

FY 2015 Houston EMA 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: 03/03/14)	
HRSA Service Category Title: RWGA Only	1. Outpatient/Ambulatory Medical Care 2. Medical Case Management 3. AIDS Pharmaceutical Assistance (local) 4. Case Management (non-Medical)
Local Service Category Title:	Adult Comprehensive Primary Medical Care - CBO <ol style="list-style-type: none"> i. Community-based Targeted to African American ii. Community-based Targeted to Hispanic iii. Community-based Targeted to White/MSM
Amount Available: RWGA Only	Total estimated available funding: <u>\$0.00</u> (to be determined) <ol style="list-style-type: none"> 1. Primary Medical Care: <u>\$0.00</u> (including MAI) <ol style="list-style-type: none"> i. Targeted to African American: <u>\$0.00</u> (incl. MAI) ii. Targeted to Hispanic: <u>\$0.00</u> (incl. MAI) iii. Targeted to White: <u>\$0.00</u> 2. LPAP <u>\$0.00</u> 3. Medical Case Management: <u>\$0.00</u> <ol style="list-style-type: none"> i. Targeted to African American <u>\$0.00</u> ii. Targeted to Hispanic <u>\$0.00</u> iii. Targeted to White <u>\$0.00</u> 4. Service Linkage: <u>\$0.00</u> <p>Note: The Houston Ryan White Planning Council (RWPC) determines overall annual Part A and MAI service category allocations & reallocations. RWGA has sole authority over contract award amounts.</p>
Target Population:	Comprehensive Primary Medical Care – Community Based <ol style="list-style-type: none"> i. Targeted to African American: African American ages 13 or older ii. Targeted to Hispanic: Hispanic ages 13 or older iii. Targeted to White: White (non-Hispanic) ages 13 or older
Client Eligibility: Age, Gender, Race, Ethnicity, Residence,	PLWHA residing in the Houston EMA (prior approval required for non-EMA clients). Contractor must adhere to Targeting requirements and Budget limitations as applicable.

etc.	
Financial Eligibility:	<i>See FY 2015 Approved Financial Eligibility for Houston EMA/HSDA</i>
Budget Type: RWGA Only	Hybrid Fee for Service
Budget Requirement or Restrictions: RWGA Only	<p>Primary Medical Care:</p> <p>No less than 75% of clients served in a Targeted subcategory must be members of the targeted population with the following exceptions:</p> <p>100% of clients served with MAI funds must be members of the targeted population.</p> <p>10% of funds designated to primary medical care must be reserved for invoicing diagnostic procedures at actual cost.</p> <p>Contractors may not exceed the allocation for each individual service component (Primary Medical Care, Medical Case Management, Local Pharmacy Assistance Program and Service Linkage) without prior approval from RWGA.</p> <p>Local Pharmacy Assistance Program (LPAP):</p> <p>Houston RWPC guidelines for Local Pharmacy Assistance Program (LPAP) services: Contractor shall offer HIV medications from an approved formulary for a total not to exceed \$18,000 per contract year per client. Contractor 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 Ryan White LPAP funding.</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 with managing the medication inventory or distribution.</p>
Service Unit	<ul style="list-style-type: none"> • Outpatient/Ambulatory Medical Care: One (1) unit of

<p>Definition/s:</p> <p>RWGA Only</p>	<p>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 or clinical nurse specialist examination of the patient, and • Medication/treatment education • Medication access/linkage • OB/GYN specialty procedures (as clinically indicated) • Nutritional assessment (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. • 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 or qualified Psychiatric Nurse Practitioner. This visit may or may not occur on the same date as a primary care office visit. • Nutritional Assessment and Plan: 1 unit of service = A single comprehensive nutritional assessment and treatment plan performed by a Licensed, Registered Dietician initiated upon a physician's order. Does not include the provision of Supplements or other products (clients may be referred to the Ryan White funded Medical Nutritional Therapy provider for provision of medically necessary supplements). The nutritional assessment visit may or may not occur on the same date as a medical office visit. • 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. • Medical Case Management: 1 unit of service = 15 minutes of direct medical case management services to an eligible
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	<p>PLWHA performed by a qualified medical case manager.</p> <ul style="list-style-type: none"> • 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>	<ul style="list-style-type: none"> • 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 and provision of specialty care (includes all medical subspecialties). Primary medical care 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. • AIDS Pharmaceutical Assistance (local) 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. • 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

	<p>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> <ul style="list-style-type: none"> • Case Management (non-Medical) 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.
Standards of Care:	<p>Contractors 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.</p>
Local Service Category Definition/Services to be Provided:	<p>Outpatient/Ambulatory Primary Medical 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 Contractor 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>Services provided to women shall further include OB/GYN physician & physician extender services on-site or by referral, 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</p>

coordination, and social services. The Contractor 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).

Outpatient/Ambulatory Primary Medical Care must provide:

- 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 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 DHHS HIV treatment guidelines. Rapid advances in HIV treatment protocols require that the Contractor 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.
- On-site Outpatient Psychiatry services.
- On-site Medical Case Management services.
- 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.

Services for women must also provide:

- 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 or by referral 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;

Nutritional Assessment: 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. 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. Clients are limited to one (1) nutritional assessment per calendar year without prior approval of RWGA.

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 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. ART) must be assessed for adherence to treatment at every clinical encounter using the EMA's approved adherence assessment tool. 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 Psychiatric Nurse Practitioner.

Outpatient Psychiatric Services:

The program must 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. 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.

Screening for Eye Disorders: Contractor must ensure that patients receive appropriate screening and treatment for CMV, glaucoma, cataracts, and other related problems.

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 only those on the 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 not include drugs available to the patient from other programs or payers or free of charge (such as birth control and TB medications) or medications available over the counter (OTC) without prescription.

Contractor must offer all medications on the Texas ADAP formulary, for a total not to exceed \$18,000.00 per contract year per client. Contractor must provide allowable HIV-related medications (i.e. non-HIV medications) for a total not to exceed \$3,000 per contract year per client. Contractor 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.

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, including an assessment of the patient's health literacy, 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 appointment adherence. 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.

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 Medical Case Management per RWGA Quality Management guidelines. Service Linkage is both office-based and field based. Service Linkage Workers are expected to coordinate activities 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). Contractor 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

	<p>pass vouchers and gas cards per published RWGA guidelines. Service Linkage complements and extends the service delivery capability of Medical Case Management services.</p>
Agency Requirements:	<p>Providers and system must be Medicaid/Medicare certified.</p> <p>Eligibility and Benefits Coordination: Contractor must implement consumer-friendly, culturally and linguistically appropriate new and ongoing patient eligibility verification and benefit coordination processes that ensure accountability with Ryan White Payer of Last Resort requirements while achieving maximum utilization of eligible benefits. Eligibility processes should provide clients with a meaningful understanding of their benefits, expected out-of-pocket expenses and other information needed to ensure full and continued participation in care.</p> <p>LPAP Services: Contractor must:</p> <p>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 RWGA.</p> <p>Either directly, or via subcontract with an eligible 340B Pharmacy program entity, must:</p> <p>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.</p> <p>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 RWGA.</p> <p>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.</p> <p>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.</p>

	<p>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. Contractor must maintain 340B Program participation throughout the contract term. All eligible medications must be purchased in accordance with Program 340B guidelines and program requirements.</p> <p>Ensure Houston area HIV/AIDS service providers are informed of this program and how the client referral and enrollment processes functions. Contractor must maintain documentation of such marketing efforts.</p> <p>Implement a consistent process to enroll eligible patients in available pharmaceutical company Patient Assistance Programs prior to using Ryan White Part A funded LPAP resources.</p> <p>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>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>Case Management Operations and Supervision: The Service Linkage Workers (SLW) and Medical Case Managers (MCM) must function within the clinical infrastructure of Contractor and receive ongoing supervision that meets or exceeds published Standards of Care. An MCM may supervise SLWs.</p>
Staff Requirements:	<p>Contractor is 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, clinical nurse specialists, 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. In addition, Contractor</p>

must ensure the following staff requirements are met:

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.

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 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 adherence education and counseling.

Nutritional Assessment (primary care): Services must be provided by a licensed registered dietician. Dieticians must have a minimum of two (2) years of experience providing nutritional assessment and counseling to PLWHA.

Medical Case Management: The program must utilize a state licensed Social Worker to provide Medical Case Management Services. The Contractor must maintain the assigned number of Medical Case Management FTEs throughout the contract term.

Contractor must provide to RWGA the names of each Medical Case Manager and the individual assigned to supervise those Medical Case Managers by 03/30/15, and thereafter within 15 days after hire.

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. Contractor must maintain the assigned number of Service Linkage

	<p>FTEs throughout the contract term. Contractor must provide to RWGA the names of each Service Linkage Worker and the individual assigned to supervise those Service Linkage Workers by 03/30/15, and thereafter within 15 days after hire.</p> <p>Supervision of Case Managers: The Service Linkage Workers and Medical Case Managers must function within the clinical infrastructure of Contractor 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>
Special Requirements:	<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>Contractor must provide all required program components - Primary Medical Care, Medical Case Management, Service Linkage (non-medical Case Management) and Local Pharmacy Assistance Program (LPAP) services.</p> <p>Primary Medical Care Services: 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 may be eligible for reimbursement under Ryan White Health Insurance Assistance (HINS) program guidelines. Patients needing such assistance should be referred to the local Ryan White-funded HINS provider for assistance. Under no circumstances may the Contractor 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 Contractor based on their reimbursement status (i.e. Medicaid/Medicare eligible clients may not be referred elsewhere in order that non-Medicaid/Medicare eligible clients may be added to the contract). Failure to serve Medicaid/Medicare eligible clients based on their reimbursement status will be grounds for the immediate termination of contract.</p> <p>For primary medical care services targeted to the Latino community at least 50% of the clinical care team must be fluent</p>

in Spanish.

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 will be reimbursed at invoice cost. 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.**

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.

Maintaining Referral Relationships (Point of Entry Agreements): Contractor 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 Health System 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 Contractor and appropriate point of entry entities and are subject to audit by RWGA. Contractor 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: Contractor must comply with CPCDMS business rules and procedures. Contractor 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. Contractor must perform Registration updates in accordance with RWGA CPCDMS business rules for all clients wherein Contractor is client's CPCDMS record-owning agency. Contractor must utilize an electronic verification system to verify insurance/3rd party payer status monthly or per visit (whichever is less frequent).

Bus Pass Distribution: The County will provide Contractor 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. Contractor may only issue METRO bus pass vouchers to clients wherein the Contractor is the CPCDMS record owning Contractor. METRO bus pass 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 CPCDMS registration update the Contractor 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. Contractor may issue METRO bus passes to eligible clients living outside the METRO service area in those situations where the Contractor 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.

Gas Cards: Primary Medical Care Contractors 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. Gas Cards are only available to Rural primary medical care Contractors without prior approval by RWGA.

FY 2015 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		Date: 04/07/2014
Recommendations:	Financial Eligibility:	
1.		
2.		
3.		
4.		

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HRSA Service Category Title: RWGA Only	1. Outpatient/Ambulatory Medical Care 2. Medical Case Management 3. AIDS Pharmaceutical Assistance (local) 4. Case Management (non-Medical)
Local Service Category Title:	Adult Comprehensive Primary Medical Care i. Targeted to Public Clinic ii. Targeted to Women at Public Clinic
Amount Available: RWGA Only	Total estimated available funding: <u>\$0.00</u> (to be determined) 1. Primary Medical Care: <u>\$0.00</u> (including MAI) i. Targeted to Public Clinic: <u>\$0.00</u> ii. Targeted to Women at Public Clinic: <u>\$0.00</u> 2. LPAP <u>\$0.00</u> 3. Medical Case Management: <u>\$0.00</u> i. Targeted to Public Clinic: <u>\$0.00</u> ii. Targeted to Women at Public Clinic: <u>\$0.00</u> 4. Service Linkage: <u>\$0.00</u> 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.
Target Population:	Comprehensive Primary Medical Care – Community Based i. Targeted to Public Clinic ii. Targeted to Women at Public Clinic
Client Eligibility: Age, Gender, Race, Ethnicity, Residence, etc.	PLWHA residing in the Houston EMA (prior approval required for non-EMA clients). Contractor must adhere to Targeting requirements and Budget limitations as applicable.
Financial Eligibility:	<i>See FY 2015 Approved Financial Eligibility for Houston EMA/HSDA</i>
Budget Type:	Hybrid Fee for Service

RWGA Only	
<p>Budget Requirement or Restrictions:</p> <p>RWGA Only</p>	<p>Primary Medical Care:</p> <p>100% of clients served under the <i>Targeted to Women at Public Clinic</i> subcategory must be female</p> <p>10% of funds designated to primary medical care must be reserved for invoicing diagnostic procedures at actual cost.</p> <p>Contractors may not exceed the allocation for each individual service component (Primary Medical Care, Medical Case Management, Local Pharmacy Assistance Program and Service Linkage) without prior approval from RWGA.</p> <p>Local Pharmacy Assistance Program (LPAP):</p> <p>Houston RWPC guidelines for Local Pharmacy Assistance Program (LPAP) services: Contractor shall offer HIV medications from an approved formulary for a total not to exceed \$18,000 per contract year per client. Contractor 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 Ryan White LPAP funding.</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 with managing the medication inventory or distribution.</p>
<p>Service Unit Definition/s:</p> <p>RWGA Only</p>	<ul style="list-style-type: none"> • Outpatient/Ambulatory Medical Care: One (1) unit of service = One (1) primary care office/clinic visit which includes the following: • Primary care physician/nurse practitioner, physician's assistant or clinical nurse specialist examination of the patient, and • Medication/treatment education • Medication access/linkage • OB/GYN specialty procedures (as clinically indicated)

- Nutritional assessment (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.
- 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 or qualified Psychiatric Nurse Practitioner. This visit may or may not occur on the same date as a primary care office visit.
- Medication Education: 1 unit of service = A single pharmacy visit wherein a Ryan White eligible client is provided medication education services by a qualified pharmacist. This visit may or may not occur on the same date as a primary care office visit. Maximum reimbursement allowable for a medication education visit may not exceed \$50.00 per visit. The visit must include at least one prescription medication being provided to clients. A maximum of one (1) Medication Education Visit may be provided to an individual client per day, regardless of the number of prescription medications provided.
- Nutritional Assessment and Plan: 1 unit of service = A single comprehensive nutritional assessment and treatment plan performed by a Licensed, Registered Dietician initiated upon a physician's order. Does not include the provision of Supplements or other products (clients may be referred to the Ryan White funded Medical Nutritional Therapy provider for provision of medically necessary supplements). The nutritional assessment visit may or may not occur on the same date as a medical office visit.
- 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.

	<ul style="list-style-type: none"> • 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. • 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:</p> <p>RWGA Only</p>	<ul style="list-style-type: none"> • 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 and provision of specialty care (includes all medical subspecialties). Primary medical care 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. • AIDS Pharmaceutical Assistance (local) 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. • 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

	<p>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> <ul style="list-style-type: none"> • Case Management (non-Medical) 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.
Standards of Care:	Contractors 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.

<p>Local Service Category Definition/Services to be Provided:</p>	<p>Outpatient/Ambulatory Primary Medical 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 Contractor 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>Services provided to women shall further include OB/GYN physician & physician extender services on-site or by referral, 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 Contractor 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>Outpatient/Ambulatory Primary Medical Care 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 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 DHHS HIV treatment guidelines. Rapid advances in HIV treatment protocols require that the Contractor 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. • On-site Outpatient Psychiatry services. • On-site Medical Case Management services.
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- 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.

Women’s Services must also provide:

- 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 or by referral 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;

Nutritional Assessment: 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. 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. Clients are limited to one (1) nutritional assessment per calendar year without prior approval of RWGA.

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 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. ART) must be assessed for adherence to treatment at every clinical encounter using the EMA’s approved adherence assessment tool. 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 Psychiatric Nurse Practitioner.

Outpatient Psychiatric Services:

The program must 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. 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.

Screening for Eye Disorders: Contractor must ensure that patients receive appropriate screening and treatment for CMV, glaucoma, cataracts, and other related problems.

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 only those on the 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 not include drugs available to the

patient from other programs or payers or free of charge (such as birth control and TB medications) or medications available over the counter (OTC) without prescription.

Contractor must offer all medications on the Texas ADAP formulary, for a total not to exceed \$18,000.00 per contract year per client.

Contractor must provide allowable HIV-related medications (i.e. non-HIV medications) for a total not to exceed \$3,000 per contract year per client. Contractor 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.

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, including an assessment of the patient's health literacy, 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 appointment adherence. 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.

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 Medical Case Management per RWGA Quality Management guidelines. Service Linkage is both office-based and field based. Service Linkage Workers are expected to coordinate activities 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

	<p>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). Contractor 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>
Agency Requirements:	<p>Providers and system must be Medicaid/Medicare certified.</p> <p>Eligibility and Benefits Coordination: Contractor must implement consumer-friendly, culturally and linguistically appropriate new and ongoing patient eligibility verification and benefit coordination processes that ensure accountability with Ryan White Payer of Last Resort requirements while achieving maximum utilization of eligible benefits. Eligibility processes should provide clients with a meaningful understanding of their benefits, expected out-of-pocket expenses and other information needed to ensure full and continued participation in care.</p> <p>LPAP Services: Contractor must:</p> <p>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 RWGA.</p> <p>Either directly, or via subcontract with an eligible 340B Pharmacy program entity, must:</p> <p>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.</p> <p>Ensure the documented capability of interfacing with the Texas HIV Medication Program operated by the Texas Department of State</p>

Health Services. This capability must be fully documented and is subject to independent verification by RWGA.

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. Contractor 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. Contractor must maintain documentation of such marketing efforts.

Implement a consistent process to enroll eligible patients in available pharmaceutical company Patient Assistance Programs prior to using Ryan White Part A funded LPAP resources.

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.

Offer, at no charge to the client, delivery options for medication refills, including but not limited to courier, USPS or other package delivery service.

Case Management Operations and Supervision: The Service Linkage Workers (SLW) and Medical Case Managers (MCM) must

	function within the clinical infrastructure of Contractor and receive ongoing supervision that meets or exceeds published Standards of Care. An MCM may supervise SLWs.
Staff Requirements:	<p>Contractor is 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, clinical nurse specialists, 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. In addition, Contractor must ensure the following staff requirements are met:</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>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 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 adherence education and counseling.</p> <p>Nutritional Assessment (primary care): Services must be provided by a licensed registered dietician. Dieticians must have a minimum of two (2) years of experience providing nutritional assessment and counseling to PLWHA.</p> <p>Medical Case Management: The program must utilize a state licensed Social Worker to provide Medical Case Management Services. The Contractor must maintain the assigned number of Medical Case Management FTEs throughout the contract term.</p> <p>Contractor must provide to RWGA the names of each Medical</p>

Case Manager and the individual assigned to supervise those Medical Case Managers by 03/30/15, and thereafter within 15 days after hire.

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. Contractor must maintain the assigned number of Service Linkage FTEs throughout the contract term. **Contractor must provide to RWGA the names of each Service Linkage Worker and the individual assigned to supervise those Service Linkage Workers by 03/30/15, and thereafter within 15 days after hire.**

Supervision of Case Managers: The Service Linkage Workers and Medical Case Managers must function within the clinical infrastructure of Contractor 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>Special Requirements:</p> <p>RWGA Only</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>Contractor must provide all required program components - Primary Medical Care, Medical Case Management, Service Linkage (non-medical Case Management) and Local Pharmacy Assistance Program (LPAP) services.</p> <p>Primary Medical Care Services: 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 may be eligible for reimbursement under Ryan White Health Insurance Assistance (HINS) program guidelines. Patients needing such assistance should be referred to the local Ryan White-funded HINS provider for assistance. Under no circumstances may the Contractor 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 Contractor based on their reimbursement status (i.e. Medicaid/Medicare eligible clients may not be referred elsewhere in order that non-Medicaid/Medicare eligible clients may be added to the 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 will be reimbursed at invoice cost. 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>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</p>
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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.

Maintaining Referral Relationships (Point of Entry Agreements): Contractor 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 Health System 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 Contractor and appropriate point of entry entities and are subject to audit by RWGA. Contractor 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: Contractor must comply with CPCDMS business rules and procedures. Contractor 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. Contractor must perform Registration updates in accordance with RWGA CPCDMS business rules for all clients wherein Contractor is client's CPCDMS record-owning agency. Contractor must utilize an electronic verification system to verify insurance/3rd party payer status monthly or per visit (whichever is less frequent).

Bus Pass Distribution: The County will provide Contractor 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. Contractor may only issue

METRO bus pass vouchers to clients wherein the Contractor is the CPCDMS record owning Contractor. METRO bus pass 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 CPCDMS registration update the Contractor 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. Contractor may issue METRO bus passes to eligible clients living outside the METRO service area in those situations where the Contractor 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.

Gas Cards: Primary Medical Care Contractors 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. Gas Cards are only available to Rural primary medical care Contractors without prior approval by RWGA.

FY 2015 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		Date: 04/07/2014
Recommendations:	Financial Eligibility:	
1.		
2.		
3.		
4.		

FY 2015 Houston EMA 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 - Rural (Revision Date: 03/03/14)	
HRSA Service Category Title: RWGA Only	1. Outpatient/Ambulatory Medical Care 2. Medical Case Management 3. AIDS Pharmaceutical Assistance (local) 4. Case Management (non-Medical)
Local Service Category Title:	Adult Comprehensive Primary Medical Care - Targeted to Rural
Amount Available: RWGA Only	Total estimated available funding: <u>\$0.00</u> (to be determined) 1. Primary Medical Care: <u>\$0.00</u> 2. LPAP <u>\$0.00</u> 3. Medical Case Management: <u>\$0.00</u> 4. Service Linkage: <u>\$0.00</u> Note: The Houston Ryan White Planning Council (RWPC) determines overall annual Part A and MAI service category allocations & reallocations. RWGA has sole authority over contract award amounts.
Target Population:	Comprehensive Primary Medical Care – Targeted to Rural
Client Eligibility: Age, Gender, Race, Ethnicity, Residence, etc.	PLWHA residing in the Houston EMA/HSDA counties other than Harris County (prior approval required for non-EMA clients). Contractor must adhere to Targeting requirements and Budget limitations as applicable.
Financial Eligibility:	<i>See FY 2015 Approved Financial Eligibility for Houston EMA/HSDA</i>
Budget Type: RWGA Only	Hybrid Fee for Service
Budget Requirement or Restrictions: RWGA Only	Primary Medical Care: No less than 75% of clients served in a Targeted subcategory must be members of the targeted population with the following exceptions: 10% of funds designated to primary medical care must be

	<p>reserved for invoicing diagnostic procedures at actual cost.</p> <p>Contractors may not exceed the allocation for each individual service component (Primary Medical Care, Medical Case Management, Local Pharmacy Assistance Program and Service Linkage) without prior approval from RWGA.</p> <p>Local Pharmacy Assistance Program (LPAP):</p> <p>Houston RWPC guidelines for Local Pharmacy Assistance Program (LPAP) services: Contractor shall offer HIV medications from an approved formulary for a total not to exceed \$18,000 per contract year per client. Contractor 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 Ryan White LPAP funding.</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 with managing the medication inventory or distribution.</p>
<p>Service Unit Definition/s:</p>	<ul style="list-style-type: none"> • Outpatient/Ambulatory Medical Care: One (1) unit of service = One (1) primary care office/clinic visit which includes the following: • Primary care physician/nurse practitioner, physician's assistant or clinical nurse specialist examination of the patient, and • Medication/treatment education • Medication access/linkage • OB/GYN specialty procedures (as clinically indicated) • Nutritional assessment (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

	<p>MD/NP/PA are considered to be a component of the original primary care visit.</p> <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 or qualified Psychiatric Nurse Practitioner. This visit may or may not occur on the same date as a primary care office visit. • Nutritional Assessment and Plan: 1 unit of service = A single comprehensive nutritional assessment and treatment plan performed by a Licensed, Registered Dietician initiated upon a physician's order. Does not include the provision of Supplements or other products (clients may be referred to the Ryan White funded Medical Nutritional Therapy provider for provision of medically necessary supplements). The nutritional assessment visit may or may not occur on the same date as a medical office visit. • 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. • 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. • 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:</p> <p>RWGA Only</p>	<ul style="list-style-type: none"> • 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

	<p>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). Primary medical care 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> <ul style="list-style-type: none">• AIDS Pharmaceutical Assistance (local) 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.• 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 of communication.
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	<ul style="list-style-type: none"> • Case Management (non-Medical) 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.
Standards of Care:	Contractors 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.
Local Service Category Definition/Services to be Provided:	<p>Outpatient/Ambulatory Primary Medical 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 Contractor 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>Services provided to women shall further include OB/GYN physician & physician extender services on-site or by referral, 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 Contractor 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>Outpatient/Ambulatory Primary Medical Care 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 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 DHHS HIV treatment guidelines. Rapid advances in HIV treatment protocols require that the Contractor 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.
- On-site Outpatient Psychiatry services.
- On-site Medical Case Management services.
- 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.

Services for women must also provide:

- 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 or by referral 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;

Nutritional Assessment: 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. 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. Clients are limited to one (1) nutritional assessment

per calendar year without prior approval of RWGA.

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 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. ART) must be assessed for adherence to treatment at every clinical encounter using the EMA's approved adherence assessment tool. 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 Psychiatric Nurse Practitioner.

Outpatient Psychiatric Services:

The program must 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. 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.

Screening for Eye Disorders: Contractor must ensure that patients receive appropriate screening and treatment for CMV, glaucoma,

cataracts, and other related problems.

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 only those on the 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 not include drugs available to the patient from other programs or payers or free of charge (such as birth control and TB medications) or medications available over the counter (OTC) without prescription.

Contractor must offer all medications on the Texas ADAP formulary, for a total not to exceed \$18,000.00 per contract year per client. Contractor must provide allowable HIV-related medications (i.e. non-HIV medications) for a total not to exceed \$3,000 per contract year per client. Contractor 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.

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, including an assessment of the patient's health literacy, 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 appointment adherence. 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.

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

	<p>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 Medical Case Management per RWGA Quality Management guidelines. Service Linkage is both office-based and field based. Service Linkage Workers are expected to coordinate activities 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). Contractor 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>
Agency Requirements:	<p>Providers and system must be Medicaid/Medicare certified.</p> <p>Eligibility and Benefits Coordination: Contractor must implement consumer-friendly, culturally and linguistically appropriate new and ongoing patient eligibility verification and benefit coordination processes that ensure accountability with Ryan White Payer of Last Resort requirements while achieving maximum utilization of eligible benefits. Eligibility processes should provide clients with a meaningful understanding of their benefits, expected out-of-pocket expenses and other information needed to ensure full and continued participation in care.</p> <p>LPAP Services: Contractor must:</p>

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 RWGA.

Either directly, or via subcontract with an eligible 340B Pharmacy program entity, must:

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 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 RWGA.

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. Contractor 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. Contractor must maintain documentation of such marketing efforts.

Implement a consistent process to enroll eligible patients in available pharmaceutical company Patient Assistance Programs prior to using

	<p>Ryan White Part A funded LPAP resources.</p> <p>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>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>Case Management Operations and Supervision: The Service Linkage Workers (SLW) and Medical Case Managers (MCM) must function within the clinical infrastructure of Contractor and receive ongoing supervision that meets or exceeds published Standards of Care. An MCM may supervise SLWs.</p>
Staff Requirements:	<p>Contractor is 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, clinical nurse specialists, 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. In addition, Contractor must ensure the following staff requirements are met:</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>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 HIV/AIDS care, to provide the educational services.</p>

	<p>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 adherence education and counseling.</p> <p>Nutritional Assessment (primary care): Services must be provided by a licensed registered dietician. Dieticians must have a minimum of two (2) years of experience providing nutritional assessment and counseling to PLWHA.</p> <p>Medical Case Management: The program must utilize a state licensed Social Worker to provide Medical Case Management Services. The Contractor must maintain the assigned number of Medical Case Management FTEs throughout the contract term. Contractor must provide to RWGA the names of each Medical Case Manager and the individual assigned to supervise those Medical Case Managers by 03/30/15, and thereafter within 15 days after hire.</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. Contractor must maintain the assigned number of Service Linkage FTEs throughout the contract term. Contractor must provide to RWGA the names of each Service Linkage Worker and the individual assigned to supervise those Service Linkage Workers by 03/30/15, and thereafter within 15 days after hire.</p> <p>Supervision of Case Managers: The Service Linkage Workers and Medical Case Managers must function within the clinical infrastructure of Contractor 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: RWGA Only</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>Contractor must provide all required program components - Primary</p>

Medical Care, Medical Case Management, Service Linkage (non-medical Case Management) and Local Pharmacy Assistance Program (LPAP) services.

Primary Medical Care Services: 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 may be eligible for reimbursement under Ryan White Health Insurance Assistance (HINS) program guidelines. Patients needing such assistance should be referred to the local Ryan White-funded HINS provider for assistance. Under no circumstances may the Contractor 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 Contractor based on their reimbursement status (i.e. Medicaid/Medicare eligible clients may not be referred elsewhere in order that non-Medicaid/Medicare eligible clients may be added to the contract). Failure to serve Medicaid/Medicare eligible clients based on their reimbursement status will be grounds for the immediate termination of contract.

For primary medical care services targeted to the Latino community at least 50% of the clinical care team must be fluent in Spanish.

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 will be reimbursed at invoice cost. 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.**

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.

Maintaining Referral Relationships (Point of Entry Agreements):

Contractor 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 Health System 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 Contractor and appropriate point of entry entities and are subject to audit by RWGA. Contractor 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: Contractor must comply with CPCDMS business rules and procedures. Contractor 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. Contractor must perform Registration updates in accordance with RWGA CPCDMS business rules for all clients wherein Contractor is client's CPCDMS record-owning agency. Contractor must utilize an electronic verification system to verify insurance/3rd party payer status monthly or per visit (whichever is less frequent).

Bus Pass Distribution: The County will provide Contractor 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. Contractor may only issue METRO bus pass vouchers to clients wherein the Contractor is the

CPCDMS record owning Contractor. METRO bus pass 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 CPCDMS registration update the Contractor 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. Contractor may issue METRO bus passes to eligible clients living outside the METRO service area in those situations where the Contractor 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.

Gas Cards: Primary Medical Care Contractors 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. Gas Cards are only available to Rural primary medical care Contractors without prior approval by RWGA.

FY 2015 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		Date: 04/07/2014
Recommendations:	Financial Eligibility:	
1.		
2.		
3.		
4.		

FY 2015 Houston EMA/HSDA Ryan White Part A/MAI Service Definition Comprehensive Outpatient Primary Medical Care including Medical Case Management and Service Linkage Services - Pediatric (Revision Date: 03/03/14)	
HRSA Service Category Title: RWGA Only	1. Outpatient/Ambulatory Medical Care 2. Medical Case Management 3. Case Management (non-Medical)
Local Service Category Title:	Comprehensive Primary Medical Care Targeted to Pediatric
Target Population:	HIV-infected resident of the Houston EMA 0 – 18 years of age. Provider may continue services to previously enrolled clients until the client's 22nd birthday.
Financial Eligibility:	<i>See FY 2015 Approved Financial Eligibility for Houston EMA/HSDA</i>
Budget Type: RWGA Only	Hybrid Fee for Service
Budget Requirement or Restrictions: RWGA Only	Primary Medical Care: 10% of funds designated to primary medical care must be reserved for invoicing diagnostic procedures at actual cost. Contractors may not exceed the allocation for each individual service component (Primary Medical Care, Medical Case Management and Service Linkage) without prior approval from RWGA.
Service Unit Definition/s: RWGA Only	<ul style="list-style-type: none"> • Outpatient/Ambulatory Medical Care: One (1) unit of service = One (1) primary care office/clinic visit which includes the following: • Primary care physician/nurse practitioner, physician's assistant or clinical nurse specialist examination of the patient, and • Medication/treatment education • Medication access/linkage • OB/GYN specialty procedures (as clinically indicated) • Nutritional assessment (as clinically indicated) • Laboratory (as clinically indicated, not including specialized tests) • Radiology (as clinically indicated, not including CAT scan or MRI)

	<ul style="list-style-type: none"> • 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. • 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 or qualified Psychiatric Nurse Practitioner. This visit may or may not occur on the same date as a primary care office visit. • 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. • 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:</p> <p>RWGA Only</p>	<ul style="list-style-type: none"> • 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 and provision of specialty care (includes all medical subspecialties). Primary medical care 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. • Medical Case Management services (including treatment adherence) are a range of client-centered services that link

	<p>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> <ul style="list-style-type: none"> • Case Management (non-Medical) 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.
Standards of Care:	Contractors 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.
Local Service Category Definition/Services to be Provided:	Outpatient/Ambulatory Primary Medical 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 Contractor 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).

Services provided to women shall further include OB/GYN physician & physician extender services on-site or by referral, 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 Contractor 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).

Outpatient/Ambulatory Primary Medical Care must provide:

- 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 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 DHHS HIV treatment guidelines. Rapid advances in HIV treatment protocols require that the Contractor 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.
- On-site Outpatient Psychiatry services.
- On-site Medical Case Management services.
- 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.

Services for females of child bearing age must also provide:

- 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 or by referral 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;

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 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. ART) must be assessed for adherence to treatment at every clinical encounter using the EMA's approved adherence assessment tool. 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 Psychiatric Nurse Practitioner.

Outpatient Psychiatric Services:

The program must 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. 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.

Screening for Eye Disorders: Contractor must ensure that patients receive appropriate screening and treatment for CMV, glaucoma, cataracts, and other related problems.

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, including an assessment of the patient's health literacy, 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 appointment adherence. 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.

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 Medical Case Management per RWGA Quality Management guidelines. Service Linkage is both office-based and field based. Service Linkage Workers are expected to coordinate activities 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

	<p>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). Contractor 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>
Agency Requirements:	<p>Providers and system must be Medicaid/Medicare certified.</p> <p>Eligibility and Benefits Coordination: Contractor must implement consumer-friendly, culturally and linguistically appropriate new and ongoing patient eligibility verification and benefit coordination processes that ensure accountability with Ryan White Payer of Last Resort requirements while achieving maximum utilization of eligible benefits. Eligibility processes should provide clients with a meaningful understanding of their benefits, expected out-of-pocket expenses and other information needed to ensure full and continued participation in care.</p> <p>Case Management Operations and Supervision: The Service Linkage Workers (SLW) and Medical Case Managers (MCM) must function within the clinical infrastructure of Contractor and receive ongoing supervision that meets or exceeds published Standards of Care. An MCM may supervise SLWs.</p>
Staff Requirements:	<p>Contractor is 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, clinical nurse specialists, physician extenders with a colposcopy provider qualification, x-ray technologists, State licensed dieticians, licensed social worker and ancillary health care providers in accordance with</p>

appropriate State licensing and/or certification requirements and with knowledge and experience of HIV disease. In addition, Contractor must ensure the following staff requirements are met:

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.

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 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 adherence education and counseling.

Medical Case Management: The program must utilize a state licensed Social Worker to provide Medical Case Management Services. The Contractor must maintain the assigned number of Medical Case Management FTEs throughout the contract term.

Contractor must provide to RWGA the names of each Medical Case Manager and the individual assigned to supervise those Medical Case Managers by 03/30/15, and thereafter within 15 days after hire.

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. Contractor must maintain the assigned number of Service Linkage FTEs throughout the contract term. **Contractor must provide to RWGA the names of each Service Linkage Worker and the individual assigned to supervise those Service Linkage Workers**

	<p>by 03/30/15, and thereafter within 15 days after hire.</p> <p>Supervision of Case Managers: The Service Linkage Workers and Medical Case Managers must function within the clinical infrastructure of Contractor 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: RWGA Only</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>Contractor must provide all required program components - Primary Medical Care, Medical Case Management and Service Linkage (non-medical Case Management) services.</p> <p>Primary Medical Care Services: 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 may be eligible for reimbursement under Ryan White Health Insurance Assistance (HINS) program guidelines. Patients needing such assistance should be referred to the local Ryan White-funded HINS provider for assistance. Under no circumstances may the Contractor 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 Contractor based on their reimbursement status (i.e. Medicaid/Medicare eligible clients may not be referred elsewhere in order that non-Medicaid/Medicare eligible clients may be added to the 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 will be reimbursed at invoice cost. 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</p>

website must have prior approval by RWGA.

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.

Maintaining Referral Relationships (Point of Entry Agreements): Contractor 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 Health System 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 Contractor and appropriate point of entry entities and are subject to audit by RWGA. Contractor 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: Contractor must comply with CPCDMS business rules and procedures. Contractor 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. Contractor must perform Registration updates in accordance with RWGA CPCDMS business rules for all clients wherein Contractor is client's CPCDMS record-owning agency. Contractor must utilize an electronic verification

system to verify insurance/3rd party payer status monthly or per visit (whichever is less frequent).

Bus Pass Distribution: The County will provide Contractor 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. Contractor may only issue METRO bus pass vouchers to clients wherein the Contractor is the CPCDMS record owning Contractor. METRO bus pass 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 CPCDMS registration update the Contractor 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. Contractor may issue METRO bus passes to eligible clients living outside the METRO service area in those situations where the Contractor 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.

FY 2015 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		Date: 04/07/2014
Recommendations:	Financial Eligibility:	
1.		
2.		
3.		
4.		

Ryan White Part A Quality Management Program – Houston EMA

Primary Care Chart Review FY 2012

Harris County Public Health & Environmental Services –
Ryan White Grant Administration

October 2013

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PREFACE

EXPLANATION OF PART A QUALITY MANAGEMENT

In 2012 the Houston Eligible Metropolitan Area (EMA) awarded Part A funds for adult Outpatient Medical Services to four organizations. Approximately 6,900 unduplicated-HIV positive individuals are serviced by these organizations.

Harris County Public Health & Environmental Services (HCPHES) must ensure the quantity, quality and cost effectiveness of primary medical care. The Ryan White Grant Administration (RWGA) Project Coordinator for Clinical Quality Improvement (PC/CQI) performed the medical services review.

Introduction

On April 8, 2013, the RWGA PC/CQI commenced the evaluation of Part A funded Primary Medical Care Services funded by the Ryan White Part A grant. This grant is awarded to HCPHES by the Health Resources and Services Administration (HRSA) to provide HIV-related health and social services to persons living with HIV/AIDS. The purpose of this evaluation project is to meet HRSA mandates for quality management, with a focus on:

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

A comprehensive review of client medical records was conducted for services provided between 3/1/12 and 2/28/13. The guidelines in effect during the year the patient sample was seen, *Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents: October 14, 2011*, were used to determine degree of compliance. The current treatment guidelines are available for download at: <http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf>. The initial activity to fulfill the purpose was the development of a medical record data abstraction tool that addresses elements of the guidelines, followed by medical record review, data analysis and reporting of findings with recommendations.

Tool Development

The PC/CQI worked with the Clinical Quality Management (CQM) committee to develop and approve data collection elements and processes that would allow evaluation of primary care services based on the *Guidelines for use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents, 2011* that were developed by the Panel on Clinical Practices for Treatment of HIV Infection convened by the U.S. Department of Health and Human Services (DHHS). In addition, data collection elements and processes were developed to align with the Health Resources and Services Administration (HRSA), HIV/AIDS Bureau's (HAB) HIV/AIDS Core Clinical Performance Measures for Adults & Adolescents. These measures are designed to serve as indicators of quality care. HAB measures are available for download at: <http://hab.hrsa.gov/deliverhivaidscares/habperformmeasures.html>. An electronic database was designed to facilitate direct data entry from patient records. Automatic edits and validation screens were included in the design and layout of the data abstraction program to "walk" the nurse reviewer through the process and to facilitate the accurate collection, entering and validation of data. Inconsistent information, such as reporting GYN exams for men, or opportunistic infection prophylaxis for patients who do not need it, was considered when designing validation functions. The PC/CQI then used detailed data validation reports to check certain values for each patient to ensure they were consistent.

Chart Review Process

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

If documentation on a particular element was not found a "no data" response was entered into the database. Some elements require that several questions be answered in an "if, then" format. For example, if a Pap smear was abnormal, then was it repeated at the prescribed interval? This logic tree type of question allows more in-depth assessment of care and a greater ability to describe the level of quality. Using another example, if only one question is asked, such as "was a mental health screening done?" the only assessment that can be reported is how many patients were screened. More questions need to be asked to get at quality and the appropriate assessment and treatment, e.g., if the mental health screening was positive, was the client referred? If the client accepted a referral, were they able to access a Mental Health Provider? For some data elements, the primary issue was not the final report per se, but more of whether the requisite test/exam was performed or not, i.e., STD screening or whether there was an updated history and physical.

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

Tale 1. Data Collection Parameters	
Review Item	Standard
Primary Care Visits	Primary care visits during review period, denoting date and provider type (MD, NP, PA, other). There is no standard of care to be met per se. Data for this item is strictly for analysis purposes only
Annual Exams	Dental and Eye exams are recommended annually
Mental Health	A Mental Health screening is recommended annually screening for depression, anxiety, and associated psychiatric issues
Substance Abuse	Clients should be screened for substance abuse potential at every visit and referred accordingly
Specialty Referrals	This item assesses specialist utilization

Table 1. Data Collection Parameters (cont.)	
Review Item	Standard
Antiretroviral Therapy (ART) adherence	Adherence to medications should be documented at every visit with issues addressed as they arise
Lab	CD4, Viral Load Assays, and CBCs are recommended every 3-6 months. Clients on ART should have a Liver Function Test and a Lipid Profile annually (minimum recommendations)
STD Screen	Screening for Syphilis, Gonorrhea, and Chlamydia should be performed at least annually
Hepatitis Screen	Screening for Hepatitis B and C are recommended at initiation to care. At risk clients not previously immunized for Hepatitis A and B should be offered vaccination.
Tuberculosis Screen	Annual screening is recommended, either PPD or chest X-ray
Cervical Cancer Screen	Women are assessed for at least one PAP smear during the study period
Immunizations	Clients are assessed for annual Flu immunizations and whether they have ever received pneumococcal vaccination.
HIV/AIDS Education	Documentation of topics covered including disease process, staging, exposure, transmission, risk reduction, diet and exercise
Pneumocystis carinii Pneumonia Prophylaxis	Labs are reviewed to determine if the client meets established criteria for prophylaxis
Mycobacterium Avium Complex Prophylaxis	Labs are reviewed to determine if the client meets established criteria for prophylaxis
Toxoplasma Gondii	Clients should be tested for prior exposure to <i>T. gondii</i> by measuring anti- <i>Toxoplasma</i> immunoglobulin G upon initiation of care

The Sample Selection Process

The sample population was selected from a pool of 5,929 clients (adults age 18+) who accessed Part A primary care (excluding vision care) between 3/1/12 and 2/28/13. The medical charts of 597 clients were used in this review, representing 10.1% of the pool of unduplicated clients. The number of clients selected at each site is proportional to the number of primary care clients served there. Two caveats were observed during the sampling process. In an effort to focus on women living with HIV/AIDS health issues, women were over-sampled, comprising 46.1% of the sample population. Second,

providers serving a relatively small number of clients were over-sampled in order to ensure sufficient sample sizes for data analysis.

In an effort to make the sample population as representative of the Part A primary care population as possible, the EMA's Centralized Patient Care Data Management System (CPCDMS) was used to generate the lists of client codes for each site. The demographic make-up (race/ethnicity, gender, age) of clients who accessed primary care services at a particular site during the study period was determined by CPCDMS. A sample was then generated to closely mirror that same demographic make-up. The clinic-specific lists were forwarded to the clinic 10 business days prior to the review.

Characteristics of the Sample Population

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

	Sample		Ryan White Part A Houston EMA	
Gender	Number	Percent	Number	Percent
Male	304	50.9%	4,386	74.72%
Female	275	46.1%	1,492	24.42%
Transgender Male to Female	18	3%	49	0.81%
Transgender Female to Male	0	0%	2	0.05%
TOTAL	597		5,929	
Race				
Asian	10	1.7%	60	1.05%
African-Amer.	280	46.9%	2,882	48.32%
Pacific Islander	2	.3%	7	0.18%
Multi-Race	3	.5%	30	0.39%
Native Amer.	1	.2%	24	0.42%
White	301	50.4%	2,929	49.65%
TOTAL	597		5,929	
Hispanic				
Non-Hispanic	362	60.6%	3,901	66.33%
Hispanic	235	39.4%	2,028	33.67%
TOTAL	597		5,929	

Report Structure

In December 2007, the Health Resource and Services Administration's (HRSA), HIV/AIDS Bureau (HAB) released group 1, in a series of *HIV/AIDS Core Clinical Performance Measures for Adults & Adolescents*¹. All measures included in the 3 group series are intended to serve as indicators for use in monitoring the quality of care provided to patients receiving Ryan White funded clinical care.

HAB performance measures fall within three groups. Each group can be customized as most appropriate to meet the population needs of the various Ryan White HIV/AIDS programs, either at the provider or system level.

- Group 1 measures are intended to serve as a foundation on which to build, and are central to quality HIV/AIDS clinical care. The list of measures included in Group 1 is shorter than in subsequent groups and are intended to be a good starting point for quality improvement activities.
- Group 2 measures are also important indicators of quality HIV/AIDS clinical care. These measures are "next level" measures intended to assist in the development of a well-rounded HIV/AIDS clinical practice and quality management program.
- Group 3 measures are "best practice," measures. However, many of these indicators measure data that is not routinely collected and/or readily available.

This report is arranged so that chart review findings are organized within the HAB HIV/AIDS Core Clinical Performance Measures for Adults & Adolescents 3 group structure. Each section includes the group's measures, and their result. When available, data and results from the 2 preceding years are also provided. Group 1 and Group 2 measures are also depicted with results categorized by race/ethnicity.

¹ <http://hab.hrsa.gov/deliverhivaids/habperformmeasures.html> Accessed May 1, 2012

Findings

HAB Group 1 Performance Measures

ART for Pregnant Women

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

	2010	2011	2012
Number of HIV-infected pregnant women who were prescribed ART during the 2nd and 3rd trimester	17	2	7
Number of HIV-infected pregnant women who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year	18	2	7
Rate	94.4%	100%	100%
Change from Previous Years Results	44.4%	5.6%	0%

2012 ARV Therapy for Pregnant Women by Race*		
	Hispanic	Black
Number of HIV-infected pregnant women who were prescribed antiretroviral therapy during the 2nd and 3rd trimester	4	3
Number of HIV-infected pregnant women who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year	4	3
Rate	100%	100%

*There were no White, non-Hispanic pregnant women in the 2012 sample.

CD4 T-Cell Count

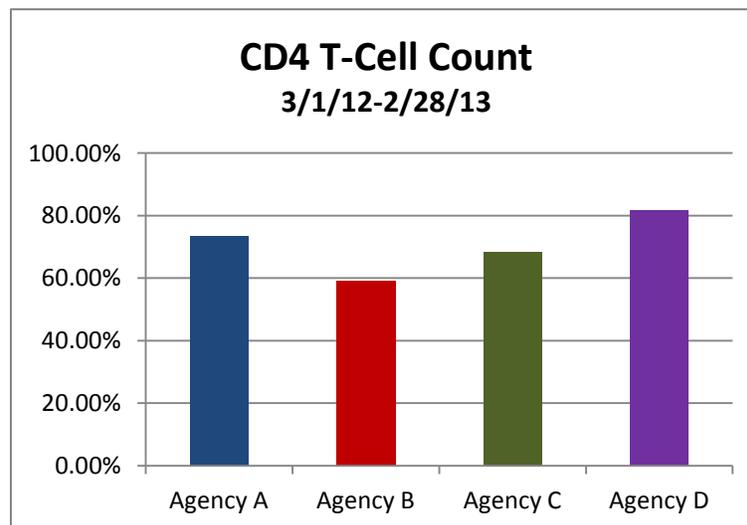
- Percentage of clients with HIV infection who had a CD4 T-cell count performed at least every six months during the measurement year

	2010	2011	2012**
Number of HIV-infected clients who had a CD4 T-cell count performed at least every six months during the measurement year*	509	549	433
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year	563	641	597
Rate	90.4%	85.6%	72.5%
Change from Previous Years Results	1.4%	-4.8%	-13.1%

*2010 used the following numerator "Number of HIV-infected clients who had 2 or more CD4 T-cell counts during the measurement year". The numerator was changed in 2011 and 2012 in order to be consistent with the new HAB viral load monitoring measure.

**In 2011, this measure was met if a client had CD4 T-cell count in each half of the measurement year. Based on HAB guidance, this measure was met in 2012 if a client had two CD4 T-cell counts at least 6 months apart in the measurement year. The decrease in performance for this measure is likely to due to the change in measurement.

2012 CD4 by Race			
	Black	Hispanic	White
Number of HIV-infected clients who had a CD4 T-cell count performed at least every six months during the measurement year	186	183	56
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges ¹ , i.e. MD, PA, NP at least twice in the measurement year	270	235	81
Rate	68.9%	77.9%	69.1%



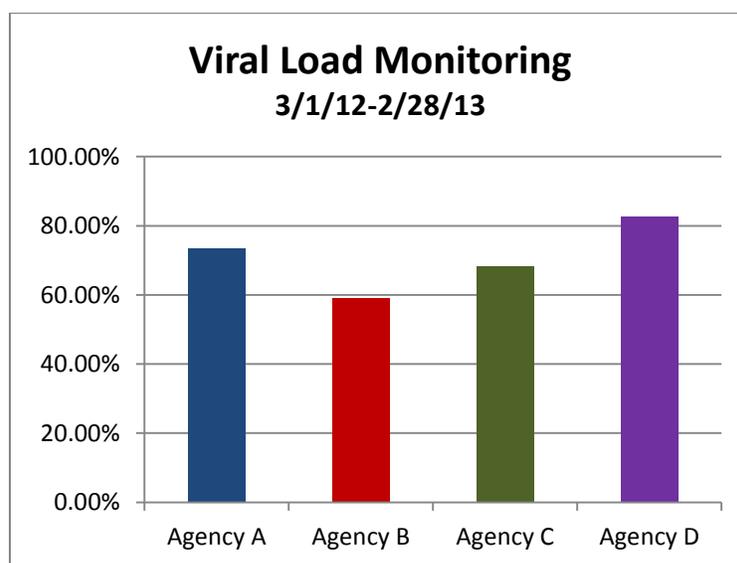
Viral Load Monitoring

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

	2011	2012*
Number of HIV-infected clients who had a viral load test performed at least every six months during the measurement year	549	435
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year	641	597
Rate	85.6%	72.9%
Change from Previous Years Results		-12.7%

* In 2011, this measure was met if a client had one viral load test in each half of the measurement year. Based on HAB guidance, this measure was met in 2012 if a client had two viral load tests at least 6 months apart in the measurement year. The decrease in performance for this measure is likely to due to the change in measurement.

2012 Viral Load by Race			
	Black	Hispanic	White
Number of HIV-infected clients who had a viral load test performed at least every six months during the measurement year	188	183	56
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges ¹ , i.e. MD, PA, NP at least twice in the measurement year	270	235	81
Rate	69.6%	77.9%	69.1%



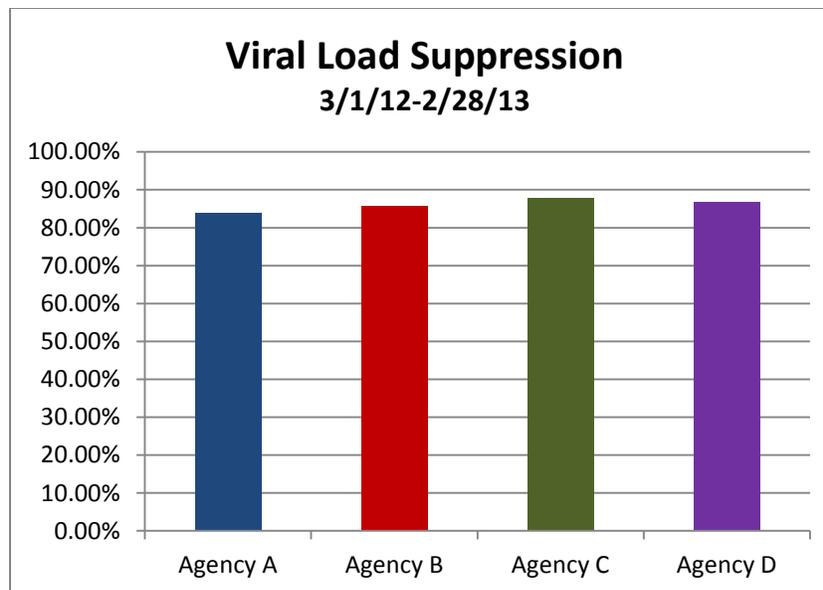
Viral Load Suppression

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

	2011	2012
Number of clients with HIV infection with viral load below limits of quantification at last test during the measurement year	471	448
Number of HIV-infected clients who: <ul style="list-style-type: none"> had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year, and were prescribed ART for at least 6 months 	538	519
Rate	87.5%	86.3%
		-1.2%

❖ HIVQUAL-US Mean 82%, 75th percentile 90%

2012 Viral Load Suppression by Race			
	Black	Hispanic	White
Number of clients with HIV infection with viral load below limits of quantification at last test during the measurement year	189	186	62
Number of HIV-infected clients who: <ul style="list-style-type: none"> had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year, and were prescribed ART for at least 6 months 	223	215	70
Rate	84.8%	86.5%	88.6%



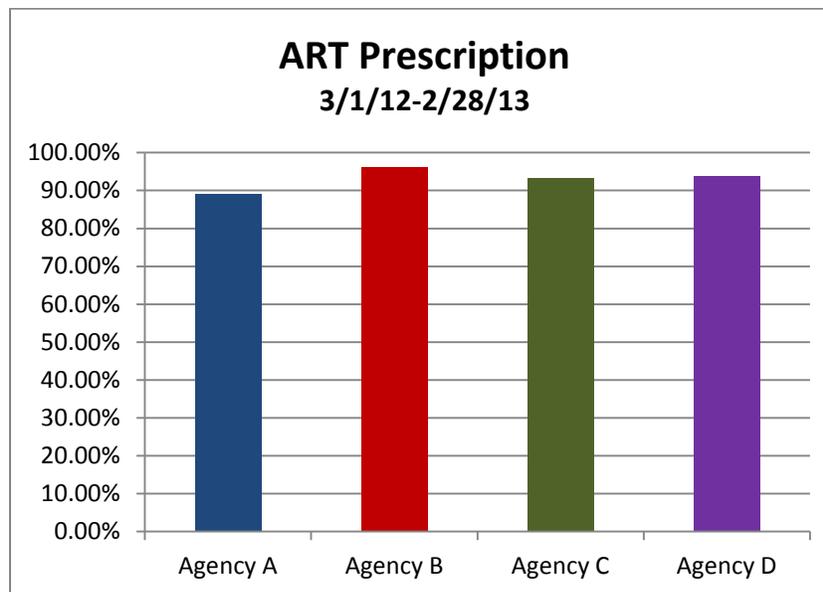
ART Prescription

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

	2011	2012
Number of clients who were prescribed an ART regimen within the measurement year	588	557
Number of clients who: • had at least two medical visit with a provider with prescribing privileges, i.e. MD, PA, NP in the measurement year	641	597
Rate	91.7%	93.3%
Change from Previous Years Results		1.6%

- Of the 40 clients not on ART, none had a CD4 <200

2012 ART Prescription by Race\Ethnicity			
	Black	Hispanic	White
Number of clients who were prescribed an ART regimen within the measurement year	243	227	76
Number of clients who: • had at least two medical visit with a provider with prescribing privileges, i.e. MD, PA, NP in the measurement year	270	235	81
Rate	90%	96.6%	93.8%



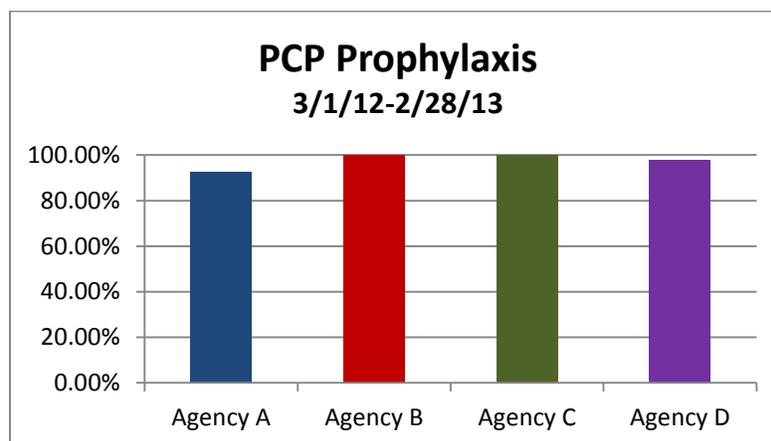
PCP Prophylaxis

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

	2010	2011	2012
Number of HIV-infected clients with CD4 T-cell counts below 200 cells/mm ³ who were prescribed PCP prophylaxis	71	97	90
Number of HIV-infected clients who: • had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year, and • had a CD4 T-cell count below 200 cells/mm ³ , or any other indicating condition	75	97	92
Rate	94.7%	100%	97.8%
Change from Previous Years Results	5.8%	5.3%	-2.2%

❖ HIVQUAL-US Mean 80%, 75th percentile 100%

2012 PCP Prophylaxis by Race/Ethnicity			
	Black	Hispanic	White
Number of HIV-infected clients with CD4 T-cell counts below 200 cells/mm ³ who were prescribed PCP prophylaxis	41	37	11
Number of HIV-infected clients who: • had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least once in the measurement year, and • had a CD4 T-cell count below 200 cells/mm ³ , or any other indicating condition	42	37	12
Rate	97.6%	100%	91.7%



Group 1 HAB HIV core clinical performance measures also includes an indicator for Medical Visits, requiring clients visit a medical provider 2 or more times a year. The measure was not included in the chart review analysis because the sample inclusion criteria requires 2 medical visits.

HAB Group 2 Performance Measures

Adherence Assessment & Counseling

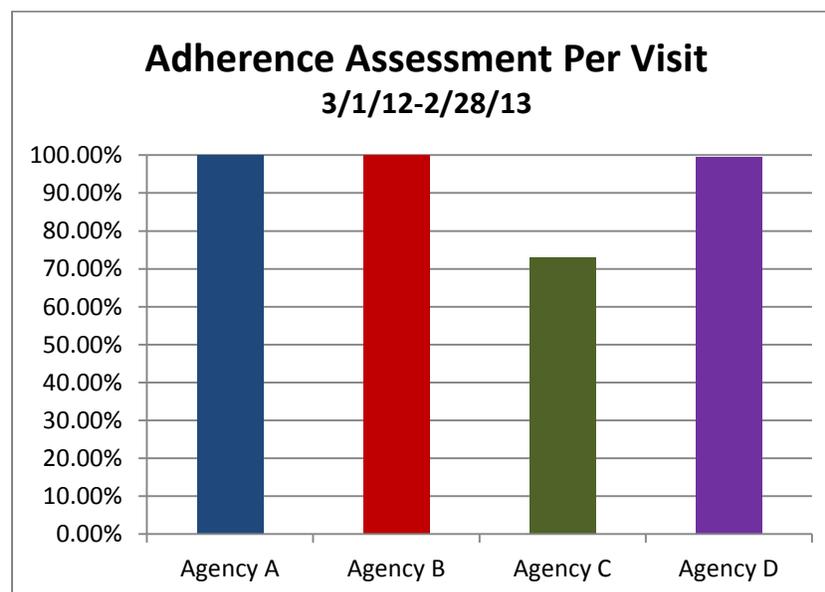
- Percentage of clients with HIV infection on ART who were assessed for adherence*

	Adherence Assessment		
	2010*	2011*	2012*
Number of HIV-infected clients, as part of their primary care, who were assessed for adherence*	386	585	549
Number of HIV-infected clients on ART who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	484	588	557
Rate	79.8%	99.5%	98.6%
Change from Previous Years Results	-6.7%	19.7%	-9%

*HAB measure indicates assessment and counseling should be done 2 or more times a year. However, chart review data was not captured in this way. Data is based on annual assessment.

❖ HIVQUAL-US Mean 96%, 75th percentile 100%

Adherence Assessment Per Visit	
	2012
Number of primary care visits where ART adherence was assessed	1,727
Number of primary care visits for HIV-infected clients on ART who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	1,848
Rate	93.5%



Most Common Reasons Cited for Less Than Excellent Adherence:	Total #
Awaiting ADAP/paperwork issues	10
Side effects	9
Acute illness/hospitalization	7
Life stress	5
Out of care	4

Other reasons with 3 or fewer responses: ran out of meds, jail, depression, financial reasons, lose weight, lack of food to take with meds.

Most Common Interventions Cited:	*Total #
Provider counseling	78
Refer to case management	17
Change Rx	15
Other**	6
Pillbox	2
Side Effect Management	1

* Multiple selections could have been made

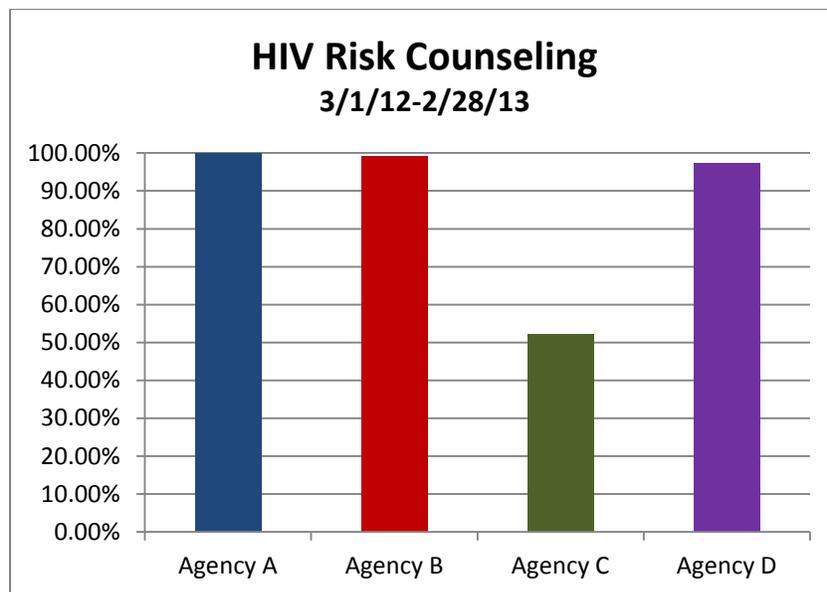
**“Other” typically included referral to psychiatry, behavioral health, or pharmacy education

HIV Risk Counseling

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

	2010	2011	2012
Number of HIV-infected clients, as part of their primary care, who received HIV risk counseling	437	526	510
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	563	641	597
Rate	77.6%	82.1%	85.4%
Change from Previous Years Results	50.7%	4.5%	3.3%

2012 HIV Risk Counseling by Race/Ethnicity			
	Black	Hispanic	White
Number of HIV-infected clients, as part of their primary care, who received HIV risk counseling	240	203	56
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	270	235	81
Rate	88.9%	86.4%	70%



Cervical Cancer Screening

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

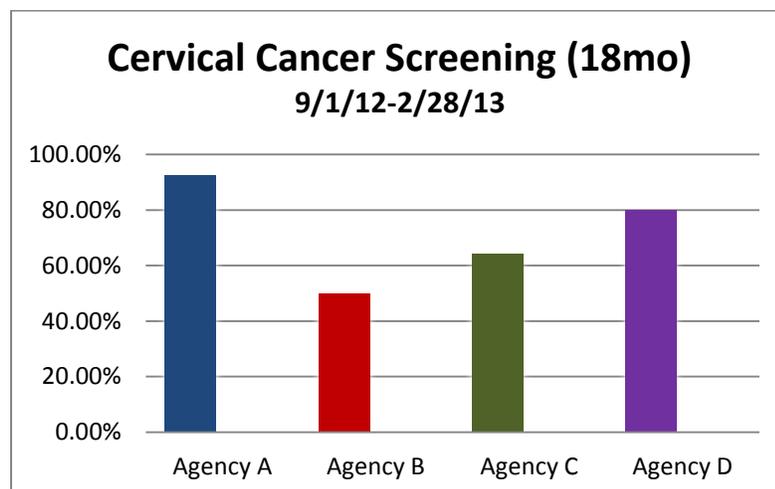
	2010*	2011	2012
Number of HIV-infected female clients who had Pap screen results documented in the measurement year	132	155	145
Number of HIV-infected female clients: <ul style="list-style-type: none"> for whom a pap smear was indicated, and who had a medical visit with a provider with prescribing privileges at least twice in the measurement year* 	232	265	266
Rate	56.9%	58.5%	54.5%
Change from Previous Years Results	3.9%	1.6%	-4%

*2010 denominator stated "Number of HIV-infected female clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year"

❖ **HIVQUAL-US Mean 60%, 75th percentile 75%**

- 18.6% (27/145) of pap smears were abnormal
- 71.4% (190/266) had a pap smear screening within an 18 month measurement period

2012 Cervical Cancer Screening Data by Race/Ethnicity			
	Black	Hispanic	White
Number of HIV-infected female clients who had Pap screen results documented in the measurement year	74	60	8
Number of HIV-infected female clients: <ul style="list-style-type: none"> for whom a pap smear was indicated, and who had a medical visit with a provider with prescribing privileges at least twice in the measurement year 	139	103	21
Rate	53.2%	58.3%	38.1%



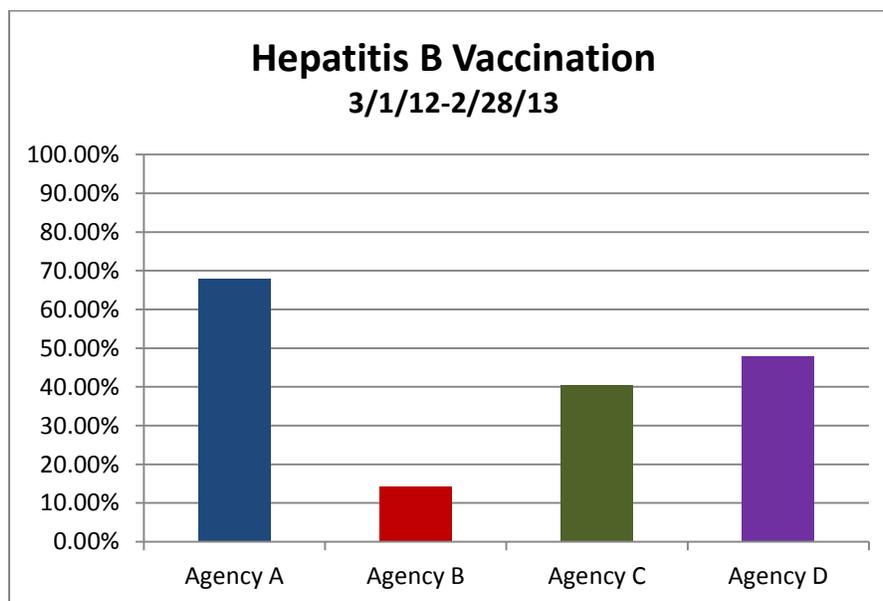
Hepatitis B Vaccination

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

	2010	2011	2012
Number of HIV-infected clients with documentation of having ever completed the vaccination series for Hepatitis B	309	105	143
Number of HIV-infected clients who are Hepatitis B Nonimmune and had a medical visit with a provider with prescribing privileges at least twice in the measurement year*	563	323	333
Rate	54.9%	32.5%	42.9%
Change from Previous Years Results	20.8%	-22.4%	10.4%

*2010 denominator stated "Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year"

2012 Hepatitis B Vaccination by Race/Ethnicity			
	Black	Hispanic	White
Number of HIV-infected clients with documentation of having ever completed the vaccination series for Hepatitis B	50	77	15
Number of HIV-infected clients who are Hepatitis B Nonimmune and had a medical visit with a provider with prescribing privileges at least twice in the measurement year	134	159	36
Rate	37.3%	48.4%	41.7%

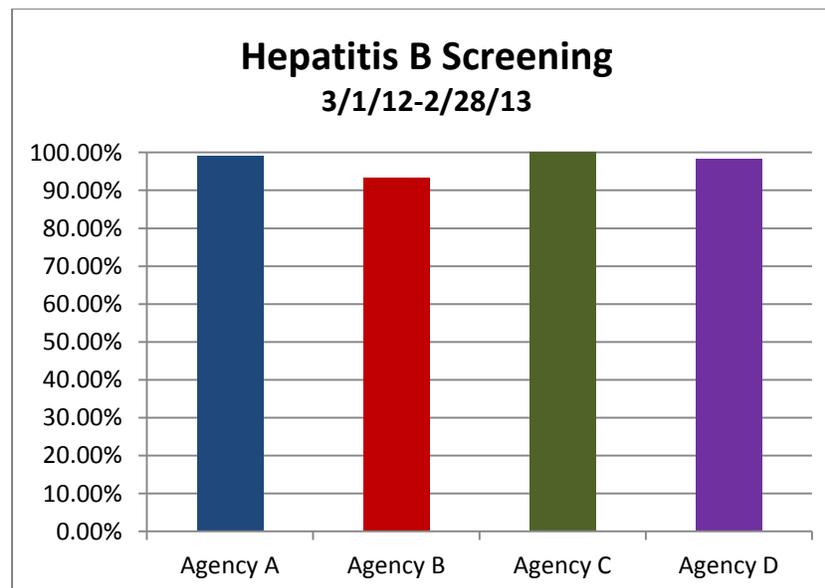


Hepatitis B Screening

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

	2010	2011	2012
Number of HIV-infected clients who have documented Hepatitis B infection status in the health record	456	632	585
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	563	641	597
Rate	80.9%	98.6%	98%
Change from Previous Years Results	6.2%	17.7%	-6%

2012 Hepatitis B Screening by Race/Ethnicity			
	Black	Hispanic	White
Number of HIV-infected clients who have documented Hepatitis B infection status in the health record	263	231	81
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	270	235	81
Rate	97.4%	98.3%	100%



Hepatitis C Screening

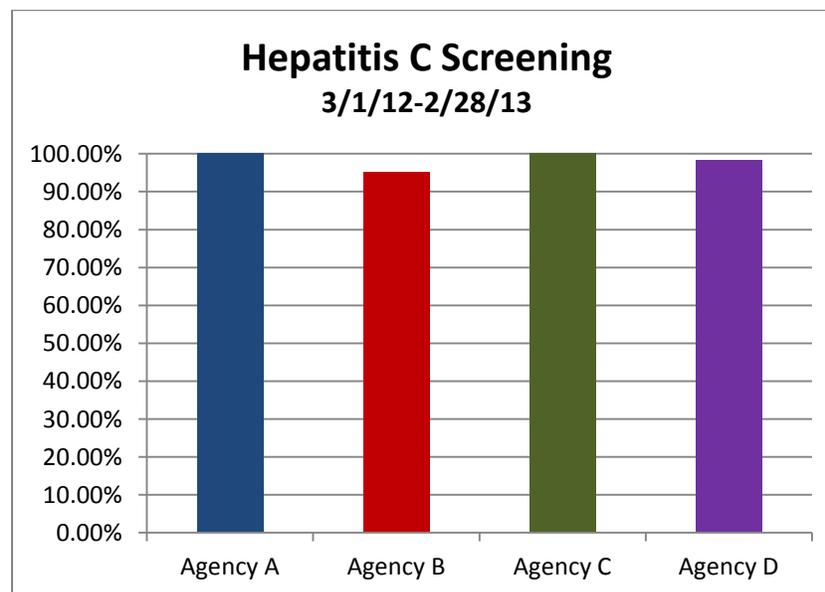
- Percentage of clients for whom Hepatitis C (HCV) screening was performed at least once since diagnosis of HIV infection

	2010	2011	2012
Number of HIV-infected clients who have documented HCV status in chart	401	633	588
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	563	641	597
Rate	71.2%	98.8%	98.5%
Change from Previous Years Results	-4.0%	27.6%	-3%

❖ HIVQUAL-US Mean 94%, 75th percentile 100%

- 6.8% (40/588) were Hepatitis C positive

2012 Hepatitis C Screening by Race/Ethnicity			
	Black	Hispanic	White
Number of HIV-infected clients who have documented HCV status in chart	264	233	81
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	270	235	81
Rate	97.8%	99.1%	100%



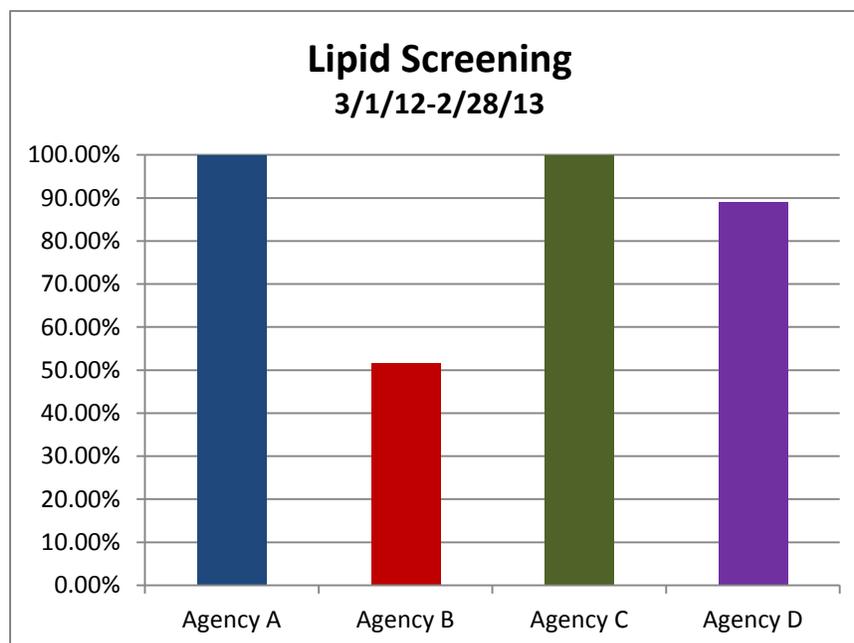
Lipid Screening

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

	2010	2011	2012
Number of HIV-infected clients who: • were prescribed ART, and • had a fasting lipid panel in the measurement year	449	535	485
Number of HIV-infected clients who are on ART and who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	484	588	557
Rate	92.8%	91%	87.1%
Change from Previous Years Results	1.9%	-1.8%	-3.9%

❖ HIVQUAL-US Mean 78%

2012 Lipid Screening by Race/Ethnicity			
	Black	Hispanic	White
Number of HIV-infected clients who: • were prescribed ART, and • had a fasting lipid panel in the measurement year	193	191	64
Number of HIV-infected clients who are on ART and who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	243	227	76
Rate	79.4%	84.1%	84.2%



Oral Exam

- Percent of clients with HIV infection who were referred to a dentist for an oral exam or self-reported receiving a dental exam at least once during the measurement year*

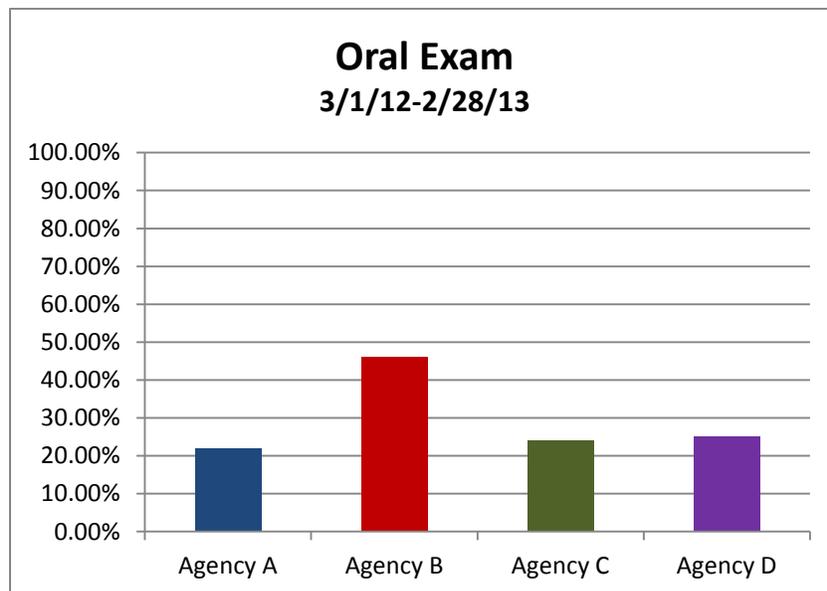
	2010	2011	2012
Number of clients with HIV infection who were referred to a dentist for an oral exam or self-reported receiving a dental exam at least once during the measurement year	1,495	1,371	1,746
Number of clients with HIV infection who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	6,149	6,257	6,356
Rate	24%	22%	27%
Change from Previous Years Results		-2%	5%

*This measure was obtained from CPCDMS

❖ **HIVQUAL-US Mean 36%, 75th percentile 53%**

- Chart review found a 54.4% (325/597) referral to dental care rate

2012 Oral Exam by Race/Ethnicity			
	Black	Hispanic	White
Number of clients with HIV infection who were referred to a dentist for an oral exam or self-reported receiving a dental exam at least once during the measurement year	753	630	951
Number of clients with HIV infection who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	3,124	2,162	3,095
Rate	24%	29%	31%



Syphilis Screening

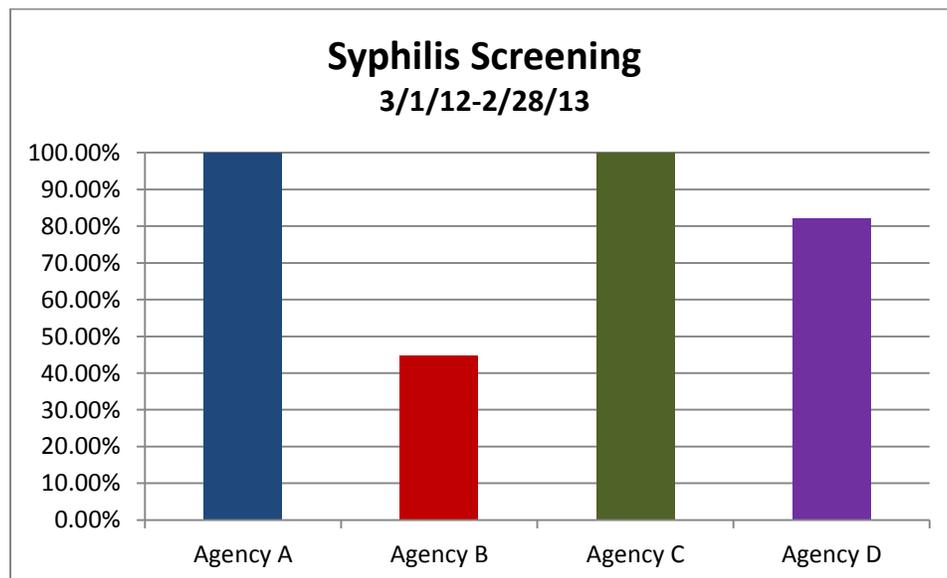
- Percentage of adult clients with HIV infection who had a test for syphilis performed within the measurement year

	2010	2011	2012
Number of HIV-infected clients who had a serologic test for syphilis performed at least once during the measurement year	492	550	499
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	563	641	597
Rate	87.4%	85.8%	83.6%
Change from Previous Years Results	.6%	-1.6%	-2.2%

❖ HIVQUAL-US Mean 82%, 75th percentile 95%

- 5.8% (29/499) new cases of syphilis diagnosed

2012 Syphilis Screening by Race/Ethnicity			
	Black	Hispanic	White
Number of HIV-infected clients who had a serologic test for syphilis performed at least once during the measurement year	222	196	73
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	270	235	81
Rate	82.2%	83.4%	90.1%



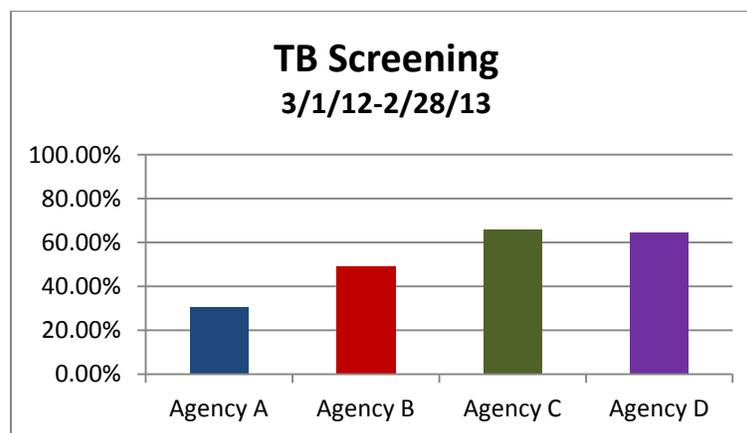
TB Screening

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

	2010	2011	2012
Number of clients who received documented testing for LTBI with any approved test (tuberculin skin test [TST] or interferon gamma release assay [IGRA]) since HIV diagnosis	169	281	310
Number of HIV-infected clients who: <ul style="list-style-type: none"> do not have a history of previous documented culture-positive TB disease or previous documented positive TST or IGRA; and had a medical visit with a provider with prescribing privileges at least twice in the measurement year. 	518	579	550
Rate	32.7%	48.5%	56.4%
Change from Previous Years Results	13.0%	15.8%	7.9%

❖ HIVQUAL-US Mean 67%, 75th percentile 87%

2012 TB Screening by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who received documented testing for LTBI with any approved test (tuberculin skin test [TST] or interferon gamma release assay [IGRA]) since HIV diagnosis	122	133	47
Number of HIV-infected clients who: <ul style="list-style-type: none"> do not have a history of previous documented culture-positive TB disease or previous documented positive TST or IGRA; and had a medical visit with a provider with prescribing privileges at least once in the measurement year. 	244	217	79
Rate	50%	61.3%	59.5%



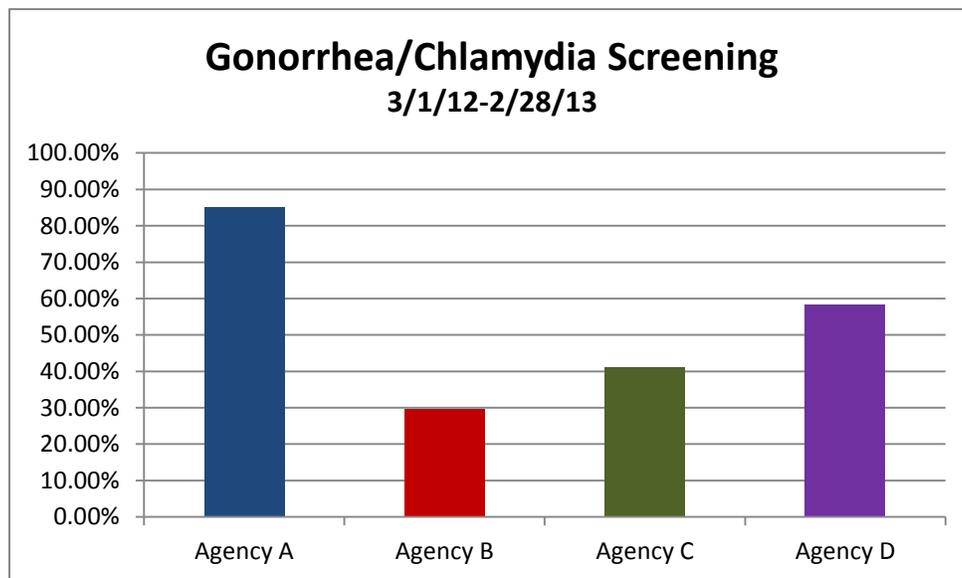
HAB Group 3 Performance Measures

Gonorrhea/Chlamydia Screening

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

	2010	2011	2012
Number of HIV-infected clients who had a test for Gonorrhea/Chlamydia	194	321	314
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	563	638	578
Rate	34.5%	50.3%	54.3%
Change from Previous Years Results	7.3%	15.8%	4%

- ❖ HIVQUAL-US Mean 59%, 75th percentile 84%
- 7 cases of CT and 4 cases of GC were identified



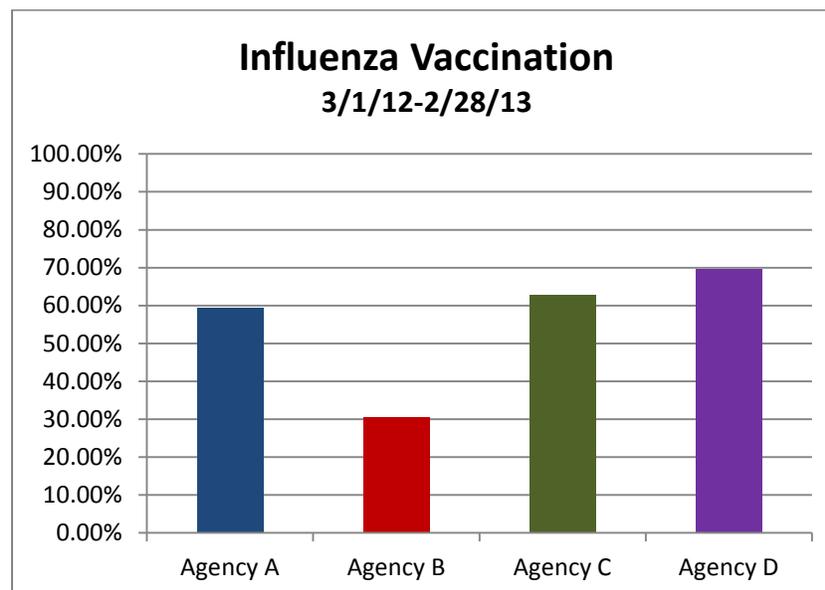
Influenza Vaccination

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

	2010	2011	2012
Number of HIV-infected clients who received influenza vaccination within the measurement year	208	317	353
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement period	563	641	597
Rate	37.1%	49.5%	59.1%
Change from Previous Years Results	-12.4%	12.4%	9.6%

❖ HIVQUAL-US Mean 65%

2012 Influenza Screening by Race/Ethnicity			
	Black	Hispanic	White
Number of HIV-infected clients who received influenza vaccination within the measurement year	149	152	47
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	270	235	81
Rate	55.2%	64.7%	58%

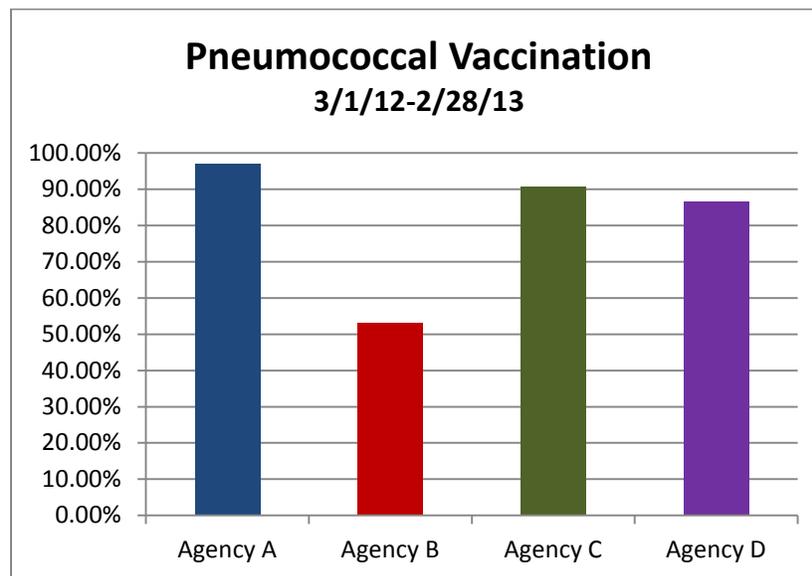


Pneumococcal Vaccination

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

	2011	2012
Number of HIV-infected clients who received pneumococcal vaccination	465	467
Number of HIV-infected clients who: <ul style="list-style-type: none"> had a CD4 count > 200 cells/mm³, and had a medical visit with a provider with prescribing privileges at least twice in the measurement period 	602	562
Rate	77.2%	83.1%
Change from Previous Years Results		5.9%

❖ HIVQUAL-US Mean 70%



Toxoplasma Screening

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

	2010	2011	2012
Number of HIV-infected clients who have documented Toxoplasma status in health record	451	545	502
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement period	563	641	597
Rate	80.1%	85%	84.1%
Change from Previous Years Results	78.0%	4.9%	-.9%

Mental Health Screening

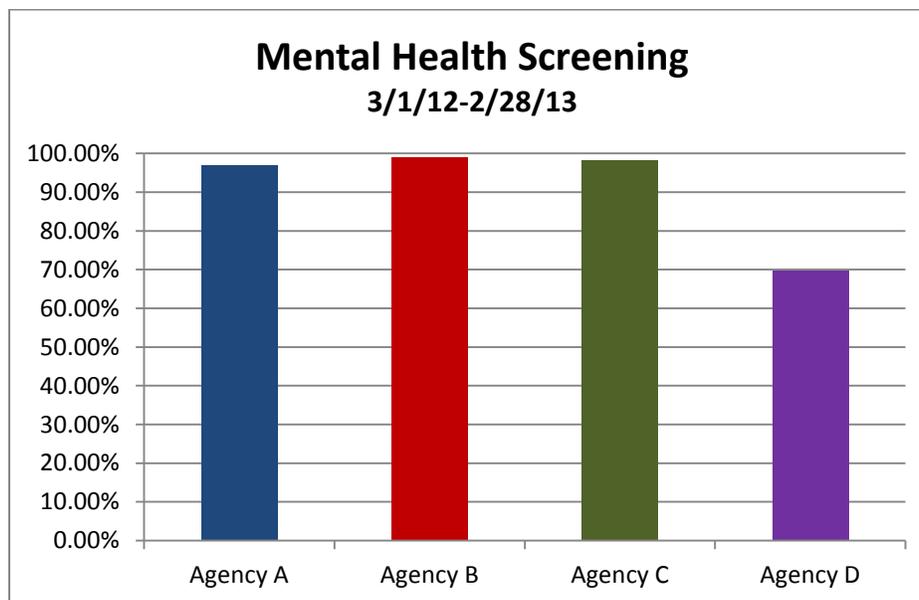
- Percentage of clients with HIV infections who have had a mental health screening*

	2010	2011	2012
Number of HIV-infected clients who received a mental health screening	553	478	522
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement period	563	641	597
Rate	98.2%	74.6%	87.4%
Change from Previous Years Results	29.4%	-23.6%	12.8%

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

❖ **HIVQUAL-US Mean 74%, 75th percentile 95%**

- 32.7% (195/597) had mental health issues. Of the 117 who needed referral, 98 (83.8%) received one



Substance Abuse Screening

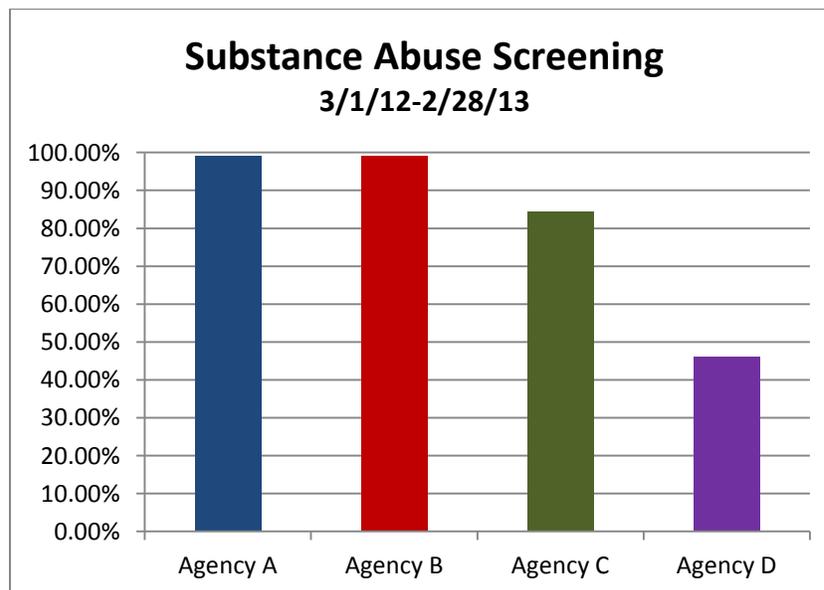
- Percentage of clients with HIV infections who have been screened for substance use (alcohol & drugs) in the measurement year*

	2010	2011	2012
Number of new HIV-infected clients who were screened for substance use within the measurement year	555	506	448
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement period	563	641	597
Rate	98.6%	78.9%	75%
Change from Previous Years Results	22.0%	-19.7%	-3.9%

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

❖ **HIVQUAL-US Mean 86%, 75th percentile 99%**

- 13.3% (45/597) had substance abuse issues. Of the 45 clients who needed referral, 25 (55.6%) received one, and 15 (33.3%) refused.



MAC Prophylaxis

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

	2010	2011	2012
Number of HIV-infected clients with CD4 count < 50 cells/mm ³ who were prescribed MAC prophylaxis	19	31	25
Number of HIV-infected clients who had a: <ul style="list-style-type: none"> CD4 count < 50 cells/mm³ or other defining condition; and medical visit with a provider with prescribing privileges at least twice in the measurement year 	23	33	27
Rate	82.6%	93.9%	92.6%
Change from Previous Years Results	-10.7%	11.3%	-1.3%

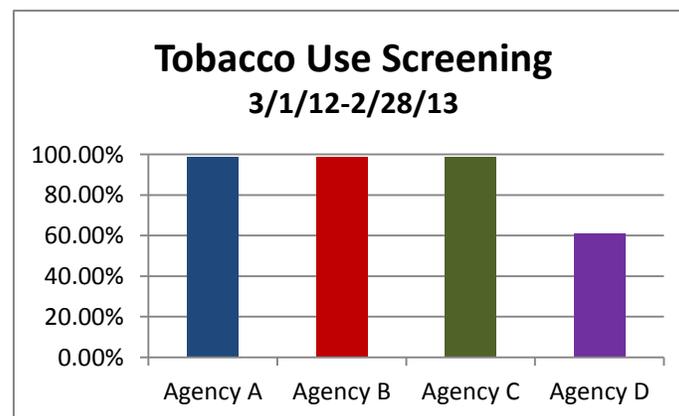
Tobacco Use: screening & cessation intervention

- Percentage of clients with HIV infection who were screened for tobacco use at least once in the measurement year and who received cessation counseling if indicated

	2011	2012
Number of HIV-infected clients who were screened for tobacco use in the measurement period	514	505
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement period	641	597
Rate	80.2%	84.6%
Change from Previous Years Results		4.4%

❖ **HIVQUAL-US Mean 86%**

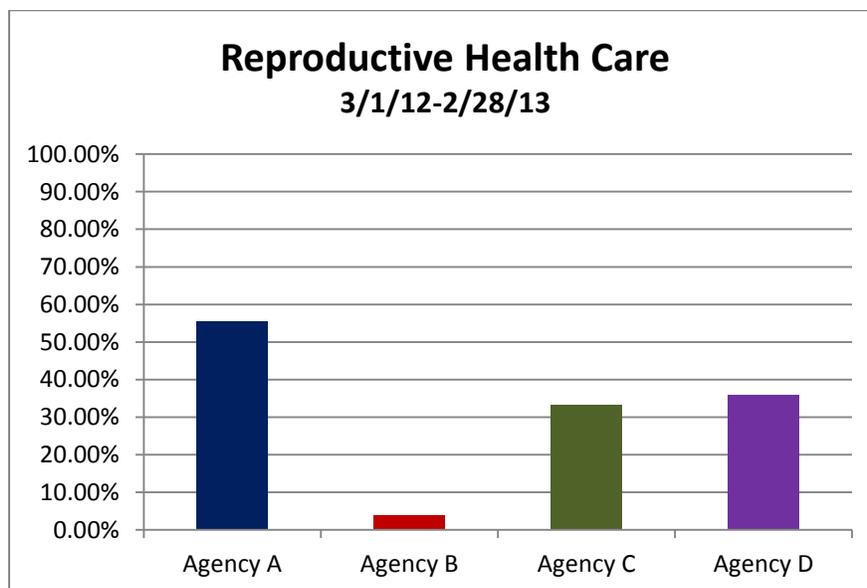
- Of the 505 clients screened, 163 (32.3%) were current smokers.
- Of the 163 current smokers, 85 (52.1%) received smoking cessation counseling, and 8 (4.9%) refused smoking cessation counseling



Other Measures: Reproductive Health Care

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

	2011	2012
Number of HIV-infected reproductive-age women who received reproductive health assessment and care	35	36
Number of HIV-infected reproductive-age women who: <ul style="list-style-type: none"> did not have a hysterectomy or bilateral tubal ligation, and had a medical visit with a provider with prescribing privileges at least twice in the measurement period 	124	112
Rate	28.2%	32.1%



Conclusions

Performance has been relatively stable compared to the 2011 chart review findings. Significant increases in performance were seen for TB screening, mental health screening, and pneumococcal, influenza, and Hepatitis B vaccinations. Decreases in CD4 T-cell and Viral Load monitoring were seen EMA-wide, however, they were most likely due to changes in monitoring these measures based on guidance from HAB. In addition, the Houston EMA performed better than average for most performance measures compared to national benchmarks.

Racial and ethnic disparities continue to be seen for most measures, with African-Americans having lower rates than White and Hispanic clients. Eliminating racial and ethnic disparities in care are a priority for the EMA, and will continue to be a focus for quality improvement.

The Houston EMA performs consistently well on ART prescription, viral load suppression, medication adherence, and Hepatitis B and C screening. Areas for improvement include cervical cancer screening, oral health exams, substance abuse screening, and reproductive health care. Quality improvement projects are currently underway to improve cervical cancer screening rates. Additional research is needed to identify barriers to oral health exams, substance abuse screening and reproductive health care.



OUTPATIENT AMBULATORY MEDICAL CARE
2013 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.

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 patient population of 227 who accessed Ryan White Part B primary care funds between 1/1/2013 – 12/31/2013. The records of 58 clients were reviewed, representing 26% 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	2013	2011	2010	2009
Number of HIV-positive clients who had two or more medical visits in the measurement year		58	35	35	17
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		58	35	36	19
	Rate	100%	100%	97%	90%
	Change from Previous Year	-	3%	7%	-5%

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	2013	2012	2011	2010
Number of HIV-infected clients who had 2 or more CD4 T-cell counts performed at least 3 months apart during the measurement year		58	32	26	17
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.		58	35	36	19
	Rate	100%	91%	72%	90%
	Change from Previous Year	9%	19%	-18%	15%

HAART Medications (HAB Group 1)

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

	Year	2013	2012	2011	2010
Number of clients with AIDS who were prescribed a HAART regimen within the measurement year		57	30	18	10
Number of clients who have a diagnosis of AIDS³ (history of a CD4 T-cell count below 200 cells/mm³ or other AIDS-defining condition), and had at least one medical visit with a provider with prescribing privileges in the measurement year.		57	30	18	10
	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	2013	2012	2011	2010
Number of HIV-infected clients with CD4 T-cell counts below 200 cells/mm³ who were prescribed PCP prophylaxis		14	16	12	12
Number of Charts Reviewed of HIV-infected clients with CD4 T-cell counts below 200 cells/mm³		14	16	12	12
	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	2013	2012	2011	2010
Number of HIV-infected clients with CD4 T-cell counts below 50 cells/mm³ who were prescribed MAC prophylaxis		7	7	5	6
Number of Charts Reviewed of HIV-infected clients with CD4 T-cell counts below 50 cells/mm³ who were prescribed MAC prophylaxis		7	7	5	6
	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	2013	2012	2011	2010
Number of HIV-infected clients who had a serologic test for syphilis performed at least once during the measurement year		53	30	27	16
Number of HIV-positive clients who had at least one medical visit with a provider with prescribing privileges in the measurement year.		28	35	36	19
	Rate	91%	86%	75%	84%
	Change from Previous Year	5%	11%	-9%	4%

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	2013	2012	2011	2010
Number of HIV-infected clients who had a test for Gonorrhea at least once during the measurement year		49	28	23	3
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.		58	35	36	19
	Rate	85%	80%	64%	16%
	Change from Previous Year	5%	16%	48%	4%

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	2013	2012	2011	2010
Number of HIV-infected clients who had a test for Chlamydia at least once during the measurement year		49	28	23	3
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.		58	35	36	19
	Rate	85%	80%	64%	16%
	Change from Previous Year	5%	16%	48%	-4%

TB Screening (HAB Group 2)

Percent of clients with HIV infection who received documented testing for LTBI; Blood test, Chest X-ray, PPD/-Mantoux/TST.

	Year	2012	2011	2010	2009
Number of clients who received documented testing for LTBI at least once during the measurement year.		43	33	25	6
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.		58	35	36	13
	Rate	65%	94%	69%	46%
	Change from Previous Year	-29%	25%	23%	-7.7%

Lipid Screening (HAB Group 2)

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

Year	2013	2012	2011	2010
Number of HIV-Infected Clients who were prescribed a HAART regimen and had a fasting lipid panel in the measurement year.	53	31	35	18
Number of HIV-Infected Clients who were prescribed a HAART regimen.	58	35	36	19
Rate	94%	89%	97%	95%
Change from Previous Year	5%	-8%	2%	30%

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	2013	2012	2011	2010*
Number of HIV-infected clients who have documented Toxoplasma status in health record	25	28	12	-
Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the measurement period	25	35	36	-
Rate	100%	80%	33%	-
Change from Previous Year	20%	47%	-	-

**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	2013	2012	2011	2010*
Number of HIV-infected clients who have documented Hepatitis B infection status in the health record	58	35	34	-
Number of clients receiving OAMC.	58	35	36	-
Rate	100%	100%	94%	-
Change from Previous Year	-	6%	-	-

**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	2013	2012	2011	2010*
Number of HIV-infected clients who have documented Hepatitis C infection status in the health record	58	35	34	-
Number of clients receiving OAMC.	58	35	36	-
Rate	100%	100%	94%	-
Change from Previous Year	-	6%	-	-

*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.

Year	2013	2012	2011	2010
Number of client records with documented mental health screening	58	35	36	19
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	58	35	36	19
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

Year	2013	2012	2011	2010
Number of client records with documented substance abuse screening	58	35	36	19
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	58	35	36	19
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

Year	2013	2012	2011	2010
Number of client records with documentation that addresses smoking cessation	28	20	20	11
Number of HIV-infected clients with a medical visit within review period who smoke.	28	24	24	12
Rate	100%	100%	83%	92%
	-	17%	-9%	25%

Nutritional Health Screening

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

	Year	2013	2012	2011	2010
Number of client records with documented substance abuse screening		58	35	36	19
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		58	35	36	19
	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	2013	2012	2011	2010
Number of HIV-infected clients who received an influenza vaccination within the measurement year.		46	31	18	14
Number of clients receiving OAMC that were eligible to receive an influenza vaccination.		50	33	30	14
	Rate	92%	94%	60%	100.0%
	Change from Previous Year	-2%	34%	-40.0%	-

Immunization – Tetanus/Diphtheria

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

	Year	2013	2012	2011	2010
Number of HIV-infected clients who showed evidence of receiving a Tetanus/Diphtheria vaccination in the past 10 years.		42	25	22	7
Number of clients receiving OAMC that were eligible to receive a Tetanus/Diphtheria vaccination.		51	31	30	11
	Rate	82%	81%	73%	64%
	Change from Previous Year	1%	8%	9%	-13%

Immunization - Pneumovax (HAB Group 3)

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

	Year	2013	2012	2011	2010
Number of HIV-infected clients who showed evidence of receiving a pneumovax vaccination in the past 5 years.		47	24	24	5
Number of clients receiving OAMC that were eligible to receive a Pneumovax vaccination.		52	31	30	12
	Rate	77%	77%	80%	42%
	Change from Previous Year	-3%	-3%	38%	-41%

Immunization – Hepatitis A

Number of HIV-infected clients with documentation of having ever completed the vaccination for Hepatitis A.

	Year	2013	2012	2011	2010
Number of HIV-infected clients with documentation of having ever completed the vaccination series for Hepatitis A		36	12	4	2
Number of clients receiving OAMC that were eligible to receive a Hepatitis A vaccination.		38	20	13	11
	Rate	96%	60%	31%	18%
	Change from Previous Year	36%	29%	13%	-26

Immunization – Hepatitis B (HAB Group 2)

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

	Year	2013	2012	2011	2010
Number of HIV-infected clients with documentation of having ever completed the vaccination series for Hepatitis B		41	21	14	4
Number of clients receiving OAMC that were eligible to receive a Hepatitis B vaccination.		41	24	18	11
	Rate	100%	88%	78%	36%
	Change from Previous Year	12%	10%	42%	-43%

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	2013	2012	2011	2010
Number of HIV-infected female clients who had Pap screen order documented in the measurement year		15	9	9	7
Number of HIV-infected female clients reviewed.		16	10	11	10
	Rate	94%	90%	82%	70%
	Change from Previous Year	8%	8%	12%	13%

If PAP is abnormal was there follow-up

	Year	2013	2012	2011	2010
Number of HIV-infected female clients had abnormal results and showed evidence of follow-up.		4	1	0	1
Number of HIV-infected female clients who had abnormal results requiring follow-up.		4	1	0	1
	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	2013	2012	2011	2010
Number of HIV-infected female clients who are over 50 years of age and have had a mammogram in the measurement year.	8	10	7	3
Number of HIV-infected female clients who are over 50 years of age.	10	12	8	6
Rate	80%	83%	88%	50%
Change from Previous Year	-3%	-5%	38%	

Education – Medication Adherence (HAB Group 2)

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

Year	2013	2012	2011	2010
Percentage of clients with HIV infection on ARVs who were assessed and counseled for adherence two or more times in the measurement year.	57	30	33	18
Number of HIV-infected clients who were prescribed HAART during the measurement year.	57	30	36	19
Rate	100%	100%	92%	95%
Change from Previous Year	-	8%	-3%	5%

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	2013	2012	2011	2010
Number of HIV-infected clients, who were counseled/provided education on the availability of clinical trials in the measurement year.	26	36	18	20
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.	26	36	19	20
Rate	100.0%	100.0%	100.0%	94.7%
Change from Previous Year	-	-	5.3%	-5.3%

Education – Preconception Counseling Information

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

Year	2013	2012	2011	2010
Number of HIV-infected clients, who were counseled/provided preconception pre-pregnancy counseling in the measurement year.	20	12	8	3
Number of eligible HIV- infected female clients.	20	12	8	3
Rate	100.0%	100.0%	100.0%	100.0%
Change from Previous Year	-	-	-	

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	2012	2011	2010	2009
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	43	30	33	10
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	50	35	36	19
Rate	86%	86%	92%	53%
Change from Previous Year	-	-6%	39%	-47%

Conclusion

Overall, there has been an increase in performance from the previous year. Twenty-six data elements show and increase or remained the same (90%), up from 86%; and 3 data elements showed a decrease (10%). These include: mammogram referrals at 80 percent versus 83 percent in 2012; TB assessment; and Influenza vaccinations.

Fourteen data elements out of 29 (58%) were at 100% threshold. This is an increase from 48%. Twenty-one (72%) data elements were between 100 and 90 percent threshold. This is an increase from 62 Percent.

HAB measures

Among the twenty-two (22) HRSA HAB measures nineteen (20), (90%) showed an increase or remained the same from the previous year:. Two (7%) showed a decrease from the previous year these include TB assessment and annual Influenza vaccination HAB measures continue to improve and over all compliance with standard of care are increasing.



CASE MANAGEMENT SERVICES
2013 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 two agencies to provide case management services in the Houston HSDA. Two agencies 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 288 who accessed case management services between 1/1/2013 – 12/31/2013. The records of 50 clients were reviewed, representing 17 % of the unduplicated population. The demographic makeup of the provider was used as a key to file sample pull.

Report Structure

A categorial 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)	Ukn
Comprehensive Assessment Completed within 10 working days	50	0	0
Number of HIV-infected clients with a medical or clinical case management visit within review period.	50	50	50
Rate	100%	0%	-

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	N/A
Service plan developed that is unique to the needs, choices, and goals of the client.	50		
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.	50	50	50
Rate	100%	0%	-

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	8	0	42
Number of medical case management clients who:	8	8	
• initiated HAART			
• had a change in HAART			
• Or recently resumed HAART.			
Rate	100%	0%	-

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.	50	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.	50	50	50
Rate	100%	-	-

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.	50	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.	50	50	50
Rate	100%	-	-

Mental Health Screening (HAB Group 2)

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

	Yes	No	Ukn
Number of client records with documented mental health screening	50	0	0
Number of HIV-infected clients with a medical or clinical case management visit within review period.	50	50	50
Rate	100%	-	-

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	Ukn
Number of client records with documented substance abuse screening	50	0	0
Number of HIV-infected clients with a medical or clinical case management visit within review period.	50	50	50
Rate	100%	-	-

Nutritional Health Screening

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

	Yes	No	Ukn
Number of client records with documented substance abuse screening	46	4	0
Number of HIV-infected clients with a medical or clinical case management visit within review period.	50	50	50
Rate	92%	20%	-

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	26	0	24
Number of HIV-infected clients with a medical or clinical case management visit within review period who smoke.	26	26	50
Rate	100%	0%	48%

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	15	2	33
Number of HIV-infected clients with a medical or clinical case management visit within review period who have an identified mental health issue.	17	17	50
Rate	88%	12%	66%

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	1	34
Number of HIV-infected clients with a medical or clinical case management visit within review period who have an identified substance abuse issue.	16	16	50
Rate	94%	6%	68%

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	21	2	27
Number of HIV-infected clients with a medical or clinical case management visit within review period who have an identified nutritional issue.	23	23	60
Rate	91%	9%	54%

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	8	1	41
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.	9	9	50
Rate	89%	11%	82%

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.	50	0	0
Number of HIV-infected clients with a medical visit within review period who have had a service referral.	50	50	50
Rate	100%	-	-

Conclusion

2013 showed continual improvement in case management. Nine out of 14 (64%) of the data elements were 100%. 14 out of the total 14 (100%) data elements were between 80-100 percent. This is an increase from 2011. Increases were noted service plan development, tobacco use, substance abuse referrals, and nutritional health screening. Of the 3 HAB measure data elements case management scored 100% all three; mental health and substance abuse screening; and tobacco use and cessation counseling.

HOUSTON★CHRONICLE
HEALTH

Texas clinics receive \$5.6 million in federal grants

The Obama administration announced Thursday it has awarded more than \$5 million in grant money to expand community health center services across Texas, with more than half of the funding slated for clinics in the Harris County region.

Ten new community health center sites in Texas will be supported by about \$5.6 million in one-time federal grants. Federal officials estimate the funds, made available by the Affordable Care Act, will help provide primary health care services for 46,150 additional low-income and uninsured patients in the state.

About \$2.9 million of the grant money the state will receive is being given to centers in the Harris County region: Three clinics in Houston and one in Conroe.

Nationwide, the administration will award about \$150 million in grants to serve an estimated 1.25 million people. Of the 382 original grant applications, 36 health center programs received funding, federal health officials said.

"It means that many more health centers then will be able to deliver affordable, quality primary health care services," Dr. Mary Wakefield, administrator of the Health Resources and Services Administration for the Department of Health and Human Services, said Wednesday during a telephone news conference.

While the grant funds awarded Thursday cannot be utilized for new construction, they can be used to expand services in existing buildings that would be turned into health centers, federal officials said.

Grant recipients can also use funding to expand a variety of health services - ranging from mammograms and diabetes treatment to dental procedures and mental health assistance- as well as to hire additional staff, buy equipment and lease space, officials said.

2 new Houston centers

Two of the health centers receiving the grant funds in Texas are new: the St. Hope Foundation and Bee Busy Wellness Center, both of which are in Houston. The other eight are existing grantees.

Currently, 67 community health centers in Texas receive federal grants.

Federally-supported community health centers primarily treat patients without health insurance or people who are considered under-insured. Patients are charged according to a sliding fee scale set by the individual health center. Last year, Texas health centers served almost 1.1 million patients, more of whom were uninsured, federal officials said.

Signing up clients

Health centers were also recently utilized to help educate patients and enroll them into the new health insurance marketplace. In July, the Obama administration awarded \$150 million in grant money under Affordable Care Act to 1,100 community health centers across the country to help sign up patients into insurance exchanges.

"This is a time in which we are focused on making sure as many Americans as possible know about the new health care options available to them that they can sign up for through the federal and state market places," Cecilia Muñoz, director of the White House domestic policy council.

"But it is just as critical to make sure we are boosting access to quality health care services, so these funds will be vital in that effort."

HEARST *newspapers*

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**Improving Engagement and
Retention in Adult Care Settings
for Lesbian, Gay, Bisexual,
Transgender and Questioning (LGBTQ)
Youth Living with HIV**

– A Guide for Adult HIV Healthcare Providers



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INTRODUCTION

Every year in the United States, 5,000 young people under 25 years old become infected with HIV, mostly due to unprotected sex or needle sharing.¹ In recent years, advances in anti-retroviral HIV medications (ARVs) have significantly reduced AIDS-related mortality, giving these young people the chance to live long and healthy lives. Whether transitioning out of a pediatric or adolescent care setting into adult care, or moving directly from the point of diagnosis into adult care, young people living with HIV are entering a system that is not set up to meet their needs. Already, young people (15-24 years old) have the lowest utilization of medical office visits of any other age group.² In HIV care, this can have a devastating impact on adherence to ARV medication, treatment of opportunistic infections and prevention of transmission to others. Engaging and retaining young people in adult care is critical to their survival and to wider prevention and public health efforts, yet too many continue to get lost in the process.

The specific and often unaddressed needs of HIV positive lesbian, gay, bisexual, transgender and questioning (LGBTQ) youth further complicate this issue. The multitude of psychosocial and structural barriers that they face due to their sexual orientation or gender identity – mental health problems, homelessness, substance use and stigma – within a society that often misunderstands and mistreats them, makes coping and living with an HIV diagnosis particularly complex.

To date, there is scant literature on how to effectively treat LGBTQ youth (13-24 years old) in adult care settings that were infected with HIV via behavioral means. The majority of related research has focused on *transition out* of pediatric care settings for perinatally infected young people and recommendations have mostly

targeted pediatric providers. As the population of transitioning and newly diagnosed young people grows, with the highest prevalence within LGBTQ communities, there is an urgent need to bring this topic to the fore among adult care providers. Therefore, the National Alliance of State and Territorial AIDS Directors (NASTAD) developed this issue brief to help health departments explore the unique issues affecting HIV positive LGBTQ youth, particularly those not perinatally infected, and assist adult HIV health providers as they *welcome them into* their care.

The following sections provide a general overview of LGBTQ youth living with HIV, barriers to engagement and a series of simple and applicable recommendations for improving engagement and retention in care for this population.

THE EPIDEMIC

At the end of 2008, there were nearly 40,000 young people, 13-24 years old, living with HIV/AIDS in the United States. Among males, 73 percent of infections were attributed to male-to-male sexual contact and 16 percent to perinatal transmission. Among females, 59 percent of infections were attributed to heterosexual contact and 34 percent to perinatal transmission¹. Male-to-female transgender youth also have particularly high incidence of HIV infection.¹¹

A QUICK OVERVIEW OF LGBTQ* YOUTH

LGBTQ youth have the same developmental challenges as all young people but with the potential added stress of minority sexual orientation and/or gender identity, internal and external homophobia, and limited family and peer support.³ Institutionalized homophobia within schools, workplaces and health care

* The term "LGBTQ" refers to a large and diverse group of people whose characteristics and needs change from one individual to the next. When reading about the following sub-populations, it is important to remember that these are just a few of the many, and are themselves very broad and general. Sub-groups are not mutually exclusive; youth may fall across many subpopulations or none at all.

settings results in high levels of violence toward LGBTQ youth plus disproportionate rates of substance use, mental health problems, suicidal ideation, school drop-out and sexual risk-taking.⁴ Twenty to 40 percent of homeless youth are LGBTQ, often as a direct result of “coming out” to families and being kicked out of the home.⁵ Internalized stigma, in addition to living with a condition that is highly stereotyped and misunderstood, only exacerbates these problems. The pervasive discrimination and rejection experienced by so many LGBTQ youth on the basis of their sexual identity and/or HIV status means that in terms of health care and day-to-day life, many are going it alone. Therefore, the ability to reach them at all with healthcare, and then retain them in care, is ever more difficult.

Young Men Who Have Sex with Men (MSM)

Young men who have sex with men (MSM), ages 13-24 years old, are the fastest growing population of people living with HIV in the U.S.⁶ and a high percentage do not know they are infected. Alcohol, methamphetamine and other drug use is common among young MSM and can lead to risky sexual behavior. Unfortunately, for young men growing up in an age where antiretroviral (ARV) medications have been readily available, some do not view HIV as dangerous and have become complacent about risky behavior.⁷ This concern is heightened with recent advances in pre-exposure prophylaxis (PrEP), Truvada, a promising daily pill to prevent HIV transmission among MSM. Advocates fear that the availability of Truvada for PrEP could lead to a false sense of protection from HIV and increased risk-taking among young MSM.

Young MSM of Color

Rates of HIV infection among young Black men 13-29 years old are higher than among any other races/ethnicities.⁸ Young Black gay/bisexual men are hardest hit, representing three-quarters of new infections among all young Black men and more infections than any other racial/ethnic group of MSM. In 2008, 17 percent of young Latino MSM were infected with HIV, with rising rates every year.⁸ Many Black and Latino youth are diagnosed late in the course of their infection,

putting them at increased risk for opportunistic infections and rapid progression to AIDS.¹² LGBTQ youth of color face special challenges. Not only do they experience stigma and discrimination from society at large because of their sexual orientation, but they may also face rejection by their own racial/ethnic communities, many of which strongly oppose homosexuality. Feeling that they have to choose between their ethnicity and their sexual identities, these youth are less likely to be involved with support organizations and activities targeting LGBTQ youth.⁹

Young Women

Young women who have sex with women (WSW) are often thought of as “safe” from negative health outcomes.⁹ However, evidence suggests that many WSW also have sex with men. Over their lifetimes, they have similar rates of sexually transmitted diseases to all women, experience pregnancy at higher rates than heterosexual women and are less likely to use protection during heterosexual intercourse.⁹ Therefore, WSW have the same sexual and reproductive health (SRH) needs as women who have sex with men, making adequate SRH services crucial for this population. Studies of pediatric HIV care have found that SRH services are limited in the pediatric setting. Often, providers assume that HIV positive young women do not want to have children or are not having sex. For sexually active young women, the adult care environment may be much healthier and more helpful in providing access to family planning and counseling services.¹⁰

Transgendered Youth

Male-to-female transgendered youth have particularly high rates of HIV infection and many providers are not prepared to manage the complexities of their situations. Transgendered youth may be taking or interested in taking gender-affirming hormone therapies or other medications in addition to their ARV therapy.¹¹ They also experience high rates of violence, victimization and suicide ideation.⁹ In 2006, the National Institute of Mental Health reported that transgender women were less likely to receive ARVs than all other people living with HIV.¹² It

is less likely that a pediatrician will have any specialization in this area, so finding an adult care provider that is knowledgeable and experienced working with transgendered youth is likely easier and advisable.

WHERE ARE THEY COMING FROM?

Some youth will be transitioning out of pediatric health settings, while others will go straight into adult care after diagnosis. NASTAD recognizes the importance of understanding these contexts, in addition to how mode of transmission can impact engagement and retention in adult care.

Pediatric/Adolescent Care

Young people that contracted HIV at birth or early in adolescence are likely to have received care in pediatric and/or adolescent health facilities for many, if not all of their adolescent years. Clinically speaking, perinatally infected youth are more likely to be in advanced stages of HIV, with a history of opportunistic infections, co-morbidities, developmental delays and more resistant mutations of the virus resulting in complex medical regimes.³ Their psychosocial needs are largely the same as those of their behaviorally infected peers. In pediatric/adolescent care, medical and psychosocial needs are often addressed together, through a multi-disciplinary, “1-stop shop” model. Coordinated services such as these are less likely to be available in adult care settings.

Youth’s strong attachment to their adolescent care team, particularly among those who have not disclosed their HIV diagnosis to anyone outside their providers, makes leaving that team particularly challenging. Mutual feelings of attachment, coupled with distrust of the adult care system, mean many pediatric/adolescent providers are equally resistant to let go of their patients.^{4,5,6}

Point of Diagnosis

Depending on age, age at diagnosis, readiness and/or clinical protocol, many young people will go directly to adult care without ever entering pediatric or adolescent HIV care settings. Some

newly diagnosed youth enter a period of denial after receiving a positive test result, meaning they do not always enter care right away. Equally, a recent diagnosis may mean that youth are still learning to cope, considering suicide and unable to take responsibility for their care. They may experience more challenges to treatment adherence, have denial and fear of HIV, have misinformation about HIV and about their personal risk. They will likely have more distrust of the medical establishment, fear, disbelief in the effectiveness of treatment, low self-esteem, depression and anxiety, and an unstructured and chaotic lifestyle without family and social supports.⁷

These youth are likely experiencing illness for the first time in their lives, necessitating increased assistance with how to navigate the health care system, treatment adherence and health insurance benefits. If new to the health system overall, young people may bring previously unaddressed issues of substance use, anxiety and depression, intimate partner violence and others that require immediate attention.

KEY STRATEGIES FOR ENGAGEMENT IN CARE

This section will provide simple and applicable solutions for improving and increasing engagement in care for HIV positive LGBTQ youth. As with any young person, the overarching goals for treating LGBTQ youth are to promote healthy development, physical health, and social and emotional well-being.⁸ For HIV positive youth, those goals also include increasing self-care behaviors, medical adherence and health-related interactions; reducing transmission and high-risk behaviors; and enhancing quality of life.¹³

Avoid Assumptions

One of the most important components of working with LGBTQ youth is to never make assumptions, particularly when it comes to sexual identity, gender and behavior. Assumptions can lead to missed information during patient visits or worse, a breakdown of trust.

Asking the Right Questions Can Make a Difference	
Young people may identify their sexuality differently from the way they behave.	Ask whether the patient has had sex with men or women or both, regardless of how he/she identifies.
Sexual behavior and identity can change over time.	Ask about previous sexual behavior or sexual desires at every visit.
Being in a committed relationship does not always equal monogamy.	Ask questions about concurrent sexual partners.
Youth may only identify sex as penile-vaginal intercourse.	Ask about whether he/she has had vaginal, anal or oral sex in the past.
Gender identity is distinct from sexual orientation.	Don't assume transgender implies gay.
Your patient is also an expert.	If you need help with all of these terms, ask the patient to help define them!

Adapted from Fenway Guide to LGBT Health Module 2

Create a Welcoming Environment

"One of the most important things that an adult provider needs to recognize is that first impressions are everything. If youth don't feel welcome or they are made to feel inferior or not intelligent -- especially if they are not cognitively ready to navigate the situation -- chances are they are not coming back and they will be lost to care" (Male, 29, Ohio).

"In our adolescent clinic, the walls are covered in graffiti and there are resources and flyers for youth. It's open on Saturdays. The adult clinic is not youth-friendly. The problem is that if they [youth] don't like it, they won't go" (Male, 20, Boston).

Pediatric and adolescent health settings are often decorated with culturally and age-appropriate artwork, equipped with relevant resources and brochures, and staffed by people that are enthusiastic about working with youth. An adult care environment that seems sterile and filled with people with whom youth cannot identify (e.g., older, sickly, etc.) could keep a young person from returning for care.

Creating a youth and LGBTQ friendly environment is a crucial component of services for HIV positive LGBTQ youth.

Creating a Youth-friendly Environment*	Creating a LGBTQ-friendly Environment**
Hold flexible clinic hours on weekends and in the evenings.	Provide comprehensive training for <u>all clinic staff</u> in the care and rights of LGBTQ youth. Make sure to include “frontline” staff; those that youth will interact with when they first walk in the door.
Cluster medical and mental health appointments together, and schedule them alongside other peer support and case management activities so youth have more of a “ 1-stop shop ”.	Make sure someone is there to greet young people when they walk into the clinic so they feel welcome .
Provide travel vouchers for public transportation.	Have posters and flyers with same-sex couples and transgendered youth.
If possible, create a separate waiting area for youth in which they can congregate, check email, etc. Provide childcare for youth with small children.	Provide information about safe sex, HIV prevention, and/or pregnancy prevention that is appropriate for LGBTQ youth (e.g., resources that only talk about heterosexual couples may not be received well).
Integrate intensive case management and relevant psychosocial support services.	Provide appropriate resources and referrals for LGBTQ-friendly services such as mental health, substance use and peer support.
Actively involve young people in program design and delivery.	Involve LGBTQ youth in the planning, delivery and evaluation of your program.
Expand social media use for engagement and retention (e.g., mobile phones and Facebook for appointment and medication reminders, and accessing results. Give youth beepers when they arrive for care so that they can leave the waiting room and be called back when they are ready to be seen.)	Discuss racism, sexism, homophobia and other forms of cultural oppression in your program. Get young people to generate ways to solve, limit or minimize the problems caused by cultural oppression.
Provide information and materials that are appropriate for young people.	Refer patients to providers that are enthusiastic about working with LGBTQ youth.

* Adapted from *Young Adult Program, St. Lukes Roosevelt Hospital, New York City.*

** Adapted from *Health Initiatives for Youth, San Francisco, California.*

Address Institutional Stigma

Few population-based studies have documented health disparities among LGBTQ people, and even fewer on LGBTQ youth. However, widespread anecdotal data, from patients as well as practitioners, provide evidence that failures in the system remain. LGBTQ patients often face difficulties in accessing quality health services due to stigma, both real and perceived, within the medical community. Lack of education and training for health professionals surrounding the specific needs of LGBTQ youth, and communication shortfalls during clinical visits,³ can have an enormous impact on a patient’s health-seeking behavior and adherence to

health recommendations. This fact cannot be overlooked when it comes to LGBTQ youth who often experience high levels of distrust of the health care system.

Young people return to environments where they know people care for them² so be empathetic, non-judgmental and kind. Remember that most HIV positive and LGBTQ youth have experienced a tremendous amount of trauma in their lives and have faced incredible adversity. Shifting your model of care from a “deficit” approach to an “asset,” or resiliency model, will help them focus on a continuum of life rather than just a continuum of care.²

Building a positive relationship with your patients*

Spend **extra time** with new patients, helping them understand the significance of learning and understanding their lab results, adherence and building relationships with providers.

Get to know the patient as a **person** (e.g., partners, jobs, interests). Ask open-ended questions, like “What do you like to do for fun?” Help validate that they are “normal” youth.

Assist youth with their autonomy and self-acceptance, concerning both their sexual orientation/gender identity and their HIV status.

Encourage young people to keep a **list of questions** for you, perhaps in their phones, so that they feel prepared and confident when they attend appointments.

Create **open and honest** dialogue, particularly around sensitive issues. Remind them that what they say is confidential and that they can trust you.

Ask **non-judgmental questions** about sex, sexuality and sexual identity. Ask questions in a way that does not assume sexuality. For instance, instead of “Do you have a boyfriend/girlfriend?” ask, “Are you in a relationship?”

Respect and address **confidentiality** proactively – do not assume whom the young person has told about his/her sexual identity or HIV status, including other providers.

Be prepared to make appropriate **referrals and recommendations**, particularly for case management, mental health, housing, substance use and peer support.

Let youth use **their own terminology** for their sexual identity even if it does not match their behavior. For instance, some MSM do not identify as gay. Rather than ask, “Are you gay?” ask “Have you ever been sexually involved with men, women or both?”

* Adapted from Fenway Guide to LGBT Health Modules 2 & 4. See these modules for comprehensive training on patient interviews with LGBTQ youth.

Recognize the Individual; Treat the Whole Person

“Often providers expect youth to be fully able to engage in care the same way an adult will; that is not the reality. Especially if they have never dealt with care settings or have always had it dealt with for them. There are small steps that any setting can take to engage youth in a way that it is going to be affirming, accepting and meeting them where they are” (Male, 29, Ohio).

There is no prescribed age for transition to adult health care, though the majority of U.S. clinicians try to transition HIV positive youth into adult care by the age of 24.¹⁷ That being said, chronological age is very different from developmental age, and the latter, in addition to patient readiness, is crucial to determining healthy engagement in care for HIV positive youth.¹⁴ Assessing the patient from an ecological perspective, taking note of all of the biopsychosocial determinants that influence his/her health, in addition to

making appropriate referrals for wrap-around services, is essential. With recent evidence that ARVs can prevent HIV transmission among sero-discordant couples,¹⁵ support and education surrounding adherence become ever more crucial. Where possible, involve a social worker and/or case manager who can assess and address pressing issues. If a young person is transitioning from a pediatric/adolescent care setting, communicate with the provider team about how best to coordinate these services.

Addressing important psychosocial support needs

Adherence: Recognize that adherence to their ARV regimens is especially hard for young people living with HIV, particularly if they are struggling with many other aspects of their lives. Ensure that adherence support, through peer and professional counseling, is provided for all young people taking medications.

Substance use: Some youth need harm reduction education, motivational interviewing and/or introduction to rehabilitation and recovery therapy.

Longer-term housing: Transitional living programs for homeless youth offer an active alternative to shelters and can be designed to meet the specific needs of this sub-population.

Mental health: Understand that depression, anxiety and suicide ideation are both predictors and consequences of an HIV diagnosis. Screen for these issues and refer appropriately.

Disclosure: Recognize that disclosure of HIV status to others is one of the biggest concerns for HIV positive youth. Provide information and counseling surrounding healthy and safe disclosure to others.

Partner violence: Many LGBTQ youth living with HIV face high rates of intimate partner violence, particularly after disclosing HIV status. Programs should incorporate counseling, support and education surrounding domestic violence.

Peer support: Peer support can be offered through regular support groups, one-to-one mentorship, youth conferences, and social activities where education is provided in a fun setting. The role of older peers who have successfully transitioned and are engaged in adult care, who can serve as mentors, cannot be overstated.

Structural support: Link youth to services and programs that focus on money management, credit, decision-making skills, job training and educational opportunities.

Solve Access Issues

Health care access is a major issue for HIV positive LGBTQ youth due to lack of insurance, homelessness and unemployment. In rural settings, patients must travel a substantial distance for HIV, mental health and substance use care.² Many young people fear disclosure by insurance companies to parents or guardians so they access care in community-based settings that do not require health insurance.⁹ LGBTQ youth may not know where to go for LGBTQ and youth friendly care, and one negative experience could persuade them to disengage completely.

A recent study by the Health Resources and Services Administration (HRSA) found that newly diagnosed, HIV positive young Black MSM are more likely to go to their first doctor's appointment if the person who diagnoses them picks up the phone and schedules that appointment.¹⁶ This simple gesture can be lifesaving.

Providing Access to Comprehensive Services

Provide **case management** services to support youth with transportation, health insurance and benefits.

Offer travel **vouchers** or bus fare.

Link youth to **peer support groups** that can help keep them engaged.

Have a **list of providers** within the region ready at each point of diagnosis to ensure successful referrals into care.

Highlight Sexual and Reproductive Health (SRH)

Comprehensive, LGBTQ and youth-friendly SRH services are essential for this population. Young people may engage in sexual risk-taking as a coping mechanism to deal with a recent diagnosis, feelings of hopelessness or preoccupation with illness. They may also engage in unsafe sex as a means of gaining peer acceptance and coping with experiences of stigma.¹⁷ Sexual curiosity and risk-taking are inevitable components of adolescent development. Like their uninfected peers, young people living with HIV have the right to seek sexual fulfillment and they should be equipped with the knowledge and skills to protect themselves and their partners.

Providing sexual and reproductive health services

Support young people with information and education surrounding positive sexual health and prevention, self-esteem, self-efficacy and the ability to manage high-risk situations.

Provide social support services and counseling surrounding **family planning** and parenthood.

Link pregnant youth to appropriate **antenatal care** and education and counseling on how to reduce the risk of mother-to-child transmission during pregnancy, delivery and breastfeeding.

Ask youth about their **fertility intentions** and desires. Recognize that expectations for sex, intimacy, loving relationships, children and family are no less evident in HIV positive young people or in those that are LGBTQ.

Provide appropriate support for youth involved in **survival sex work** (providing sex for money or resources), particularly if they are homeless.

Provide **assertiveness training**, particularly for those youth still struggling with “coming out.” This should include training on condom negotiation and communicating about safe sex options.

Strengthen Youth Voice...and Listen

The meaningful involvement of young people living with HIV in the planning and delivery of their care and support is a critical and often under-addressed component of youth engagement in adult care settings.¹⁸ Putting youth at the center of their care will not only ensure that their individual needs are met, but that the system as a whole becomes more welcoming and sustainable for young people over time.

Involving youth

Create a **mechanism for young people** to provide feedback to providers about the quality of care they are receiving. Examples include a youth advisory board, anonymous suggestion boxes and simply asking them during visits.

Teach **decision-making skills** so youth are able to make informed decisions around high-risk behaviors as well as important decisions about their healthcare.

Create **safe spaces** for young people to meet and network with one another within the clinic setting. Knowing they are not alone will strengthen their voice and their incentive to stay engaged in care.

Provide paid or volunteer **opportunities for young people** to work in the clinic, particularly as peer educators and counselors.

Introduce youth to peer education trainings, advisory boards and other outreach opportunities that will strengthen their ability to **advocate for themselves**.

CONCLUSION

LGBTQ youth living with HIV in the U.S. remain a hidden population. Stigma and misunderstanding at the individual, community and institutional levels, coupled with a health care system that is not prepared to receive them, pave the way for a disease burden that is impossible to manage. Failing to successfully engage and retain these youth in adult care not

only jeopardizes their health and wellbeing; it threatens the success of HIV prevention efforts to date, which could cost valuable lives and resources. It is timely and urgent that we shift our focus to retaining HIV positive LGBTQ youth in adult care, and begin an honest dialogue with young people and one another about how we are going to do it.

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