services, the agency will offer to refer the client 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). Each client must have a documented screening completed based on best practice standards of care with use of the Texas Department of Insurance criteria per TAC standards. The screening process shall collect information necessary to determine the type of services that are required to meet the client's needs.[14]	Percentage of client charts with documentation of completed screening as indicated.

[14] ~~Texas Administrative Code, Title 25, Part 1, Chapter 448, Subchapter H, Rule §448.801, Screening~~

<table>
<tr><th colspan="2">B. Comprehensive Psychosocial Assessment</th></tr>
<tr><th>Standards</th><th>Performance Measure</th></tr>
<tr><td rowspan="2">All clients referred to the program will receive a Comprehensive Psychosocial Assessment (in accordance with TAC Standards) by a licensed substance use counselor. Initial comprehensive psychosocial assessment protocols shall provide for screening individuals to determine level of need and appropriate development of treatment plan.

A comprehensive psychosocial assessment will be completed prior to the third counseling session* and will include the following:
• Presenting problems resulting in need;
• Alcohol and other drug use;
• Psychiatric and chemical dependency treatment;
• Medical history and current health status, to include an assessment of Tuberculosis (TB), HIV, and other sexually transmitted infections (STI) risk behaviors as permitted by law;
• Relationships with family including domestic/intimate partner violence;
• History of trauma/related events;
• Stigma;
• Housing Stability, expelled from home;
• Treatment adherences (e.g. HIV meds);
• Social and leisure activities;
• Education and vocation training;
• Employment history;
• Legal issues;
• Mental/emotional functioning; and
• Strengths and weaknesses.[15]
• The assessment shall result in a diagnosed substance use issue, as allowed by the license and scope of practice of the counselor.</td><td>Percentage of client charts that have documentation of initial comprehensive assessments completed as indicated.</td></tr>
<tr><td>Percentage of client charts with documented use of assessment tools as indicated for substance use and sexual history.</td></tr>
</table>

[15] ~~Texas Administrative Code, Title 25, Part 1, Chapter 448, Subchapter H, Rule §448.801, Screening~~

**Note*: Clients are assessed for care coordination needs, and referrals are made to other case management programs as appropriate. If pressing needs emerge during the assessment requiring immediate attention that results in the assessment not finalized by the third session, this must be documented in the client's primary record. Specific assessment tools such as the Substance Abuse and Mental Illness Symptoms Screener (SAMISS) and Addiction Severity Index (ASI) may be used for substance use and sexual history, and the Mini Mental State Examination (MMSE) may be used for cognitive assessment. A copy of the assessment(s) will be offered/provided to the client.	Percentage of client charts with documented use of assessment tool as indicated for cognitive assessment.

C. Treatment Modalities	
Standards	Performance Measure
Providers must discuss treatment options with substance-using clients and should ask which treatment options they prefer. Providers should inquire about use of multiple substances and should consider the full spectrum of the client's drug use when discussing treatment options with the client. Providers must discuss alternative treatment modalities with the client that are targeted toward the substance(s) that the client is still using. Providers must rely on the *Patient Placement Criteria of the American Society of Addiction Medicine (ASAM)* for guidance on selecting the best treatment alternatives for specific clients. Medical treatment for substance use must adhere to current HIV Clinical Guidelines. For medication-assisted therapies (e.g.	Percentage of client charts with documentation of discussion of treatment modalities with the client. Percentage of client charts, for clients on medication-assisted therapies, with documentation of contact with client's medical provider within 72 hours of treatment initiation or the client's refusal to authorize the communication.

methadone, suboxone) treatment, client charts will document contact with the client's medical provider within 72 hours of initiation of methadone/suboxone to inform the medical provider of the new prescription OR client refusal to authorize this communication. Treatment for non-pharmacologic treatment modalities may include, but are not limited to, Twelve-Step Programs and Acupuncture. All acupuncture services will be performed in accordance with the Acupuncture Act § 205.001(2)(A) and TAC Title 22, Chapter 9, §183.1.[16]	Percentage of clients with acupuncture services rendered with documented evidence of a physician's order.

D. Treatment Plan	
Standards	Performance Measure
A treatment plan shall be completed within 30 calendar days of completed comprehensive psychosocial assessment specific to individual client needs. The treatment plan shall be prepared and documented for each client. Treatment planning will be a collaborative process through which the provider and client develop desired treatment outcomes and identify the strategies for achieving them. Individual, and family case records will include documentation of the following: • Identification of the identified substance use disorder • Goals and objectives • Treatment modality (group or individual) • Start date for substance use counseling • Recommended number of sessions • Date for reassessment • Projected treatment end date • Any recommendations for follow up	Percentage of client charts that have documentation of treatment plans completed within 30 calendar days of the completed comprehensive assessment.

[16] ~~Texas Administrative Code, Title 22, Part 8, Chapter 193, Acupuncture~~

Treatment, as appropriate, will include counseling about (at minimum): • Prevention and transmission risk behaviors, including root causes and underlying issues related to increased HIV transmission behaviors • Treatment adherence • Development of social support systems • Community resources • Maximizing social and adaptive functioning • The role of spirituality and religion in a client's life, disability, death and dying and exploration of future goals The treatment plan will be signed by the substance use counselor rendering service. In accordance with TAC on Substance Abuse, the treatment plan shall be reviewed at a minimum midway through the number of determined sessions agreed upon for frequency of modality and must reflect ongoing reassessment of client's problems, needs and response to therapy.	Percentage of client charts with documented evidence of treatment plans reviewed/modified at minimum midway through the number of determined sessions agreed upon for frequency of modality in the client's primary record.

E. Progress Notes	
Standards	Performance Measure
Services will be provided according to the individual's treatment plan and documented in the client's record. Progress notes are completed for every professional counseling session and include: • Client name • Session date • Clinical observations • Focus of session • Interventions • Assessment • Duration of session • Newly identified issues/goals • Client's responses to interventions and referrals • HIV medication adherence • Substance use treatment adherence • Counselor authentication, in accordance	Percentage of client charts with documented progress notes for each counseling session as indicated.

with current TAC Standards of Care for Substance Abuse Services.	

F. Referrals	
Standards	Performance Measure
Agency will make appropriate referrals out when necessary.	Percentage of client charts, as applicable, with documented referrals made based on need demonstrated in the assessment and/or progress notes.

G. Discharge Planning	
Standards	Performance Measure
Discharge planning will be done with each client when treatment goals are met and include: • Circumstances of discharge • Summary of needs at admission • Summary of services provided • Goals and objectives completed during counseling • Referral after completing substance use treatment to case manager and/or primary care provider, as appropriate • Discharge plan • Counselor authentication, in accordance with TAC Standards and the counselor licensure requirements. In all cases, providers/case managers shall ensure that, to the greatest extent possible clients who leave care are linked with appropriate services to meet their needs.	Percentage of client charts with documentation, as applicable, of discharge planning with the client prior to case closure.

H. Discharge	
Standards	Performance Measure
Services may be discontinued when the client has: • Reached goals and objectives in their treatment plan • Missed three (3) consecutive appointments in a six (6) month period.	Percentage of client charts with documentation of case closure (discharge) and reason for discharge, or discharge summary if applicable.

• Continued non-adherence to treatment plan • Chooses to terminate services • Unacceptable client behavior • Deceased Completed discharge summary, in accordance with TAC Standards (§448.805) [3], as applicable.	Percentage of clients who demonstrate improved viral suppression after completing Substance Use Outpatient Treatment Plan objectives. *(Proposed System Level Outcome Measure)*

References:

- Public Health Service Act, 42 U.S.C.
  - https://legcounsel.house.gov/Comps/PHSA-merged.pdf
- Public Health Service Act, 42 U.S.C. Title XXVI—HIV Healthcare Services Program
  - https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/legislationtitlexxvi.pdf
- HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A
  - 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
  - https://hab.hrsa.gov/sites/default/files/hab/Global/programmonitoringpartb.pdf
- HRSA/HAB Ryan White & Global HIV/AIDS Programs, Program & Grants Management, Policy Notices and Program Letters, Policy Clarification Notice 16-02
  - https://hab.hrsa.gov/program-grants-management/policy-notices-and-program-letters
- DSHS HIV Core and Support Service Categories
  - https://www.dshs.texas.gov/hivstd/taxonomy/
- DSHS Monitoring Tools
  - https://www.dshs.texas.gov/hivstd/taxonomy/#section7
- DSHS HIV/STD Policy #220.001 "*Eligibility to Receive HIV Services*"
  - https://www.dshs.texas.gov/hivstd/policy/policies/220-001.shtm
- DSHS HIV/STD Policy #270.001 "*Calculation of Estimated Expenditures on Covered Clinical Services*"
  - https://www.dshs.texas.gov/hivstd/policy/policies/270-001.shtm
- Department of State Health Services Substance Abuse Treatment Facilities
- New York HIV Clinical Guidelines for Substance Use Treatment Modalities.
- Texas Administrative Code, Title 22, Part 30, Chapter 681 - Texas Board of Examiners of Professional Counselors.
- Texas Administrative Code, Title 25, Part 1, Chapter 448.
- Texas Health and Safety Code, Title 6. Food, Drugs, Alcohol, and Hazardous Substances, Subtitle B. Alcohol and Substance Programs, Chapter 464.
- Texas Administrative Code, Title 25. Part 1, Chapter 448 Standards of Care, Subchapter H Screening and Assessment.

APPENDIX A CONFLICT OF INTEREST

Conflict of Interest Disclosure Form

Ryan White Program

I understand that I must fully disclose any and all professional or personal affiliations with organizations that receive or may request funds from the Administrative Agency (AA) for goods or services to the AA or its clients.

I further understand I must not use my official position to influence decisions that result or appear to result in direct or indirect financial, personal, organizational, or professional gain for myself or any party with whom I have family, business, or other ties.

I certify that I have read and understand the above statement and I understand that I may not have interest in, or in any manner be connected with, any contract or bid for furnishing supplies, materials, services, and equipment of any kind to the AA. Neither shall I, under penalty of dismissal, accept or receive from any person, firm, or corporation to whom any contract may be awarded, directly or indirectly, by rebate, gift, or otherwise, any money or other thing of value whatever, nor shall I receive any promise, obligation, or contract for future reward or compensation from any such party.

To the best of my knowledge:

I ____ **do not** have any personal, professional, family or business affiliations with organizations or persons who either are funded through the AA or who may apply for funding.

I ____ **do** have personal, professional, family or business affiliations with organizations or persons who either are funded through the AA or who may apply for funding, and will not take part in any decision or exert influence upon another person in regard to those persons or entities disclosed below.

Name:
Organization:
Position in organization:
Services provided by organization:

Name:
Organization:
Position in organization:
Services provided by organization:

Name:
Organization:
Position in organization:
Services provided by organization:

(Attach additional sheets if necessary.)

This information is provided in good faith to avoid any real or perceived conflict of interest in the discharge of my duties as a member of the staff or Board of Directors.

_____
Printed Name

_____
Board Member/Employee Signature

_____
Date

cc: Personnel File

APPENDIX B STATEMENT OF CONSUMER RESPONSIBILITIES

1. RESPECT, COURTESY, AND CONFIDENTIALITY – YOU HAVE THE RESPONSIBILITY

To treat health and social service providers and staff with respect and courtesy at all times.

2. GIVING CORRECT AND COMPLETE INFORMATION – YOU HAVE THE RESPONSIBILITY

To give your provider accurate and complete information about your health condition and social situation, medication use, past and current treatment and the names and addresses of other providers you are using or have used. You must give this information to the best of your ability. You are responsible for coming to appointments with your providers, prepared to ask questions if needed and be able to tell them about things that concern you. This makes it easier for the providers to give you the best information about your care.

3. SEEKING FACTS ABOUT YOUR CARE – YOU HAVE THE RESPONSIBILITY

To ask questions about the care you are receiving if you do not completely understand it. This means that you should know about the risks, benefits and financial aspects of your care. You also have the right to have advocate/s ask about this information.

4. FOLLOWING THE TREATMENT PLAN – YOU HAVE THE RESPONSIBILITY

To follow treatment plans that you and your provider/s have agreed upon. You have the responsibility to tell your provider right away if you decide to stop treatment or go against your provider's advice. You are responsible for what happens to you.

5. SCHEDULED APPOINTMENTS – YOU HAVE THE RESPONSIBILITY

To keep appointments that you and your providers have scheduled. If you have to cancel, you are responsible for telling your provider that you will not be there.

6. COMMUNICATING YOUR FINANCIAL NEEDS – YOU HAVE THE RESPONSIBILITY

To give accurate and complete information about third-party payers, (like insurance companies, Medicaid, Medicare, etc.) to your providers and their facilities. You should make sure that you give them any forms that they may ask for, or to send in any forms that are required of you as soon as you possibly can. You also have the responsibility to talk to your providers about your financial situation, regarding your financial needs and tell them of you need help in figuring out what your financial needs are before you start receiving services from your provider.

7. RULES AND REGULATIONS OF SERVICE PROVIDER ORGANIZATIONS – YOU HAVE THE RESPONSIBILITY

To follow the rules and regulations of your providers and their agencies/facilities**.**

8. VOICING COMPLAINTS AND GRIEVANCES – YOU HAVE THE RESPONSIBILITY

To voice complaints and present grievances in an appropriate and timely manner. You should do this by following the providers' grievance policies and procedures and you may ask for help in doing this if you need it.

9. CONTINUING CARE – YOU HAVE THE RESPONSIBILITY

To ask when and where to go for more treatment and follow-up services whenever you leave a providers' facility or care.

10. AN ADVANCED DIRECTIVE FOR CARE - YOU HAVE THE RESPONSIBILITY

To make formal decisions about your care that can be used if you are not able to speak for yourself if you become ill. These include living wills, health care proxies, and durable powers of attorney for health and social services.

11. ACCESS TO FINANCIAL INFORMATION – YOU HAVE THE RESPONSIBILITY

To look and ask questions about all health care bills. To get referrals and help with any payment problems.

12. A CONSUMER GRIEVANCE PROCEDURE – YOU HAVE THE RESPONSIBILITY

To voice complaints, to suggest changes and to be informed about how to file a grievance (a formal written complaint.) To do this without harassment, interference and pressure.

13. CONFIDENTIALITY AND ACCESS TO RECORDS – YOU HAVE THE RESPONSIBILITY

To have all of your records kept strictly confidential and not to be released without your written permission. To access all of your records and to have copies of these at a fair copying cost.

APPENDIX C STATEMENT OF CONSUMER RIGHTS

1. RESPECT, COURTESY, AND PRIVACY – YOU HAVE THE RIGHT
To be treated at all times with respect and courtesy within a setting, this provides you with the highest degree of privacy possible.

2. FREEDOM FROM DISCRIMINATION – YOU HAVE THE RIGHT
To freedom from discrimination because of age, ethnicity, gender, religion, sexual orientation, values and beliefs, marital status, medical condition, or any other arbitrary criteria.

3. ACCESS TO HIV/AIDS SERVICE INFORMATION – YOU HAVE THE RIGHT
To be informed by your healthcare and/or social service provider about the full range of available HIV/AIDS treatments and about related available social and support services. To be advised of the risks and to discuss benefits of any proposed treatments. You have the right to give your informed consent to any treatments or services before they are provided.

4. IDENTITY AND PROVIDER CREDENTIALS – YOU HAVE THE RIGHT
To know the names, titles, specialties, and affiliation of all health and social service providers and anyone else involved in your care. To know about the health or social service organization's policies and procedures.

5. CULTURALLY SENSITIVE SHARING OF INFORMATION – YOU HAVE THE RIGHT
To have information shared with you in a respectful manner and in a way that is easy to understand, which takes into account the differences in each person's background, culture, and preferences.

6. CONSENT AND THE CARE PLAN – YOU HAVE THE RIGHT
To be informed involved in and make individualized plane of care prior to the start of and during the course of treatment. To disagree, change your mind, or request a medical second opinion without affecting the ongoing availability of treatment services. The second opinion provider must notify you of any change they have made to your care plan before it happens.

7. CHOICE AND ACCESS TO SERVICE – YOU HAVE THE RIGHT
To be informed of all available services upon intake. To choose and access all treatment/services for which you qualify.

8. DECLINING SERVICE – YOU HAVE THE RIGHT
To decline treatment/services without pressure from your health care or social service provider. To refuse to participate in any research studies or experiments that the provider may recommend. To change your mind after refusing OR consenting to treatment, trial, counseling, or any other service without affecting ongoing care. To make these decisions without pressure from your services**.**

9. NAMING AN ADVOCATE – YOU HAVE THE RIGHT

To choose an advocate (such as a family member of another person) to give you support and to represent your rights. This person (the Advocate) makes sure that your rights are not forgotten due to your HIV status. They also make sure that you are getting the correct kind of HIV services and care.

10. AN ADVANCED DIRECTIVE FOR CARE - YOU HAVE THE RIGHT

To make formal decisions about your care that can be used if you are not able to speak for yourself if you become ill. These include living wills, health care proxies, and durable powers of attorney for health and social services.

11. ACCESS TO FINANCIAL INFORMATION – YOU HAVE THE RIGHT

To look and ask questions about all health care bills. To get referrals and help with any payment problems.

12. A CONSUMER GRIEVANCE PROCEDURE – YOU HAVE THE RIGHT

To voice complaints, to suggest changes and to be informed about how to file a grievance (a formal written complaint.) To do this without harassment, interference and pressure.

13. CONFIDENTIALITY AND ACCESS TO RECORDS – YOU HAVE THE RIGHT

To have all of your records kept strictly confidential, not to be released without your written permission. To access all of your records and to have copies of these at a fair copying cost.

14. FREEDOM FROM CONSTRAINTS – YOU HAVE THE RIGHT

To be free from all types of constraints when you deal with health or social service providers and treatment plans.

15. TRANSFERS AND CONTINUITY OF CARE – YOU HAVE THE RIGHT

To uninterrupted treatment. If possible, your requests to leave one provider and be seen by another should be honored and happen as soon as possible. You may NOT be transferred TO another provider or facility without an explanation for the transfer. You must be informed of other options that are available.

APPENDIX D CASE MANAGEMENT CHART

<table>
<tr><th>Yes-MCM</th><th>Yes-NMCM</th><th>No-CM; Yes-Referral</th></tr>
<tr><td>Requires assistance with achieving or maintaining viral suppression</td><td rowspan="2">Advice and assistance in obtaining medical, social, community, legal, financial and other needed services</td><td>Clients who do not need case management but require a voucher for a service</td></tr>
<tr><td>Follow-up of Medical Treatments – includes either accompanying client to medical appointments</td><td>Needs help with transportation for medical appointments</td></tr>
<tr><td rowspan="2">Treatment Adherence – the provision of counseling or special programs to ensure readiness for, and adherence to, complex HIV/AIDS treatments</td><td rowspan="2">Providing specific services such as housing assistance or transportation are not case management; but identifying and arranging to have that assistance provided is case management</td><td>Client requires general financial assistance</td></tr>
<tr><td>Client needs referrals for health services</td></tr>
<tr><td colspan="3">Chart courtesy of DSHS</td></tr>
</table>