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2012-2013**

FY 2013 Houston EMA/HSDA Ryan White Part A/MAI Service Definition Comprehensive Outpatient Primary Medical Care including Medical Case Management, Service Linkage and Local Pharmacy Assistance Program (LPAP) Services (Revision Date:03/19/12)	
HRSA Service Category Title: RWGA Only	1. <i>Outpatient/Ambulatory Medical Care</i> 2. <i>Medical Case Management</i> 3. <i>AIDS Pharmaceutical Assistance (local)</i> 4. <i>Case Management (non-Medical)</i>
Local Service Category Title:	a. Adult Comprehensive Primary Medical Care – Public Clinic b. Adult Comprehensive Primary Medical Care – Community Based <i>i. Targeted to African American</i> <i>ii. Targeted to Hispanic</i> <i>iii. Targeted to White</i> c. Part A Adult Comprehensive Primary Medical Care – Targeted to Rural d. Adult Comprehensive Primary Medical Care Targeted to Women at Public Clinic
Estimated Amount Available: RWGA Only	a. Public Clinic: \$ _____ b. Community Based: <i>i. Targeted to African American \$ _____</i> <i>ii. Targeted to Hispanic \$ _____</i> <i>iii. Targeted to White \$ _____</i> c. Part A Targeted to Rural \$ _____ d. Targeted to Women at Public Clinic \$ _____ <i>Note: The Houston Ryan White Planning Council (RWPC) determines annual Part A and MAI service category allocations & reallocations. RWGA has sole authority over contract award amounts.</i>
Estimated Clients to be Served during contract term: RWGA Only	a. Public Clinic _____ b. Community Based (Part A and MAI combined) <i>i. Targeted to African American _____</i> <i>ii. Targeted to Hispanic _____</i> <i>iii. Targeted to White _____</i> c. Part A Targeted to Rural _____ d. Targeted to Women at Public Clinic _____
Target Population:	a. Comprehensive Primary Medical Care – Public Clinic: Persons Living with HIV and AIDS (PLWHA), ages 13 or older b. Comprehensive Primary Medical Care – Community Based <i>i. Targeted to African American: African American PLWHA ages 13 or older</i> <i>ii. Targeted to Hispanic: Hispanic PLWHA ages 13 or older</i> <i>iii. Targeted to White: White (non-Hispanic) PLWHA ages 13 or older</i> c. Part A Targeted to Rural: PLWHA, ages 13 or older, residing in Counties other than Harris d. Comprehensive Primary Medical Care Targeted to Women at Public Clinic: Female PLWHA ages 13 or older
Client Eligibility: Age, Gender, Race, Ethnicity, Residence, etc.	PLWHA residing in the Houston EMA (prior approval required for non-EMA clients). Provider <u>must</u> adhere to Targeting and Budget requirements as applicable.

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Financial Eligibility:	See <i>FY 2013 Approved Financial Eligibility for Houston EMA/HSDA</i>
Budget Type: RWGA only	Hybrid Unit Cost
Budget Requirement or Restrictions: RWGA only unless otherwise specified*	<p>Primary Medical Care:</p> <ol style="list-style-type: none"> a. Public Clinic: Must include Primary Medical Care, Medical Case Management, Service Linkage and Local Pharmacy Assistance Program LPAP b. Community Based: Must include Primary Medical Care, Medical Case Management, Service Linkage and LPAP <ol style="list-style-type: none"> i. Targeted to African American (includes MAI funding) ii. Targeted to Hispanic (includes MAI funding) iii. Targeted to White c. Targeted to Rural: Must include Primary Medical Care, Medical Case Management, Service Linkage and Local Pharmacy Program d. Targeted to Women at Public Clinic: Must include Primary Medical Care, Medical Case Management, Service Linkage and LPAP. e. No less than 75% of clients served in a Targeted subcategory must be members of the targeted population with the following exceptions: f. Community-Based: 100% of clients served with <u>MAI funds</u> must be members of the targeted population g. Targeted to Women at Public Clinic: 100% of clients served must be female <p>10% of funds designated to primary medical care must be reserved for invoicing diagnostic procedures at actual cost.</p> <p>Providers may <u>not</u> exceed the allocation for each individual service element (i.e. Primary Medical Care, Medical Case Management, Local Pharmacy Assistance Program and Service Linkage) without prior approval from RWGA.</p> <p>Local Pharmacy Assistance Program: Houston RWPC guidelines for Local Pharmacy Assistance Program (LPAP) services: Provider shall offer HIV medications from an approved formulary for a total not to exceed \$18,000 per contract year per client. Provider shall offer HIV-related medications for a total not to exceed \$3,000 per contract year per client. These guidelines are determined by the RWPC. <u>The RWPC determines the subcategories that shall include Ryan White LPAP funding.</u></p> <p>Medications must be provided in accordance with Houston EMA guidelines, HRSA/HAB rules and regulations and applicable Office of Pharmacy Affairs 340B guidelines.</p> <p>At least 75% of the total amount of the budget for LPAP services must be solely allocated to the actual cost of medications and may not include any storage, administrative, processing or other costs associated</p>

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<p>Service Unit Definition/s: RWGA only</p>	<p>with managing the medication inventory or distribution.</p> <ol style="list-style-type: none"> 1. Outpatient/Ambulatory Medical Care: One (1) unit of service = One (1) primary care office/clinic visit which includes the following: <ul style="list-style-type: none"> • Primary care physician/nurse practitioner/physician's assistant examination of the patient, and • Medication/treatment education • Medication access/linkage • OB/GYN specialty procedures (as clinically indicated) • Nutritional counseling (as clinically indicated) • Laboratory (as clinically indicated, not including specialized tests) • Radiology (as clinically indicated, not including CAT scan or MRI) • Eligibility verification/screening (as necessary) • Follow-up visits wherein the patient is not seen by the MD/NP/PA are considered to be a component of the original primary care visit. <ul style="list-style-type: none"> • Outpatient Psychiatric Services: 1 unit of service = A single (1) office/clinic visit wherein the patient is seen by a State licensed and board-eligible Psychiatrist <u>or qualified Psychiatric Nurse Practitioner</u>. This visit may or may not occur on the same date as a primary care office visit. 2. Medical Case Management: 1 unit of service = 15 minutes of direct medical case management services to an eligible PLWHA performed by a qualified medical case manager. 3. AIDS Pharmaceutical Assistance (local): A unit of service = a transaction involving the filling of a prescription or any other allowable medication need ordered by a qualified medical practitioner. The transaction will involve at least one item being provided for the client, but can be any multiple. The cost of medications provided to the client must be invoiced at actual cost. 4. Service Linkage (non-Medical Case Management): 1 unit of service = 15 minutes of direct service linkage services to an eligible PLWHA performed by a qualified service linkage worker.
<p>HRSA Service Category Definition: RWGA Only</p>	<ol style="list-style-type: none"> 1. Outpatient/Ambulatory medical care is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings. Services includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to

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	<p>and provision of specialty care (includes all medical subspecialties). <i>Primary medical care</i> for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.</p> <p>2. <i>Medical Case Management services (including treatment adherence)</i> are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication.</p> <p>3. <i>AIDS Pharmaceutical Assistance (local)</i> includes local pharmacy assistance programs implemented by Part A or Part B Grantees to provide HIV/AIDS medications to clients. This assistance can be funded with Part A grant funds and/or Part B base award funds. Local pharmacy assistance programs are not funded with ADAP earmark funding.</p> <p>4. <i>Case Management (non-Medical)</i> includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does.</p>
Standards of Care: RWGA only	Providers must adhere to the most current published Part A/B Standards of Care for the Houston EMA/HSDA. Services must meet or exceed applicable United States Department of Health and Human Services (DHHS) guidelines for the Treatment of HIV/AIDS.
Service to be Provided:	<p>Providers are responsible for ensuring that primary medical care services are provided by State licensed internal medicine and OB/GYN physicians, specialty care physicians, psychiatrists, registered nurses, nurse practitioners, vocational nurses, pharmacists, physician assistants, physician extenders with a colposcopy provider qualification, x-ray technologists, State licensed dietitians, licensed social worker and ancillary health care providers in accordance with appropriate State licensing and/or certification requirements and with knowledge and experience of HIV disease.</p> <p>For primary medical care services targeted to the Latino community at least</p>

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	<p>50% of the clinical care team must be fluent in Spanish.</p> <p>Medication and Adherence Education: The program must utilize an RN, LVN, PA, NP, pharmacist or MD licensed by the State of Texas, who has at least two (2) years paid experience in the preceding five (5) years in a HIV/AIDS care, to provide the educational services. Licensed social workers who have at least two (2) years paid experience in the preceding five (5) years in HIV/AIDS care may also provide <u>adherence</u> education and counseling.</p> <p>Medical Case Management: The program must utilize a state licensed Social Worker to provide Medical Case Management Services. Provider must provide to RWGA the names of each Medical Case Manager and the individual assigned to supervise those Medical Case Managers by 03/30/13, and thereafter within 15 days after hire. The Provider must maintain the assigned number of Medical Case Management FTEs throughout the contract term.</p> <p>Service Linkage: The program must utilize Service Linkage Workers who have at a minimum a Bachelor's degree from an accredited college or university with a major in social or behavioral sciences. Documented paid work experience in providing client services to PLWHA may be substituted for the Bachelor's degree requirement on a 1:1 basis (1 year of documented paid experience may be substituted for 1 year of college). All Service Linkage Workers must have a minimum of one (1) year paid work experience with PLWHA. Provider must provide to RWGA the names of each Service Linkage Worker and the individual assigned to supervise those Service Linkage Workers by 03/30/13, and thereafter within 15 days after hire. Provider must maintain the assigned number of Service Linkage FTEs throughout the contract term.</p> <p>Supervision: The Service Linkage Workers (SLW) and Medical Case Managers (MCM) must function within the clinical infrastructure of Provider and receive ongoing supervision that meets or exceeds published Standards of Care. An MCM may supervise SLWs.</p> <p>Outpatient Psychiatric Services: Director of the Program must be a Board Certified Psychiatrist. Licensed and/or Certified allied health professionals (Licensed Psychologists, Physicians, Psychiatric Nurse Practitioners, Licensed Master Social Workers, Licensed Professional Counselors, Licensed Marriage and Family Therapists, Certified Alcohol and Drug Abuse Counselors, etc.) must be used in all treatment modalities. Documentation of the Director's credentials, licensures and certifications must be included in the proposal. Documentation of the Allied Health professional licensures and certifications must be included in the proposal appendices.</p> <p>Local Pharmacy Assistance Program (LPAP): Provider must offer all medications on the Texas ADAP formulary, for a total not to exceed \$18,000.00 per contract year per client. Provider must provide allowable</p>
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	<p>HIV-related medications (i.e. non-HIV medications) for a total not to exceed \$3,000 per contract year per client. Provider may be reimbursed ADAP dispensing fees (e.g. \$5/Rx) in accordance with RWGA business rules for those ADAP clients who are unable to pay the ADAP dispensing fee.</p>
<p>Local Service Category Definition:</p>	<p>a. Public Clinic-Based Primary Care: Services include on site physician, physician extender, nursing, phlebotomy, radiographic, laboratory, pharmacy, intravenous therapy, home health care referral, licensed dietician, patient medication education, and patient care coordination. The Provider/clinic must provide continuity of care with inpatient services and subspecialty services (either on-site or through specific referral to appropriate Provider/clinic upon primary care Physician's order).</p> <p>b. (all), c. Community-Based Primary Care: Services include on-site physician, physician extender, nursing, phlebotomy, radiographic, laboratory, pharmacy, intravenous therapy, home health care referral, licensed dietician, patient medication education, and patient care coordination. The Provider must provide continuity of care with inpatient services and subspecialty services (either on-site or through specific referral to appropriate medical provider upon primary care Physician's order).</p> <p>d. Women's Public Clinic-Based Primary Care: These services shall include on-site OB/GYN physician, physician extender, OB/GYN services, colposcopy, nursing, phlebotomy, radiographic, laboratory, pharmacy, intravenous therapy, home health care referral, licensed dietician, patient medication/women's health education, patient care coordination, and social services. The Provider must provide continuity of care with inpatient services and subspecialty services (either on-site or through specific referral protocols to appropriate agencies upon primary care Physician's order).</p> <p>Public Clinic-Based Primary Care, Community-Based Primary Care and Public Clinic-Based Women's Primary Care all must provide:</p> <ul style="list-style-type: none"> • Continuity of care for all stages of adult HIV infection; • Laboratory and pharmacy services including intravenous medications (either on-site or through established referral systems); • Outpatient psychiatric care, including lab work necessary for the prescribing of psychiatric medications when appropriate (either on-site or through established referral systems); • Access to the Texas ADAP program (either on-site or through established referral systems); • Access to compassionate use HIV medication programs (either directly or through established referral systems); • Access to HIV related research protocols (either directly or through established referral systems); • Must at a minimum, comply with Houston EMA/HSDA Part A/B Standards for HIV Primary Medical Care. The Provider must demonstrate on an ongoing basis the ability to provide state-of-the-art HIV-related primary care medicine in accordance with the most recent DHHS HIV treatment guidelines. Rapid advances in HIV treatment protocols require that the Provider provide services that to

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	<p>the greatest extent possible maximize a patient's opportunity for long-term survival and maintenance of the highest quality of life possible.</p> <ul style="list-style-type: none"> • On-site Outpatient Psychiatry services. • On-site Medical Case Management services. • On-site Nutritional Counseling. • On-site Medication Education. • Physical therapy services (either on-site or via referral). • Specialty Clinic Referrals (either on-site or via referral). • On-site pelvic exams as needed for female patients with appropriate follow-up treatment and referral. • On site Nutritional Counseling by a Licensed Dietitian. <p>Women's Primary Care Services must <u>also</u> provide:</p> <ul style="list-style-type: none"> • Well woman care, including but not limited to: PAP, pelvic exam, breast examination, mammography, hormone replacement and education, pregnancy testing, contraceptive services excluding birth control medications. • Obstetric Care: ante-partum through post-partum services, child birth/delivery services. Perinatal preventative education and treatment. • On-site Colposcopy exams as needed, performed by an OB/GYN physician, or physician extender with a colposcopy provider qualification. • Social services, including but not limited to, providing women access to child care, transportation vouchers, food vouchers and support groups at the clinic site; <p>Medical Case Management Services: Services include screening all primary medical care patients to determine each patient's level of need for Medical Case Management services, performing a comprehensive assessment and developing a medical service plan for each client that demonstrates a documented need for such services, monitoring medical service plan to ensure its implementation, and educating client regarding wellness, medication and health care compliance. The <i>Medical Case Manager</i> serves as an advocate for the client and as a liaison with medical providers on behalf of the client. The Medical Case Manager ensures linkage to mental health, substance abuse and other client services as indicated by the medical service plan. The Medical Case Manager will perform, or contribute to, <i>Readiness Assessments</i> in accordance with RWGA Quality Management guidelines in order to assess a patient's readiness for HAART.</p> <p>Service Linkage: The purpose of Service Linkage is to assist clients with the procurement of needed services so that the problems associated with living with HIV are mitigated. Service Linkage is a working agreement between a client and a Service Linkage Worker for an indeterminate period, based on client need, during which information, referrals and service linkage are provided on an as-needed basis. Service Linkage assists clients who do not require the intensity of <i>Medical Case Management</i> per RWGA Quality Management guidelines. Service Linkage is <u>both office-based and</u></p>
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	<p><u>filed based</u>. Service Linkage Workers are expected to coordinate activities with programs with referral sources where newly-diagnosed or not-in-care PLWHA may be identified, including 1:1 case conferences with testing site personnel to ensure the successful transition of referrals into Primary Care Services. Such incoming referral coordination includes meeting prospective clients at the referring Provider location in order to develop rapport with individuals prior to the individual's initial Primary Care appointment and ensuring such new intakes to Primary Care services have sufficient support to make the often difficult transition into ongoing primary medical care. Service Linkage also includes follow-up to re-engage lost-to-care patients. Lost-to-care patients are those patients who have not returned for scheduled appointments with Provider nor have provided Provider with updated information about their current Primary Medical Care provider (in the situation where patient may have obtained alternate service from another medical provider). Provider must document efforts to re-engage lost-to-care patients prior to closing patients in the CPCDMS. Service Linkage extends the capability of existing programs by providing "hands-on" outreach and linkage to care services to those PLWHA who are not currently accessing primary medical care services. Service Linkage includes the issuance of bus pass vouchers and gas cards per published RWGA guidelines. Service Linkage complements and extends the service delivery capability of Medical Case Management services.</p> <p>Nutritional Counseling: Services include provision of information about therapeutic nutritional/supplemental foods that are beneficial to the wellness and increased health conditions of clients by a Licensed Dietitian. Services may be provided either through educational or counseling sessions. Also included in this service are follow up sessions with clients and/or clients' Primary Care Physicians regarding the effectiveness of the services. Clients who receive these services may utilize the Ryan White Part A-funded nutritional supplement provider to obtain recommended nutritional supplements in accordance with program rules.</p> <p>Patient Medication Education Services must adhere to the following requirements:</p> <ul style="list-style-type: none"> • Medication Educators must be State Licensed Medical Doctor (MD), Nurse Practitioner (NP), Physician Assistant (PA), Nurse (RN, LVN) or Pharmacist. Prior approval must be obtained prior to utilizing any other health care professional not listed above to provide medication education. • Clients who will be prescribed ongoing medical regimens (i.e. HAART) must be assessed for adherence to treatment at <u>every clinical encounter using the EMA's approved adherence assessment tool</u>. Clients with adherence issues related to lack of understanding must receive more education regarding their medical regimen. Clients with adherence issues that are behavioral or involve mental health issues must be provided counseling by the Medical Case Manager, Physician or Physician Extender and/or licensed nursing staff and, if clinically indicated, assessment and treatment by a qualified Psychiatrist or <u>Psychiatric Nurse Practitioner</u>.
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	<p>Outpatient Psychiatric Services: The program must provide:</p> <ul style="list-style-type: none"> • Diagnostic Assessments: comprehensive evaluation for identification of psychiatric disorders, mental status evaluation, differential diagnosis which may involve use of other clinical and laboratory tests, case formulation, and treatment plans or disposition. • Emergency Psychiatric Services: rapid evaluation, differential diagnosis, acute treatment, crisis intervention, and referral. Must be available on a 24 hour basis including emergency room referral. • Brief Psychotherapy: individual, supportive, group, couple, family, hypnosis, biofeedback, and other psychophysiological treatments and behavior modification. • Psychopharmacotherapy: evaluation and medication treatment of psychiatric disorders, including, but not limited to, anxiety disorders, major depression, pain syndromes, habit control problems, psychosis and organic mental disorders. • Rehabilitation Services: Physical, psychosocial, behavioral, and/or cognitive training. <p>Screening for Eye Disorders: Provider must ensure that patients receive appropriate screening and treatment for CMV, glaucoma, cataracts, and other related problems.</p> <p>Local Medication Assistance Program (LPAP): LPAP provides pharmaceuticals to patients otherwise ineligible for medications through private insurance, Medicaid/Medicare, State ADAP, SPAP or other sources. Allowable medications are those on the current Texas ADAP formulary and Houston EMA Ryan White Part A Formulary. Eligible clients may be provided Fuzeon™ on a case-by-case basis with prior approval of Ryan White Grant Administration (RWGA). The cost of Fuzeon™ does not count against a client's annual maximum. HIV-related medication services are the provision of physician or physician-extender prescribed HIV-related medications to prevent serious deterioration of health. Does <u>not</u> include drugs available free of charge (such as birth control and TB medications) or medications available over the counter (OTC) without prescription.</p>
Agency Requirements:	<p>Providers and system must be Medicaid/Medicare certified. If applicable, provider must:</p> <ol style="list-style-type: none"> 1) Provide pharmacy services <u>on-site</u> or through an established contractual relationship that meets all requirements. Alternate (off-site) approaches must be approved prior to implementation by RWGA. 2) Provider must either directly, or via subcontract with an eligible 340B Pharmacy program entity, ensure the following: <ul style="list-style-type: none"> • Ensure a comprehensive financial intake application to determine client eligibility for this program to insure that these funds are used as a last resort for purchase of medications. • Ensure access to the local drug reimbursement program via collaboration between HIV Primary Care sites and Provider. • Ensure the documented capability of interfacing with the Texas

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	<p>HIV Medication Program operated by the Texas Department of State Health Services. This capability must be fully documented and is subject to independent verification by RWGA.</p> <ul style="list-style-type: none"> • Ensure medication assistance provided to clients does not duplicate services already being provided in the Houston area. The process for accomplishing this must be fully documented and is subject to independent verification by RWGA. • Ensure, either directly or via a 340B Pharmacy Program Provider, at least 2 years of continuous documented experience in providing HIV/AIDS medication programs utilizing Ryan White Program or similar public sector funding. This experience must be documented and is subject to independent verification by RWGA. • Ensure all medications are purchased via a qualified participant in the federal 340B Drug Pricing Program and Prime Vendor Program, administered by the HRSA Office of Pharmacy Affairs. Note: failure to maintain 340B or Prime Vendor drug pricing may result in a negative audit finding, cost disallowance or termination of contract awarded. Provider must maintain 340B Program participation throughout the contract term. All eligible medications must be purchased in accordance with Program 340B guidelines and program requirements. • Ensure Houston area HIV/AIDS service providers are informed of this program and how the client referral and enrollment processes functions. Provider must maintain documentation of such marketing efforts. <p>3) <u>Implement a consistent process to enroll eligible patients in available pharmaceutical company <i>Patient Assistance Programs</i> prior to using Ryan White Part A funded LPAP resources.</u></p> <p>4) Ensure information regarding the program is provided to PLWHA, including historically under-served and unserved populations (e.g., African American, Hispanic/Latino, Asian, Native American, Pacific Islander) and women not currently obtaining prescribed HIV and HIV-related medications.</p> <p>5) Provider must offer, at no charge to the client, delivery options for medication refills, including but not limited to courier, USPS or other package delivery service.</p> <p>6) For patients other than those of the covered entity Provider may provide medications to otherwise eligible patients of other qualified primary medical care providers at a cost comparable to the cost of the same medication under Provider's 340B program. *340B rules do not allow an entity to provide medications to clients who are not patients of the covered entity.</p>
<p>Staff Requirements:</p>	<p>Primary medical care providers are responsible for ensuring that services are provided by State licensed internal medicine and OB/GYN physicians, specialty care physicians, psychiatrists, registered nurses, nurse practitioners, vocational nurses, pharmacists, physician assistants, physician extenders with a colposcopy provider qualification, x-ray technologists, State licensed dieticians, licensed social worker and ancillary health care providers in accordance with appropriate State licensing and/or certification</p>

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	<p>requirements and with knowledge and experience of HIV disease.</p> <p>For primary medical care services targeted to the Latino community at least 50% of the clinical care team must be fluent in Spanish.</p> <p>Medication and Adherence Education: The program must utilize an RN, LVN, PA, NP, pharmacist or MD licensed by the State of Texas, who has at least two years paid experience in all areas of HIV/AIDS care, to provide the educational services. Medical Case Managers may also provide <u>adherence</u> education/counseling.</p> <p>Medical Case Management: The program must utilize a state licensed Social Worker to provide Medical Case Management (MCM) Services. The Provider must maintain the budgeted number of medical case management FTEs throughout the contract term.</p> <p>Service Linkage: The program must utilize Service Linkage Workers (SLW) who at a minimum have a Bachelor's degree from an accredited college or university with a major in social or behavioral sciences. Documented paid work experience in providing client services to PLWH/A may be substituted for the Bachelor's degree requirement on a 1:1 basis (1 year of documented paid experience may be substituted for 1 year of college). All Service Linkage Workers must have a minimum of one (1) year paid work experience with PLWHA. Provider must maintain the budgeted number of service linkage FTEs throughout the contract term.</p> <p>Supervision of Case Managers: The Service Linkage Workers and Medical Case Managers must function within the clinical infrastructure of Provider and receive ongoing supervision that meets or exceeds Houston EMA/HSDA Part A/B Standards of Care for Service Linkage and Medical Case Management as applicable. An MCM may supervise SLWs.</p> <p>Outpatient Psychiatric Services: Director of the Program must be a Board Certified Psychiatrist. Licensed and/or Certified allied health professionals (Licensed Psychologists, Physicians, Psychiatric Nurse Practitioners, Licensed Master Social Workers, Licensed Professional Counselors, Licensed Marriage and Family Therapists, Certified Alcohol and Drug Abuse Counselors, etc.) must be used in all treatment modalities. Provider must submit to RWGA documentation of the Director's credentials, licensures and certifications and documentation of the Allied Health professional licensures and certifications.</p>
<p>Special Requirements: RWGA only unless otherwise specified</p>	<p>Provider <u>must</u> provide all required program components - Primary Medical Care, Medical Case Management, Service Linkage (non-medical Case Management) and Local Pharmacy Assistance Program services <u>unless otherwise specified</u>.</p> <p>Primary Medical Care Services: In a clinical setting where a physician extender is utilized, the client must be examined by a physician a minimum of once per year (and more often if clinically indicated). Services funded under this grant cannot be used to supplant insurance or Medicare/Medicaid reimbursements for such services. Clients eligible for such reimbursement may not be billed to this contract. Medicare and private insurance co-payments are eligible for reimbursement under the contract (in this situation</p>

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	<p>the County will reimburse the client's co-payment only, not the cost of the session which must be billed to Medicare and/or the Third Party payer). Under no circumstances may the Provider bill the County for the difference between the reimbursement from Medicaid, Medicare or Third Party insurance and the fee schedule under the contract. Furthermore, potential clients who are Medicaid/Medicare eligible or have other Third Party payers may not be denied services or referred elsewhere by the Provider based on their reimbursement status (Medicaid/Medicare eligible clients may not be referred elsewhere in order that non-Medicaid/Medicare eligible clients may be added to this contract). Failure to serve Medicaid/Medicare eligible clients based on their reimbursement status will be grounds for the immediate termination of contract.</p> <p>Diagnostic Procedures: A single Diagnostic Procedure limited to procedures on the approved list of diagnostic procedures (see below) without prior County approval. Approved diagnostic procedures <u>will be reimbursed at invoice cost.</u> Part A and Part A/MAI-funded programs must refer to the RWGA website for the most current list of approved diagnostic procedures and corresponding codes: www.hcphes.org/rwga. Diagnostic procedures not listed on the website must have prior approval by RWGA.</p> <p>All primary medical care services must meet or exceed current United States DHHS Treatment Guidelines for the treatment and management of HIV disease.</p> <p>Outpatient Psychiatric Services: Client must not be eligible for services from other programs/providers or any other reimbursement source (i.e. Medicaid, Medicare, private insurance) unless the client is in crisis and cannot be provided immediate services from the other programs/providers. In this case, clients may be provided services, as long as the client applies for the other programs/providers, until the other programs/ providers can take over services. Program must be supervised by a Psychiatrist and include diagnostic assessments, emergency evaluations and psycho-pharmacotherapy.</p> <p>Maintaining Referral Relationships (Point of Entry Agreements) Provider must maintain appropriate relationships with entities that constitute key points of access to the health care system for individuals with HIV disease, including but not limited to, Harris County Hospital District and other Houston EMA-located emergency rooms, Harris County Jail, Texas Department of Criminal Justice incarceration facilities, Immigration detention centers, substance abuse treatment and detoxification programs, adult and juvenile detention facilities, Sexually Transmitted Disease clinics, federally qualified health centers (FQHC), HIV disease counseling and testing sites, mental health programs and homeless shelters. These referral relationships must be documented with written collaborative agreements, contracts or memoranda of understanding between Provider and appropriate point of entry entities and are subject to audit by RWGA. Provider and POE entity staff must regularly (e.g. weekly, bi-weekly depending on volume of referrals) meet 1:1 to discuss new referrals to primary medical care services. Such case conferences must be documented in the client</p>
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	<p>record and properly entered into the CPCDMS.</p> <p>Use of CPCDMS Data System: Provider must comply with CPCDMS business rules and procedures. Provider must enter into the CPCDMS all required clinical data, including but not limited to, HAART treatment including all changes in medication regimens, Opportunistic Infections, screening and treatment for STDs and Hepatitis A, B, C and other clinical screening and treatment data required by HRSA, TDSHS and the County. <u>Provider must perform semi-annual Registration updates in accordance with RWGA CPCDMS business rules for all clients wherein Provider is client's CPCDMS record owning agency. Provide utilized an electronic verification system to verify insurance/3rd party payer status monthly or per visit (whichever is less frequent).</u></p> <p>Bus Pass Distribution: The County will provide Provider with METRO bus pass vouchers. Bus Pass vouchers must be distributed in accordance with RWGA policies and procedures, standards of care and financial eligibility guidelines. Provider may only issue METRO bus pass vouchers to clients wherein the Provider is the CPCDMS record owning Provider. METRO bus pass vouchers shall be distributed as follows:</p> <p>Expiration of Current Bus Pass: In those situation wherein the bus pass expiration date does not coincide with the semi-annual CPCDMS registration update the Provider must distribute METRO bus pass vouchers to eligible clients upon the expiration of the current bus pass or when a Value-based bus card has been expended on eligible transportation needs. Provider may issue METRO bus passes to eligible clients living outside the METRO service area in those situations where the Provider has documented in the client record that the client will utilize the METRO system to access needed HIV-related health care services located in the METRO service area.</p> <p>Gas Cards: Rural Primary Medical Care Providers must distribute gasoline vouchers to eligible clients residing in the rural service area in accordance with RWGA policies and procedures, standards of care and financial eligibility guidelines.</p>
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FY 2013 How to Best Meet the Need Process

Step in Process: Council		Date:
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		
Step in Process: Steering Committee		Date:
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		
Step in Process: Quality Assurance Committee		Date:
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		
Step in Process: HTBMTN Workgroup #1		Date: 04/19/12
Recommendations:	Financial Eligibility:	
1.		
2.		
3.		

**Service Category Definition - Ryan White Part A Grant
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HRSA Service Category Title: RWGA only	Ambulatory/Outpatient Medical Care and Medical Case Management
Local Service Category Title:	Primary Medical Care, Medical Case Management and Service Linkage targeted to Pediatric
Budget Type: RWGA only	Hybrid
Budget Requirements or Restrictions: RWGA only	<p>In situations where a client is examined by both the Physician and Physician Extender on the same date, only the Physician Visit may be billed.</p> <p>At least 10% of the primary medical care budget must be reserved for invoicing diagnostic procedures at actual cost.</p>
HRSA Service Category Definition: RWGA only	<p>Ambulatory/Outpatient Medical Care is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings. Services includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). <i>Primary medical care</i> for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.</p> <p>Medical Case management services (including treatment adherence) are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms</p>

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	<p>of communication.</p> <p><i>Service Linkage (Case Management - non-Medical)</i> includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does.</p>
Local Service Category Definition:	<p>Primary Care Office/Clinic Visit is defined as client examination by a qualified Medical Doctor, Nurse Practitioner, and/or Physician's Assistant and includes all ancillary services below:</p> <ul style="list-style-type: none"> • Eligibility Screening (as necessary) • Patient Medication/Treatment Education • Adherence Education, Counseling and Support • Medication Access/Linkage • OB/GYN specialty procedures (as clinically indicated) • Nutritional Counseling (as clinically indicated) • Routine Laboratory (as clinically indicated) • Routine Radiology (as clinically indicated) <p>Medical Case Management Visit is defined as assessment, education and consultation by an licensed social worker within a system of information, referral, case management, and/or social services and includes:</p> <ul style="list-style-type: none"> • Social Services/Case Coordination • Assessment of Readiness for HAART therapy (as indicated) <p>Service Linkage is defined as the provision of information, referrals and assistance with linkage to medical, mental health, substance abuse and psychosocial services as needed; advocating on behalf of clients to decrease service gaps and remove barriers to services helping clients develop and utilize independent living skills and strategies. Service Linkage supports linkage to Agency primary care services for newly-diagnosed clients identified through Agency HIV Counseling and Testing (C&T) activities and for individuals who test positive at other C&T sites located in the EMA. Assist clients in obtaining needed resources, including bus pass vouchers and gas cards per published HCPHES/RWGA policies.</p> <p>Psychiatry Visit is defined as provision of outpatient psychiatric care by a Board certified Psychiatrist</p>
Target Population (age, gender, geographic, race, ethnicity, etc.):	<p>g. Pediatric Outpatient Services: All eligible pediatric clients (ages 0-18) with HIV disease. With prior approval by RWGA provider may continue services to previously enrolled clients until the client's 22nd birthday.</p>
Services to be Provided:	<p>Pediatric Primary Care: Services include on site physician, physician extender, nursing, phlebotomy, radiographic, laboratory, pharmacy,</p>

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intravenous therapy, home health care referral, licensed dietician, patient medication education, and patient care coordination. The Agency/clinic must provide continuity of care with inpatient services and subspecialty services (either on-site or through specific referral to appropriate agency/clinic upon primary care. Services must include, but are not limited to,

- Continuity of care for all stages of Pediatric HIV infection;
- Laboratory and pharmacy services including intravenous medications (either on-site or through established referral systems);
- Outpatient psychiatric care, including lab work necessary for the prescribing of psychiatric medications when appropriate (either on-site or through established referral systems);
- Access to the Texas ADAP program (either on-site or through established referral systems);
- Access to compassionate use HIV medication programs (either directly or through established referral systems);
- Access to HIV related research protocols (either directly or through established referral systems);
- Must at a minimum, comply with Houston Ryan White Program Standards for HIV Primary Medical Care as applicable to Children and Youth. The Agency must demonstrate on an ongoing basis the ability to provide state-of-the-art HIV-related primary care medicine in accordance with the most recent U.S. Dept. of Health and Human Services (HHS) HIV treatment guidelines. The recent rapid advances in HIV treatment protocols require that the Agency provide services that to the greatest extent possible maximize a patient's opportunity for long-term survival and maintenance of the highest quality of life possible.
- When clinically indicated, on-site pelvic exams as needed with appropriate treatment and referral.
- Nutritional Counseling by a Licensed Dietitian.
- Specialty Clinic Referrals.

Nutritional Counseling: Services include provision of information about therapeutic nutritional/supplemental foods that are beneficial to the wellness and increased health conditions of clients by a Licensed Dietitian. Services may be provided either through educational or counseling sessions. Also included in this service are follow up sessions with clients and/or clients' Primary Care Physicians regarding the effectiveness of the services. Clients who receive these services may utilize Ryan White Part A funded supplement providers to obtain recommended nutritional supplements.

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Patient Medication Education Services must adhere to the following requirements:

- Medication Educators must be State Licensed Medical Doctor (MD), Nurse Practitioner (NP), Physician Assistant (PA), Nurse (RN, LVN) or Pharmacist. **Prior approval from RWGA must be obtained prior to utilizing any other health care professional not listed above for medication education.**
- Clients who will be prescribed ongoing medical regimens (e.g. HAART) must be assessed for adherence to treatment. Clients with adherence issues related to lack of understanding must receive more education regarding their medical regimen. Clients with adherence issues that are behavioral or involve mental health issues must be provided counseling by the Medical Case Manager, Physician or Physician Extender and/or licensed nursing staff and, if clinically indicated, assessment and treatment by a qualified Psychiatrist.

Must also provide Outpatient Psychiatric Services:

The program must be able to provide:

- Diagnostic Assessments: comprehensive evaluation for identification of psychiatric disorders, mental status evaluation, differential diagnosis which may involve use of other clinical and laboratory tests, case formulation, and treatment plans or disposition.
- Emergency Psychiatric Services: rapid evaluation, differential diagnosis, acute treatment, crisis intervention, and referral. To be available on a 24 hour basis, emergency room referral o.k.
- Brief Psychotherapy: individual, supportive, group, couple, family, hypnosis, biofeedback, and other psychophysiological treatments and behavior modification.
- Psychopharmacotherapy: evaluation and medication treatment of psychiatric disorders, including, but not limited to, anxiety disorders, major depression, pain syndromes, habit control problems, psychosis and organic mental disorders.

Must also provide age appropriate Rehabilitation Services:

Physical, psychosocial, behavioral, and/or cognitive training. Agency must ensure that Pediatric patients receive appropriate treatment for HIV-related medical conditions as appropriate.

Medical Case Management: Services include performing a comprehensive assessment and developing a medical service plan for each client; monitoring plan to ensure its implementation; and educating client regarding wellness, medication and health care compliance. The *Medical Case Manager* serves as an advocate for the client and as a liaison with medical providers on behalf of the client. The Medical Case Manager ensures linkage to mental health, substance abuse and other

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	<p>client services as indicated by the medical service plan. The Medical Case Manager will perform, or contribute to, <i>Readiness Assessments</i> in accordance with RWGA Quality Management guidelines in order to assess a patient’s readiness for HAART.</p> <p>Service Linkage: The purpose of Service Linkage is to assist clients with the procurement of needed services so that the problems associated with living with HIV are mitigated. Service Linkage is a working agreement between a client and a Service Linkage Worker for an indeterminate period, based on client need, during which information, referrals and service linkage are provided on an as-needed basis. Service Linkage assists clients who do not require the intensity of <i>Medical Case Management</i> per HCPHES/RWGA Quality Management guidelines. Service Linkage is primarily office-based, however Service Linkage Workers are expected to coordinate activities with programs where newly-diagnosed or not-in-care PLWHA may be referred from, including 1:1 case conferences to ensure the successful transition into Primary Care Services. Such incoming referral coordination includes meeting prospective clients at the referring agency location in order to develop rapport with individuals prior to the individual’s initial Primary Care appointment and ensuring such new intakes to Primary Care services have sufficient support to make the often difficult transition into ongoing primary medical care. Service Linkage extends the capability of existing programs by providing “hands-on” outreach and linkage to care services to those PLWHA who are not currently accessing primary medical care services. Service Linkage includes the issuance of bus pass vouchers and gas cards per published RWGA guidelines.</p> <p>The Service Linkage Worker complements and extends the service delivery capability of Medical Case Management services.</p>
<p>Service Unit Definition(s): RWGA only</p>	<p>Primary Care: One (1) unit of service = One (1) primary care office/clinic visit which includes the following:</p> <ul style="list-style-type: none"> • Primary care physician/nurse practitioner/physician’s assistant examination of the patient • Medication/treatment education • Medication access/linkage • OB/GYN specialty procedures (as clinically indicated) • Nutritional counseling (as clinically indicated) • Laboratory (as clinically indicated) • Radiology (as clinically indicated, not including CAT scan or MRI) • Eligibility verification/screening (as necessary) • Follow-up visits wherein the patient is not seen by the MD/NP/PA are considered to be a component of the original primary health care visit that is billed to the County. <p>Outpatient Psychiatric Services: 1 unit of service = A single (1)</p>

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	<p>office/clinic visit wherein the patient is seen by a State licensed and board-eligible Psychiatrist. This visit may or may not occur on the same date as a primary care office visit.</p> <p>Medical Case Management: 1 unit of service = 15 minutes of direct client service providing medical care coordination by a qualified Medical Case Manager for eligible HIV-infected clients.</p> <p>Service Linkage: 1 unit of service = 15 minutes of direct client service providing non-medical case management services by a Service Linkage Worker for eligible HIV-infected clients.</p>
Financial Eligibility:	Refer to the RWPC's approved <i>Financial Eligibility for Houston EMA Services</i> .
Client Eligibility:	HIV-infected resident of the Houston EMA 0 – 18 years of age. Provider may continue services to previously enrolled clients until the client's 22 nd birthday.
Agency Requirements:	Providers and system must be Medicaid/Medicare certified.
Staff Requirements:	<p>Primary care providers are responsible for ensuring that services are provided by State licensed internal medicine and OB/GYN physicians, specialty care physicians, psychiatrists, registered nurses, nurse practitioners, vocational nurses, pharmacists, physician assistants, physician extenders with a colposcopy provider qualification, x-ray technologists, State licensed dieticians, Licensed Social Worker and ancillary health care providers in accordance with appropriate State licensing and/or certification requirements and with knowledge and experience of HIV disease.</p> <p>Medication and Adherence Education: The program must utilize an LMSW, RN, LVN, PA, NP, pharmacist or MD licensed by the State of Texas, who has at least two years paid experience in all areas of HIV/AIDS care, to provide the educational services. Licensed Social Workers may also provide adherence education/counseling.</p> <p>Medical Case Management: The program must utilize a social worker licensed by the State of Texas to provide Medical Case Management Services. Contractor must provide to RWGA the names, and licensure if applicable, of each case manager and the individual assigned to supervise these case managers by 03/30/12. Thereafter, Contractor must inform RWGA in writing of any changes in case management personnel assigned to contract within ten (10) business days of change. Contractor must maintain the assigned number of case management FTEs throughout the contract term. Contractor inability to fully staff funded case management positions may result in loss of funding for such positions.</p>

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	<p>Service Linkage: Service Linkage Workers (SLW) must have at a minimum a Bachelor’s degree from an accredited college or university with a major in social or behavioral sciences. Documented paid work experience in providing client services to PLWH/A may be substituted for the Bachelor’s degree requirement on a 1:1 basis (1 year of documented paid experience may be substituted for 1 year of college). All Service Linkage Workers must have a minimum of one (1) year paid work experience with PLWHA.</p> <p>Outpatient Psychiatric Services: Director of the Program must be a Board Certified Psychiatrist. Licensed and/or Certified allied health professionals (Licensed Psychologists, Physicians, Licensed Master Social Workers, Licensed Professional Counselors, Licensed Marriage and Family Therapists, Certified Alcohol and Drug Abuse Counselors, etc.) must be used in all treatment modalities. Documentation of the Director’s credentials, licensures and certifications must be included in the proposal.</p>
<p>Special Requirements: RWGA only</p>	<p>Applicant agency must provide Primary Medical Care, Medical Case Management and Service Linkage Services.</p> <p>Primary Medical Care Services: In a clinical setting where a physician extender is utilized, the client must be examined by a physician a minimum of once per year (and more often if clinically indicated). Services funded under this grant cannot be used to supplant insurance or Medicare/Medicaid reimbursements for such services. Clients eligible for such reimbursement may not be billed to this contract. Medicare and private insurance co-payments are eligible for reimbursement under the contract (in this situation the County will reimburse the client’s co-payment only, not the cost of the session which must be billed to Medicare and/or the Third Party payer). Under no circumstances may the Agency bill the County for the difference between the reimbursement from Medicaid, Medicare or Third Party insurance and the fee schedule under the contract. Furthermore, potential clients who are Medicaid/Medicare eligible or have other Third Party payers may not be denied services or referred elsewhere by the Agency based on their reimbursement status (Medicaid/Medicare eligible clients may not be referred elsewhere in order that non-Medicaid/Medicare eligible clients may be added to this contract). Failure to serve Medicaid/Medicare eligible clients based on their reimbursement status may be grounds for the immediate termination of contract.</p> <p>Diagnostic Procedures: A single Diagnostic Procedure (limited to procedures below without prior County approval). Approved diagnostic procedures <u>will be reimbursed at invoice cost.</u></p>

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The following diagnostic procedures are approved by RWGA:
Refer to the RWGA website for the most current list of approved diagnostic procedures and corresponding codes: www.hcpbes.org/rwga.

Diagnostic procedures not listed on the website must have prior approval by RWGA:

Outpatient Psychiatric Services: Client must not be eligible for services from other programs/providers (i.e. MHMRA of Harris County) or any other reimbursement source (i.e. Medicaid, Medicare, Private Insurance) unless the client is in crisis and cannot be provided immediate services from the other programs/providers. In this case, clients may be provided services, as long as the client applies for the other programs/providers, until the other programs/ providers can take over services. Program must be supervised by a Psychiatrist and include diagnostic assessments, emergency evaluations and psychopharmacotherapy.

All primary care services must meet or exceed current HHS Treatment Guidelines for the treatment and management of HIV disease as applicable for Children and Youth.

Agency must have documented capability to bill eligible medical case management service encounters to Medicaid.

Maintaining Referral Relationships (Point of Entry Agreements)
Agency must maintain appropriate relationships with entities that constitute key points of access to the health care system for pediatric PLWHA, including but not limited to, Harris County Hospital District and other Houston EMA-located emergency rooms, juvenile detention facilities, Sexually Transmitted Disease clinics, Federally qualified health centers, HIV disease counseling and testing sites, mental health programs and homeless shelters. These referral relationships must be documented with written collaborative agreements, contracts or memoranda of understanding between Agency and appropriate point of entry entities and are subject to audit by the County.

Agency must comply with CPCDMS system business rules and procedures.

Bus Pass Distribution

The County will provide Agency with METRO bus pass vouchers. Bus Pass vouchers must be distributed in accordance with RWGA policies and procedures, standards of care and financial eligibility guidelines. Agency may only issue METRO bus pass vouchers to clients wherein the Agency is the CPCDMS record owning agency. METRO bus pass

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vouchers shall be distributed as follows:

Expiration of Current Bus Pass: In those situation wherein the bus pass expiration date does not coincide with the semi-annual CPCDMS registration update the Provider must distribute METRO bus pass vouchers to eligible clients upon the expiration of the current bus pass or when a Value-based bus card has been expended on eligible transportation needs. Provider may issue METRO bus passes to eligible clients living outside the METRO service area in those situations where the Provider has documented in the client record that the client will utilize the METRO system to access needed HIV-related health care services located in the METRO service area.

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FY 2013 RWPC “How to Best Meet the Need” Decision Process

Step in Process: Council		Date:
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		
Step in Process: Steering Committee		Date:
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		
Step in Process: Quality Assurance Committee		Date:
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		
Step in Process: HTBMTN Workgroup #1		Date: 04/19/12
Recommendations:	Financial Eligibility:	
1.		
2.		
3.		

**Service Category Definition - Ryan White Part B Grant
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Local Service Category:	Outpatient /Ambulatory Medical Care - Rural (including Medical Case Management and AIDS Pharmaceutical Assistance) West of Harris County and North of Harris County
Amount Available:	To be determined
Unit Cost:	
Budget Requirements or Restrictions (TRG Only):	<p>Maximum of 10% of budget for Administrative Costs.</p> <p><u>Providers may not exceed the allocation for each individual service element (i.e. Primary Medical Care, Medical Case Management, Local Pharmacy Assistance Program) without prior approval from TRG.</u></p> <p><u>AIDS Pharmaceutical Assistance (APA) Program:</u> <u>Houston RWPC guidelines for APA Program services: Provider shall offer HIV medications from an approved formulary for a total not to exceed \$18,000 per contract year per client. Provider shall offer HIV-related medications for a total not to exceed \$3,000 per contract year per client. These guidelines are determined by the RWPC. The RWPC determines the subcategories that shall include APA funding.</u></p> <p><u>Medications must be provided in accordance with Houston HSDA guidelines, HRSA/HAB rules and regulations and applicable Office of Pharmacy Affairs 340B guidelines.</u></p> <p><u>At least 75% of the total amount of the budget for APA services must be solely allocated to the actual cost of medications and may not include any storage, administrative, processing or other costs associated with managing the medication inventory or distribution.</u></p>
Local Service Category Definition:	<p>OAMC Office/Clinic Visit is defined as client examination by a qualified Medical Doctor, Nurse Practitioner, and/or Physician's Assistant and includes all ancillary services below:</p> <ul style="list-style-type: none"> • Eligibility Screening (as necessary) • Patient Medication/Treatment Education • Social Services/Case Coordination • Medication Access/Linkage • OBGYN specialty procedures (as clinically indicated) • Nutritional Counseling (as clinically indicated) • Laboratory (as clinically indicated) • Radiology (as clinically indicated) <p>Medical Case Management Services: Services include screening all primary medical care patients to determine each patient's level of need for Medical Case Management services, performing a comprehensive assessment and developing a medical service plan for each client that demonstrates a documented need for such services, monitoring medical service plan to ensure its implementation, and educating client regarding wellness, medication and health care compliance. The Medical Case Manager serves as an advocate for the client and as a liaison with medical providers on behalf of the client. The Medical Case Manager ensures linkage to mental health, substance abuse and other client services as indicated by the medical service plan.</p>

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	<p>APA: APA provides pharmaceuticals to patients otherwise ineligible for medications through private insurance, Medicaid/Medicare, State ADAP, SPAP or other sources. Allowable medications are those on the current Texas ADAP formulary and Houston Ryan White Drug Formulary. Eligible clients may be provided Fuzeon™ on a case-by-case basis with prior approval of TRG. The cost of Fuzeon™ does not count against a client’s annual maximum. HIV-related medication services are the provision of physician or physician-extender prescribed HIV-related medications to prevent serious deterioration of health. Does <u>not</u> include drugs available free of charge (such as birth control and TB medications) or medications available over the counter (OTC) without prescription</p>
<p>Target Population (age, gender, geographic, race, ethnicity, etc.):</p>	<p>HIV positive; individuals residing in the defined rural areas of the Houston HSDA (outside of Harris County).</p> <p>Medical Case Management: Priority will be given to clients with higher acuity. Services will target low income individuals with HIV/AIDS who demonstrate multiple medical and psychosocial needs including, but not limited to: primary care, specialized care, alternative treatment, medications, placement in a medical facility, emotional support, mental health counseling, substance abuse treatment, basic needs for food, clothing, and shelter, transportation, legal services and vocational services. Services will also target clients who cannot function in the community due to barriers which include, but are not limited to: extreme lack of knowledge regarding available services, inability to maintain financial independence, inability to complete necessary forms, inability to arrange and complete entitlement and medical appointments, homelessness, deteriorating medical condition, psychiatric illness, illiteracy, language/cultural barriers and/or the absence of speech, sight, hearing, or mobility.</p>
<p>Services to be Provided:</p>	<p>Providers are responsible for ensuring that primary medical care services are provided by State licensed internal medicine and OB/GYN physicians, specialty care physicians, psychiatrists, registered nurses, nurse practitioners, vocational nurses, pharmacists, physician assistants, physician extenders with a colposcopy provider qualification, x-ray technologists, State licensed dieticians, licensed social worker and ancillary health care providers in accordance with appropriate State licensing and/or certification requirements and with knowledge and experience of HIV disease.</p> <p>OAMC services include on site physician, physician extender, nursing, OBGYN physician, OBGYN services, phlebotomy, radiographic, laboratory, pharmacy, intravenous therapy, home health care and hospice referral, patient medication and adherence education, and patient care coordination. The agency/clinic must provide continuity of care with inpatient services and subspecialty services (either on-site or through specific referral to appropriate agencies).</p> <ul style="list-style-type: none"> • Continuity of care for all stages of adult HIV infection; • Specialty Clinic Referrals. (i.e. obstetrics and gynecology, vision care, gastroenterology, neurology, etc.) • Laboratory and pharmacy services including intravenous medications (either on-site or through established referral systems); • Prenatal and Perinatal Preventative education and treatment; • Access to the Texas HIV Medication Program (either on-site or through established referral systems); • Access to compassionate use HIV medication programs (either

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	<p>directly or through established referral systems). Utilization of Pharmaceutical Patient Assistance Program (PAP) is encouraged.</p> <ul style="list-style-type: none"> • Access to HIV related research protocols (either directly or through established referral systems); • Must at a minimum, comply with the attached Adult Standards for HIV Primary Medical Care Components of Medical Practice. The Contractor must demonstrate on an ongoing basis the ability to provide state-of-the-art HIV-related primary care medicine in accordance with the most recent National Institute of Health (NIH) HIV treatment guidelines. The rapid advances in HIV treatment protocols require that the Contractor provide services that will to the greatest extent possible maximize a patient’s opportunity for long-term survival and maintenance of the highest quality of life possible. <p>Medical Case Management: A working agreement between a client and a case manager for a defined period of time based on the client’s acuity. The purpose of case management is to assist clients with the procurement of needed services so that the problems associated with living with HIV are mitigated. Direct case management services include any activities with a client (face-to-face or by telephone), communication with other service providers or significant others to access client services, client acuity assessment, monitoring client care, and accompanying clients to services. Indirect activities include travel to and from a client's residence or agency, staff meetings, supervision, community education, documentation, and computer input.</p> <p>The focus of the Medical Case Management will be to provide short-term intensive intervention by case managers which will address service linkage, medical needs and psychosocial needs depending on client need followed by long-term availability of information, referrals and intermittent interventions, if required. Clients at all levels of acuity will be served. The Medical Case Manager will perform Mental Health and Substance Abuse/Use Assessments. Service Plan must reflect an ongoing discussion of Mental Health treatment and/or substance abuse treatment per client need.</p> <p>AIDS Pharmaceutical Assistance: Provider must offer all medications on the Texas ADAP formulary, for a total not to exceed \$18,000.00 per contract year per client. Provider must provide allowable HIV-related medications (i.e. non-HIV medications) for a total not to exceed \$3,000 per contract year per client. Provider may be reimbursed ADAP dispensing fees (e.g. \$5/Rx) for those ADAP clients who are unable to pay the ADAP dispensing fee.</p> <p>Supervision: The Service Linkage Workers (SLW) and Medical Case Managers (MCM) must function within the clinical infrastructure of Provider and receive ongoing supervision that meets or exceeds published Standards of Care. An MCM may supervise SLWs.</p>
<p>Service Unit Definition(s) (TRG Only):</p>	<p>OAMC: 1 unit of service = 1 primary care office/clinic visit which includes the following:</p> <ul style="list-style-type: none"> • Primary care physician/nurse practitioner/physician’s assistant examination of the patient • Medication/treatment education • Social services/care coordination • Medication access/linkage

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April 1, 2012 - March 31, 2013**

DRAFT

	<ul style="list-style-type: none"> • OBGYN specialty procedures (as clinically indicated) • Nutritional counseling (as clinically indicated) • Laboratory (as clinically indicated) • Radiology (as clinically indicated, not including CAT scan or MRI) • Eligibility verification/screening (as necessary) • Follow-up visits where in the patient is not seen by the MD/NP/PA are considered to be a component of the original primary health care visit that is billed to the County. <p><u>Medical Case Management:</u> 1 unit of service = 15 minutes of direct medical case management services to an eligible PLWHA performed by a qualified medical case manager.</p> <p>AIDS Pharmaceutical Assistance (local): A unit of service = a transaction involving the filling of a prescription or any other allowable medication need ordered by a qualified medical practitioner. The transaction will involve at least one item being provided for the client, but can be any multiple. The cost of medications provided to the client must be invoiced at actual cost.</p>
Financial Eligibility:	Outpatient /Ambulatory Medical Care and AIDS Pharmaceutical Assistance eligibility at or below 300% of Federal Poverty Guidelines.
Client Eligibility:	HIV-positive resident of the rural Houston HSDA. North counties include Chambers, Liberty, Montgomery and Walker. South Counties include Austin, Colorado, Fort Bend, Waller, and Wharton.
Agency Requirements (TRG Only):	<p><u>Providers and system must be Medicaid/Medicare certified. If applicable, provider must:</u></p> <ol style="list-style-type: none"> 1) <u>Provide pharmacy services on-site or through an established contractual relationship that meets all requirements. Alternate (off-site) approaches must be approved prior to implementation by TRG.</u> 2) <u>Provider must either directly, or via subcontract with an eligible 340B Pharmacy program entity, ensure the following:</u> <ul style="list-style-type: none"> • <u>Ensure a comprehensive financial intake application to determine client eligibility for this program to insure that these funds are used as a last resort for purchase of medications.</u> • <u>Ensure access to the local drug reimbursement program via collaboration between HIV Primary Care sites and Provider.</u> • <u>Ensure the documented capability of interfacing with the Texas HIV Medication Program operated by the Texas Department of State Health Services. This capability must be fully documented and is subject to independent verification by TRG.</u> • <u>Ensure medication assistance provided to clients does not duplicate services already being provided in the Houston area. The process for accomplishing this must be fully documented and is subject to independent verification by TRG.</u> • <u>Ensure, either directly or via a 340B Pharmacy Program Provider, at least 2 years of continuous documented experience in providing HIV/AIDS medication programs utilizing Ryan White Program or similar public sector funding. This experience must be documented and is subject to independent verification by TRG.</u> • <u>Ensure all medications are purchased via a qualified participant in the federal 340B Drug Pricing Program and Prime Vendor Program.</u>

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	<p><u>administered by the HRSA Office of Pharmacy Affairs. Note: failure to maintain 340B or Prime Vendor drug pricing may result in a negative audit finding, cost disallowance or termination of contract awarded. Provider must maintain 340B Program participation throughout the contract term. All eligible medications must be purchased in accordance with Program 340B guidelines and program requirements.</u></p> <ul style="list-style-type: none"> • <u>Ensure Houston area HIV/AIDS service providers are informed of this program and how the client referral and enrollment processes functions. Provider must maintain documentation of such marketing efforts.</u> <p>3) <u>Implement a consistent process to enroll eligible patients in available pharmaceutical company Patient Assistance Programs prior to using Ryan White funded LPAP resources.</u></p> <p>4) <u>Ensure information regarding the program is provided to PLWHA, including historically under-served and unserved populations (e.g., African American, Hispanic/Latino, Asian, Native American, Pacific Islander) and women not currently obtaining prescribed HIV and HIV-related medications.</u></p> <p>5) <u>Provider must offer, at no charge to the client, delivery options for medication refills, including but not limited to courier, USPS or other package delivery service.</u></p>
<p>Staff Requirements:</p>	<p>Primary medical care providers are responsible for ensuring that services are provided by State licensed internal medicine and OB/GYN physicians, specialty care physicians, psychiatrists, registered nurses, nurse practitioners, vocational nurses, pharmacists, physician assistants, physician extenders with a colposcopy provider qualification, x-ray technologists, State licensed dieticians, licensed social worker and ancillary health care providers in accordance with appropriate State licensing and/or certification requirements and with knowledge and experience of HIV disease.</p> <p>Medical Case Management: The program must utilize a state licensed Social Worker to provide Medical Case Management (MCM) Services. The Provider must maintain the budgeted number of medical case management FTEs throughout the contract term.</p> <p>Supervision of Case Managers: The Service Linkage Workers and Medical Case Managers must function within the clinical infrastructure of Provider and receive ongoing supervision that meets or exceeds Houston EMA/HSDA Part A/B Standards of Care for Service Linkage and Medical Case Management as applicable. An MCM may supervise SLWs.</p>
<p>Special Requirements (TRG Only):</p>	<p>Applicants (if applicable) must submit separate applications for services in West of Harris County and North of Harris County. Provider must provide all required program components - Medical Care, Medical Case Management, and AIDS Pharmaceutical Assistance services.</p> <p>OAMC: <u>In a clinical setting where a physician extender is utilized, the client must be examined by a physician a minimum of once per year (and more often if clinically indicated). Services funded under this grant cannot be used to supplant insurance or Medicare/Medicaid reimbursements for such services. Clients eligible for such reimbursement may not be billed to this contract. Medicare and private insurance co-payments are eligible for reimbursement under the contract (in this</u></p>

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situation the County will reimburse the client's co-payment only, not the cost of the session which must be billed to Medicare and/or the Third Party payer). Under no circumstances may the Provider bill the County for the difference between the reimbursement from Medicaid, Medicare or Third Party insurance and the fee schedule under the contract. Furthermore, potential clients who are Medicaid/Medicare eligible or have other Third Party payers may not be denied services or referred elsewhere by the Provider based on their reimbursement status (Medicaid/Medicare eligible clients may not be referred elsewhere in order that non-Medicaid/Medicare eligible clients may be added to this contract). Failure to serve Medicaid/Medicare eligible clients based on their reimbursement status will be grounds for the immediate termination of contract.

Maintaining Referral Relationships (Point of Entry Agreements)

Provider must maintain appropriate relationships with entities that constitute key points of access to the health care system for individuals with HIV disease, including but not limited to, Harris County Hospital District and other Houston EMA-located emergency rooms, Harris County Jail, Texas Department of Criminal Justice incarceration facilities, Immigration detention centers, substance abuse treatment and detoxification programs, adult and juvenile detention facilities, Sexually Transmitted Disease clinics, federally qualified health centers (FQHC), HIV disease counseling and testing sites, mental health programs and homeless shelters. These referral relationships must be documented with written collaborative agreements, contracts or memoranda of understanding between Provider and appropriate point of entry entities and are subject to audit by TRG. Provider and POE entity staff must regularly (e.g. weekly, bi-weekly depending on volume of referrals) meet 1:1 to discuss new referrals to primary medical care services. Such case conferences must be documented in the client record and properly entered into the CPCDMS.

Use of CPCDMS Data System: Provider must comply with CPCDMS business rules and procedures. Provider must enter into the CPCDMS all required clinical data, including but not limited to, HAART treatment including all changes in medication regimens, Opportunistic Infections, screening and treatment for STDs and Hepatitis A, B, C and other clinical screening and treatment data required by HRSA, TDSHS and the County. Provider must perform semi-annual Registration updates in accordance with CPCDMS business rules for all clients wherein Provider is client's CPCDMS record owning agency. Provide utilized an electronic verification system to verify insurance/3rd party payer status monthly or per visit (whichever is less frequent).

Providers must adhere to the most current published Part A/B Standards of Care for the Houston EMA/HSDA. **Services must meet or exceed applicable United States Department of Health and Human Services (DHHS) guidelines for the Treatment of HIV/AIDS.**

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FY 2013 RWPC “How to Best Meet the Need” Decision Process

Step in Process: Council		Date:
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		
Step in Process: Steering Committee		Date:
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		
Step in Process: Quality Assurance Committee		Date:
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		
Step in Process: HTBMTN Workgroup #1		Date: 04/19/12
Recommendations:	Financial Eligibility:	
1.		
2.		
3.		

2012-2013 HOUSTON ELIGIBLE METROPOLITAN AREA: RYAN WHITE CARE
ACT PART A/B
STANDARDS OF CARE FOR HIV SERVICES
RYAN WHITE GRANT ADMINISTRATION SECTION
HARRIS COUNTY PUBLIC HEALTH AND ENVIRONMENTAL SERVICES (HCPHES)

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INTRODUCTION

According to the Joint Commission on Accreditation of Healthcare Organization (JCAHO) 2008¹, a standard is a “statement that defines performance expectations, structures, or processes that must be in place for an organization to provide safe, high-quality care, treatment, and services”. Standards are developed by subject experts and are usually the minimal acceptable level of quality in service delivery. The Houston EMA Ryan White Grant Administration (RWGA) Standards of Care (SOCs) are based on multiple sources including RWGA on-site program monitoring results, consumer input, the US Public Health Services guidelines, Centers for Medicare and Medicaid Conditions of Participation (COP) for health care facilities, JCAHO accreditation standards, the Texas Administrative Code, Center for Substance Abuse and Treatment (CSAT) guidelines and other federal, state and local regulations.

Purpose

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

Scope

The Houston EMA SOCs apply to Part A, Part B and State Services, funded HRSA defined core and support services including the following services in FY 2012-2013:

- Primary Medical Care
- Vision Care
- Medical Case Management
- Clinical Case Management
- Local AIDS Pharmaceutical Assistance
Program (LPAP)
- Oral Health
- Health insurance
- Hospice Care
- Mental Health Services
- Substance Abuse services
- Home & Community Based Services
Program (Facility-Based)
- Early Intervention Services
- Legal Services
- Medical Nutrition Therapy
- Non-Medical Case Management (Service Linkage)
- Food Bank
- Transportation
- Linguistic Services

Standards Development

The first group of standards was developed in 1999 following HRSA requirements for sub grantees to implement monitoring systems to ensure subcontractors complied with contract requirements. Subsequently, the RWGA facilitates annual work group meetings to review the standards and to make applicable changes. Workgroup participants include physicians, nurses, case managers and executive staff from subcontractor agencies as well as consumers.

Organization of the SOCs

The standards cover all aspect of service delivery for all funded service categories. Some standards are consistent across all service categories and therefore are classified under general standards.

These include:

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

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

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

GENERAL STANDARDS

	Standard	Measure
1.0	Staff Requirements	
1.1	<p><u>Staff Screening (Pre-Employment)</u> Staff providing services to clients shall be screened for appropriateness by provider agency as follows:</p> <ul style="list-style-type: none"> • Personal/Professional references • Personal interview • Written application <p>Criminal background checks, if required by Agency Policy, must be conducted prior to employment and thereafter for all staff and/or volunteers per Agency policy.</p>	<ul style="list-style-type: none"> • Review of Agency's Policies and Procedures Manual indicates compliance • Review of personnel and/or volunteer files indicates compliance
1.2	<p><u>Initial Training: Staff/Volunteers</u> Initial training includes eight (8) hours HIV/AIDS basics, safety issues (fire & emergency preparedness, hazard communication, infection control, universal precautions), confidentiality issues, role of staff/volunteers, agency-specific information (e.g. Drug Free Workplace policy). Initial training must be completed within 60 days of hire.</p>	<ul style="list-style-type: none"> • Documentation of all training in personnel file. • Specific training requirements are specified in Agency Policy and Procedure • Materials for staff training and continuing education are on file • Staff interviews indicate compliance
1.3	<p><u>Staff Performance Evaluation</u> Agency will perform annual staff performance evaluation.</p>	<ul style="list-style-type: none"> • Completed annual performance evaluation kept in employee's file • Signed and dated by employee and supervisor (includes electronic signature)
1.4	<p><u>Cultural and HIV Mental Health Co-morbidity Competence Training/Staff and Volunteers</u> All staff must receive four (4) hours of cultural competency training and an additional one (1) hour of HIV/Mental Health co-morbidity sensitivity training annually. All new employees must complete these within ninety (90) days of hire.</p>	<ul style="list-style-type: none"> • Documentation of training is maintained by the agency in the personnel file
1.5	<p><u>Staff education on eligibility determination and fee schedule</u> Agency must provide training on agency's policies and procedures for eligibility determination and sliding fee</p>	<p>Documentation of training in employee's record</p>

	<p>schedule for, but not limited to, case managers, and eligibility & intake staff annually.</p> <p>All new employees must complete within ninety (90) days of hire.</p>	
2.0	Services utilize effective management practices such as cost effectiveness, human resources and quality improvement.	
2.1	<p><u>Service Evaluation</u></p> <p>Agency has a process in place for the evaluation of client services.</p>	<ul style="list-style-type: none"> • Review of Agency's Policies and Procedures Manual indicates compliance • Staff interviews indicate compliance.
2.2	<p><u>Subcontractor Monitoring</u></p> <p>Agency that utilizes a subcontractor in delivery of service, must have established policies and procedures on subcontractor monitoring that include:</p> <ul style="list-style-type: none"> • Fiscal monitoring • Program • Quality of care • Compliance with guidelines and standards <p>Reviewed Annually</p>	<ul style="list-style-type: none"> • Documentation of subcontractor monitoring • Review of Agency's Policies and Procedures Manual indicates compliance
2.3	<p><u>Staff Guidelines</u></p> <p>Agency develops written guidelines for staff, which include, at a minimum, agency-specific policies and procedures (staff selection, resignation and termination process, job descriptions); client confidentiality; health and safety requirements; complaint and grievance procedures; emergency procedures; and statement of client rights.</p> <p>Reviewed Annually</p>	<ul style="list-style-type: none"> • Personnel file contains a signed statement acknowledging that staff guidelines were reviewed and that the employee understands agency policies and procedures
2.4	<p><u>Work Conditions</u></p> <p>Staff/volunteers have the necessary tools, supplies, equipment and space to accomplish their work.</p>	<ul style="list-style-type: none"> • Inspection of tools and/or equipment indicates that these are in good working order and in sufficient supply • Staff interviews indicate compliance
2.5	<p><u>Staff Supervision</u></p> <p>Staff services are supervised by a paid coordinator or manager.</p>	<ul style="list-style-type: none"> • Review of personnel files indicates compliance • Review of Agency's Policies and Procedures Manual indicates

		compliance
2.6	<u>Professional Behavior</u> Staff must comply with written standards of professional behavior.	<ul style="list-style-type: none"> • Staff guidelines include standards of professional behavior • Review of Agency's Policies and Procedures Manual indicates compliance • Review of personnel files indicates compliance • Review of agency's complaint and grievance files
2.7	<u>Communication</u> There are procedures in place regarding regular communication with staff about the program and general agency issues.	<ul style="list-style-type: none"> • Review of Agency's Policies and Procedures Manual indicates compliance • Documentation of regular staff meetings • Staff interviews indicate compliance
2.8	<u>Accountability</u> There is a system in place to document staff work time.	<ul style="list-style-type: none"> • Staff time sheets or other documentation indicate compliance
2.9	<u>Staff Availability</u> Staff are present to answer incoming calls during agency's normal operating hours.	<ul style="list-style-type: none"> • Published documentation of agency operating hours • Staff time sheets or other documentation indicate compliance
3.0	Clients Rights and Responsibilities	
3.1	<u>Clients Rights and Responsibilities</u> Agency has a Client Rights and Responsibilities Statement that is reviewed with each client in a language and format the client can understand. Agency will provide client with written copy of client rights and responsibilities, including: <ul style="list-style-type: none"> • Informed consent • Confidentiality • Grievance procedures • Duty to warn or report certain behaviors • Scope of service • Criteria for end of services 	<ul style="list-style-type: none"> • Documentation in client's record
3.2	<u>Confidentiality</u> Agency has Policy and Procedure regarding client confidentiality in accordance with RWGA /TRG site visit	<ul style="list-style-type: none"> • Review of Agency's Policies and Procedures Manual indicates compliance • Clients interview indicates compliance

	<p>guidelines, local, state and federal laws. Providers must implement mechanisms to ensure protection of clients' confidentiality in all processes throughout the agency.</p> <p>There is a written policy statement regarding client confidentiality form signed by each employee and included in the personnel file.</p>	<ul style="list-style-type: none"> • Agency's structural layout and information management indicates compliance • Signed confidentiality statement in each employee's personnel file
<p>3.3</p>	<p><u>Consents</u></p> <p>All consent forms comply with state and federal laws, are signed by an individual legally able to give consent and must include the Consent for Services form and a consent for release/exchange of information for every individual/agency to whom client identifying information is disclosed, regardless of whether or not HIV status is revealed.</p>	<ul style="list-style-type: none"> • Agency Policy and Procedure and signed and dated consent forms in client record
<p>3.4</p>	<p><u>Up to date Release of Information</u></p> <p>Agency obtains an informed written consent of the client or legally responsible person prior to the disclosure or exchange of certain information about client's case to another party (including family members) in accordance with the RWGA Site Visit Guidelines, local, state and federal laws. The release/exchange consent form must contain:</p> <ul style="list-style-type: none"> • Name of the person or entity permitted to make the disclosure • Name of the client • The purpose of the disclosure • The types of information to be disclosed • Entities to disclose to • Date on which the consent is signed • The expiration date of client authorization (or expiration event) no longer than two years • Signature of the client/or parent, guardian or person authorized to sign in lieu of the client. • Description of the <i>Release of Information</i>, its components, and ways the client can nullify it <p>Released/exchange of information forms must be completed</p>	<ul style="list-style-type: none"> • Current Release of Information form with all the required elements signed by client or authorized person in client's record

	<p>entirely in the presence of the client. Any unused lines must have a line crossed through the space.</p>	
<p>3.5</p>	<p><u>Grievance Procedure</u> Agency has Policy and Procedure regarding client grievances that is reviewed with each client in a language and format the client can understand and a written copy of which is provided to each client. Grievance procedure includes but is not limited to:</p> <ul style="list-style-type: none"> • to whom complaints can be made • steps necessary to complain • form of grievance, if any • time lines and steps taken by the agency to resolve the grievance • documentation by the agency of the process, including a standardized grievance/complaint form available in a language and format understandable to the client • all complaints or grievances initiated by clients are documented on the Agency’s standardized form • resolution of each grievance/complaint is documented on the Standardized form and shared with client • confidentiality of grievance • addresses and phone numbers of licensing authorities and funding sources 	<ul style="list-style-type: none"> • Signed receipt of agency Grievance Procedure, filed in client chart • Review of Agency’s Policies and Procedures Manual indicates compliance • Review of Agency’s Grievance file indicates compliance, • Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #2
<p>3.6</p>	<p><u>Conditions Under Which Discharge/Closure May Occur</u> A client may be discharged from Ryan White funded services for the following reasons.</p> <ul style="list-style-type: none"> • Death of the client • At the client’s or legal guardian request • Changes in client’s need which indicates services from another agency • Fraudulent claims or documentation about HIV diagnosis by the client • Client actions put the agency, case manager or other clients at risk. Documented supervisory review is 	<ul style="list-style-type: none"> • Documentation in client record and in the Centralized Patient Care Data Management System • A copy of written notice and a certified mail receipt for involuntary termination

	<p>required when a client is terminated or suspended from services due to behavioral issues.</p> <ul style="list-style-type: none"> Client moves out of service area, enters jail or cannot be contacted for sixty (60) days. Agency must document three (3) attempts to contact clients by more than one method (e.g. phone, mail, email, text message, in person via home visit). <p>Client must be provided a written notice prior to involuntary termination of services (e.g. due to dangerous behavior, fraudulent claims or documentation, etc).</p>	
<p>3.7</p>	<p><u>Client Closure</u> A summary progress note is completed in accordance with Site Visit Guidelines within three (3) working days of closure, including:</p> <ul style="list-style-type: none"> Date and reason for discharge/closure Summary of all services received by the client and the client’s response to services <p>Referrals made and/or instructions given to the individual at discharge (when applicable)</p>	<ul style="list-style-type: none"> Documentation in client record and in the Centralized Patient Care Data Management System
<p>3.8</p>	<p><u>Client Feedback</u> In addition to the RWGA standardized client satisfaction survey conducted on an ongoing basis (no less than annually), Agency must have structured and ongoing efforts to obtain input from clients (or client caregivers, in cases where clients are unable to give feedback) in the design and delivery of services. Such efforts may include client satisfaction surveys, focus groups and public meetings conducted at least annually. Agency may also maintain a visible suggestion box for clients’ inputs. Analysis and use of results must be documented. Agency must maintain a file of materials documenting Consumer Advisory Board (CAB) membership and meeting materials (applicable only if agency has a CAB).</p> <ul style="list-style-type: none"> Agencies that serve an average of 100 or more 	<ul style="list-style-type: none"> Documentation of clients’ evaluation of services is maintained Documentation of CAB and public meeting minutes Documentation of existence and appropriateness of a suggestion box or other client input mechanism Documentation of content, use, and confidentiality of a client satisfaction survey or focus groups conducted annually Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #1

	<p>unduplicated clients monthly under combined RW/A, MAI, RW/B and SS funding must implement a CAB. The CAB must meet regularly (at least 4 times per year) at a time and location conducive to consumer participation to gather, support and encourage client feedback, address issues which impact client satisfaction with services and provide Agency with recommendations to improve service delivery, including accessibility and retention in care.</p>	
3.9	<p><u>Patient Safety (Core Services Only)</u> Agency shall establish mechanisms to implement National Patient Safety Goals (NPSG) modeled after the current Joint Commission accreditation <i>for Ambulatory Care</i> (www.jointcommission.org) to ensure patients' safety. The NPSG to be addressed include the following as applicable:</p> <ul style="list-style-type: none"> • “Improve the accuracy of patient identification • Improve the safety of using medications • Reduce the risk of healthcare-associated infections • Accurately and completely reconcile medications across the continuum of care • Universal Protocol for preventing Wrong Site, Wrong Procedure and Wrong Person Surgery” (www.jointcommission.org) 	<ul style="list-style-type: none"> • Review of Agency’s Policies and Procedures Manual indicates compliance
3.10	<p><u>Client Files</u> Provider shall maintain all client files.</p>	<ul style="list-style-type: none"> • Review of agency’s policy and procedure for records administration indicates compliance
4.0	<u>Accessibility</u>	
4.1	<p><u>Cultural Competence</u> Agency demonstrates a commitment to provision of services that are culturally sensitive and language competent for Limited English Proficient (LEP) individuals.</p>	<ul style="list-style-type: none"> • Agency has procedures for obtaining translation services • Client satisfaction survey indicates compliance • Policies and procedures demonstrate commitment to the community and culture of the clients • Availability of interpretive services, bilingual staff, and staff trained in cultural competence • Agency has vital documents including, but not limited to

		applications, consents, complaint forms, and notices of rights translated in client record
4.2	<u>Client Education</u> Agency demonstrates capacity for client education and provision of information on community resources	<ul style="list-style-type: none"> • Availability of the blue book and other educational materials • Documentation of educational needs assessment and client education in clients' records
4.3	<u>Special Service Needs</u> Agency demonstrates a commitment to assisting individuals with special needs	<ul style="list-style-type: none"> • Agency compliance with the Americans with Disabilities Act (ADA). • Review of Policies and Procedures indicates compliance • Environmental Review shows a facility that is handicapped accessible
4.4	<u>Provision of Services for low-Income Individuals</u> Agency must ensure that facility is handicap accessible and is also accessible by public transportation (if in area served by METRO). Agency must have policies and procedures in place that ensures access to transportation services if facility is not accessible by public transportation. Agency should not have policies that dictate a dress code or conduct that may act as barrier to care for low income individuals.	<ul style="list-style-type: none"> • Facility is accessible by public transportation • Review of Agency's Policies and Procedures Manual indicates compliance • Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #4
4.5	<u>Proof of HIV Diagnosis</u> Documentation of the client's HIV status is obtained at or prior to the initiation of services or registration services. An anonymous test result may be used to document HIV status temporarily (up to sixty [60] days). It must contain enough information to ensure the identity of the subject with a reasonable amount of certainty.	<ul style="list-style-type: none"> • Documentation in client record as per RWGA site visit guidelines or TRG Policy SG-03 • Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #3
4.6	<u>Provision of Services Regardless of Current or Past Health Condition</u> Agency must have Policies and Procedures in place to ensure that HIV+ clients are not denied services due to current or pre-existing health condition or non-HIV related condition. A file must be maintained on all clients who are refused services and the reason for refusal.	<ul style="list-style-type: none"> • Review of Policies and Procedures indicates compliance • A file containing information on clients who have been refused services and the reasons for refusal
4.7	<u>Client Eligibility</u>	<ul style="list-style-type: none"> • Documentation of HIV+ status, residence, identification and

	<p>In order to be eligible for services, individuals must meet the following:</p> <ul style="list-style-type: none"> • HIV+ • Residence in the Houston EMA/ HSDA (With prior approval, clients can be served if they reside outside of the Houston EMA/HSDA.) • Income no greater than 300% of the Federal Poverty level (unless otherwise indicated) • Proof of identification • Ineligibility for third party reimbursement 	<p>income in the client record</p> <ul style="list-style-type: none"> • Documentation of ineligibility for third party reimbursement • Documentation of screening for Third Party Payers in accordance with TRG Policy SG-06 Documentation of Third Party Payer Eligibility or RWGA site visit guidelines • Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section B:Eligibility Determination/Screening #1
4.8	<p><u>Re-evaluation of Client Eligibility</u> Agency conducts six (6) month re-evaluations of eligibility for all clients. At a minimum, agency confirms renewed eligibility with the CPCDMS and re-screens, as appropriate, for third-party payers. Third party payers include State Children's Health Insurance Programs (SCHIP), Medicare (including Part D prescription drug benefit) and private insurance. Agency must ensure that Ryan White is the Payer of last resort and must have policies and procedures addressing strategies to enroll all eligible uninsured clients into Medicare, Medicaid, private health insurance and other programs. Agency policy must also address coordination of benefits, billing and collection. Clients eligible for Department of Veterans Affairs (VA) benefits are duly eligible for Ryan White services and therefore exempted from the payer of last resort requirement</p> <ul style="list-style-type: none"> • Agency must verify 3rd party payment coverage for eligible services at every visit or monthly (whichever is less frequent) 	<ul style="list-style-type: none"> • Client file contains documentation of re-evaluation of client residence, income and rescreening for third party payers at least every six (6) months • Review of Policies and Procedures indicates compliance • Information in client's files that includes proof of screening for insurance coverage • Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section B:Eligibility Determination/Screening #1 and #2
4.9	<p><u>Charges for Services</u> Agency must institute Policies and Procedures for cost sharing including enrollment fees, premiums, deductibles, co-payments, co-insurance, sliding fee discount, etc. and an annual cap on these charges. Agency should not charge any of the above fees regardless of terminology to any Ryan White eligible patient whose gross income level (GIL) is ≤</p>	<ul style="list-style-type: none"> • Review of Policies and Procedures indicates compliance • Review of system for tracking patient charges and payments indicate compliance • Review of charges and payments in client records indicate compliance with annual cap • Sliding fee application forms on client record is consistent with Federal guidelines

	<p>100% of the Federal Poverty Level (FPL) as documented in the CPCDMS for any services provided. Clients whose gross income is between 101-300% may be charged annual aggregate fees in accordance with the legislative mandate outlined below:</p> <ul style="list-style-type: none"> • 101%-200% of FPL---5% or less of GIL • 201%-300% of FPL---7% or less of GIL • >300% of FPL -----10% or less of GIL <p>Additionally, agency must implement the following:</p> <ul style="list-style-type: none"> • Six (6) month evaluation of clients to establish individual fees and cap (i.e. the six (6) month CPCDMS registration or registration update.) • Tracking of charges • A process for alerting the billing system when the cap is reached so client will not be charged for the rest of the calendar year. • <u>Documentation of fees</u> 	
<p>4.10</p>	<p><u>Information on Program and Eligibility/Sliding Fee Schedule</u></p> <p>Agency must provide broad-based dissemination of information regarding the availability of services. All clients accessing services must be provided with a clear description of their sliding fee charges in a simple understandable format at intake and annually at registration update. Agency should maintain a file documenting promotion activities including copies of HIV program materials and information on eligibility requirements. Agency must proactively inform/educate clients when changes occur in the program design or process, client eligibility rules, fee schedule, facility layout or access to program or agency.</p>	<ul style="list-style-type: none"> • Agency has a written substantiated annual plan to targeted populations • Zip code data show provider is reaching clients throughout service area (as applicable to specific service category). • Agency file containing informational materials about agency services and eligibility requirements including the following: Brochures Newsletters Posters Community bulletins any other types of promotional materials • Signed receipt for client education/ information regarding eligibility and sliding fees on client record • Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #5
<p>4.11</p>	<p><u>Linkage Into Core Services</u></p> <p>Agency staff will provide out-of-care clients with</p>	<ul style="list-style-type: none"> • Documentation of client referral is present in client file

	<p>individualized information and referral to connect them into ambulatory outpatient medical care and other core medical services.</p>	
<p>4.12</p>	<p><u>Wait Lists</u> It is the expectation that clients will not be put on a Wait List nor will services be postponed or denied due to funding. Agency must notify the Administrative agency when funds for service are either low or exhausted for appropriate measures to be taken to ensure adequate funding is available. Should a wait list become required, the agency must, at a minimum, develop a policy that addresses how they will handle situations where service(s) cannot be immediately provided and a process by which client information will be obtained and maintained to ensure that all clients that requested service(s) are contacted after service provision resumes;</p> <p>The Agency will notify The Resource Group (TRG) or RWGA of the following information when a wait list must be created: An explanation for the cessation of service; and A plan for resumption of service. The Agency’s plan must address:</p> <ul style="list-style-type: none"> • Action steps to be taken Agency to resolve the service shortfall; and • Projected date that services will resume. <p>The Agency will report to TRG or RWGA in writing on a monthly basis while a client wait list is required with the following information:</p> <ul style="list-style-type: none"> • Number of clients on the wait list. • Progress toward completing the plan for resumption of service. • A revised plan for resumption of service, if necessary. 	<ul style="list-style-type: none"> • Review of Agency’s Policies and Procedures Manual indicates compliance • Documentation of compliance with TRG’s Policy SG-19 Client Wait Lists • Documentation that agency notified their Administrative Agency when funds for services were either low or exhausted
<p>4.13</p>	<p><u>Intake</u> The agency conducts an intake to collect required data</p>	<ul style="list-style-type: none"> • Documentation in client record

	<p>including, but not limited to, eligibility, appropriate consents and client identifiers for entry into CPCDMS. Intake process is flexible and responsive, accommodating disabilities and health conditions.</p> <p>When necessary, client is provided alternatives to office visits, such as conducting business by mail or providing home visits. Agency has established procedures for communicating with people with hearing impairments.</p>	<ul style="list-style-type: none"> Review of Agency's Policies and Procedures Manual indicates compliance
5.0	Quality Management	
5.1	<p><u>Continuous Quality Improvement (CQI)</u></p> <p>Agency demonstrates capacity for an organized CQI program and has a CQI Committee in place to review procedures and to initiate Performance Improvement activities.</p> <p>The Agency shall maintain an up-to-date Quality Management (QM) Manual. The QM Manual will contain at a minimum:</p> <ul style="list-style-type: none"> The Agency's QM Plan Meeting agendas and/or notes (if applicable) Project specific CQI Plans Root Cause Analysis & Improvement Plans Data collection methods and analysis Work products QM program evaluation Materials necessary for QM activities 	<ul style="list-style-type: none"> Review of Agency's Policies and Procedures Manual indicates compliance Up to date QM Manual
5.2	<p><u>Data Collection and Analysis</u></p> <p>Agency demonstrates capacity to collect and analyze client level data including client satisfaction surveys and findings are incorporated into service delivery. Supervisors shall conduct and document ongoing record reviews as part of quality improvement activity.</p>	<ul style="list-style-type: none"> Review of Agency's Policies and Procedures Manual indicates compliance Up to date QM Manual Supervisors log on record reviews signed and dated Source Citation: HAB Monitoring Standards; Part I: Universal Standards; Section A: Access to Care #2
6.0	Point Of Entry Agreements	
6.1	<p><u>Points of Entry (Core Services Only)</u></p> <p>Agency accepts referrals from sources considered to be points of entry into the continuum of care, in accordance with</p>	<ul style="list-style-type: none"> Review of Agency's Policies and Procedures Manual indicates compliance Documentation of formal agreements with appropriate Points

	HIV Services policy approved by HRSA for the Houston EMA.	<p>of Entry</p> <ul style="list-style-type: none"> • Documentation of referrals and their follow-up
7.0	Emergency Management	
7.1	<p><u>Emergency Preparedness</u> Agency leadership including medical staff must develop an Emergency Preparedness Plan modeled after the Joint Commission’s regulations and/or Centers for Medicare and Medicaid guidelines for Emergency Management. The plan should, at a minimum utilize “all hazard approach” (hurricanes, floods, earthquakes, tornadoes, wide-spread fires, infectious disease outbreak and other public health threats, terrorist attacks, civil disturbances and collapse of buildings and bridges) to ensure a level of preparedness sufficient to support a range of emergencies. Agencies shall conduct an annual Hazard Vulnerability Analysis (HVA) to identify potential hazards, threats, and adverse events and assess their impact on care, treatment, and services they must sustain during an emergency. The agency shall communicate hazards identified with its community emergency response agencies and together shall identify the capability of its community in meeting their needs. The HVA shall be reviewed annually.</p>	<ul style="list-style-type: none"> • Emergency Preparedness Plan • Review of Agency’s Policies and Procedures Manual indicates compliance
7.2	<p><u>Emergency Management Training</u> In accordance with the Department of Human Services recommendations, all applicable agency staff must complete the following National Incident Management System (NIMS) courses developed by the Department of Homeland Security:</p> <ul style="list-style-type: none"> • IS -100.HC – Introduction to the Incident command system for healthcare/hospitals • IS-200.HC- Applying ICS to Healthcare organization • IS-700.A-National Incident Management System (NIMS) Introduction • IS-800.B National Response Framework (management) 	<ul style="list-style-type: none"> • Documentation of all training including certificate of completion in personnel file

	<p>The above courses may be accessed at: www.training.fema.gov.</p> <p>Agencies providing support services only may complete alternate courses listed for the above areas</p> <p>All new employees are required to complete the courses within 90 days of hire.</p>	
7.3	<p><u>Emergency Preparedness Plan</u></p> <p>The emergency preparedness plan shall address the six critical areas for emergency management including</p> <ul style="list-style-type: none"> • Communication pathways • Essential resources and assets • patients' safety and security • staff responsibilities • Supply of key utilities such as portable water and electricity • Patient clinical and support activities during emergency situations. (www.jointcommission.org) 	<ul style="list-style-type: none"> • Emergency Preparedness Plan
7.4	<p><u>Emergency Management Drills</u></p> <p>Agency shall implement emergency management drills twice a year either in response to actual emergency or in a planned exercise. Completed exercise should be evaluated by a multidisciplinary team including administration, clinical and support staff. The emergency plan should be modified based on the evaluation results and retested.</p>	<ul style="list-style-type: none"> • Emergency Management Plan • Review of Agency's Policies and Procedures Manual indicates compliance
8.0	Building Safety	
8.1	<p><u>Required Permits</u></p> <p>All agencies will maintain Occupancy and Fire Marshal's permits for the facilities.</p>	<ul style="list-style-type: none"> • Current required permits on file

SERVICE SPECIFIC STANDARDS OF CARE

Case Management (All Case Management Categories)

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

1.0	Staff Training	
1.1	<p><u>Required Meetings</u> <u>Case Managers and Service Linkage Workers</u> Case managers and Service Linkage Workers will attend on an annual basis a minimum of four (4) of the five (5) bi-monthly networking meetings facilitated by RWGA. Case Managers and Service Linkage Workers will attend the “Joint Prevention and Care Coordination Meeting” held annually and facilitated by the RWGA and the City of Houston STD/HIV Bureau.</p> <p>Medical Case Management (MCM), Clinical Case Management (CCM) and Service Linkage Worker Supervisors will attend on an annual basis a minimum of five (5) of the six (6) bi-monthly Supervisor meetings facilitated by RWGA (in the event a MCM or CCM supervises SLW staff the MCM or CCM must attend the Supervisor meetings and may, as an option, attend the networking</p>	<ul style="list-style-type: none"> • Agency will maintain verification of attendance (RWGA will also maintain sign-in logs)

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

³ National Association of Social Workers (1992). NASW standards for social work case management. Retrieved 02/9/2009 from www.socialworkers.org/practice/standards/sw_case_mgmt.asp

	meetings)	
1.2	<p><u>Required Training for New Employees</u></p> <p>Within the first ninety (90) days of employment in the case management system, case managers will successfully complete HIV Case Management 101: A Foundation, through the State of Texas TRAIN website (https://tx.train.org) with a minimum of 70% accuracy. Incumbent case managers must successfully complete HIV Case Management 101: A Foundation, with a minimum of 70% no later than May 31, 2012. RWGA expects HIV Case Management 101: A Foundation, course completion to take no longer than 16 hours. Within the first six (6) months of employment, case managers will complete at least four (4) hours review of Community resources, and at least four (4) hours cultural competency training offered by RWGA.</p> <p>For cultural competency training only, Agency may request a waiver for agency based training alternative that meets or exceeds the RWGA requirements for the first year training for case management staff.</p>	<ul style="list-style-type: none"> • Certificates of completion for applicable trainings in the case manager's file • Sign-in sheets for agency based trainings maintained by Agency • RWGA Waiver is approved prior to Agency utilizing agency-based training curriculum
1.3	<p><u>Case Management Supervisor Peer-led Training</u></p> <p>Supervisory Training: On an annual basis, Part A/B-funded clinical supervisors of Medical, Clinical and Community (SLW) Case Managers must fully participate in the four (4) Case Management Supervisor Peer-Led three-hour training curriculum conducted by RWGA.</p>	<ul style="list-style-type: none"> • Review of attendance sign-in sheet indicates compliance
1.4	<p><u>Child Abuse Screening, Documenting and Reporting Training</u></p> <p>Case Managers are trained in the agency's policy and procedure for determining, documenting and reporting instances of abuse, sexual or nonsexual, in accordance with the DSHS Child Abuse Screening, Documenting and Reporting Policy prior to patient interaction.</p>	<ul style="list-style-type: none"> • Documentation of staff training
2.0	Timeliness of Services	
2.1	<u>Initial Case Management Contact</u>	<ul style="list-style-type: none"> • Documentation in client record

	Contact with client and/or referring agent is attempted within one working day of receiving a case assignment. If the case is unable to make contact within one (1) working day, this is documented and explained in the client record. Case manager should also notify their supervisor. All subsequent attempts are documented.	
2.2	<u>Intake</u> In addition to the general intake requirements, a thorough intake is completed at the earliest convenience of the client, but no later than two (2) weeks after initial contact.	<ul style="list-style-type: none"> • Documentation in client record
2.3	<u>Acuity</u> The case manager should use an acuity scale or other standardized system as a measurement tool to determine client needs (applies to TDSHS funded case managers only).	<ul style="list-style-type: none"> • Completed acuity scale in client's records
2.4	<u>Progress Notes</u> All case management activities, including but not limited to all contacts and attempted contacts with or on behalf of clients are documented in the client record within 72 hours of their occurrence.	<ul style="list-style-type: none"> • Legible, signed and dated documentation in client record. • Documentation of time expended with or on behalf of patient in progress notes
2.5	<u>Client Referral and Tracking</u> Agency will have policies and procedures in place for referral and follow-up for clients with medical conditions, nutritional, psychological/social and financial problems. The agency will maintain a current list of agencies that provide primary medical care, prescription medications, assistance with insurance payments, dental care, transportation, nutritional counseling and supplements, support for basic needs (rent, food, financial assistance, etc.) and other supportive services (e.g. legal assistance, partner elicitation services and Client Risk Counseling Services (CRCS)). The Case Manager will: <ul style="list-style-type: none"> • Initiate referrals within two (2) weeks of the plan being completed and agreed upon by the Client and the Case Manager • Work with the Client to determine barriers to referrals and facilitate access to referrals 	<ul style="list-style-type: none"> • Review of Agency's Policies and Procedures Manual indicates compliance • Documentation of follow-up tracking activities in clients records • A current list of agencies that provide services including availability of the Blue Book

	<ul style="list-style-type: none"> Utilize a tracking mechanism to monitor completion of all case management referrals 	
2.6	<p><u>Client Transfers between Agencies: Open or Closed less than One Year</u></p> <p>The case manager should facilitate the transfer of clients between providers. All clients are transferred in accordance with Case Management Policy and Procedure, which requires that a “consent for transfer and release/exchange of information” form be completed and signed by the client, the client’s record be forwarded to the receiving care manager within five (5) working days and a Request for Transfer form be completed for the client and submitted to RWGA by the receiving agency.</p>	<ul style="list-style-type: none"> Documentation in client record
2.7	<p><u>Caseload</u></p> <p>Case load determination should be based on client characteristics, acuity level and the intensity of case management activities.</p>	<ul style="list-style-type: none"> Review of the agency’s policies and procedures for Staffing ratios

Non-Medical Case Management Services (Service Linkage Worker)

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

<p>1.0</p>	<p>Staff Requirements</p>	
<p>1.1</p>	<p><u>Minimum Qualifications</u> Service Linkage Worker – unlicensed community case manager Service linkage workers must have a bachelor’s degree from an accredited college or university with a major in social or behavioral sciences. Documented paid work experience in providing client services to PLWHA may be substituted for the bachelor’s degree requirement on a 1:1 basis (1 year of documented paid experience may be substituted for 1 year of college). Service linkage workers must have a minimum of 1 year paid work experience with PLWHA. Bilingual (English/Spanish) targeted service linkage workers must have written and verbal fluency in English and Spanish. Agency will provide Service Linkage Worker a written job description upon hiring.</p>	<ul style="list-style-type: none"> • A file will be maintained on service linkage worker. Supportive documentation of credentials and job description are maintained by the agency and in each service linkage worker’s file. Documentation may include, but is not limited to, transcripts, diplomas, certifications and/or licensure.
<p>2.0</p>	<p>Timeliness of Services/Documentation</p>	
<p>2.1</p>	<p><u>Client Eligibility – Service Linkage targeted to Not-in-Care and Newly Diagnosed</u> In addition to general eligibility criteria individuals must meet the following in order to be eligible for non-medical case management services:</p> <ul style="list-style-type: none"> • HIV+ and not receiving outpatient HIV primary medical care services within the previous 180 days as documented by the CPCDMS, or • Newly diagnosed (within the last six (6) months) and not currently receiving outpatient HIV primary medical care 	<ul style="list-style-type: none"> • Documentation of HIV+ status, residence, identification and income in the client record • Documentation of “not in care” status through the CPCDMS

	<p>services as documented by the CPCDMS, or</p> <ul style="list-style-type: none"> Newly diagnosed (within the last six (6) months) and not currently receiving case management services as documented by the CPCDMS 	
2.2	<p><u>Service Linkage Worker Assessment</u></p> <p>Assessment begins at intake. The service linkage worker will provide client and, if appropriate, his/her personal support system information regarding the range of services offered by the case management program during intake/assessment.</p> <p>The service linkage worker will complete RWGA -approved brief assessment tool within five (5) working days, on all clients to identify those who need comprehensive assessment. Clients with mental health, substance abuse and/or housings issues should receive comprehensive assessment. Clients needing comprehensive assessment should be referred to a licensed case manager. <u>Low-need, non-primary care clients who have only an intermittent need for information about services may receive brief SLW services without being placed on open status. Clients issued a value-based bus pass must be maintained on Open Status and be reassessed per SOC.</u></p>	<ul style="list-style-type: none"> Documentation in client record on the brief assessment form, signed and dated A completed DSHS checklist for screening of suspected sexual child abuse and reporting is evident in case management records, when appropriate
2.3	<p><u>Service Linkage Worker Reassessment</u></p> <p>Clients on <u>open status</u> will be reassessed at six (6) month intervals following the initial assessment. A RWGA/ TRG-approved reassessment form as applicable must be utilized.</p>	<ul style="list-style-type: none"> Documentation in RWGA approved client reassessment form or agency's equivalent form, signed and dated
2.4	<p><u>Transfer of Not-in-Care and Newly Diagnosed Clients</u></p> <p>Service linkage workers targeting their services to Not-in-Care and newly diagnosed clients will work with clients for a maximum of 120 days. Clients must be transferred to a Ryan White-funded primary medical care, clinical case management or medical case management program within 120 days of the initiation of services.</p>	<ul style="list-style-type: none"> Documentation in client record and in the CPCDMS
3.0	Supervision and Caseload	
3.1	<p><u>Service Linkage Worker Supervision</u></p> <p>A minimum of four (4) hours of supervision per month must be</p>	<ul style="list-style-type: none"> Documentation in supervision notes, which must include:

	<p>provided to each service linkage worker by a master’s level health professional.) At least one (1) hour of supervision must be individual supervision.</p> <p>Supervision includes, but is not limited to, one-to-one consultation regarding issues that arise in the case management relationship, case staffing meetings, group supervision, and discussion of gaps in services or barriers to services, intervention strategies, case assignments, case reviews and caseload assessments.</p>	<ul style="list-style-type: none"> ➤ date ➤ name(s) of case manager(s) present ➤ topic(s) covered and/or client(s) reviewed ➤ plan(s) of action ➤ supervisor’s signature <ul style="list-style-type: none"> • Supervision notes are never maintained in the client record
<p>3.2</p>	<p><u>Caseload Coverage – Service Linkage Workers</u></p> <p>Supervisor ensures that there is coverage of the caseload in the absence of the service linkage worker or when the position is vacant. Service Linkage Workers may assist clients who are routinely seen by other CM team members in the absence of the client’s “assigned” case manager.</p>	<ul style="list-style-type: none"> • Documentation of all client encounters in client record and in the Centralized Patient Care Data Management System
<p>3.3</p>	<p><u>Case Reviews – Service Linkage Workers.</u></p> <p>Supervisor reviews each open case with the service linkage worker at least once ninety (90) days, and concurrently ensures that all required record components are present, timely, legible, and that services provided are appropriate.</p>	<ul style="list-style-type: none"> • Documentation of case reviews in client record, signed and dated by supervisor and/or quality assurance personnel and SLW

Medical Case Management

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

1.0	Staff/Training	
1.1	<p><u>Qualifications/Training</u> Minimum Qualifications - The program must utilize a Social Worker licensed by the State of Texas to provide Medical Case Management Services.</p> <p>A file will be maintained on each medical case manager. Supportive documentation of medical case manager credentials is maintained by the agency and in each medical case manager’s file. Documentation may include, but is not limited to, transcripts, diplomas, certifications, and/or licensure.</p>	<ul style="list-style-type: none"> • Documentation of credentials in medical case manager’s file
1.2	<p><u>Scope of Services</u></p> <p>The medical case management services will include at a minimum, screening of primary medical care patients to determine each patient’s level of need for medical case management; comprehensive assessment, development, implementation and evaluation of medical case management service plan; follow-up; direction of clients through the entire spectrum of health and support services; facilitation and coordination of services from one service provider to another. Others include referral to clinical case management if indicated, client education regarding wellness, medication and health care compliance and peer support.</p>	<ul style="list-style-type: none"> • Review of clients’ records indicates compliance
1.3	<p><u>Ongoing Education/Training for Medical Case Managers</u></p> <p>After the first year of employment in the case management system each medical case manager will obtain the minimum number of hours</p>	<ul style="list-style-type: none"> • Attendance sign-in sheets and/or certificates of completion are maintained by the agency

	of continuing education to maintain his or her licensure.	
2.0	<p>Timeliness of Service/Documentation</p> <p>Medical case management for persons with RWGA disease should reflect competence and experience in the assessment of client medical need and the development and monitoring of medical service delivery plans.</p>	
2.1	<p><u>Screening Criteria for Medical Case Management</u></p> <p>In addition to the general eligibility criteria, agencies are advised to use screening criteria before enrolling a client in medical case management. Examples of such criteria include the following:</p> <ul style="list-style-type: none"> i. Newly diagnosed ii. New to HAART iii. CD4<200 iv. VL>100,000 or fluctuating viral loads v. Excessive missed appointments vi. Excessive missed dosages of medications vii. Mental illness that presents a barrier to the patient’s ability to access, comply or adhere to medical treatment viii. Substance abuse that presents a barrier to the patient’s ability to access, comply or adhere to medical treatment ix. Opportunistic infections x. Chronic health problems/injury/Pain xi. Viral resistance xii. Clinician’s referral <p>Clients with one or more of these criteria would be considered the most appropriate for medical case management services. Clients with substance abuse, mental illness and/or housing issues should receive intensive case management by a licensed case manager or have an active referral to a licensed case manager. Clients enrolling in intensive medical case management services should be placed on “open” status in the CPCDMS.</p> <p>The following criteria are an indication a client may be an appropriate referral for Clinical Case Management services.</p> <ul style="list-style-type: none"> • Client is actively symptomatic with an axis I DSM-IV diagnosis especially including substance-related disorders (abuse/dependence), mood disorders (major depression, 	<ul style="list-style-type: none"> • Review of agency’s screening criteria for medical case management

	<p>Bipolar depression), anxiety disorders, and other psychotic disorders; or axis II DSMIV diagnosis personality disorders;</p> <ul style="list-style-type: none"> • Client has a mental health condition or substance abuse pattern that interferes with his/her ability to adhere to medical/medication regimen and needs motivated to access mental health or substance abuse treatment services; • Client is in mental health counseling or chemical dependency treatment. 	
<p>2.2</p>	<p><u>Assessment</u> Assessment begins at intake. The case manager will provide client, and if appropriate, his/her support system information regarding the range of services offered by the case management program during intake/assessment. <u>Medical case managers will provide a comprehensive assessment at intake and at least annually thereafter.</u> The comprehensive client assessment will include an evaluation of the client’s medical and psychosocial needs, strengths, resources (including financial and medical coverage status), limitations, beliefs, concerns and projected barriers to service. Other areas of assessment include demographic information, health history, sexual history, mental history/status, substance abuse history, medication adherence and risk behavior practices, adult and child abuse (if applicable). A RWGA-approved comprehensive client assessment form must be completed within two weeks after initial contact. Medical Case Management will use an RWGA-approved assessment tool that, with Agency specific enhancements tailored to Agency’s program needs.</p>	<ul style="list-style-type: none"> • Documentation in client record on the comprehensive client assessment forms, signed and dated, or agency’s equivalent forms. Updates to the information included in the assessment will be recorded in the comprehensive client assessment. • A completed DSHS checklist for screening of suspected sexual child abuse and reporting is evident in case management records, when appropriate.
<p>2.3</p>	<p><u>Reassessment</u> Clients will be reassessed at six (6) month intervals following the initial assessment or more often if clinically indicated including when unanticipated events or major changes occur in the client’s life (e.g. needing referral for services from other providers, increased risk behaviors, recent hospitalization, suspected child abuse, significant changes in income and/or loss of psychosocial support system). A</p>	<ul style="list-style-type: none"> • Documentation in client record on the comprehensive client reassessment form or agency’s equivalent form signed and dated • Documentation of initial and updated service plans in the URS (applies to TDSHS – funded case managers only)

	RWGA or TRG -approved reassessment form as applicable must be utilized.	
2.4	<p><u>Service Plan</u></p> <p>Service planning begins at admission to medical case management services and is based upon assessment. The medical case manager shall develop the service plan in collaboration with the client and if appropriate, other members of the support system. An RWGA-approved service plan form will be completed no later than ten (10) working days following the comprehensive client assessment. A temporary care plan may be executed upon intake based upon immediate needs or concerns). The service plan will seek timely resolution to crises, short-term and long-term needs, and may document crisis intervention and/or short term needs met before full service plan is completed.</p> <p>Service plans reflect the needs and choices of the client based on their health and related needs (including support services) and are consistent with the progress notes. A new service plan is completed at each six (6) month reassessment or each reassessment. The case manager and client will update the care plan upon achievement of goals and when other issues or goals are identified and reassessed. Service plan must reflect an ongoing discussion of primary care, mental health treatment and/or substance abuse treatment, treatment and medication adherence and other client education per client need.</p>	<ul style="list-style-type: none"> • Documentation in client’s record on the medical case management service plan or agency’s equivalent form • Service Plan signed by the client and the case manager
2.5	<p><u>Brief Interventions</u></p> <p>Clients who are not appropriate for intensive medical case management services may still receive brief medical case management interventions. In lieu of completing the comprehensive client re-assessment, the medical case manager should document each brief intervention in the progress notes. Any referrals made should be documented, including their outcomes in the progress notes.</p>	<ul style="list-style-type: none"> • Documentation in the progress notes reflects a brief re-assessment and plan (referral)
3.0	Supervision and Caseload	
3.1	<u>Clinical Supervision and Caseload Coverage</u>	<ul style="list-style-type: none"> • Review of the agency’s Policies and

	<p>The medical case manager must receive supervision in accordance with their licensure requirements. Agency policies and procedures should account for clinical supervision and coverage of caseload in the absence of the clinical case manager or when the position is vacant.</p>	<p>Procedures for clinical supervision, and documentation of supervisor qualifications in personnel files.</p> <ul style="list-style-type: none"> • Documentation on file of date of supervision, type of supervision (e.g., group, one on one), and the content of the supervision
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Local Pharmacy Assistance Program

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

1.0	Services are offered in such a way as to overcome barriers to access and utilization. Service is easily accessible to persons with HIV/AIDS.	
1.1	<u>Client Eligibility</u> In addition to the general eligibility criteria individuals must meet the following in order to be eligible for LPAP services: <ul style="list-style-type: none"> • Income no greater than 500% of the Federal poverty level for HIV medications and no greater than 300% of the Federal poverty level for HIV-related medications 	<ul style="list-style-type: none"> • Documentation of income in the client record.
1.2	<u>Timeliness of Service Provision</u> <ul style="list-style-type: none"> • Agency will process prescription for approval within two (2) business days • Pharmacy will fill prescription within one (1) business day of approval 	<ul style="list-style-type: none"> • Documentation in the client record and review of pharmacy summary sheets • Review of agency's Policies & Procedures Manual indicates compliance
1.3	<u>LPAP Medication Formulary</u> RW funded prescriptions for program eligible clients shall be based on the current RWGA LPAP medication formulary. Ryan White funds may not be used for non-prescription medications or drugs not on the approved formulary. Providers wishing to prescribe other medications not on the formulary must obtain a waiver from the RWGA prior to doing so. Agency policies and procedures must ensure that MDs and physician extenders comply with the current clinical/Public Health Services guidelines for ART and treatment of opportunistic infections.	<ul style="list-style-type: none"> • Review of agency's Policies & Procedures Manual indicates compliance • Review of billing history indicates compliance • Documentation in client's record
2.0	Staff HIV/AIDS knowledge is based on documented training.	

2.1	<p><u>Orientation</u> Initial orientation includes twelve (12) hours of HIV/AIDS basics, confidentiality issues, role of new staff and agency-specific information within sixty (60) days of contract start date or hires date.</p>	<ul style="list-style-type: none"> • Review of training curriculum indicates compliance • Documentation of all training in personnel file • Specific training requirements are specified in the staff guidelines
2.2	<p><u>Ongoing Training</u> Eight (8) hours annually of continuing education in HIV/AIDS related or other specific topics is required.</p>	<ul style="list-style-type: none"> • Materials for staff training and continuing education are on file • Staff interviews indicate compliance
2.3	<p><u>Pharmacy Staff Experience</u> A minimum of one year documented HIV/AIDS work experience is preferred.</p>	<ul style="list-style-type: none"> • Documentation of work experience in personnel file
2.4	<p><u>Pharmacy Staff Supervision</u> Staff will receive at least two (2) hours of supervision per month to include client care, job performance and skill development.</p>	<ul style="list-style-type: none"> • Review of personnel files indicates compliance • Review of agency's Policies & Procedures Manual indicates compliance • Review of documentation which includes, date of supervision, contents of discussion, duration of supervision and signatures of supervisor and all staff present

Primary Medical Care

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

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

1.0	Medical Care for persons with HIV disease should reflect competence and experience in both primary care and therapeutics known to be effective in the treatment of HIV infection and is consistent with the most current published U.S. Public Health Service treatment guidelines	
1.1	<u>Minimum Qualifications</u> Medical care for HIV infected persons shall be provided by MD, NP or PA licensed in the State of Texas and has at least two years paid experience in HIV/AIDS care including fellowship. The agency must keep professional licensure of all staff providing clinical services including physicians, nurses, social workers, etc.	<ul style="list-style-type: none"> • Credentials on file
1.2	<u>Licensing, Knowledge, Skills and Experience</u> <ul style="list-style-type: none"> • All staff maintain current organizational licensure (and/or applicable certification) and professional licensure • Supervising/attending physicians of the practice show continuous professional development through the following HRSA recommendations for HIV-qualified physicians (www.hivma.org): • Clinical management of at least 25 HIV-infected patients within the last year • Maintain a minimum of 15 hours of HIV-specific CME (including a minimum of 5 hours related to antiretroviral therapy) per year. Agencies using contractors must ensure 	<ul style="list-style-type: none"> • Documentation in personnel record

	<p>that this requirement is met and must provide evidence at the annual program monitoring site visits.</p> <ul style="list-style-type: none"> • Physician extenders must obtain this experience within six months of hire • All staff receive professional supervision • Staff show training and/or experience with the medical care of adults with HIV 	
<p>1.3</p>	<p><u>Primary Care Guidelines</u> Primary medical care must be provided in accordance with the most current published U.S. Public Health Service treatment guidelines (www.hivatis.org).</p>	<ul style="list-style-type: none"> • Documentation in client’s record • Exceptions noted in client’s record
<p>1.4</p>	<p><u>Medical Evaluation/Assessment</u> All HIV infected clients receiving medical care shall have an initial comprehensive medical evaluation/assessment and physical examination. The comprehensive assessment/evaluation will be completed by the MD, NP or PA in accordance with professional and established HIV practice guidelines (www.hivatis.org) within 4 weeks of initial contact with the client. A comprehensive reassessment shall be completed on an annual basis or when clinically indicated. The initial assessment and reassessment shall include at a minimum, general medical history, a comprehensive HIV related history and a comprehensive physical examination. Comprehensive HIV related history shall include:</p> <ul style="list-style-type: none"> • Psychosocial history • HIV treatment history and staging • Most recent CD4 counts and VL test results • Resistance testing and co receptor tropism assays as clinically indicated • medication adherence history • History of HIV related illness and infections • History of Tuberculosis • History of Hepatitis and vaccines • Psychiatric history • Transfusion/blood products history • Past medical care 	<ul style="list-style-type: none"> • Completed assessment in client’s record

	<ul style="list-style-type: none"> • Sexual history • Substance abuse history • Review of Systems 	
1.5	<p><u>Central Medical “Problems List”</u></p> <p>A central “Problems List” exists, separate from progress notes which clearly prioritizes problems for primary care management and additionally identifies:</p> <ul style="list-style-type: none"> • History and activity of mental health and substance use/abuse disorders (if applicable) • The location/provider of ancillary continuing healthcare (e.g. mental health or substance abuse service provider, or other continuing specialty service) • The status of vaccinations, including date of Pneumovax 	<ul style="list-style-type: none"> • Documentation in client’s record
1.6	<p><u>Plan of Care</u></p> <p>A plan of care shall be developed for each identified problem and should address diagnostic, therapeutic and educational issues in accordance with the current U.S. Public Health Service treatment guidelines.</p>	<ul style="list-style-type: none"> • Plan of Care documented in client’s record
1.7	<p><u>Follow- Up Visits</u></p> <p>All patients shall have follow –up visits at least every four months or more frequently if clinically indicated for treatment monitoring and also to detect any changes in the client’s HIV status. At each clinic visit the provider will at a minimum:</p> <ul style="list-style-type: none"> • Measure vital signs including height and weight • Perform physical examination and update client history • Measure CBC, CD4 and VL levels every 3-6 months or in accordance with current treatment guidelines, • Evaluate need for HAART • Evaluate need for prophylaxis of opportunistic infections • Document current therapies on all clients receiving treatment or assess and reinforce adherence with the treatment plan • Update problem list • Refer client for ophthalmic examination by an ophthalmologist every six months when CD4 count falls below 50CU/MM 	<ul style="list-style-type: none"> • Content of Follow-up documented in client’s record • Documentation of specialist referral including dental in client’s records

	<ul style="list-style-type: none"> • Refer Client for dental evaluation or care every 12 months • Incorporate HIV prevention strategies into medical care for of persons living with HIV • Screen for risk behaviors • Refer for other clinical and social services where indicated <p>Follow-up visits may be less frequent if client is clinically stable.</p>	
1.8	<p><u>Yearly Surveillance Monitoring and Vaccinations</u></p> <ul style="list-style-type: none"> • All HIV–infected women should have annual PAP smear <ul style="list-style-type: none"> ➤ An initial negative pap smear should be followed with another smear in six months and if negative, annually thereafter. ➤ A pap smear showing abnormal results should be managed per guidelines and reevaluated in three (3) to six (6) months • Resistance Testing if clinical indicated • Chem. panel with LFT and renal function test • Influenza vaccination • PPD test (this should be done in accordance with current U.S Public Health Service guidelines (US Public Health Service, Infectious Diseases Society of America. <i>Guidelines for preventing opportunistic infections among HIV-infected persons</i>) (Available at aidsinfo.nih.gov/Guidelines/) • STD testing including syphilis, gonorrhea and Chlamydia as clinically indicated 	<ul style="list-style-type: none"> • Documentation in client’s
1.9	<p><u>Preconception Care for HIV Infected Women of Child Bearing Age</u></p> <p>In accordance with US Public Health Service Task Force recommendations (http://aidsinfo.nih.gov/contentfiles/PerinatalGL.pdf), preconception care shall be woven into routine primary care for HIV infected women of child bearing age and should include preconception counseling. At a minimum, the preconception counseling should include:</p> <ul style="list-style-type: none"> • Use of appropriate contraceptive method to prevent unintended pregnancy 	<ul style="list-style-type: none"> • Documentation of preconception counseling and care at initial visit and annual updates in Client’s record as applicable

	<ul style="list-style-type: none"> • Safe sexual practices • Elimination of illicit drugs and smoking • Education and counseling on risk factors for perinatal HIV transmission and prevention and potential effects of HIV and treatment on pregnancy and outcomes • Available reproductive options <p>Other preconception care consideration should include:</p> <ul style="list-style-type: none"> • The choice of appropriate antiretroviral therapy effective in treating maternal disease with no teratogenicity or toxicity should pregnancy occur • Maximum suppression of viral load prior to conception 	
1.10	<p><u>Obstetrical Care for HIV Infected Pregnant Women</u></p> <p>Obstetrical care for HIV infected pregnant women shall be provided by board certified obstetrician experienced in the management of high risk pregnancy and has at least two years experience in the care of HIV infected pregnant women. Antiretroviral therapy during ante partum, perinatal and postpartum should be based on the current USPHS guidelines http://www.aidsinfo.nih.gov/Guidelines.</p>	<ul style="list-style-type: none"> • Documentation in client's record
1.11	<p><u>Coordination of Services in Prenatal Care</u></p> <p>To ensure adherence to treatment, agency must ensure coordination of services among prenatal care providers, primary care and HIV specialty care providers, mental health and substance abuse treatment services and public assistance programs as needed.</p>	<ul style="list-style-type: none"> • Documentation in client's records.
1.12	<p><u>Care of HIV-Exposed and HIV- Infected Infants, Children and Pre-pubertal Adolescents</u></p> <p>Care and monitoring of HIV-exposed children must be done in accordance to the USPHS guidelines.</p> <p>Treatment of HIV infected infants and children should be managed by a specialist in pediatric and adolescent HIV infection. Where this is not possible, primary care providers must consult with such specialist. Providers must utilize current USPHS Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Infection (http://aidsinfo.nih.gov/contentfiles/PediatricGuidelines.pdf) in providing and monitoring antiretroviral therapy in infants, children</p>	<ul style="list-style-type: none"> • Documentation in client's record

	<p>and pre pubertal adolescents. Patients should also be monitored for growth and development, drug toxicities, neurodevelopment, nutrition and symptoms management.</p> <p>A multidisciplinary team approach must be utilized in meeting clients' need and team should consist of physicians, nurses, case managers, pharmacists, nutritionists, dentists, psychologists and outreach workers.</p>	
1.13	<p><u>Patient Medication Education</u></p> <p>All clients must receive comprehensive documented education regarding their most current prescribed medication regimen. Medication education must include the following topics, which should be discussed and then documented in the patient record: the names, actions and purposes of all medications in the patient's regimen; the dosage schedule; food requirements, if any; side effects; drug interactions; and adherence. Patients must be informed of the following: how to pick up medications; how to get refills; and what to do and who to call when having problems taking medications as prescribed. Medication education must also include patient's return demonstration of the most current prescribed medication regimen.</p> <p>The program must utilize an RN, LVN, PA, NP, pharmacist or MD licensed by the State of Texas, who has at least two years paid experience in HIV/AIDS care, to provide the educational services.</p>	<ul style="list-style-type: none"> • Documentation in the patient record and on the required Patient Medication Education form. Documentation in patient record must include the clinic name; the session date and length; the patient's name, patient's ID number, or patient representative's name; the Educator's signature with license and title; the reason for the education (i.e. initial regimen, change in regimen, etc.) and documentation of all discussed education topics.
1.14	<p><u>Adherence Assessment</u></p> <p>Agency will incorporate adherence assessment into primary care services. Clients who are prescribed on-going ART regimen must receive adherence assessment and counseling on every HIV-related clinical encounter. Adherence assessment and counseling shall be provided by an RN, LVN, PA, NP, Case Manager, pharmacist or MD licensed by the State of Texas, who has at least two years paid experience in HIV/AIDS care. Agency must utilize the RWGA standardized adherence assessment tool. Case managers must refer clients with adherence issues beyond their scope of practice to the appropriate health care professional for counseling.</p>	<ul style="list-style-type: none"> • Completed adherence tool in client's record • Documentation of counseling in client records
1.15	<p><u>Documented Non-Compliance with Prescribed Medication Regimen</u></p>	<ul style="list-style-type: none"> • Review of Policies and Procedures Manual indicates compliance.

	The agency must have in place a written policy and procedure regarding client non-compliance with a prescribed medication regimen. The policy and procedure should address the agency's process for intervening when there is documented non-compliance with a client's prescribed medication regimen.	
1.16	<p><u>Client Mental Health and Substance Use Policy</u></p> <p>The agency must have in place a written policy and procedure regarding client mental health and substance use. The policy and procedure should address: the agency's process for assessing clients' mental health and substance use; the treatment and referral of clients for mental illness and substance abuse; and care coordination with mental health and/or substance abuse providers for clients who have mental health and substance abuse issues.</p>	<ul style="list-style-type: none"> Review of Policies and Procedures Manual indicates compliance.
2.0	Psychiatric care for persons with HIV disease should reflect competence and experience in both mental health care and therapeutics known to be effective in the treatment of psychiatric conditions and is consistent with the most current published Texas Society of Psychiatric Physicians/American Psychiatric Association treatment guidelines	
2.1	<p><u>Psychiatric Guidelines</u></p> <p>Outpatient psychiatric care must be provided in accordance with the most current published treatment guidelines, including: Texas Society of Psychiatric Physicians guidelines (www.txpsych.org) and the American Psychiatric Association (www.psych.org/aids) guidelines.</p>	<ul style="list-style-type: none"> Documentation in patient record
3.0	In addition to demonstrating competency in the provision of HIV disease specific care, HIV clinical service programs must show evidence that their performance follows norms for ambulatory care.	
3.1	<p><u>Access to Care</u></p> <p>Primary care providers shall ensure all new referrals from testing sites are scheduled for a new patient appointment within 15 working days of referral. (All exceptions to this timeframe will be documented)</p> <p>Agency must assure the time-appropriate delivery of services, with 24 hour on-call coverage including:</p> <ul style="list-style-type: none"> Mechanisms for urgent care evaluation and/or triage Mechanisms for in-patient care 	<ul style="list-style-type: none"> Agency Policy and Procedure regarding continuity of care.

	<ul style="list-style-type: none"> • Mechanisms for information/referral to: <ul style="list-style-type: none"> ➤ Medical sub-specialties: Gastroenterology, Neurology, Psychiatry, Ophthalmology, Dermatology, Obstetrics and Gynecology and Dentistry ➤ Social work and case management services ➤ Mental health services ➤ Substance abuse treatment services ➤ Anti-retroviral counseling/therapy for pregnant women ➤ Local federally funded hemophilia treatment center for persons with inherited coagulopathies ➤ Clinical investigations 	
3.2	<p><u>Patient Contact with Physician</u></p> <p>In a clinical setting where a physician extender is utilized (e.g. Nurse Practitioner or Physician Assistant), the client must be examined by a physician at a minimum of once per grant year (i.e. once every twelve (12) months) and more often if clinically indicated.</p>	<ul style="list-style-type: none"> • Documentation in patient record
3.3	<p><u>Continuity with Referring Providers</u></p> <p>Agency must have a formal policy for coordinating referrals for inpatient care and exchanging patient information with inpatient care providers.</p>	<ul style="list-style-type: none"> • Review of Agency's Policies and Procedures Manual indicates compliance
3.4	<p><u>Clients Referral and Tracking</u></p> <p>Agency receives referrals from a broad range of sources and makes appropriate referrals out when necessary. Agencies must implement tracking systems to identify clients who are out of care and/or need health screenings (e.g. Hepatitis b & c, cervical cancer screening, etc, for follow-up).</p>	<ul style="list-style-type: none"> • Documentation of referrals out • Staff interviews indicate compliance • Established tracking systems
3.5	<p><u>Recommended Format for Operational Standards</u></p> <p>Detailed standards and routines for program assessment are found in most recent Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) performance standards.</p>	<ul style="list-style-type: none"> • Ambulatory HIV clinical service should adopt and follow performance standards for ambulatory care as established by the Joint Commission on the Accreditation of Healthcare Organizations.

Wellness Program (Public Clinic Only)

The Wellness program consist of a physician ordered/client self referral outpatient wellness services provided to HIV-positive clients in the Public Clinic. Services may include evaluation and screening, resistance exercise therapy; low impact cardiovascular exercise therapy for patients with low endurance and educational information on nutrition, weight issues and exercises.

1.0	Staff knowledge is based on documented training and experience.	
1.1	<p><u>Qualifications</u></p> <p>Educational requirements include graduation from an accredited institution and appropriate certification or accreditation in the field of physical therapy. Providers of wellness services (billed to Ryan White Part A) are limited to Licensed Physical Therapists (PT), Licensed Physical Therapist Assistants (PTA) and PT Aides. Providers must have documented expertise in providing HIV-specific therapies.</p>	<ul style="list-style-type: none"> • Proof of credentials in personnel file
1.2	<p><u>Staff Training</u></p> <p>All wellness program staff must comply with the educational requirements under the general standards.</p>	<ul style="list-style-type: none"> • Materials for staff training are on file • Staff interviews indicate compliance. • Documentation of all training in personnel file
1.3	<p><u>Ongoing Education/Training for Physical Therapist</u></p> <p>Each PT/PTA must obtain the minimum number of hours of continuing education to maintain his or her license.</p>	<ul style="list-style-type: none"> • Attendance sign-in sheets and/or certificates of completion are maintained by the agency • Current license on personnel file
1.4	<p><u>Scope of Services</u></p> <p>The wellness program will include services for screening of patients prior to enrollment; resistance and low impact cardiovascular exercises for patients with low endurance; education on nutrition, weight issues and exercises to clients who are asymptomatic. Patient must be screened by a PT practitioner prior to the commencement of any exercise program, wellness or health promotion activities. The duration of services may depend on client's needs and goals. A client may be discharged from the program once his/her</p>	<ul style="list-style-type: none"> • Agency's policies and procedures • Review of client's records indicates compliance

	needs/goals are met, or he/she may discontinue participation voluntarily.	
1.5	<u>Staff Supervision</u> Staff services must be supervised in accordance with PT licensure requirements. In addition, supervision will be provided by a qualified professional with a minimum of 1 year documented HIV/AIDS work experience.	<ul style="list-style-type: none"> • Review of personnel files indicates compliance • Agency Policies & Procedures
2.0	Timeliness of Service/Documentation	
2.1	<u>Client Eligibility</u> Only Public Clinic clients are eligible for this program. In addition to general eligibility criteria, clients enrolled in the wellness program should not have any functional impairment. Patients must receive medical clearance by the primary medical care provider before enrolling in any exercise program.	<ul style="list-style-type: none"> • Medical clearance on client's record • Review of client's records indicates compliance
3.1	<u>Goals</u> Written patient specific goals should be developed by the PT practitioner based on the patient's screening and in collaboration with the client, within one week of enrollment into the program.	<ul style="list-style-type: none"> • Documentation completed by a PT practitioner in client's record.
3.2	<u>Monitoring and update of Goals.</u> At a minimum, the PT practitioner must perform a Body Impedance Analysis (BIA) to monitor changes in body composition and review goals with the client on a monthly basis.	<ul style="list-style-type: none"> • Documentation completed by a PT practitioner in client's record

THRESHOLDS

Measurement thresholds will be set at 100%.

IV. IMPLEMENTATION & REPORTING

Agencies will be required to adhere to the QA guidelines provided by RWGA, or the Part B administrative agency, as applicable.

Harris County
HCPHES
Public Health & Environmental Services

Herminia Palacio, M.D., M.P.H.
Executive Director

Tele: (713) 439-6000
Fax: (713) 439-6080

FY 2011 MID-YEAR OUTCOMES REPORTS HIGHLIGHTS
RYAN WHITE GRANT ADMINISTRATION
HARRIS COUNTY
PUBLIC HEALTH & ENVIRONMENTAL SERVICES
(HCPHES)

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Ryan White Part A
OUTCOME MEASURES RESULTS
FY 2011 Mid-Year Report

Community-Based Case Management (Service Linkage)
All Providers

Outcome Measure	Indicator	Data Collection Method
1.0 Knowledge, Attitudes, and Practices		
1.1. Increased or maintained utilization of primary care services	a. A minimum of 70% of clients will utilize Part A/B/C/D primary care two or more times at least three months apart after accessing community-based case management (service linkage) b. Percentage of HIV positive clients linked to outpatient/ambulatory medical care	<ul style="list-style-type: none"> • CPCDMS • ECLIPS*

A. Primary Care:

From 3/1/2011 through 8/31/2011, 4,013 clients utilized Part A community-based case management. According to CPCDMS, 1,361 (34%) of these clients accessed primary care two or more times at least three months apart during this time period after utilizing community-based case management, and 95 (2.4%) clients accessed primary care for the first time after utilizing community-based case management.

B. HIV Positive Clients Linked to Care:

This outcome measure has been deferred pending development of the ECLIPS system by the Houston Department of Health and Human Services.

**When implemented, now forecast to be April 2012*

Outcome Measure	Indicator	Data Collection Method
1.0 Knowledge, Attitudes, and Practices		
1.2 Increased or maintained utilization of support services	a. A minimum of 30% of clients will utilize Part A/B Local Pharmacy Assistance Program services after accessing community-based case management b. A minimum of 25% of clients will utilize Part A/B oral health care after accessing community-based case management c. Increase in the percent of clients who utilize mental health services after accessing community-based case management	<ul style="list-style-type: none"> • CPCDMS

From 3/1/2011 through 8/31/2011, 4,013 clients utilized Part A community-based case management.

A. Local Pharmacy Assistance Program (LPAP):

According to CPCDMS, 854 (21%) of these clients accessed LPAP services at least once during this time period after utilizing community-based case management, and 214 (5.3%) clients accessed LPAP services for the first time after utilizing community-based case management.

B. Oral Health Care:

According to CPCDMS, 551 (14%) of these clients accessed oral health care at least once during this time period after utilizing community-based case management, and 82 (2.0%) clients accessed oral health care for the first time after utilizing community-based case management.

C. Mental Health Services:

According to CPCDMS, 67 (1.7%) of these clients accessed mental health services at least once during this time period after utilizing community-based case management, and 19 (0.5%) clients accessed mental health services for the first time after utilizing community-based case management.

Ryan White Part A
 OUTCOME MEASURES RESULTS
 FY 2011 Mid-Year Report

Local Pharmacy Assistance Program
 All Providers

Outcome Measure	Indicator	Data Collection Method
2.0 Health		
2.1 Slowing/Prevention of disease progression	a. 75% of clients for whom there is lab data in the CPCDMS will show improved or maintained CD4 counts over time b. 75% of clients for whom there is lab data in the CPCDMS will show improved or maintained viral loads over time	<ul style="list-style-type: none"> • CPCDMS

For CD4 and viral load tests in the CPCDMS, a baseline test is a client’s earliest test result date within 365 days prior to the latest test result date entered into the CPCDMS by a Part A-funded primary care provider – this is not necessarily a client’s earliest test ever.

A. CD4 Counts:

Table A compares FY 2011 clients’ baseline CD4 count to their most recent CD4 count. Note: it is desirable to increase (or maintain) CD4 counts over time.

Out of 1,327 Local Pharmacy Assistance Program (LPAP) clients who have had more than one CD4 count recorded in the CPCDMS as of 8/31/2011 (see “Total” column), 373 (28%) clients increased their CD4 count, 843 (64%) clients maintained their CD4 count, and 111 (8%) clients had a decrease in their CD4 count.

B. Viral Loads:

Table B compares FY 2011 clients' baseline viral load to their most recent viral load. Note: it is desirable to decrease (or maintain) viral loads over time.

Out of 1,340 LPAP clients who have had more than one viral load recorded in the CPCDMS as of 8/31/2011 (see "Total" column), 139 (10%) clients increased their viral load, 843 (63%) clients maintained their viral load, and 358 (27%) clients had a decrease in their viral load.

Table A: CD4 Counts of Local Pharmacy Assistance Program Clients by Gender, Race and Ethnicity

	Increased CD4 Count*				Maintained CD4 Count**			Decreased CD4 Count				Total
	Number	Avg Baseline	Avg Latest	Percent	Number	Avg Latest	Percent	Number	Avg Baseline	Avg Latest	Percent	Number
Female	89	339	560	23%	267	612	68%	37	430	239	9%	393
Male	281	312	510	31%	567	549	62%	73	633	340	8%	921
Trans F to M	0	0	0	0%	1	225	100%	0	0	0	0%	1
Trans M To F	3	258	458	25%	8	676	67%	1	316	201	8%	12
African American	191	314	529	31%	364	564	60%	56	552	282	9%	611
Asian	5	403	655	50%	4	454	40%	1	570	372	10%	10
Multi-Race	1	312	421	12%	7	645	88%	0	0	0	0%	8
Native American	1	359	674	20%	4	359	80%	0	0	0	0%	5
Hawaiian/Pacific Islander	1	151	235	33%	2	677	67%	0	0	0	0%	3
White	174	320	512	25%	462	576	67%	54	573	328	8%	690
Hispanic	113	319	512	25%	301	549	67%	32	510	300	7%	446
Non-Hispanic	260	317	526	30%	542	582	62%	79	584	307	9%	881
Total	373	318	522	28%	843	570	64%	111	563	305	8%	1,327

*mm3

**“Maintained” is defined as a change of less than 30% from the baseline CD4 count

Table B: Viral Loads of Local Pharmacy Assistance Program Clients by Gender, Race and Ethnicity

	Increased Viral Load*				Maintained Viral Load**			Decreased Viral Load				Total
	Number	Avg Baseline	Avg Latest	Percent	Number	Avg Latest	Percent	Number	Avg Baseline	Avg Latest	Percent	Number
Female	47	10,075	90,985	12%	254	10,363	64%	93	94,673	3,349	24%	394
Male	92	6,514	89,456	10%	578	8,207	62%	263	128,881	1,157	28%	933
Trans F to M	0	0	0	0%	1	48	100%	0	0	0	0%	1
Trans M To F	0	0	0	0%	10	36,945	83%	2	45,615	20	17%	12
African American	71	11,123	107,420	12%	362	11,111	59%	180	125,983	2,614	29%	613
Asian	0	0	0	0%	6	791	60%	4	34,807	431	40%	10
Multi-Race	0	0	0	0%	6	8,038	75%	2	3,775	20	25%	8
Native American	2	100	137,525	40%	0	0	0%	3	30,503	103	60%	5
Pacific Islander/Hawaiian	0	0	0	0%	2	20	100%	0	0	0	0%	2
White	66	4,286	69,763	9%	467	7,859	67%	169	117,611	847	24%	702
Hispanic	37	2,394	45,066	8%	303	9,025	67%	109	128,812	689	24%	449
Non-Hispanic	102	9,650	106,263	11%	540	9,279	61%	249	115,466	2,171	28%	891
Total	139	7,718	89,973	10%	843	9,188	63%	358	119,529	1,720	27%	1,340

*c/ml

**“Maintained” is defined as a change of less than threefold from the baseline viral load

In addition, 65% of LPAP clients’ most recent viral load tests were undetectable (below 50 c/ml).

Outcome Measure	Indicator	Data Collection Method
2.0 Health		
2.2 Reduced incidence of opportunistic infections	Change in the frequency of occurrence of opportunistic infections among Local Pharmacy Assistance Program clients over time	<ul style="list-style-type: none"> CPCDMS (please note that ADAP dispensing clients are included)

Opportunistic Infection	Number of Diagnoses	Number with Follow-up	*Resolved		*Not Resolved	
			#	%	#	%
Candidiasis	1	0				
Cervical Cancer						
Coccidioidomycosis						
Cryptococcosis						
Cryptosporidiosis						
Cytomegalovirus disease						
Cytomegalovirus (CMV Retinitis)						
HIV encephalopathy						
Histoplasmosis						
Herpes simplex virus	1	0				
Isosporiasis						
Kaposi's Sarcoma						
Lymphoid interstitial pneumonitis						
Lipodistrophy						
Lymphoma						
Mycobacterium avium complex						
Mycobacterium tuberculosis, any site						
Pneumocystis carinii pneumonia						
Progressive multifocal leukoencephalopathy	1	0				
Pneumonia, recurrent						
Salmonellosis						
Toxoplasmosis of the brain						
Wasting syndrome						
Other						
Total	3	0				

*Of diagnoses with follow-up

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Medical Case Management
 All Providers

Outcome Measure	Indicator	Data Collection Method
1.0 Knowledge, Attitudes, and Practices		
1.1 Increased or maintained utilization of primary care services	A minimum of 85% of clients will utilize Part A/B/C/D primary care two or more times at least three months apart after accessing medical case management	<ul style="list-style-type: none"> • CPCDMS

Primary Care:

From 3/1/2011 through 8/31/2011, 2,724 clients utilized Part A medical case management. According to CPCDMS, 1,234 (45%) of these clients accessed primary care two or more times at least three months apart during this time period after utilizing medical case management, and 26 (1.0%) clients accessed primary care for the first time after utilizing medical case management.

Outcome Measure	Indicator	Data Collection Method
1.0 Knowledge, Attitudes, and Practices		
1.2 Increased or maintained utilization of support services	<ul style="list-style-type: none"> a. A minimum of 30% of clients will utilize Part A/B Local Pharmacy Assistance Program services after accessing medical case management b. A minimum of 25% of clients will utilize Part A/B oral health care after accessing medical case management c. Increase in the percentage of clients who access vision care after accessing medical case management. d. Increase in the percentage of clients who utilize mental health services after accessing medical case management. e. Increase in the percentage of clients who have 3rd party payer coverage (e.g. Medicare, Medicaid) after accessing medical case management. 	<ul style="list-style-type: none"> • CPCDMS

From 3/1/2011 through 8/31/2011, 2,724 clients utilized Part A medical case management.

A. Local Pharmacy Assistance Program (LPAP):

According to CPCDMS, 969 (36%) of these clients accessed LPAP services at least once during this time period after utilizing medical case management, and 167 (6.1%) clients accessed LPAP for the first time after utilizing medical case management.

B. Oral Health Care:

According to CPCDMS, 464 (17%) of these clients accessed oral health care at least once during this time period after utilizing medical case management, and 88 (3.2%) clients accessed oral health care for the first time after utilizing medical case management.

C. Vision Care:

According to CPCDMS, 201 (7.4%) of these clients accessed vision care at least once during this time period after utilizing medical case management, and 72 (2.6%) clients accessed vision care for the first time after utilizing medical case management.

D. Mental Health Services:

According to CPCDMS, 52 (1.9%) of these clients accessed mental health services at least once during this time period after utilizing medical case management, and 16 (0.6%) clients accessed mental health services for the first time after utilizing medical case management.

E. Third Party Payer Coverage:

Approximately 894 (33%) of clients utilizing Part A medical case management had third party coverage.

Outcome Measure	Indicator	Data Collection Method
2.0 Health		
2.1 Slowing/prevention of disease progression	a. 75% of clients for whom there is lab data in the CPCDMS will show improved or maintained CD4 counts over time b. 75% of clients for whom there is lab data in the CPCDMS will show improved or maintained viral loads over time	<ul style="list-style-type: none"> • CPCDMS
2.2 Stabilized stage of illness	75% of clients for whom there is data in the CPCDMS will maintain current stage of illness over time	

For CD4 and viral load tests in the CPCDMS, a baseline test is a client's earliest test result date within 365 days prior to the latest test result date entered into the CPCDMS by a Part A-funded primary care provider – this is not necessarily a client's earliest test ever.

A. CD4 Counts:

Table A compares FY 2011 clients' baseline CD4 count to their most recent CD4 count. Note: it is desirable to increase (or maintain) CD4 counts over time.

Out of 906 medical case management clients who have had more than one CD4 count recorded in the CPCDMS as of 8/31/2011 (see "Total" column), 319 (35%) clients increased their CD4 count, 517 (57%) clients maintained their CD4 count, and 70 (8%) clients had a decrease in their CD4 count.

B. Viral Loads:

Table B compares FY 2011 clients' baseline viral load to their most recent viral load. Note: it is desirable to decrease (or maintain) viral loads over time.

Out of 924 medical case management clients who have had more than one viral load recorded in the CPCDMS as of 8/31/2011 (see "Total" column), 97 (10%) clients increased their viral load, 544 (59%) clients maintained their viral load, and 283 (31%) clients had a decrease in their viral load.

Stage of Illness:

This outcome measure has been deferred pending further review by the Clinical Quality Improvement Committee.

Table A: CD4 Counts of Medical Case Management Clients by Gender, Race and Ethnicity

	Increased CD4 Count*				Maintained CD4 Count**			Decreased CD4 Count				Total
	Number	Avg Baseline	Avg Latest	Percent	Number	Avg Latest	Percent	Number	Avg Baseline	Avg Latest	Percent	Number
Female	106	279	493	32%	202	614	60%	26	580	347	8%	334
Male	212	290	517	37%	312	539	55%	44	510	271	8%	568
Trans M To F	1	302	546	25%	3	636	75%	0	0	0	0%	4
African American	192	283	516	38%	279	592	55%	40	550	296	8%	511
Asian	4	344	531	44%	3	436	33%	2	1,022	673	22%	9
Multi-Race	0	0	0	0%	1	741	100%	0	0	0	0%	1
Native American	0	0	0	0%	4	524	100%	0	0	0	0%	4
White	123	290	498	32%	230	543	60%	28	482	277	7%	381
Hispanic	80	251	463	31%	162	514	62%	20	489	281	8%	262
Non-Hispanic	239	298	524	37%	355	594	55%	50	555	306	8%	644
Total	319	286	509	35%	517	569	57%	70	536	299	8%	906

*mm3

**"Maintained" is defined as +/- 30% from the baseline CD4 count.

Table B: Viral Loads of Medical Case Management Clients by Gender, Race and Ethnicity

	Increased Viral Load*				Maintained Viral Load**			Decreased Viral Load				Total
	Number	Avg Baseline	Avg Latest	Percent	Number	Avg Latest	Percent	Number	Avg Baseline	Avg Latest	Percent	Number
Female	39	8,208	122,344	12%	202	15,113	60%	96	127,828	937	28%	337
Male	58	7,100	116,417	10%	339	6,144	58%	185	206,068	1,430	32%	582
Trans F To M	0	0	0	0%	1	48	100%	0	0	0	0%	1
Trans M To F	0	0	0	0%	2	20	50%	2	63,220	3,745	50%	4
African American	62	10,108	157,834	12%	286	11,114	55%	168	143,502	1,620	33%	516
Asian	2	27,340	136,500	22%	5	953	56%	2	42,435	76	22%	9
Multi-Race	0	0	0	0%	0	0	0%	1	51,070	350	100%	1
Native American	1	60	350	25%	1	50	25%	2	67,470	136	50%	4
White	32	1,577	45,767	8%	252	7,747	64%	110	237,648	808	28%	394
Hispanic	16	12,840	194,539	6%	175	6,687	65%	77	193,489	1,072	29%	268
Non-Hispanic	81	6,500	103,839	12%	369	10,747	56%	206	172,922	1,356	31%	656
Total	97	7,545	118,800	10%	544	9,441	59%	283	178,518	1,279	31%	924

*c/ml

**"Maintained" is defined as a change of less than threefold from the baseline viral load

In addition, 62% of medical case management clients' most recent viral load tests were undetectable (< 50 c/ml).

Ryan White Part A
 OUTCOME MEASURES RESULTS
 FY 2011 Mid-Year Report

Primary Medical Care
 All Providers

Outcome Measure	Indicator	Data Collection Method
1.0 Knowledge, Attitudes, and Practices		
1.1 Increased retention rates	a. Percentage of Ryan White Part A program-funded outpatient/ambulatory care organizations in the system/network with a waiting time of 15 or fewer business days for a Ryan White Part A program-eligible patient to receive an appointment to enroll in outpatient/ambulatory medical care b. 90% of clients with HIV infection will have two or more medical visits in an HIV care setting	<ul style="list-style-type: none"> • Clinical Quality Management • CPCDMS

A. Ryan White Part A Program Access Time

From 3/1/2011 through 8/31/2011, 75% of Ryan White Part A outpatient/ambulatory care organizations provided a waiting time of 15 or fewer business days for a program-eligible patient to receive an appointment to enroll medical care.

Average wait time for initial appointment availability:

EMA: 9.3 Days

Primary Care Provider A: 12 Days

Primary Care Provider B: 10.8 Days

Primary Care Provider C: 2.2 Days

Primary Care Provider D: 9 Days

- * Appointment to enroll in outpatient/ambulatory medical care = 3rd available appointment on reporting date
- * Due to intake restrictions of the Primary Care Provider D, wait time for Primary Care Provider D are not included in outcomes EMA average.
- * Average wait time for Primary Care Provider D reflects restricted intake and average time for 3 months during reporting period

B. Primary Medical Care

This outcome measure requires a parameter of 12 months so has been deferred until the year-end report.

Outcome Measure	Indicator	Data Collection Method
2.0 Health		
2.1 Slowing/prevention of disease progression	a. 75% of clients for whom there is lab data in the CPCDMS will show improved or maintained CD4 counts over time b. 75% of clients for whom there is labe data in the CPCDMS will show improved or maintained viral loads over time c. Percentage of clients with new Hepatitis B and C infections d. Percentage of clients with new syphilis infections e. Percentage of individuals with an AIDS diagnosis at the time of initial outpatient/ambulatory medical visit in the measurement year	<ul style="list-style-type: none"> • CPCDMS

For CD4 and viral load tests in the CPCDMS, a baseline test is a client's earliest test result date within 365 days prior to the latest test result date entered into the CPCDMS by a Part A-funded primary care provider – this is not necessarily a client's earliest test ever.

A. CD4 Counts:

Table A compares FY 2011 clients' baseline CD4 count to their most recent CD4 count. Note: it is desirable to increase (or maintain) CD4 counts over time.

Out of 3,216 primary care clients who have had more than one CD4 count recorded in the CPCDMS as of 8/31/2011 (see "Total" column), 967 (30%) clients increased their CD4 count, 2,002 (62%) clients maintained their CD4 count, and 247 (8%) clients had a decrease in their CD4 count.

B. Viral Loads:

Table B compares FY 2011 clients' baseline viral load to their most recent viral load. Note: it is desirable to decrease (or maintain) viral loads over time.

Out of 3,214 primary care clients who have had more than one viral load recorded in the CPCDMS as of 8/31/2011 (see "Total" column), 282 (9%) clients increased their viral load, 2,072 (64%) clients maintained their viral load, and 860 (27%) clients had a decrease in their viral load.

C. Hepatitis B and C:

This outcome measure requires a parameter of 12 months so has been deferred until the year-end report.

D. Syphilis Infections:

This outcome measure requires a parameter of 12 months so has been deferred until the year-end report.

E. AIDS Diagnoses:

This outcome measure has been deferred until year-end pending development of a custom CPCDMS report.

Table A: CD4 Counts of Primary Medical Care Clients by Gender, Race and Ethnicity

	Increased CD4 Count*				Maintained CD4 Count**			Decreased CD4 Count				Total
	Number	Avg Baseline	Avg Latest	Percent	Number	Avg Latest	Percent	Number	Avg Baseline	Avg Latest	Percent	Number
Female	244	309	519	27%	581	601	64%	78	489	280	9%	903
Male	719	289	486	31%	1410	534	61%	167	558	310	7%	2296
Trans F to M	0	0	0	0%	1	225	50%	1	485	262	50%	2
Trans M To F	4	256	488	27%	10	594	67%	1	520	296	7%	15
African American	472	288	489	32%	896	554	60%	127	519	286	8%	1495
Asian	13	292	496	34%	23	532	61%	2	499	306	5%	38
Multi-Race	1	312	421	9%	10	597	91%	0	0	0	0%	11
Native American	1	359	674	9%	10	626	91%	0	0	0	0%	11
Hawaiian/Pacific Islander	1	151	235	17%	5	643	83%	0	0	0	0%	6
White	479	300	500	29%	1058	552	64%	118	555	316	7%	1655
Hispanic	354	295	495	29%	779	538	64%	78	497	284	6%	1211
Non-Hispanic	613	293	494	31%	1223	564	61%	169	554	308	8%	2005
Total	967	294	494	30%	2002	554	62%	247	536	300	8%	3,216

*mm3

**"Maintained" is defined as +/- 30% from the baseline CD4 count.

Table B: Viral Loads of Primary Medical Care Clients by Gender, Race and Ethnicity

	Increased Viral Load*				Maintained Viral Load**			Decreased Viral Load				Total
	Number	Avg Baseline	Avg Latest	Percent	Number	Avg Latest	Percent	Number	Avg Baseline	Avg Latest	Percent	Number
Female	96	8,812	77,029	11%	581	9,232	65%	216	141,497	3,014	24%	893
Male	184	5,042	79,847	8%	1,480	8,426	64%	640	204,881	1,816	28%	2,304
Trans F to M	0	0	0	0%	2	48	100%	0	0	0	0%	2
Trans M To F	2	34	3,245	13%	9	12,690	60%	4	52,008	2,028	27%	15
African American	251	10,406	166,673	10%	1,499	14,462	61%	717	209,976	5,831	29%	2,467
Asian	1	48	247,000	2%	30	2,580	75%	9	213,517	22,368	22%	40
Multi-Race	2	799	5,805	11%	10	13,946	56%	6	1,193,288	2,249	33%	18
Native American	4	74	72,571	20%	10	24,458	50%	6	55,102	318	30%	20
Hawaiian/Pacific Islander	1	770	93,810	10%	8	37	80%	1	342	48	10%	10
White	172	4,207	108,344	7%	1,611	9,222	67%	604	181,793	3,698	25%	2,387
Hispanic	122	4,728	88,702	8%	1,068	6,440	68%	383	156,692	3,555	24%	1,573
Non-Hispanic	309	8,937	162,755	9%	2,100	14,342	62%	960	218,495	5,489	28%	3,369
Total	282	6,290	78,345	9%	2,072	8,662	64%	860	188,250	2,118	27%	3,214

*c/ml

**“Maintained” is defined as a change of less than threefold from the baseline viral load

In addition, 59% of primary medical care clients’ most recent viral load tests were undetectable (< 50 c/ml).

Outcome Measure	Indicator	Data Collection Method
2.0 Health		
2.2 Reduced rates of perinatal transmission	Maintain at zero the number of infants born to HIV+ mothers who are HIV+ (virologic testing after birth)	

This outcome is not provider-specific. Most HIV-positive pregnant women in the Houston area receive prenatal care through Medicaid, therefore only a small number of infants are born to mothers who received Part A primary care during the fiscal year.

Outcome Measure	Indicator	Data Collection Method
2.0 Health		
2.3 Reduced incidence of AIDS-defining conditions	a. Change in the frequency of occurrences of AIDS-defining opportunistic infections among clients over time b. Percentage of clients with opportunistic infections (excludes patients newly enrolled in care in the measurement year)	<ul style="list-style-type: none"> CPCDMS

Opportunistic Infection	Number of Diagnoses	Number with Follow-up	*Resolved		*Not Resolved	
			#	%	#	%
Candidiasis	1	0				
Cervical Cancer						
Coccidioidomycosis						
Cryptococcosis						
Cryptosporidiosis						
Cytomegalovirus disease	1	0				
Cytomegalovirus (CMV Retinitis)	1	0				
HIV encephalopathy						
Histoplasmosis						
Herpes simplex virus	1	0				
Isosporiasis						
Kaposi's Sarcoma						
Lymphoid interstitial pneumonitis						
Lipodistrophy						
Lymphoma						
Mycobacterium avium complex						
Mycobacterium tuberculosis, any site						
Pneumocystis carinii pneumonia						
Progressive multifocal leukoencephalopathy	1	0				
Pneumonia, recurrent						
Salmonellosis						
Toxoplasmosis of the brain						
Wasting syndrome						
Other						

Opportunistic Infection	Number of Diagnoses	Number with Follow-up	*Resolved		*Not Resolved	
			#	%	#	%
Total	5	0				

*Of diagnoses with follow-up

The percentage of primary care clients with opportunistic infections for FY 2011 will be reported at year-end.

Outcome Measure	Indicator	Data Collection Method
2.0 Health		
2.4 Reduced rate of HIV-related mortality	Percentage of HIV-related mortality	

This outcome measure has been deferred pending further review by the Clinical Quality Improvement Committee.

Outcome Measure	Indicator	Data Collection Method
4.0 Cost-Effectiveness		
4.1 Reduced incidence of HIV/AIDS-related hospitalization	Percentage of patients with HIV-related hospitalizations in the measurement year	

This outcome measure has been deferred pending further review by the Clinical Quality Improvement Committee.



OUTPATIENT AMBULATORY MEDICAL CARE
2011 CHART REVIEW

PREFACE

DSHS Monitoring Requirements

The Texas Department of State Health Services (DSHS) contracts with The Houston Regional HIV/AIDS Resource Group, Inc. (TRG) to ensure that Ryan White Part B and State of Texas HIV Services funding is utilized to provide in accordance to negotiated Priorities and Allocations for the designated Health Service Delivery Area (HSDA). In Houston, the HSDA is a ten-county area including the following counties: Austin, Chambers, Colorado, Fort Bend, Harris, Liberty, Montgomery, Walker, Waller, and Wharton. As part of its General Provisions for Grant Agreements, DSHS also requires that TRG ensures that all Subgrantees comply with statutes and rules, perform client financial assessments, and delivery service in a manner consistent with established protocols and standards.

As part of those requirements, TRG is required to perform annual quality compliance reviews on all Subgrantees. Quality Compliance Reviews focus on issues of administrative, clinical, consumer involvement, data management, fiscal, programmatic and quality management nature. Administrative review examines Subgrantee operating systems including, but not limited to, non-discrimination, personnel management and Board of Directors. Clinical review includes review of clinical service provision in the framework of established protocols, procedures, standards and guidelines. Consumer involvement review examines the Subgrantee's frame work for gather client feedback and resolving client problems. Data management review examines the Subgrantee's collection of required data elements, service encounter data, and supporting documentation. Fiscal review examines the documentation to support billed units as well as the Subgrantee's fiscal management and control systems. Programmatic review examines non-clinical service provision in the framework of established protocols, procedures, standards and guidelines. Quality management review ensures that each Subgrantee has systems in place to address the mandate for a continuous quality management program.

QM Component of Monitoring

As a result of quality compliance reviews, the Subgrantee receives a list of findings that must be address. The Subgrantee is required to submit an improvement plan to bring the area of the finding into compliance. This plan is monitored as part of the Subgrantee's overall quality management monitoring. Additional follow-up reviews may occur (depending on the nature of the finding) to ensure that the improvement plan is being effectively implemented.

Scope of Funding

Outpatient Ambulatory Medical Care: TRG contracts with two Subgrantees to provide medical care in the rural areas of the HSDA. These areas are designated North of Harris County and West of Harris County.

INTRODUCTION

Description of Service

Outpatient Ambulatory Medical Care services include on site physician, physician extender, nursing, OBGYN physician, OBGYN services, phlebotomy, radiographic, laboratory, pharmacy, intravenous therapy, home health care and hospice referral, patient medication and adherence education, and patient care coordination. The agency/clinic must provide continuity of care with inpatient services and subspecialty services (either on-site or through specific referral to appropriate agencies).

- Continuity of care for all stages of adult HIV infection;
- Specialty Clinic Referrals. (i.e. obstetrics and gynecology, vision care, gastroenterology, neurology, etc.)
- Laboratory and pharmacy services including intravenous medications (either on-site or through established referral systems);
- Prenatal and Perinatal Preventative education and treatment;
- Access to the Texas the Texas HIV Medication Program (either on-site or through established referral systems);
- Access to compassionate use HIV medication programs (either directly or through established referral systems). Utilization of Pharmaceutical Care Patient drug assistance program is encouraged.
- Access to HIV related research protocols (either directly or through established referral systems);
- Must at a minimum, comply with the attached Adult Standards for HIV Primary Medical Care Components of Medical Practice. The Contractor must demonstrate on an ongoing basis the ability to provide state-of-the-art HIV-related primary care medicine in accordance with the most recent National Institute of Health (NIH) HIV treatment guidelines. The rapid advances in HIV treatment protocols require that the Contractor provide services that will to the greatest extent possible maximize a patient's opportunity for long-term survival and maintenance of the highest quality of life possible.

Tool Development

The TRG OAMC Clinical Chart Review Tool was developed in accordance with published standards of care established by the United States Public Health Service (www.aidsinfo.nih.gov) and other recognized practice guidelines, standards, and protocols. Including:

- a. *OPR/HAB HIV Clinical Performance Measures*. <http://hab.hrsa.gov/special/habmeasures.htm>
- b. The Center for Disease Control, Division of AIDS Prevention – Treatment (www.cdc.gov),
- c. *Clinical Manual for the Management of HIV-Infected Adult (2006 Edition)*, AIDS Education and Training Centers. http://img.thebody.com/hhs/se_midlevel_2005.pdf
- d. *Primary Guidelines for HIV* by the Infectious Disease Society of America. <http://www.idsociety.org/content.aspx?id=9202>
- e. *Sexually Transmitted Diseases Treatment Guidelines, 2006* – MMWR.
- f. John Hopkins AIDS Service (www.hopkins-aids.edu); HIV/AIDS Bureau (www.hab.hrsa.gov)
- g. Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents. Department of Health and Human Services. December 1, 2009; 1-128. Available at <http://aidsinfo.nih.gov/contentfiles/AdultandAdolescentGL.pdf>
- h. Guidelines for Preventing Opportunistic Infections Among HIV-Infected Persons – 2002. MMWR 2002;51(No. RR-8): 1-51. <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5108a1.htm>

- i. Treating Opportunistic Infections Among HIV-Exposed and Infected Children Recommendations from CDC, the National Institutes of Health, and the Infectious Diseases Society of America; December 2004: 1-74.
<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5314a1.htm>
- j. Clinical Manual for Management of the HIV-Infected Adult, 2006 Edition. AIDS Education & Training Centers (AETC).
http://img.thebody.com/hhs/se_midlevel_2005.pdf
- k. Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Infection developed by the François-Xavier Bagnoud Center, UMDNJ, HRSA, and the NIH; August 16, 2010: 1-126.
<http://www.aidsinfo.nih.gov/ContentFiles/PediatricGuidelines.pdf>
- l. Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents. NIH; December 1, 2009.
<http://www.aidsinfo.nih.gov/contentfiles/AdultandAdolescentGL.pdf>
- m. DSHS HIV/STD program. <http://www.dshs.state.tx.us/hivstd/healthcare/treatment.shtm>

The chart review tool is reviewed each year for changes and updated to reflect trends in healthcare delivery and HRSA HAB, DSHS reporting changes. The TRG OAMC Clinical Chart Review tool had a major rework for the 2011 grant year.

Chart Review Process

All charts were reviewed by Bachelors-degree registered nurse experienced in treatment, management, and clinical operations in HIV of over 10 years. The collected data for each site was recorded directly into a preformatted computerized database. The data collected during this process is to be used for service improvement.

File Sample Selection Process

File sample was selected from a provider population of 172 who accessed Ryan White Part B primary care funds between 1/1/2011 – 12/31/2011. The records of 19 clients were reviewed, representing 11% of the unduplicated population. The demographic makeup of the provider was used as a key to file sample pull.

Report Structure

A categorical reporting structure was used. The report is as follows:

- Medical Visits
- CD4 T-Cell count
- HAART Medications
- PCP & MAC Prophylaxis
- Screenings
- Immunizations
- Woman's Health
- Education
- Referrals

FINDINGS

Medical Visits (HAB Group 1)

Percentage of clients with HIV infection who had two or more medical visits in a HIV care setting in the measurement year

Year	2011	2010	2009	2008
Number of HIV-positive clients who had two or more medical visits in the measurement year	35	17	19	16
Number of HIV-positive clients who had at least one medical visit with a provider with prescribing privileges, i.e. MD, PA, NP in the measurement year	36	19	20	16
Rate	97.2%	89.5%	95.0%	100.0%
Change from Previous Year	7.7%	-5.5%	-5.0%	-

CD4 T-Cell Count (HAB Group 1)

Percentage of clients with HIV infection who had 2 or more CD4 T-cell counts performed in the measurement year.

Year	2011	2010	2009	2008
Number of HIV-infected clients who had 2 or more CD4 T-cell counts performed at least 3 months apart during the measurement year	26	17	15	13
Number of HIV-positive clients who had at least one medical visit with a provider with prescribing privileges, i.e. MD, PA, NP in the measurement year.	36	19	20	16
Rate	72.2%	89.5%	75.0%	81.3%
Change from Previous Year	-17.3%	14.5	-6.3	12.1

HAART Medications (HAB Group 1)

Number of clients with AIDS who were prescribed a HAART regimen within the measurement year

Year	2011	2010	2009	2008
Number of clients with AIDS who were prescribed a HAART regimen within the measurement year	18	10	5	5
Number of clients who have a diagnosis of AIDS (history ³ of a CD4 T-cell count below 200 cells/mm ³ or other AIDS-defining condition), and had at least one medical visit with a provider with prescribing privileges in the measurement year.	18	10	5	5
Rate	100.0%	100.0%	100.0%	100.0%
Change from Previous Year	-	-	-	-

PCP Prophylaxis (HAB Group 1)

Percentage of clients with HIV infection and a CD4 T-cell count below 200 cells/mm³ who were prescribed PCP prophylaxis.

Year	2011	2010	2009	2008
Number of HIV-infected clients with CD4 T-cell counts below 200 cells/mm ³ who were prescribed PCP prophylaxis	12	12	11	5
Number of Charts Reviewed of HIV-infected clients with CD4 T-cell counts below 200 cells/mm ³	12	12	11	5
Rate	100.0%	100.0%	100.0%	100.0%
Change from Previous Year	-	-	-	-

MAC Prophylaxis (HAB Group 3)

Percentage of clients with HIV infection with CD4 counts < 50 cells/mm³ who were prescribed MAC prophylaxis within the measurement year.

Year	2011	2010	2009	2008
Number of HIV-infected clients with CD4 T-cell counts below 50 cells/mm ³ who were prescribed MAC prophylaxis	5	6	6	1
Number of Charts Reviewed of HIV-infected clients with CD4 T-cell counts below 50 cells/mm ³ who were prescribed MAC prophylaxis	5	6	6	1
Rate	100.0%	100.0%	100.0%	100.0%
Change from Previous Year	-	-	-	-

STI Screening - Syphilis (HAB Group 2)

Percentage of adult clients with HIV infection who had a test for Syphilis performed within the measurement year.

Year	2011	2010	2009	2008
Number of HIV-infected clients who had a serologic test for syphilis performed at least once during the measurement year	27	16	16	11
Number of HIV-positive clients who had at least one medical visit with a provider with prescribing privileges in the measurement year.	36	19	20	16
Rate	75.0%	84.2%	80.0%	86.8%
Change from Previous Year	-9.2%	4.2%	-6.8%	48.3

STI Screening - Gonorrhea (HAB Group 3)

Percentage of adult clients with HIV infection who had a test for Gonorrhea performed within the measurement year.

Year	2011	2010	2009	2008
Number of HIV-infected clients who had a test for Gonorrhea at least once during the measurement year	23	3	4	7
Number of HIV-positive clients who had at least one medical visit with a provider with prescribing privileges, i.e. MD, PA, NP in the measurement year.	36	19	20	16
Rate	63.9%	15.8%	20.0%	43.8%
Change from Previous Year	40.1%	-4.2%	-23.8%	5.2

STI Screening - Chlamydia (HAB Group 3)

Percentage of adult clients with HIV infection who had a test for Chlamydia performed within the measurement year.

Year	2011	2010	2009	2008
Number of HIV-infected clients who had a test for Chlamydia at least once during the measurement year	23	3	4	7
Number of HIV-positive clients who had at least one medical visit with a provider with prescribing privileges, i.e. MD, PA, NP in the measurement year.	36	19	20	16
Rate	63.9%	15.8%	20.0%	43.8%
Change from Previous Year	40.1%	-4.2%	-23.8%	5.2

TB Screening (HAB Group 2)

Percent of clients with HIV infection who received a documented testing for LTBI.
Was the Test Placed.

Year	2011	2010	2009	2008
Number of clients who received documented testing for LTBI at least once during the measurement year.	25	6	7	7
Number of HIV-positive clients who had at least one medical visit with a provider with prescribing privileges, i.e. MD, PA, NP in the measurement year and who are eligible for tuberculin skin test [TST].	36	13	13	13
Rate	69.4%	46.2%	53.9%	53.9
Change from Previous Year	23.2%	-7.7%	-	20.6%

Lipid Screening (HAB Group 2)

Percentage of clients with HIV infection on HAART who had a fasting lipid panel during the measurement year.

Year	2011	2010	2009	2008
Number of HIV-Infected Clients who were prescribed a HAART regimen and had a fasting lipid panel in the measurement year.	35	18	13	13
Number of HIV-Infected Clients who were prescribed a HAART regimen.	36	19	20	16
Rate	97.2%	94.7%	65.0%	81.3%
Change from Previous Year	2.5%	29.7%	-16.3	80.5%

Toxoplasmosis Screening (HAB Group 3)

Percentage of clients with HIV infection for whom Toxoplasma screening was performed at least once since the diagnosis of HIV infection. .

Year	2011	2010*	2009	2008
Number of HIV-infected clients who have documented Toxoplasma status in health record	12	-	16	13
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the measurement period	36	-	20	16
Rate	33.3%	-	80.0	81.3%
Change from Previous Year	-	-	-1.3%	-3.3

**2010 INDETERMINATE: Paper medical records to the EMR lab values greater than two years were not in the EMR. Therefore, without pulling all old paper medical records this SOC could not be determined at time of review*

Hepatitis B Screening (HAB Group 3)

Percentage of clients for whom Hepatitis B screening was performed at least once since diagnosis of HIV infection.

Year	2010	2010*	2009	2008
Number of HIV-infected clients who have documented Hepatitis B infection status in the health record	34	-	20	16
Number of clients receiving OAMC.	36	-	20	16
Rate	94.4%	-	100.0%	100.0%
Change from Previous Year	-	-	-	30.8%

**2010 INDETERMINATE: Paper medical records to the EMR lab values greater than two years were not in the EMR. Therefore, without pulling all old paper medical records this SOC could not be determined at time of review.*

Hepatitis C Screening (HAB Group 2)

Percentage of clients for whom Hepatitis C screening was performed at least once since diagnosis of HIV infection.

Year	2011	2010*	2009	2008
Number of HIV-infected clients who have documented Hepatitis C infection status in the health record	34	-	20	16
Number of clients receiving OAMC.	36	-	20	16
Rate	94.4%	-	100.0%	100.0%
Change from Previous Year	-	-	-	30.8%

*2010 INDETERMINATE: Paper medical records to the EMR lab values greater than two years were not in the EMR. Therefore, without pulling all old paper medical records this SOC could not be determined at time of review.

Mental Health Screening (HAB Group 2)

Percentage of clients with HIV infections who have had a mental health screening.

	2011	2010	2009	2008
Number of client records with documented mental health screening	36	19	20	16
Number of HIV-positive clients who had at least one medical visit with a provider with prescribing privileges, i.e. MD, PA, NP in the measurement year	36	19	20	16
Rate	100.0%	100.0%	100.0%	100.0%
	-	-	-	-

Substance Abuse Screening (HAB Group 3)

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

	2011	2010	2009	2008
Number of client records with documented substance abuse screening	36	19	20	16
Number of HIV-positive clients who had at least one medical visit with a provider with prescribing privileges, i.e. MD, PA, NP in the measurement year	36	19	20	16
Rate	100.0%	100.0%	100.0%	100.0%
	-	-	-	-

Tobacco Use Screening and Cessation Counseling (HAB Group 3)

Percentage of clients with HIV infection who received tobacco cessation counseling within the measurement year

	2011	2010	2009	2008
Number of client records with documentation that addresses smoking cessation	20	11	6	2
Number of HIV-infected clients with a medical visit within review period who smoke.	24	12	9	2
Rate	83.3%	91.7%	66.7%	100.0%
	-8.4%	25%	-33.3	75%

Nutritional Health Screening

Percentage of clients with HIV infections who have had a nutritional screening.

	2011	2010	2009	2008
Number of client records with documented substance abuse screening	36	19	20	16
Number of HIV-positive clients who had at least one medical visit with a provider with prescribing privileges, i.e. MD, PA, NP in the measurement year	36	19	20	16
Rate	100.0%	100.0%	100.0%	100.0%
	-	-	-	-

Immunizations – Influenza (HAB Group 3)

Percentage of clients with HIV infection who have received influenza vaccination with the measurement year.

Year	2011	2010	2009	2008
Number of HIV-infected clients who received an influenza vaccination within the measurement year.	18	14	16	14
Number of clients receiving OAMC that were eligible to receive an influenza vaccination.	30	14	16	16
Rate	60.0%	100.0%	100.0%	87.5
Change from Previous Year	-40.0%	-	12.5%	-4.8%

Immunization – Tetanus/Diphtheria

Percentage of clients with HIV infection who have received a Tetanus/Diphtheria vaccination in the last 10 years.

Year	2011	2010	2009	2008
Number of HIV-infected clients who showed evidence of receiving a Tetanus/Diphtheria vaccination in the past 10 years.	22	7	13	12
Number of clients receiving OAMC that were eligible to receive a Tetanus/Diphtheria vaccination.	30	11	17	15
Rate	73.3%	63.6%	76.5%	80.0%
Change from Previous Year	9.7%	-12.9%	-3.5%	-4.6%

Immunization - Pneumovax (HAB Group 3)

Number of HIV-infected clients who showed evidence of receiving a pneumovax vaccination in the past 5 years.

Year	2011	2010	2009	2008
Number of HIV-infected clients who showed evidence of receiving a pneumovax vaccination in the past 5 years.	24	5	15	15
Number of clients receiving OAMC that were eligible to receive a Pneumovax vaccination.	30	12	18	16
Rate	80.0%	41.7%	83.3%	93.8%
Change from Previous Year	38.3%	-41.6%	-10.5%	1.5%

Immunization – Hepatitis A

Number of HIV-infected clients with documentation of having ever completed the vaccination for Hepatitis A. *(Not a data element for 2007 Chart Review)*

Year	2011	2010	2009
Number of HIV-infected clients with documentation of having ever completed the vaccination for Hepatitis A.	4	2	8
Number of clients receiving OAMC that were eligible to receive a Hepatitis A vaccination.	13	11	18
Rate	30.8%	18.2%	44.4%
Change from Previous Year	12.6%	-26.2	-5.6%

Immunization – Hepatitis B (HAB Group 2)

Percentage of clients with HIV infection who completed the vaccination series for Hepatitis B.

Year	2011	2010	2009	2008
Number of HIV-infected clients with documentation of having ever completed the vaccination series for Hepatitis B	14	4	11	8
Number of clients receiving OAMC that were eligible to receive a Hepatitis B vaccination.	18	11	14	13
Rate	77.8%	36.4%	78.6%	61.5%
Change from Previous Year	41.4%	-42.2%	17.1%	-7.7

Women's Health – Pap Smear (HAB Group 2)

Percentage of women with HIV infection who have Pap screening results documented in the measurement year

Year	2011	2010	2009	2008
Number of HIV-infected female clients who had Pap screen order documented in the measurement year	9	7	4	6
Number of HIV-infected female clients reviewed.	11	10	7	6
Rate	81.8%	70.0%	57.1%	100.0%
Change from Previous Year	11.8%	12.9%	-42.9%	-

If PAP is abnormal was there follow-up

Year	2011	2010	2009	2008
Number of HIV-infected female clients had abnormal results and showed evidence of follow-up.	0	1	1	4
Number of HIV-infected female clients who had abnormal results requiring follow-up.	0	1	1	4
Rate	-	100.0%	100.0%	100.0%
Change from Previous Year	-	-	-	-

Women's Health - Mammogram

Percentage of HIV-infected female clients who are over 50 years of age and have had a mammogram in the measurement year.

Year	2011	2010	2009	2008
Number of HIV-infected female clients who are over 50 years of age and have had a mammogram in the measurement year.	10	7	3	4
Number of HIV-infected female clients who are over 50 years of age.	12	8	6	4
Rate	83.3%	87.5%	50.0%	100.0%
Change from Previous Year	-4.2%	37.5%	-50.0%	-

Education – Medication Adherence (HAB Group 2)

Percentage of clients with HIV infection on ARV's who were assessed for adherence.

Year	2011	2010	2009	2008
Percentage of clients with HIV infection on ARVs who were assessed and counseled for adherence two or more times in the measurement year.	33	18	18	16
Number of HIV-infected clients who were prescribed HAART during the measurement year.	36	19	20	16
Rate	91.7%	94.7%	90.0%	100.0%
Change from Previous Year	-3.0%	4.7%	-10.0%	-

Education – Clinical Trials Information

Number of HIV-infected clients, who were counseled/provided education on the availability of clinical trials in the measurement year.

Year	2010	2010	2009	2008
Number of HIV-infected clients, who were counseled/provided education on the availability of clinical trials in the measurement year.	36	18	20	5
Number of HIV-positive clients who had at least one medical visit with a provider with prescribing privileges, i.e. MD, PA, NP in the measurement year.	36	19	20	16
Rate	100.0%	94.7%	100.0%	31.3%
Change from Previous Year	5.3%	-5.3%	68.7%	-68.7

Education – Preconception Counseling Information

Number of HIV-infected clients, who were counseled/provided preconception pre-pregnancy counseling in the measurement year.

Year	2011	2010	2009	2008
Number of HIV-infected clients, who were counseled/provided preconception pre-pregnancy counseling in the measurement year.	8	3	4	3
Number of eligible HIV- infected female clients.	8	3	4	5
Rate	100.0%	100.0%	100.0%	60.0%
Change from Previous Year	-	-	40.0%	-40.0%

Oral Exam (HAB Group 2)

Percent of clients with HIV infection who received an oral exam by a dentist at least once during the measurement year.

Year	2011	2010	2009	2008
Number of HIV-positive clients who had an oral exam by a dentist during the measurement year, based on patient self report or other documentation such as a referral	33	10	20	7
Number of HIV-positive clients who had at least one medical visit with a provider with prescribing privileges, i.e. MD, PA, NP in the measurement year	36	19	20	16
Rate	91.7%	52.6%	100.0%	43.8%
Change from Previous Year	39.1%	-47.4%	56.2%	-56.2%

Conclusion

Overall, there has been an increase in performance from the previous year. Twenty-three data elements show an increase or remained the same (79.3%) and six data elements showed a decrease (20.7%).

Eight data elements out of 29 (27.6%) were at 100% threshold. Fourteen (48.3%) data elements were between 100 and 90 percent threshold.

HAB measures

Among the twenty-three (22) HRSA HAB measures thirteen (17), (77.3%) showed an increase or remained the same from the previous year. Five (22.7%) showed a decrease from the previous year. This is an increase in overall compliance from last year.



CASE MANAGEMENT SERVICES
2011 CHART REVIEW

PREFACE

DSHS Monitoring Requirements

The Texas Department of State Health Services (DSHS) contracts with The Houston Regional HIV/AIDS Resource Group, Inc. (TRG) to ensure that Ryan White Part B and State of Texas HIV Services funding is utilized to provide in accordance to negotiated Priorities and Allocations for the designated Health Service Delivery Area (HSDA). In Houston, the HSDA is a ten-county area including the following counties: Austin, Chambers, Colorado, Fort Bend, Harris, Liberty, Montgomery, Walker, Waller, and Wharton. As part of its General Provisions for Grant Agreements, DSHS also requires that TRG ensures that all Subgrantees comply with statutes and rules, perform client financial assessments, and delivery service in a manner consistent with established protocols and standards.

As part of those requirements, TRG is required to perform annual quality compliance reviews on all Subgrantees. Quality Compliance Reviews focus on issues of administrative, clinical, consumer involvement, data management, fiscal, programmatic and quality management nature. Administrative review examines Subgrantee operating systems including, but not limited to, non-discrimination, personnel management and Board of Directors. Clinical review includes review of clinical service provision in the framework of established protocols, procedures, standards and guidelines. Consumer involvement review examines the Subgrantee's frame work for gather client feedback and resolving client problems. Data management review examines the Subgrantee's collection of required data elements, service encounter data, and supporting documentation. Fiscal review examines the documentation to support billed units as well as the Subgrantee's fiscal management and control systems. Programmatic review examines non-clinical service provision in the framework of established protocols, procedures, standards and guidelines. Quality management review ensures that each Subgrantee has systems in place to address the mandate for a continuous quality management program.

QM Component of Monitoring

As a result of quality compliance reviews, the Subgrantee receives a list of findings that must be address. The Subgrantee is required to submit an improvement plan to bring the area of the finding into compliance. This plan is monitored as part of the Subgrantee's overall quality management monitoring. Additional follow-up reviews may occur (depending on the nature of the finding) to ensure that the improvement plan is being effectively implemented.

Scope of Funding

TRG contracts with four Subgrantees to provide case management services in the Houston HSDA. Two providers target rural areas of the HSDA. These areas are designated North of Harris County and West of Harris County.

INTRODUCTION

Description of Service

Case Management is a working agreement between a client and a case manager for a defined period of time based on the client's acuity. The purpose of case management is to assist clients with the procurement of needed services so that the problems associated with living with HIV are mitigated. Direct case management services include any activities with a client (face-to-face or by telephone), communication with other service providers or significant others to access client services, client acuity assessment, monitoring client care, and accompanying clients to services. Indirect activities include travel to and from a client's residence or agency, staff meetings, supervision, community education, documentation, and computer input. The focus of the Case Management Services will be to provide short-term intensive intervention by case managers which will address service linkage, medical needs and psychosocial needs depending on client need followed by long-term availability of information, referrals and intermittent interventions, if required. Clients at all levels of acuity will be served. The Case Manager will perform Mental Health and Substance Abuse/Use Assessments. Service Plan must reflect an ongoing discussion of Mental Health treatment and/or substance abuse treatment per client need.

Tool Development

The TRG Case Management Clinical review tool is based upon the established local and DSHS standards of care.

Chart Review Process

All charts were reviewed by Bachelors-degree registered nurse experienced in treatment, management, and clinical operations in HIV of over 10 years. The collected data for each site was recorded directly into a preformatted computerized database. The data collected during this process is to be used for service improvement.

File Sample Selection Process

File sample was selected from a provider population of 969 who accessed case management services between 1/1/2011 – 12/31/2011. The records of 78 clients were reviewed, representing 8% of the unduplicated population. The demographic makeup of the provider was used as a key to file sample pull.

Report Structure

A categoral reporting structure was used. The report is as follows:

- Assessment
- Service Plan Development
- Medication Readiness
- Coordination of Services
- Progress Notes
- Screenings
- Referrals
- Follow-up

FINDINGS

Case Management Assessment

Medical case management is to complete a comprehensive assessment with the client no later than 10 working days from initial contact. Chart review finding indicate:

	Yes	Not Completed (>10 days)	Unknown	N/A
Comprehensive Assessment Completed within 10 working days	65	13	0	0
Number of HIV-infected clients with a medical or clinical case management visit within review period.	78	78	78	78
Rate	83.3%	16.7%	-	-

Service Plan Development

Percentage of medically case managed HIV-positive clients who had a service plan that is reflective of their needs, choices, and goals.

	Yes	No	Unknown	N/A
Service plan developed that is unique to the needs, choices, and goals of the client.	75	3		
Number of HIV-infected clients in medical case management and received at least one medical visit with a provider with prescribing privileges in the measurement year.	78	78	78	78
Rate	96.2%	3.8%	-	-

Medication Readiness

Percentage of medically case managed HIV-positive clients who had a completed medication readiness assessment for initiation of highly active antiretroviral therapy (HAART), had a change in HAART, or a recent restart of HAART.

	Yes	No	N/A
Number of client records with documented medication readiness assessment	60	1	0
Number of medical case management clients who: <ul style="list-style-type: none"> • initiated HAART • had a change in HAART • Or recently resumed HAART. 	61	61	61
Rate	98.4%	1.6%	-

Coordination of Services

Percentage of medically case managed HIV-positive clients who had coordination of services across provider organizations and/or between interdisciplinary primary care provider teams.

	Yes	No	N/A
Number of client records with documented coordination of services.	78	0	0
Number of HIV-infected clients in medical case management and received at least one medical visit with a provider with prescribing privileges in the measurement year.	78	78	78
Rate	100.0%	-	-

Progress Notes

Percentage of medically case managed HIV-positive clients who had clear, concise, and comprehensive progress notes in their medical record.

	Yes	No	N/A
Number of client records clear, concise, and comprehensive progress notes.	78	0	0
Number of HIV-infected clients in medical case management and received at least one medical visit with a provider with prescribing privileges in the measurement year.	78	78	78
Rate	100.0%	-	-

Mental Health Screening (HAB Group 2)

Percentage of clients with HIV infection who have had a mental health screening.

	Yes	No	Unknown
Number of client records with documented mental health screening	78	0	0
Number of HIV-infected clients with a medical or clinical case management visit within review period.	78	78	78
Rate	100.0%	-	-

Substance Abuse Screening (HAB Group 3)

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

	Yes	No	Unknown
Number of client records with documented substance abuse screening	78	0	0
Number of HIV-infected clients with a medical or clinical case management visit within review period.	78	78	78
Rate	100.0%	-	-

Nutritional Health Screening

Percentage of clients with HIV infection who have had a nutritional screening.

	Yes	No	Unknown
Number of client records with documented substance abuse screening	58	20	0
Number of HIV-infected clients with a medical or clinical case management visit within review period.	78	78	78
Rate	74.3%	25.7%	-

Tobacco Use and Cessation Counseling (HAB Group 3)

Percentage of clients with HIV infection who received tobacco cessation counseling within the measurement year

	Yes	No	N/A
Number of client records with documentation that addresses smoking cessation	32	6	40
Number of HIV-infected clients with a medical or clinical case management visit within review period who smoke.	38	38	78
Rate	84.2%	15.8%	51.3%

Referrals – Mental Health

Percentage of medically case managed HIV-positive clients who had an identified mental health issue and who have had a referral during the measurement year.

	Yes	No	N/A
Number of client records with documented mental health referral	27	0	51
Number of HIV-infected clients with a medical or clinical case management visit within review period who have an identified mental health issue.	27	27	78
Rate	100%	-	65.4%

Referrals – Substance Abuse

Percentage of medically case managed HIV-positive clients who had an identified substance abuse issue and who have had a referral during the measurement year.

	Yes	No	N/A
Number of client records with documented substance abuse referral	15	4	59
Number of HIV-infected clients with a medical or clinical case management visit within review period who have an identified substance abuse issue.	19	16	78
Rate	78.9%	21.7%	75.6%

Referrals – Nutritional Health

Percentage of medically case managed HIV-positive clients who had an identified nutritional health issue and who have had a referral to a dietitian during the measurement year.

	Yes	No	N/A
Number of client records with documented nutritional referral	16	0	62
Number of HIV-infected clients with a medical or clinical case management visit within review period who have an identified nutritional issue.	16	16	78
Rate	100.0%	-	79.5%

Referrals – Eye Exam

Percentage of medically case managed HIV-positive clients who had a referral for an eye exam.

	Yes	No	N/A
Number of client records with documented vision care referral	33	3	43
Number of HIV-infected clients with a medical or clinical case management visit within review period who have identified vision issues and/or CD4 <50.	35	35	78
Rate	94.3%	5.8%	55.1%

Follow-Up

Percentage of medically case managed HIV-positive clients who had successful completion of at least one service referral

	Yes	No	N/A
Number of client records with documented evidence of follow-up to at least one service referral.	78	0	0
Number of HIV-infected clients with a medical visit within review period who have had a service referral.	78	78	78
Rate	100.0%	-	-

Conclusion

2011 showed an improvement over all in case management. Seven out 14 (50%) of the data elements were 100%. This is an increase from 2010 which was 30.8%. 12 out of the total 14 (85.7%) data elements were between 80-100 percent. This was also an increase from the 2010 data, which was 61.6%. Increases were noted in assessments, service plan development, medication readiness, coordination of care, tobacco use and cessation counseling, substance and nutritional referrals, and follow-up documentation. Only two decreases were found: nutritional screening and vision referral. Of the 3 HAB measure data elements case management scored 100% in two of them and 84.2% in the third.

Penn Medicine News

March 5, 2012

CONTACT: Holly Auer

O: 215-349-5659

C: 215-200-2313

holly.auer@uphs.upenn.edu



This release is available online at

http://www.uphs.upenn.edu/news/News_Releases/2012/03/hiv/

One in Four U.S. HIV Patients Don't Stay in Care, Penn Study Shows

More Than Half of Patients Found to Have Long Gaps in Between Appointments

PHILADELPHIA — Only about 75 percent of HIV/AIDS patients in the United States remain in care consistently, according to new research from the [Perelman School of Medicine at the University of Pennsylvania](#) published online this week in *AIDS*. The study of patients across the United States is the first to provide a comprehensive national estimate of HIV care retention and information about patients who are most likely to continue their treatment over time.

"Helping patients with HIV stay in care is a key way to reduce their chances of getting sick from their disease and prevent the spread of HIV in the community. Our findings show that too many patients are falling through the cracks," says the study's lead author, **Baligh R. Yehia, MD**, a fellow in the division of Infectious Disease and the Health Policy Research Program at Penn Medicine. "The benefits of keeping patients in care are clear both for patients and the community at large, and it may even result in decreased health care costs by preventing unnecessary hospitalization for an acute illness."

The researchers studied 17,425 adult patients cared for at 12 clinics within the HIV Research Network, a consortium that cares for HIV-infected patients across the nation, between 2001 and 2008. Just 42 percent of patients studied had what researchers defined as "no gap" in treatment — intervals of no more than six months in between outpatient visits — over the timeframe studied, while 31 percent had one or more seven- to 12-month gaps in care. Twenty-eight percent appeared to have gone without care for more than a year on one or more occasions. Since there is no gold standard on the best way to measure retention in care, the team used three different measures of retention to examine each patient's visit record.

Women, white patients, older patients, male patients who were infected via sex with men, and patients who began treatment on Medicare (compared to those on private insurance) were all more likely to remain in care more consistently. Retention was also greater among patients whose CD4 counts — the measure of how advanced the disease is — were very low, at the point associated with AIDS, when they entered care.

The team suggests that their findings may help guide clinicians in assessing which patients are more likely to follow their prescribed visit schedule, and develop intervention strategies to improve their chances of adhering to their care. "Clinicians need to know what barriers to screen for, so our findings help to better define groups of patients who may require extra help to stay on track," says the study's senior author and Yehia's mentor, Kelly Gebo, MD, an associate professor of Medicine at the Johns Hopkins University School of Medicine. Housing, transportation and financial problems, substance abuse and mental illness can all be contributors to problems with care retention, and patients who don't have symptoms may not believe they're "sick" enough to require regular visits with their providers.

Yehia also notes that a standardized criteria for determining the appropriate time between visits is needed, since patients who are at various stages in their disease, have other health conditions or certain social circumstances may require unique plans for care — thus making it hard to assess aggregate retention across the entire HIV population. And since patients may switch doctors, move frequently, go to jail or become institutionalized and still receive care during those times, the research team suggests additional studies that track patients across those circumstances, such as research involving data from insurance records.

Questions also remain about how HIV treatment retention may change as time passes during what has become, for many, a chronic condition spanning decades of their lives.

"It's possible that as time goes by, some patients may become more regular users of care, while others may become complacent and skip appointments," Yehia says. "We need to better pinpoint times when certain patients may be less likely to remain in treatment and find ways to ensure their continued care."

In addition to Yehia and Josh Metlay, MD, PhD, also from Penn, other authors of the paper include investigators from Hopkins, Oregon Health and Sciences University, and the Agency for Healthcare Research and Quality.

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Penn Medicine is one of the world's leading academic medical centers, dedicated to the related missions of medical education, biomedical research, and excellence in patient care. Penn Medicine consists of the [Raymond and Ruth Perelman School of Medicine at the University of Pennsylvania](#) (founded in 1765 as the nation's first medical school) and the [University of Pennsylvania Health System](#), which together form a \$4.3 billion enterprise.

The Perelman School of Medicine is currently ranked #2 in U.S. News & World Report's survey of research-oriented medical schools. The School is consistently among the nation's top recipients of funding from the National Institutes of Health, with \$479.3 million awarded in the 2011 fiscal year.

The University of Pennsylvania Health System's patient care facilities include: The Hospital of the University of Pennsylvania -- recognized as one of the nation's top 10 hospitals by U.S. News & World Report; Penn Presbyterian Medical Center; and Pennsylvania Hospital — the nation's first hospital, founded in 1751. Penn Medicine also includes additional patient care facilities and services throughout the Philadelphia region.

Penn Medicine is committed to improving lives and health through a variety of community-based programs and activities. In fiscal year 2011, Penn Medicine provided \$854 million to benefit our community.

How the Affordable Care Act Helps People Living with HIV/AIDS: 2011 and Beyond

In 2010, President Obama signed the [Affordable Care Act](#) into law. The health care law ends the worst practices of the insurance industry, such as dropping people's coverage when they get sick. The law also offers Americans strong consumer protections, more coverage options, and lower costs.

The Affordable Care Act is particularly important for people living with HIV/AIDS (PLWHAs), as well as other people living with serious medical conditions. Historically, getting—and keeping—private health insurance has been difficult for many PLWHAs. They have faced barriers to finding qualified providers to care for their needs. The law makes significant progress in addressing these concerns and in advancing the rights of PLWHAs consistent with the goals of the President's [National HIV/AIDS Strategy](#).

Improving Access to Coverage and Protecting People with HIV/AIDS Now

Currently, fewer than one in five (13%) people living with HIV has private insurance and nearly 24% do not have any coverage at all. The rest are covered by government programs including [Medicaid](#), the federal-state program that provides health care benefits to low-income people and those living with disabilities; [Medicare](#), the federal program for seniors and people with disabilities; and the [Ryan White HIV/AIDS Program](#), which provides HIV-related services for those who do not have enough health care coverage or the financial resources to cope with their HIV disease.

The Affordable Care Act helps address coverage issues and provides new protections for patients and consumers. Many important features of the law went into effect soon after President Obama signed it in 2010. For example:

- Insurance companies can no longer deny coverage to children because of their HIV or AIDS or any other pre-existing condition.
- Insurers cannot rescind coverage for adults or children except in cases of fraud or intentional misrepresentation of a material fact.
- Insurers can no longer impose a lifetime dollar limit on essential health benefits.
- [AIDS Drug Assistance Program](#) (ADAP) benefits are now considered as contributions toward a Medicare beneficiary's true Out of Pocket Spending Limit for drug coverage, a huge relief for low-income beneficiaries living with HIV and AIDS because it helps them move through the "donut hole" more quickly.

These changes will begin to help people living with HIV/AIDS find—and keep—health insurance now.

Medicaid Expansion, Insurance Reforms, and Closing the "Donut Hole"

These changes will also provide an important bridge to 2014, when the Affordable Care Act will take full effect and additional changes in health insurance options will be made available for many Americans. In 2014, all Americans will have access to affordable coverage because of important changes in health insurance options. For example:

- In 2014, the Affordable Care Act will ensure that Medicaid coverage is available to all low-income Americans – including adults with no children – with income below 133% of the federal poverty level (about \$14,500 for an individual and \$29,700 for a family of four) wherever they might live. As a result, low-income adults living with HIV will no longer have to wait for an AIDS diagnosis to become eligible for coverage.
- Insurers will not be able to deny coverage or charge more for anyone who has a pre-existing condition, like HIV/AIDS—or impose annual dollar limits on essential health benefits.
- People without access to employer-sponsored insurance or Medicaid will be able to buy private coverage from [Affordable Insurance Exchanges](#), which are designed to make buying health insurance easier and more affordable. And people with low and middle incomes will have access to Federal premium tax credits that will ensure that this coverage is affordable for them.

The Affordable Care Act also gradually closes the gap in Medicare's prescription drug benefit known as the "donut hole." This will give people with Medicare who are living with HIV and AIDS more resources to pay for life-saving medications. For example:

- Medicare beneficiaries who reached the donut hole in 2010 received a one-time rebate of \$250.
- In 2011, beneficiaries who reach the donut hole receive a 50% discount on covered brand-name drugs while they are in the

donut hole, a considerable savings for people taking costly HIV/AIDS drugs.

- Those discounts for brand-name and generic drugs will grow over the course of the decade until the donut hole is closed.
- As noted above, [AIDS Drug Assistance Program](#) (ADAP) benefits are now considered as contributions toward a Medicare beneficiary's true Out of Pocket Spending Limit for drug coverage, a huge relief for low-income beneficiaries living with HIV and AIDS because it helps them move through the donut hole more quickly.

Ensuring People Have Quality Care, Good Insurance Coverage, and Access to Information

The Affordable Care Act seeks to ensure that people with public or private coverage can find high-quality health care:

- **Better information.** Health insurance plans must provide information in a user-friendly way that clearly explains what is and isn't covered.
- **Quality, comprehensive care.** Individuals and small business that purchase insurance, including people who buy coverage in the Affordable Insurance Exchanges, will have access to a benefit package that equals the scope of a typical employer plan. The package will offer coverage to meet the health care needs of Americans, including prescription drugs, preventive care, chronic disease management, and substance abuse and mental health treatment.
- **Preventive care.** Medicare and many private insurance plans are now required to cover many recommended preventive services, including screening for HIV, mammograms and other cancer screenings, with absolutely no cost-sharing for patients. This will help people living with HIV/AIDS stay healthy.
- **Coordinated care.** The Affordable Care Act calls for new investments to help providers manage chronic disease. The law also recognizes the value of patient-centered [medical homes](#) as a way to strengthen the quality of care, especially for people with complex chronic conditions such as HIV. Medical homes provide a way to offer coordinated, integrated, and comprehensive care that has proven to be particularly effective for treating people living with HIV.

Increasing Opportunities for Health, Well-Being, and Cultural Competency

Health care coverage is a key issue for people living with HIV/AIDS, but their overall health is also influenced by other economic, social, and physical factors. The Affordable Care Act acknowledges the importance of these other factors by addressing:

- **Prevention and wellness.** The law makes critical investments in prevention, wellness, and public health activities to improve public health surveillance, community-based programs, and outreach efforts. The law requires many insurance plans to offer HIV screening tests for at-risk people at no additional cost to them—making it more likely they will get tested and, if necessary, get access to life-saving treatment more quickly. And starting in 2012, the law also requires many plans to provide coverage without cost-sharing of HIV and other STI counseling for all sexually active women.
- **Diversity and cultural competency.** The Affordable Care Act expands initiatives to strengthen [cultural competency training](#) for all health care providers and ensure all populations are treated equitably. It also bolsters the Federal commitment to reducing health disparities—another key aspect of the President's National HIV/AIDS Strategy. In addition, HHS has released its first-ever, department-wide [Action Plan to Reduce Health Disparities](#), which outlines goals, strategies and actions HHS will take to reduce health disparities among racial and ethnic minorities.
- **Health care providers for underserved communities.** A key recommendation of the National HIV/AIDS Strategy is to increase the number and diversity of available clinical-care providers and related services for people living with HIV. Today, a network of more than 1,100 community health centers operates 8,100 sites that provide care to nearly 19.5 million people throughout the country. The health care law expands the health care workforce and increases funding for [community health centers](#) — an important safety net for low-income individuals and families. Expanding the health care workforce can improve access to care for vulnerable populations like people living with HIV/AIDS. Already, investments in the National Health Service Corps program have allowed for nearly three times the number of clinicians working in underserved communities across America than there were three years ago. This increased the number from 3,600 Corps members in 2008 to more than 10,000 clinicians in 2011.

PLWHAs often face challenges in finding health care coverage, treatment options, and accessing care. President Obama signed the Affordable Care Act into law so that all Americans would have stronger consumer protections, more coverage options, and lower costs. The law helps improve access to comprehensive quality health care, thereby improving the health and well-being of all PLWHAs.

For more information, visit: www.healthcare.gov or <http://www.cuidadodesalud.gov>

Posted on: November 9, 2011

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March 6, 2012

New IAPAC Recommendations on Getting and Keeping People in Care for HIV

Addressing a key issue in the HIV/AIDS epidemic, the International Association of Physicians in AIDS Care (IAPAC) has released “Guidelines for Improving Entry Into and Retention in Care and Antiretroviral Adherence for Persons With HIV: Evidence-Based Recommendations.” The recommendations were published March 5 ahead of print in the *Annals of Internal Medicine*.

While it is well established that entering care immediately after an HIV diagnosis, staying in care and adhering to antiretroviral (ARV) therapy are necessary steps on the road to successfully controlling the virus, figuring out how to ensure that people living with the virus take these steps has turned out to be a challenge. The Centers for Disease Control and Prevention (CDC) estimates that only half of people living with HIV in the United States are receiving regular medical care, and far fewer have their virus under control with ARVs. Numerous studies have been undertaken to address this challenge. Until now, they have not been compiled and assessed based on their results.

“Over the last 15 years, we have made astounding progress in HIV treatment, resulting in longer and healthier lives for people living with HIV,” Melanie A. Thompson, MD, co-chair of the IAPAC panel said in a press release accompanying the guidelines. “Yet many people are unable to optimally benefit from these advances.” The guidelines, Thompson continued, are geared to address the problems that interfere with ARV access and adherence, leading to viral resistance and possibly treatment failure. Successful retention in care and ARV adherence have been shown to reduce the transmission of HIV. They also help solve the issues of viral resistance and treatment failure—in addition to improving the lives of HIV-positive people.

The guidelines, compiled by a group of 20 health care professionals including Tim Horn, editor-in-chief of AIDSmeds.com, list and discuss 37 recommendations along with several suggestions for future research. The list, accumulated from 325 evidence-based studies, includes a review of successful interventions to monitor adherence to care and medication doses and improve adherence among special populations (including homeless people, pregnant women, incarcerated people and children and adolescents).

Among the key recommendations:

- Self-reported adherence should be routinely obtained from all patients.
- Once-daily ARV regimens and fixed-dose combinations should be used where possible.
- Adherence tools such as interactive reminder devices should be accompanied by one-on-one adherence education.
- The practice of directly observing people take their medications (Directly Administered Antiretroviral Therapy, or DAART) should not be used generally, but should be considered for special groups such as IV-drug users and currently or recently incarcerated people.
- Case management should be provided to assist HIV-positive people who experience food or housing insecurity or transportation needs, and for children and adolescents.

In their recommendations for future research, the authors suggest investigating the success of using HIV biomarkers (measuring blood levels of ARVs) as part of adherence monitoring, and analyzing the cost effectiveness of various interventions.

“These guidelines are the foundation of an evolving blueprint that practitioners and health systems can use as a resource to improve entry into and retention in HIV care as well as adherence to HIV treatments,” Thompson said. To follow up on the recommendations, IAPAC plans to create a continuing education program to educate providers about the recommendations in the new guidelines.

To read the IAPAC recommendations, [click here](#).