SAN ANTONIO TRANSITIONAL GRANT AREA/HEALTH SERVICE DELIVERY AREA

STANDARDS OF CARE FOR HIV/AIDS SERVICES

RYAN WHITE PART A (Including Minority AIDS Initiative {MAI}), PART B, AND STATE SERVICES

Providing High Quality, Comprehensive Health and Social Services to Individuals Infected With or Affected By HIV/AIDS

TABLE OF CONTENTS

STANDARDS OF CARE INTRODUCTION

The Standards of Care (SOC) represent an effort by the San Antonio HIV Health Services Planning Council to improve and enhance the 2009 SOC by including Health Resource Service Administration (HRSA) HIV/AIDS Bureau (HAB) performance measures. These performance measures were designed to monitor and enhance the quality of care provided in the service delivery areas by setting goal-specific measurable outcomes. Further, the SOC are a reflection of our mission statement which reads, "***To create a broad-based community response to the HIV epidemic affecting people within the San Antonio Transitional Grant Area (TGA) and to ensure the availability and coordination of high quality, comprehensive health and social services to individuals infected or affected by HIV and/or AIDS."***

Universal Standards

In 2006, the Universal Standards were first developed as "Core Standards" by the Comprehensive Planning/Continuum of Care (CPCC) committee of the Planning Council. With the re-authorization of the Ryan White HIV/AIDS Treatment Modernization Act of 2006 changes to terms such as "core medical services" prompted the CPCC committee to coin the new title "Universal Standards" in the 2007 SOC document. Items addressed in the Universal Standards apply to all service categories and are "stand alone" from service category specific standards of care. Universal Standards are critical to the service delivery within the TGA and the Health Service Delivery Areas (HSDA) and their applicability cannot be over-emphasized.

Service Category Specific Standards

Service Category specific Standards of Care are designed for core medical and supportive service categories that receive Ryan White Part A and Part B funding in the following jurisdictions: 1) San Antonio TGA[1], 2) San Antonio Health Services Delivery Area (HSDA)[2]. The service category standards include: 1) HRSA definitions, 2) a description of the services provided, 3) specific standards related to personnel, training, and licensure, and 4) a quality management component with specific measureable outcomes and goals to include all HAB performance measures. Standards for each service category are presented in alphabetical order irrespective of whether the category is deemed a "core medical" or "supportive service" category by HRSA.

It is important to note that the SOC is a living document and will evolve based on 1) Federal Law updates, changes, or modifications, 2) changing needs and realities of the infected and affected communities within the service delivery areas, and 3) the capacity of the service delivery areas. The CPCC committee, the San Antonio Area HIV Health Services Planning Council, and Support Staff of the Administrative Agency (University Health System Ryan White Program) continually propose revisions and update the SOC as needed.

Comments regarding this document or considerations for future revisions should be directed in writing to the following:

San Antonio Area HIV Health Services Planning Council Liaison
University Health System
Ryan White Program
4502 Medical Drive
MS 83-2-(Corporate Square)
San Antonio, TX 78229
Phone: (210) 644-1370; Fax: (210) 702-6952
E-Mail: Catherine.Johnson@uhs-sa.com

The CPCC committee meets on the first Thursday of each month and the Planning Council meets on the fourth Wednesday of each month at the above location. All CPCC committee and Planning Council meetings are open to the public. For meeting times, contact the Planning Council Liaison at the phone number or e-mail address listed above

[1] San Antonio TGA comprises: Bexar, Comal, Guadalupe, and Wilson counties.
[2] San Antonio HSDA comprises: Atascosa, Bandera, Bexar, Comal, Frio, Gillespie, Guadalupe, Karnes, Kendall, Kerr, Medina, and Wilson.

UNIVERSAL STANDARDS

ACCESS TO CARE

#	Standard	Performance Measure / Method	Sub-Recipient Responsibility
1.0	Structured and ongoing efforts to obtain input from clients in the design and delivery of services	1. Documentation of Consumer Advisory Board and public meetings – minutes, and/or 2. Documentation of existence and appropriateness of a suggestion box or other client input mechanism, and/or 3. 3. Documentation of content, use, and confidentiality of a client satisfaction survey or focus groups conducted at least annually	1. Maintain file of materials documenting Consumer Advisory Board (CAB) membership and meetings, including minutes and/or; 2. Regularly implement client satisfaction survey tool, focus groups, and/or public meetings, with analysis and use of results documented and/or; 3. Maintain visible suggestion box or other client input mechanism
2.0	Provision of services regardless of an individual's ability to pay for the service	Sub-recipients billing and collection policies and procedures do not: • Deny services for non-payment • Deny payment for inability to produce income documentation • Require full payment prior to service • Include any other procedure that denies services for non-payment	1. Have billing, collection, co-pay, and sliding fee policies that do not act as a barrier to providing services regardless of the client's ability to pay 2. Maintain file of individuals refused services with reasons for refusal specified; include in file any complaints from clients, with documentation of compliant review and decision reached
3.0	Provision of services regardless of the current or past health condition of the individual to be served	Documentation of eligibility and clinical policies to ensure that they do not: • Permit denial of services due to preexisting conditions • Permit denial of services due to non-HIV-related conditions (primary care) • Provide any other barrier to care due to a person's past or present health condition	1. Maintain files of eligibility and clinical policies 2. Maintain file of individuals refused services
4.0	Provision of services in a setting accessible to low-income individuals with HIV disease	1. A facility that is handicapped accessible, accessible by public transportation 2. Policies and procedures that provide, by referral or vouchers, transportation if facility is not accessible to public transportation 3. No policies that may act as a barrier to care for low-income individuals	1. Comply with Americans with Disabilities Act (ADA) requirements 2. Ensure that the facility is accessible by public transportation or provide for transportation assistance
5.0	Outreach to inform low-income individuals of the availability of HIV-related services and how to access them	Availability of informational materials about sub-recipient services and eligibility requirements such as: • Newsletters; Brochures • Posters • Community Bulletins • Any other types of promotional materials	Maintain file documenting sub-recipient activities for the promotion of HIV services to low- income individuals, including copies of HIV program materials promoting services and explaining eligibility requirements

ELIGIBILITY DETERMINATION

#	Standard	Performance Measure / Method	Sub-Recipient Responsibility
1.0	Eligibility determination and reassessment of clients to determine eligibility as specified by the jurisdiction or ADAP: • Eligibility determination of clients to determine eligibility for Ryan White services within a predetermined timeframe • Reassessments of clients every 6 months to determine continued eligibility	1. Documentation of eligibility required in client records, with copies of documents (e.g., proof of HIV status, proof of residence, proof of income eligibility based on the income limit established by the State, ADAP, or local area, proof of insurance, uninsured or underinsured), using approved documentation as required by the State • **Income**: Client must meet financial eligibility requirements as defined by the San Antonio Area HIV Health Services Planning Council, which is not more than 300% of FPL for Part A and MAI and 500% for Part B and State Services. There is no financial eligibility requirement for case management services (medical and non-medical). • **Residency**: To receive services funded by Part A and MAI, client should reside in the TGA, which includes the following counties: Bexar, Comal, Guadalupe, and Wilson. To receive services funded by Part B and State Services, client should reside in the HSDA, which includes the following counties: Atascosa, Bandera, Bexar, Comal, Frio, Gillespie, Guadalupe, Karnes, Kendall, Kerr, Medina, and Wilson. 2. Eligibility and Determination Enrollment forms for other third party payers such as Medicaid and Medicare • **Insurance Status**: Sub-recipients are responsible for doing routine screening for third party payers to see if the client is enrolled in other health coverage. <u>Clients will have either documentation of insurance coverage OR signed attestation that they are ineligible to use the ACA marketplace in their files.</u> 3. Eligibility policy and procedures on file 4. Documentation that all staff involved in eligibility determination has participated in required training 5. Sub-recipient client data reports are consistent with eligibility requirements specified by funder 6. Documentation of reassessment of client's eligibility status every six months 7. Training provided by the sub-recipient to ensure understanding of the policy and procedures	1. Initial Eligibility Determination & Once a year/12 month period recertification documentation requirements: • HIV/AIDS diagnosis (at initial determination) o Documentation in client's file: ▪ HIV Lab result; or ▪ Written statement from a physician or medical record, pending confirmatory testing within 3 months of receipt of statement or record. • Proof of residence o Documentation in client's file: ▪ Current government-issued ID or Driver's license noting Texas address; ▪ Utility bills; ▪ Benefits Award letter in name of client showing address; ▪ Voter registration; ▪ Lease or mortgage in clients name; ▪ Notarized Affidavit; or ▪ Verification, on letterhead, from Residential programs (e.g., nursing homes, treatment centers, halfway houses, hospice);. or ▪ For homeless and/or undocumented, temporary affidavit signed and dated by the client which must be updated every 90 days. • Low income **(Not more than 300% of FPL for Part A and MAI and 500% for Part B and State Services)** o Documentation in client's file: ▪ benefit award letter; ▪ pay stubs; ▪ standardized declaration of income statement; ▪ standardized supporter statement; ▪ standardized statement of no income; ▪ tax forms (i.e. W2, tax returns); ▪ Texas Workforce Commission unemployment benefits letter; or

		Citizenship is not a requirement to access services.	▪ Prison release paper within 30 days of release date. • Uninsured or underinsured status (insurance verification as proof) • Determination of eligibility and enrollment in other third party insurance programs including Medicaid and Medicare • For underinsured, proof this service is not covered by other third party insurance programs including Medicaid and Medicare • Proof of compliance with eligibility determination as defined by the State or ADAP 2. Recertification (minimum of every six months) documentation requirements: • Proof of residence • Low income documentation **(Not more than 300% of FPL for Part A and MAI and 500% for Part B and State Services)** • Uninsured or underinsured status (insurance verification as proof) • Determination of eligibility and enrollment in other third party insurance programs including Medicaid and Medicare **Note:** At six-month recertification one of the following is acceptable: full application and documentation, self-attestation of no change or self-attestation of change with documentation. 3. Proof of compliance with eligibility determination as defined by the State or ADAP 4. Document that the process and timelines for establishing initial client eligibility, assessment, and recertification takes place at a minimum of every six months 5. Document that all staff involved in eligibility determination have participated in required training 6. Sub-recipient client data reports are consistent with eligibility requirements specified by funder, which demonstrates eligible clients are receiving allowable services
2.0	Ensure military veterans with Department of Veterans Affairs (VA) benefits are deemed eligible for Ryan White services	Documentation that eligibility determination policies and procedures do not consider VA health benefits as the veteran's primary insurance and deny access to Ryan White services citing "payer of last resort"	Ensure that policies and procedures classify veterans receiving VA health benefits as uninsured, thus exempting these veterans from the "payer of last resort" requirement

3.0	All Ryan White Providers are responsible for ensuring that eligibility documents are entered into ARIES in a timely fashion.	All providers are required to verify the following documents for clients are entered into ARIES: Agency Consent Form, ARIES Consent Form, Release of Information, Client Confidentiality Form, Proof of Residency, HIV Letter of Diagnosis, Proof of Income, and Picture ID. As a note, if a referral is received from another Ryan White agency, the referring agency is required to have all eligibility documents entered into ARIES with the correct date of document expiration. Agencies receiving referrals are required to verify that this information has been entered into ARIES. If this information has been entered in ARIES there will be no further action required of the receiving agency. If eligibility information has not been entered into ARIES then the receiving agency can either enter the documents with an expiration date which is reflected on the documents or contact the referring agency to have documents entered into ARIES.	Current Documentation in ARIES: Every 6 Months: • Proof of Residency • Proof of Income Annually: • Agency Consent Form • ARIES Consent Form • Release of Information • Client Confidentiality Form • Picture ID Once: • HIV Letter of Diagnosis • Proof of Positivity
4.0	**Payer of Last Resort:** Ensure that RWHAP Part A and MAI and Part B and State Services funds distributed are used as PoLR for eligible services and eligible clients.	Agencies have written policies and/or protocols for ensuring RWHAP Part A and MAI and Part B and State Services funds are used as PoLR for eligible services and eligible clients.	Recipients will develop and assure compliance with local policies required by DSHS policies, and monitor provider billing of third party payers to determine compliance with PoLR requirements.

Anti-Kickback Statute

#	Standard	Performance Measure / Method	Sub-Recipient Responsibility
1.0	Demonstrated structured and ongoing efforts to avoid fraud, waste and abuse (mismanagement) in any federally funded program	Documentation of Agency's Employee Code of Ethics, which includes: • Conflict of Interest • Prohibition on use of property, information or position without approval or to advance personal interest • Fair dealing – engaged in fair and open competition • Confidentiality • Protection and use of company assets • Compliance with laws, rules and regulations • Timely and truthful disclosure of significant accounting deficiencies • Timely and truthful disclosure of non-compliance	1. Maintain and review file documentation of: • Corporate Compliance Plan (required by CMS if providing Medicare-or Medicaid-reimbursable services) • Personnel Policies • Code of Ethics or Standards of Conduct • Bylaws and Board policies • File documentations of any employee or Board Member violation of the Code of Ethics or Standards of Conduct • Documentation of any complaint of violation of the Code of Ethics or Standards of Conduct and its resolution 2. For not-for-profit sub-recipient organizations, ensure documentation of sub-recipient Bylaws, Board Code of Ethics, and business conduct practices
2.0	Prohibition of employees (as individuals or entities), from soliciting or receiving payment in kind or cash for the purchase, lease, ordering, or recommending the purchase, lease, or ordering, of any goods, facility services, or items.	Any documentation required by the Compliance Plan or employee conduct standards that prohibits employees from receiving payments in kind or cash from suppliers and contractors of goods or services	1. Have adequate policies and procedures to discourage soliciting cash or in-kind payments for: • Awarding contracts • Referring clients • Purchasing goods or services, and/or • Submitting fraudulent billings 2. Have employee policies that discourage: • The hiring of persons who have a criminal record relating to or are currently being investigated for Medicaid/Medicare fraud • Large signing bonuses

RECIPIENT ACCOUNTABILITY

#	Standard	Performance Measure / Method	Sub-Recipient Responsibility
1.0	Proper stewardship of all grant funds including compliance with programmatic requirements	Policies, procedures, and contracts that require: • Timely submission of detailed fiscal reports by funding source, with expenses allocated by service category • Timely submission of programmatic reports • Documentation of method used to track unobligated balances and carryover funds • A documented reallocation process • Report of total number of funded sub-recipients / contractors • A-133 or single audit • Auditor management letter	Meet contracted programmatic and fiscal requirements, including: • Provide financial reports that specify expenditures by service category and use of Ryan White funds as specified by Recipient • Develop financial and sub-recipient Policies and Procedures Manual that meet federal and Ryan White program requirements • Closely monitor any sub-recipients / contractors • Commission an independent audit; for those meeting thresholds, an audit that meet A-133 requirements • Respond to audit requests initiated by Recipient
2.0	Recipient accountability for the expenditure of funds it shares with lead agencies (usually health departments), sub-recipients	1. A copy of each contract 2. Fiscal, program site visit reports and action plans 3. Audit reports 4. Documented reports that track funds by formula, supplemental, service categories 5. Documented reports that track unobligated balance and carryover funds 6. Documented reallocation process 7. Report of total number of funded sub-recipients / contractors 8. Sub-recipient A-133 or single audit conducted annually and made available to the State every one year. (Note: State requires submission to the System Agency and Office of Inspector General within 30 calendar days of receipt of the audit reports every year an audit is completed)* 9. Auditor management letter	Establish and implement: 1. Fiscal and general policies and procedures that include compliance with federal and Ryan White 1. programmatic requirements 2. Flexible fiscal reporting systems that allow the tracking of unobligated balances and carryover funds and detail service reporting of funding sources 3. Timely submission of independent audits (A-133 audits if required) to the State
3.0	Business management systems that meet the requirements of the Office of Management and Budget code of federal regulations, programmatic expectations outlined in the Recipient assurances and the Notice of Grant Award	1. Review of sub-recipient contracts 2. Fiscal and program site visit reports and action plans 3. Policies and Procedures that outline compliance with federal and Ryan White programmatic requirements 4. Independent audits 5. Auditor management letter	Ensure that the following are in place: 1. Documented policies and procedures and fiscal / programmatic reports that provide effective control over and accountability for all funds in accordance with federal and Ryan White programmatic requirements

4.0	Responsibility for activities that are supported under the Ryan White Program as outlined by Office of Management and Budget, Code of Federal Regulations, HHS Grant Policy Statement Program Assurances, and Notice of Grant Award (NOA)	Desk audits of budgets, applications, yearly expenses, programmatic reports; audit reports or on-site review when assessing compliance with fiscal and programmatic requirements	Ensure fiscal and programmatic policies and procedures are in place that comply with federal and Ryan White program requirements

REPORTING

#	Standard	Performance Measure / Method	Sub-Recipient Responsibility
1.0	Submission of standard reports as required in circulars as well as program-specific reports as outlined in the Notice of Grant Award	Records that contain and adequately identify the source of information pertaining to: • Federal award revenue, expenses, obligations, unobligated balances, assets, outlays, program income, interest • Client level data • Aggregate data on services provided; clients served, client demographics and selected financial information	Ensure: 1. Submission of timely sub-recipient reports 2. File documentation or data containing analysis of required reports to determine accuracy and any reconciliation with existing financial or programmatic data. Example: Test program income final FFR with calendar year RDR. 3. Submission of periodic financial reports that document the expenditure of Ryan White funds, positive and negative spending variances, and how funds have been reallocated to other line-items or service categories

MONITORING

#	Standard	Performance Measure / Method	Sub-Recipient Responsibility
1.0	Any recipient or sub-recipient or individual receiving federal funding is required to monitor for compliance with federal requirements and programmatic expectations at least annually	Development and consistent implementation of policies and procedures that establish uniform administrative requirements governing the monitoring of awards	1. Participate in and provide all material necessary to carry out monitoring activities at least annually 2. Monitor any service contractors for compliance with federal and programmatic requirements at least annually
2.0	Monitoring activities expected to include annual site visits of all Provider/Sub-recipients.	Review of the following program monitoring documents and actions: a. Policies and procedures b. Tools, protocols, or methodologies c. Reports d. Corrective action plans e. Progress on meeting goals of corrective action plans	1. Establish policies and procedures to ensure compliance with federal and programmatic requirements 2. Submit auditable reports 3. Provide the recipient access to financial documentation
3.0	Performance of fiscal monitoring activities to ensure that Ryan White funding is being used for approved purposes	Review of the following fiscal monitoring documents and actions: • Fiscal monitoring policy and procedures • Fiscal monitoring tool or protocol • Fiscal monitoring reports • Fiscal monitoring corrective action plans • Compliance with goals of corrective action plans	Have documented evidence that federal funds have been used for allowable services and comply with Federal and Ryan White requirements
4.0	Salary Limit: HRSA funds may not be used to pay the salary of an individual at a rate in excess of the most current HRSA Executive Salary Level II. This amount reflects an individual's base salary exclusive of fringe and any income that an individual may be permitted to earn outside of the duties to the applicant organization. This salary limitation also applies to sub-awards/subcontracts for substantive work under a HRSA grant or cooperative agreement.	1. Identification and description of individual employee salary expenditures to ensure that salaries are within the HRSA Executive Salary Limit. 2. Determine whether individual staff receive additional HRSA income through other sub-awards or subcontracts.	1. Monitor staff salaries to determine whether the salary limit is being exceeded. 2. Monitor prorated salaries to ensure that the salary, when calculated at 100%, does not exceed the HRSA Executive Salary Limit 3. Monitor staff salaries to determine that the salary limit is not exceeded when the aggregate salary funding from other federal sources including all parts of Ryan White do not exceed the limitation. 4. Review payroll reports, payroll allocation journals, and employee contracts.
5.0	Salary Limit Fringe Benefits: If an individual is under the salary cap limitation, fringe is applied as usual. If an individual is over the salary cap limitation, fringe is calculated on the adjusted base salary.	Identification of individual employee fringe benefit allocation.	Monitor to ensure that when an employee salary exceeds the salary limit, the fringe benefit contribution is limited to the percentage of the maximum allowable salary.

6.0	Corrective actions taken when sub-recipient outcomes do not meet program objectives and recipient expectations, which may include: • Improved oversight • Redistribution of funds • A "corrective action" letter • Sponsored technical assistance	1. Review corrective action plans 2. Review resolution of issues identified in corrective action plan 3. Policies that describe actions to be taken when issues are not resolved in a timely manner	Prepare and submit: • Timely and detailed response to monitoring findings • Timely progress reports on implementation of corrective action plan

QUALITY MANAGEMENT

#	Standard	Performance Measure / Method	Sub-Recipient Responsibility
1.0	Provision of QM participation	Sub-recipient will participate in local, State, and Federal planning and monitoring projects as requested by the AA.	The AA will monitor participation in planning projects as requested by the AA.
2.0	Provision of QM data	Sub-recipient will provide data as requested by the AA for monitoring purposes.	Provision of data as requested by the AA.
3.0	Provision of QM monitoring	Sub-recipient shall monitor for programmatic compliance on a quarterly basis.	Sub-recipient has documentation of self-monitoring for programmatic compliance. AA to track this quarterly.
4.0	Provision of sub-recipient location	Sub-recipient's physical location will comply with appropriate building, zoning, health and safety codes, be clean, well-ventilated, properly lighted, heated, air conditioned, maintained and handicap accessible as required by City, State and Federal Law.	Sub-recipient will maintain documentation of certificate of occupancy, appropriate licenses and inspection approvals of all physical location issues, including compliance with zoning, building, health and safety codes, lighting, heating and air conditioning, as well as accessibility to handicapped persons.
5.0	Provision of QM plan	All sub-recipients are required to have a written quality management plan. The quality management plan must include: a. A mechanism for consumers to express their level of satisfaction with services; agencies are expected to collect, analyze and report client satisfaction data. b. A grievance procedure, which sub-recipients for the objective review of client grievances and alleged violations of universal and service standards. Clients will be informed about and assisted in utilizing this procedure and shall not be subject to retaliation for doing so. c. Quality assurance and continuous quality improvement activities designed to check the quality of services delivered to the client, documentation of services, and the degree to which the client is satisfied with the services received. d. It is recommended that quality management plans include monitoring of client-level health outcomes.	Documented plan on file.

6.0	Provision of QM training	Staff will be trained on the agency Quality Management (QM) plan and related activities.	The sub-recipient documents self-audit for compliance with the SOC semiannually.
7.0	Provision of QM compliance	Sub-recipient will self-monitor compliance with these SOC on a semiannual basis. Sub-recipient must have a single point of contact (SPOC) on staff to account for compliance.	Staff personnel files reflect training in QM as appropriate and written identification of SPOC on site.

OTHER SERVICE REQUIREMENTS

#	Standard	Performance Measure / Method	Sub-Recipient Responsibility
1.0	1. *WICY* – Women, Infants, Children, and Youth: Amounts set aside for women, infants, children, and youth to be determined based on each of these population's relative percentage of the total number of persons living with AIDS in the State Note: *Waiver* available if recipient can document that funds sufficient to meet the needs of these population groups are being provided through other federal or state programs	1. Documentation that the amount of Part B funding spent on services for women, infants, children, and youth is at least equal to the proportion each of these populations represents of the entire population of persons living with AIDS in the State 2. If a waiver is requested, documentation that the service needs of one or more of these populations are already met through funding from another federal or state program	AA will request data to document HRSA report requirements. DSHS will conduct all necessary documentation requirements to fulfill the State WICY report.

DATA REPORTING REQUIREMENTS

#	Standard	Performance Measure / Method	Sub-Recipient Responsibility
1.0	Submission of the online service providers report of the Ryan White HIV/AIDS Program Services Report (RSR).	Submission of the online service providers report of the Ryan White HIV/AIDS Program Services Report (RSR).	Submission of the online service providers report of the Ryan White HIV/AIDS Program Services Report (RSR).
2.0	Submission of the online client report	Documentation that all service providers have submitted their sections of the online client report	1. Maintain client-level data on each client served, including in each client record demographic status, HIV clinical information, HIV-care medical and support services received, and the client's Unique Client Identifier 2. Submit this report online as an electronic file upload using the standard format 3. Submit both interim and final reports by the specified deadlines

ARIES

1.0	**ARIES Security Policy:** Policies are in place to ensure that ARIES and the information collected in ARIES is protected and maintained to ensure patient confidentiality.	Policies are in place at all agency locations that are funded in the state of Texas with RWHAP funds that ensure ARIES information is protected and maintained to ensure patient confidentiality.	Agencies will maintain policies and procedures to ensure ARIES information is protected and maintained to ensure patient confidentiality.
2.0	**ARIES Data Managers Core Competencies:** Data managers are required to perform certain activities and possess certain knowledge, skills, and abilities, which includes but is not limited to managing and overseeing data collecting, reporting, and the Uniform Reporting System ARIES.	Data managers develop and implement local policy and procedures relating to ARIES and the data collected through ARIES.	Agencies have local policies and procedures in place relating to ARIES and the data collected through ARIES.

CODE OF ETHICS

#	Standard	Performance Measure / Method	Sub-Recipient Responsibility
1.0	Provision of services without discrimination	Services will be provided to all Ryan White qualified individuals without discrimination on the basis of HIV infection, race, ethnicity, creed, color, age, sex, gender, gender identity or expression, marital or parental status, sexual orientation, religion, ancestry, national origin, physical or mental handicap (including substance abuse), immigrant status, political affiliation or belief, ex-offender status, unfavorable military discharge, membership in an activist organization, or any basis prohibited by law.	Agency has statement/policy onsite.
2.0	Provision of services with confidentiality and respect	All services provided under the Ryan White Treatment Extension act of 2009 will serve the best interests of the client/consumer/patient emphasizing confidentiality, respect for the client's rights and protect the client's dignity and self-esteem.	Agency has statement/policy onsite.
3.0	Provision of a grievance procedure	All Agencies shall maintain a grievance procedure, which provides for the objective review of client grievances and alleged violations of universal and service standards. Clients will be routinely informed about and assisted in utilizing this procedure and shall not be discriminated against for doing so.	Agency has statement/policy onsite.

CONSUMER RIGHTS & RESPONSIBILITIES

#	Standard	Performance Measure / Method	Sub-Recipient Responsibility
1.0	Provision of Statement of Consumer Rights and Responsibilities	Each client shall be provided with a copy of the Statement of Consumer Rights and Responsibilities, which are attached as appendices to the Standards of Care (SOC). Each agency will take all necessary actions to ensure that services are provided in accordance with the consumer rights and responsibilities statement and that each consumer understands fully his or her rights and responsibilities.	A signed statement must be in client file.
2.0	Provision of informed consent	Each client shall have a signed informed consent statement on file prior to receipt of services.	Documentation in client files of statement.

CONFIDENTIALITY OF CLIENT INFORMATION

#	Standard	Performance Measure / Method	Sub-Recipient Responsibility
1.0	Provision of client confidentiality by Sub-Recipient	Each agency will protect client confidentiality in accordance with state and federal laws including the Health Insurance Portability and Accountability Act (HIPAA) and will have a system for the safeguarding of client information.	Sub-Recipient Policy and Procedures Manual on file. All client records belong to the University Health System Ryan White Program.
2.0	Provision of client confidentiality by staff and volunteers	Agency employees and volunteers shall sign a confidentiality statement following completion of staff training on the subject of confidentiality. Confidentiality statement will be signed yearly.	Personnel files have documentation of training in confidentiality of client information and signed confidentiality statement.
3.0	Provision of client confidentiality issued to clients	Clients will be informed of their right to confidentiality and provided with a document that expressly describes under what circumstances client information can be released.	Each sub-recipient maintains documentation in the client's file that the client has been informed and received a copy of their rights and responsibilities regarding release of information to include the ARIES consent form.
4.0	All subcontractors and sub-recipient agencies must have policies that outline how to address negligent or purposeful release of confidential client information.	Agencies will have detailed policies outlining how to address negligent or purposeful release of confidential client information in accordance with the Texas Health and Safety Code and HIPAA regulations	AAs are to ensure that all subcontractors, vendors, and Sub-recipient agencies have detailed policies outlining how to address negligent or purposeful release of confidential information in accordance with the Texas Health and Safety Code and HIPAA regulations

USE OF VOLUNTEERS

#	Standard	Performance Measure / Method	Sub-Recipient Responsibility
1.0	Provision of list of volunteer support activities or opportunities	Agencies will maintain a list of volunteer support activities or opportunities that are available at the site.	List on file at provider agency.
2.0	Provision of volunteer orientation and training	Volunteers will be oriented and trained before working with clients. Orientation must include issues of confidentiality, consumer rights and responsibilities, boundaries, and other orientation topics pertinent to a specific service category.	Documentation of completed orientation and training on file at provider agency signed by volunteer and supervisor.
3.0	Provision of volunteer supervision	Volunteers will be offered supervision at least once per month, and as needed.	Documentation of supervision sessions by supervisors on file at provider agency.
4.0	Provision of volunteer policies	Agency has protocols or policies to support volunteer recruitment, recognition, and retention.	Protocols or policies on file at provider agency.

ORIENTATION/TRAINING OF STAFF/VOLUNTEERS

#	Standard	Performance Measure / Method	Sub-Recipient Responsibility
1.0	Provision of staff orientation	Sub-recipients shall have an established, detailed staff orientation process. Orientation must be provided to all staff providing direct services to clients within ten (10) working days of employment. Primary areas to be covered, as applicable to position held, must include at a minimum: a. HIV Basic Science and Psychosocial Issues b. Clinical protocols and standards for pharmacological treatment of HIV c. Client rights and responsibilities d. Confidentiality (with signed confidentiality agreement) e. Listing of indigent drug access programs f. Client relations g. Cultural competency h. Professional ethics i. Programmatic requirements including applicable Standards of Care and protocol for assessing treatment adherence j. Proper documentation in case records k. Emergency and safety procedures l. Infection control and universal precautions m. Eligibility verification process and policy n. Review of job description	Orientation program educates staff on above described required subject matter. Personnel file reflects completion of orientation and signed job description.
2.0	Provision of staff training	Staff participating in the direct provision of services to clients must satisfactorily complete a minimum of eight (8) hours of job-related educational programs/in-services annually, as determined by Agency personnel policy. Appropriate and professional-training priorities for training should include but not be limited to: current state of the art medical therapy, psychosocial issues (adherence, mental health, substance abuse, etc.), and cultural competency.	Personnel files of staff, volunteers, and/or sub-contractors staff reflect eight (8) hours of training annually.

CULTURAL COMPETENCY

#	Standard	Performance Measure / Method	Sub-Recipient Responsibility
1.0	Provision of appropriate services and referrals	Agencies will provide appropriate services and referrals in an equitable and non-judgmental manner to all clients	Agency has statement/policy onsite.
2.0	Provision of cultural differences	Cultural differences will be considered in connection with the provision of services.	Agency has statement/policy onsite.
3.0	Provision of training in cultural competency	All agency staff having direct contact with clients will receive training in cultural competency. Agency shall provide annual training in cultural competency to all staff.	Documentation of annual cultural competency training in personnel file.
4.0	Provision of to overcome barriers for clients	All services will be provided in such a way as to overcome barriers to access and utilization, including efforts to accommodate linguistic and cultural diversity.	Sub-recipient maintains a source list of interpretive services. There is documentation of staff training to explain information in plain language and with cultural competency.

COLLABORATIVE HIV SERVICE DELIVERY

#	Standard	Performance Measure / Method	Sub-Recipient Responsibility
1.0	Provision of service referrals	Sub-recipient must have available a full range of service referrals. To establish this base of referrals, providers need to network with other AIDS service organizations and prevention programs, and city, state, and private organizations providing similar services in the community.	Agency has linkage agreements with service providers representing the continuum of care. Memorandum of Understanding (MOU) must be on file.
2.0	Provision of resources	Sub-recipient will establish relationships with providers of such services and will become familiar with and utilize referral processes and coordination of services among the multi-disciplinary provider network.	Provider will maintain a current resource guide of services. Documentation of staff training of available resources.
3.0	Provision of mileage reimbursement	Sub-recipient may reimburse staff for program related travel at a rate consistent with the agency policy and the rate cannot exceed IRS approved rate.	Agency policy for staff mileage reimbursement.
4.0	Provision of service fees	Sub-recipient shall not charge the Ryan White Fund any additional transaction fee of any kind for services rendered.	Service fee imputed in ARIES matches billing statements
5.0	Provision of no direct cash payments	No direct payment(s) shall be made to client/patient.	Agency policy on file.

AIDS PHARMACEUTICAL ASSISTANCE (LOCAL) {LPAP}

Service Category Definition:

AIDS Pharmaceutical Assistance (Local) (LPAP) includes local pharmacy assistance programs implemented by Part A or Part B Recipient to provide HIV/AIDS and HIV/AIDS-related medications to clients who are not eligible for medications through private insurance, Medicaid/Medicare, State ADAP, State SPAP or other sources. This assistance can be funded with Part A grant funds and/or Part B base award funds. Medications covered under this service category must be listed on the most current formulary approved by the Quality Management Formulary Subcommittee. Other FDA-approved prescription medications necessary for the treatment of HIV-related conditions that are not listed on the formulary may be requested on a case-by-case basis with prior approval from the AA.

The purpose of a Local Pharmaceutical Assistance Program (LPAP) is to provide therapeutics to treat HIV/AIDS or to prevent the serious deterioration of health arising from HIV/AIDS in eligible individuals including measures for prevention and treatment of opportunistic infections. There is no definitive list of medications that are to be included or excluded from a formulary. The SATGA/HSDA will determine formularies based on client need.

Local AIDS Pharmaceutical Programs provide:

- HIV medications that are not included in the ADAP formulary
- Medications when the ADAP financial eligibility is restrictive
- Medications if there is a protracted State ADAP eligibility process and/or other means of accessing medications are not available (i.e., pharmaceutical company assistance programs)
- Vaccinations

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

- Consistent with the most current HIV/AIDS Treatment Guidelines
- Coordinated with the State's Part B AIDS Drug Assistance Program (ADAP)
- Implemented in accordance with requirements of the 340B Drug Pricing Vendor Program and/or Alternative Methods Project

LPAP can be used to fund dispensing fees associated with ADAP/LPAP medications.

It is preferable that LPAP medication be purchased at the lowest possible cost, preferably 340B Program pricing. Where possible clients need to obtain their medications through a 340B covered entity or pharmacy that is under contract with the 340B Program.

Over-the-Counter medications to include vitamins may be purchased with LPAP funds if the medication is listed on the LPAP formulary and the provider has deemed that the medication is needed for prevention and treatment of opportunistic infections or to prevent the serious deterioration of health.

Medications not included in the LPAP formulary cannot be purchased. The provider wishing to prescribe a medication not on the formulary shall make a request to the Administrative Agency.

Service Category Limitations:

- Local pharmacy assistance programs (LPAP) are not funded with AIDS Drug Assistance Program (ADAP) earmark funding.
- LPAPs are not to take the place of the ADAP program.

- LPAPs are not emergency financial assistance for medications.
- Clients cannot be enrolled in another medication assistance program for the same medication, excluding co-payment discounts.
- Funds may not be used to make direct payments of cash/vouchers to a client.
- No charges may be imposed on clients with incomes below 100% of the Federal Poverty Level (FPL).

This program does not pay for medications as:

- A result or component of a primary medical visit
- A single occurrence of short duration (an emergency)
- Vouchers to clients on an emergency basis

Emergency Financial Assistance (EFA) service category should be used for the above situations.

Clients with insurance who seek medication co-payment assistance should be referred to Health Insurance Premium and Cost-sharing Assistance (HIPCSA) service category.

Personnel Qualifications:

Qualification	Expected Practice
Bachelor's degree preferred or equivalent experience or pharmacy tech certification under the supervision of a pharmacist	Personnel files/resumes/applications for employment reflect requisite experience and education.

Service Standards, Measures, and Goals:

Service Standard	*Outcome Measure*	*Goal*
Service providers dispensing medications shall adhere to all local, state and federal regulations and maintain current licenses required to operate as a medication dispensary in the State of Texas.	Pharmacy license is on site. 340B certification current and on file within Agency records.	90%
Each prescription is dispensed/delivered within two (2) working days (including mail orders).	Prescription log shows date and time each prescription was submitted and filled.	90%
Available label descriptions in Spanish when necessary.	Labels are available in Spanish upon request.	100%
A procedure to voice complaints or grievances with service. Grievances must be maintained as required by licensure.	Pharmacy has a means to receive and address client complaints.	90%
Confidentiality statement signed by pharmacy employees.	Signed confidentiality statements of staff on file.	90%
Provider will ensure that all feasible alternative revenue systems (e.g. pharmaceutical company patient assistance programs) have been explored before request for LPAP.	Documentation of patient assistance programs (PAP) was explored prior to request for LPAP.	100%
The client is assessed for eligibility of Texas HIV Medication Program (THMP).	Applications submitted to THMP within 2 weeks of client assessment.	100%.
Provider will utilize the most affordable/cost efficient form of medication accessible.	Prescriptions filled are the most cost-efficient medications provided by pharmacy dispensing	90%

A copy of the client's prescription from a medical provider is on file.	Charts document prescriptions with: • Name of the client • Date of birth • Medication • Dose • Prescribing medical provider	90%
Clients are offered counseling on medication adherence.	Clients are screened for medication adherence and counseled if not adherent.	90%
Clients who access HIV medications for long-term assistance (more than 60 days) have documentation in their files of viral suppression.	Percentage of clients accessing HIV medication assistance for long-term (more than 60 days) have documented evidence of viral suppression within the measurement year.	90%

EARLY INTERVENTION SERVICES (EIS)

Service Category Definition:

Early Intervention Services (EIS) include identification of individuals at points of entry and access to services and provision of HIV Testing (including tests to confirm the presence of the disease, tests to diagnose the extent of immune deficiency, tests to provide information on appropriate therapeutic measures) and Targeted counseling; Referral services; Linkage to are; Health education and literacy training that enable clients to navigate the HIV system of care.

NOTE: EIS provided by Ryan White Part C and Part D Programs should NOT be reported here. Part C and Part D EIS should be included under Ambulatory/Outpatient Medical Care.

Early Intervention Services (EIS) are the provision of a combination of services that include the following services as related to HIV/AIDS: counseling, testing, case finding, outreach, referrals, and other clinical and diagnostic services designed and coordinated to bring individuals with HIV disease into the local HIV continuum of care. These services must focus on expanding key points of entry and documented tracking of referrals.

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

Service Category Limitations:

All four of the above components must be present, but Ryan White Part A & B funds can only be used for HIV Testing as necessary to supplement, not supplant, existing funding. Part A and B funds are used for HIV testing only where existing federal, state, and local funds are not adequate. If HIV testing is performed as part of EIS, no eligibility documentation is required.

Personnel Qualifications:

Qualification	Expected Practice
Staff providing care and/or counseling services to clients participating in the Early Intervention program must be trained to provide these services to recently diagnosed HIV/AIDS clients and to PLWHAs who know their status and are not in care. They also must receive supervision by a senior member with experience and skill in the field. All agency staff that provide direct-care services shall possess: • Advanced training/experience in the area of HIV/infectious disease, • HIV early intervention skills and abilities as evidenced by training, certification, and/or licensure, and documented competency assessment; and • The skills necessary to work with a variety of health care professionals, medical case managers, and interdisciplinary personnel. • Phlebotomy certification, if required. Supervisors must possess a degree in a health/social service field or equivalent experience.	Personnel files/resumes/applications for employment reflect requisite experience and education.

Each agency staff person who provides direct services to clients shall be properly trained in case management. Supervisors will be a degreed or licensed individual (by the State of Texas) in the fields of health, social services, mental health, or a related area, preferably Master's Level.	Personnel files/resumes/applications for employment reflect requisite experience and education.
Within three (3) months of hire, all staff must complete a minimum of sixteen (16) hours of training regarding the target population and the HIV service delivery system in the San Antonio TGA/HSDA, including but not limited to: 1. The full complement of HIV/AIDS services available within the TGA/HSDA 2. How to access such services [including how to ensure that particular subpopulations are able to access services (i.e., undocumented individuals) 3. Ryan White Standards of Care (Universal and Service Category Standards) Education on applications for eligibility under entitlement and benefit programs other than Ryan White services will be included and periodically updated as changes occur.	Personnel file reflects completion of orientation and signed job description.
EIS Specialists/Case Managers and EIS Specialists/Case supervisors must satisfactorily complete continuing education as required by state licensing boards. Each staff will complete a minimum of 12 hours of training annually to remain current on HIV care.	Documented in personnel file or training log.
Each EIS Specialists/Case Management Agency must have and implement a written plan for supervision of all EIS Specialists/Case Management staff. Supervisors must review a 10 percent sample of each EIS Specialist's/Case Manager's case records each month for completeness, compliance with these standards, and quality and timeliness of service delivery.	Agency has written plan for supervision of all EIS Specialists/Case Management staff. Agency will keep on file supervision logs demonstrating the review of random client files citing the date and outcome of chart reviews Personnel files contain annual performance evaluations.
Each supervisor must maintain a file on each EIS Specialist/Case Manager supervised and hold supervisory sessions on at least a monthly basis. The file on the case manager must include, at a minimum: 1. Date, time, and content of the supervisory sessions 2. Results of the supervisory case review addressing, at a minimum of completeness and accuracy of records, compliance with standards and effectiveness of service.	Documentation of supervision provided Supervisors' files on each EIS Specialists/Case Managers reflect ongoing supervision, supervisory sessions and case review as described above.

Agency Qualifications:

Qualification	Expected Practice
Agency License	The agency's facility(s) shall be appropriately licensed or certified as required by Texas Department of State Health Services, for the provision of HIV Early Intervention Services, including phlebotomy services.
Agency Policies and Procedures	The agency shall have policies/procedures for each of the following: • Patient rights and responsibilities, including confidentiality guidelines • Patient grievance policies and procedures • Patient eligibility requirements • Data collection procedures and forms, including data reporting • Guidelines for language accessibility

	Agency will have a policy that: • Defines and describes EIS services (funded through Ryan White or other sources) that include and are limited to counseling and HIV testing, referral to appropriate services based on HIV status, linkage to care, and education and health literacy training for clients to help them navigate the HIV care system • Specifies that services shall be provided at specific points of entry • Specifies required coordination with HIV prevention efforts and programs • Requires coordination with providers of prevention services • Requires monitoring and reporting on the number of HIV tests conducted and the number of positives found • Requires monitoring of referrals into care and treatment
Entry into care: According to HRSA National Monitoring Standards, key points of entry will be established.	Agency/staff will establish memoranda of understanding (MOUs) with key points of entry into care to facilitate access to care for those who test positive.
Health Education and Literacy Training Curriculum: According to the HRSA National Monitoring Standards health education and literacy training will be defined	Agency will develop/use an approved health education curriculum to provide client: • Education concerning the HIV disease process, risk reduction, and maintenance of the immune system • Literacy training to help client navigate the HIV care system.
HIV Testing and Targeted Counseling: According to the HRSA National Monitoring Standards all four components must be present. Funds can only be used for HIV testing to supplement, not supplant, existing funding.	If Ryan White funds are used for HIV testing, agency must document the reason(s) necessary to supplement existing funding.

Service Standards, Measures, and Goals:

Service Standard	***Outcome Measure***	***Goal***
Service Provider shall provide physical examination and assessment to identify urgent health issues/need.	Documentation of physical examination in client files.	90%
Service Provider shall provide client education concerning the HIV disease process, risk reduction, maintenance of the immune system and literacy training that enable clients to navigate the HIV system of care.	Documentation of client education in client files.	90%
Service Provider shall develop an initial care plan in direct cooperation and agreement with the client that identifies client needs, resources, goals, and planned course of action to meet immediate needs, and revise the plan as necessary.	Documentation of Care Plan and follow up reassessment of care plan as indicated, in client files.	90%
Service Provider shall develop an initial care plan in direct cooperation and agreement with the client that identifies client needs, resources, goals, and planned course of action to meet immediate needs, and revise the plan as necessary.	Documentation of Care Plan coordination and referral to Primary Medical Case Management.	90%
EIS programs will ensure that clients are connected to Primary Medical Care within 30 Days of initial intake.	Documentation of first medical visit within 30 days of EIS intake in client files.	90%

EIS programs will make available mental health and psychosocial support services performed by a master's level social worker and/or other appropriate licensed healthcare provider or counselor. Services will be provided in accordance with the National Association of Social Workers' Code of Ethics. Mental health and psychosocial services will include (but not be limited to): • Comprehensive psychosocial assessment of all new clients including: ▪ Mental health or substance use issues • Client's adjustment to HIV disease and illness • Client's understanding of diagnosis and treatment • Recommended treatment • Barriers to treatment adherence • History of client's family background, education, vocational experience, and housing status. • Development of an individualized psychosocial treatment plan.	Documentation of mental health and psychosocial support services screening and/or assessment in client files.	90%
Individual, group, couple, family and/or counseling and crisis intervention services may also be offered for those clients who are experiencing acute or ongoing psychological stress. Such services will usually be provided on a regularly-scheduled basis with special arrangements made for non-scheduled visits at the time of crisis. All mental health services will be provided in accordance with the approved Mental Health and Substance Abuse Services-Outpatient Standards of Care.	Documentation of referral to Mental Health and Substance Abuse Services-Outpatient as indicated in client files.	90%
Counseling and Crisis intervention services will be offered as needed and provided in accordance with current approved standards of care.	Documentation of agency policy and protocol for counseling and crisis intervention services.	90%
EIS programs are encouraged to work in partnership with clients to develop and track health self-management goals in such critical areas as: • Adherence • Exercise • Substance abuse • Sexual risk management • Nutrition • Oral Health	Documentation of self-management goals in client files.	90%

HEALTH INSURANCE PREMIUM AND COST SHARING ASSISTANCE (HIPCSA)

Service Category Definition:

Health Insurance Premium and Cost Sharing Assistance (HIPCSA) provides financial assistance for eligible clients living with HIV to maintain continuity of health insurance or to receive medical and pharmacy benefits under a health care coverage program.

To use Ryan White HIV/AIDS Program (RWHAP) funds for health insurance premium and cost sharing assistance, a RWHAP Part recipient must implement a methodology that incorporates the following requirements:

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

The provision of financial assistance for eligible individuals living with HIV to maintain a continuity of health insurance or to receive medical benefits under a health insurance program. This includes out-of-pocket costs such as premium payments, co-payments, coinsurance, and deductibles.

The cost of insurance plans must be lower than the cost of providing health services through grant-supported direct delivery (be "cost-effective"), including costs for participation in the Texas AIDS Drug Assistance Program (ADAP).

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

Funds may be used for:

- Purchasing health insurance (both job or employer-related plans and plans on the individual and group market) that provides comprehensive primary care and pharmacy benefits for clients that provide a full range of HIV medications;
- Standalone dental insurance premiums when cost effective and/or cost sharing assistance when provided in compliance with requirements described in HRSA Policy Clarification Notice (PCN) 16-02, including the FAQ;
- Paying co-pays (including co-pays for prescription eyewear for conditions related to HIV infection), deductibles, and co-insurance for medical and dental plans on behalf of the client;
- Certain tax liabilities
- Funds can be used for assistance with payments under the local government cost sharing programs (i.e. Carelink program of the Bexar County University Health System). Such assistance shall be limited to those clients paying their cost sharing assistance bills and must be evidenced by documentation showing the client has a current account which is not past due or in default status.

FPL limitation for Ryan White Part B HIPCSA shall be evidence of an annual gross earned and/or unearned income not greater than 500% of the federal poverty guidelines according to family size.

Service Category Limitations:

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

HIPCSA excludes plans that do not cover HIV-treatment drugs; specifically, the plan must cover at least one drug in each class of core antiretroviral therapeutics from the HHS clinical guidelines as well as appropriate primary care services.

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

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

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

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

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

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

RWHAP funds may not be used to cover a client's Medicare Part D "true out-of-pocket" costs, i.e. TrOOP or donut hole.

Personnel Qualifications:

Qualification	Expected Practice
Service providers shall employ staff who have at least a Bachelor's degree and a minimum of six (6) months experience providing services in this or a related field. A total of three (3) years of relevant experience in this or a related field can be substituted for the education requirement. Staff must be able to comprehend the different scenarios involving health insurance and have a working knowledge of the COBRA and OBRA insurance programs and various private insurance programs and policies, including eligibility requirements, benefits, applicable deductibles and co-pays, Parts A, B and D of Medicare, Medicaid, the Children's Health Insurance Program (CHIP), Medicare Savings Programs, Medicare Advantage Plans, Veterans Administration (VA) benefits, CareLink, Texas HIV Medication Program (THMP), State Pharmaceutical Assistance Program (SPAP) and other health insurance, financial assistance and medication assistance programs and have a general understanding of the system of health care delivery within the TGA and surrounding HSDAs.	Personnel files/resumes/applications for employment reflect requisite experience/education/knowledge and understanding.

Agency Qualifications:

Qualification	Expected Practice
Cash payments to clients are prohibited	Documentation of policy and procedures in agency manuals that addresses prohibition

	of cash payments to clients	

Service Standards, Measures, and Goals:

Service Standard	*Outcome Measure*	*Goal*
HIPCSA providers must maintain individual files which document client demographics, eligibility, services provided, other agencies contacted, and benefits programs accessed.	Documentation in client's file and in ARIES.	90%
The agency must ensure that clients are buying health coverage that, at a minimum, includes at least one drug in each class of core anti-retro viral treatment (ART) from the HHS treatment guidelines along with Outpatient/Ambulatory Health Services (OAHS) that meet the requirements of the ACA law for essential health benefits. This must be documented in the client's primary record.	Percentage of clients with documented evidence of health care coverage that includes at least one drug in each class of core ART from HHS treatment guidelines along with OAHS services that meet the requirements of the ACA law for essential health benefits as indicated in the client's primary record.	90%
Co-payments, Premiums, Deductibles, and Co-insurance: Otherwise eligible clients with job or employer-based insurance coverage, Qualified Health Plans (QHP), or Medicaid plans, can be provided assistance to offset any cost-sharing programs may impose. Clients must be educated on the cost and their responsibilities to maintaining medical adherence. Education must be provided to clients specific to what is reasonably expected to be paid for by an eligible plan and what RWHAP can assist with to ensure healthcare coverage is maintained. Agencies will ensure payments are made directly to the health or dental insurance vendor within five (5) business days of approved request.	Percentage of clients with documented evidence of education provided regarding reasonable expectations of assistance available through RWHAP Health Insurance to assist with healthcare coverage as indicated in the client's primary record. Percentage of clients with documented evidence of insurance payments made to the vendor within five (5) business days of the approved request.	90%
Cost Sharing Education: Education is provided to clients, as applicable, regarding cost-sharing reductions to lower their out-of-pocket expenses. It must be evidenced in the client's primary record that the individual must receive a premium tax credit and enroll in a silver level plan offered in the Marketplace. Clients who are not eligible for cost-sharing reductions (those under 100% FPL in Texas; those with incomes above 400% FPL; clients who have minimum essential coverage other than individual market coverage and choose to purchase in the marketplace; and those who are ineligible to purchase insurance through the marketplace) are provided education on cost-effective resources available for the client's health care needs.	Percentage of clients with documented evidence of education provided regarding cost sharing reductions as applicable, as indicated in the client's primary record.	90%
Premium Tax Credits Education: Agencies have documented evidence in the client's primary record of the enrollment in a QHP in the Marketplace, as applicable to the individual (clients that are between 100-400% FPL without access to minimum essential coverage).	Percentage of clients with documented evidence of education provided regarding premium tax credits as indicated in the client's primary record.	90%

Education provided to the client regarding tax credits and the requirement to file income tax returns must be documented in the client's primary record. Clients must be provided education on the importance of reconciling any Advanced Premium Tax Credit (APTC) well before the IRS tax filing deadline.		
Prescription Eyewear: Agency must keep documentation from physician stating that the eye condition is related to the client's HIV infection when HIPCSA funds are used to cover co-pays for prescription eyewear.	Percentage of client files with documented evidence, as applicable, of prescribing physician's order relating eye condition warranting prescription eyewear is medically related to the client's HIV infection as indicated in the client's primary record.	90%
Medical Visits: Clients accessing health insurance premium and cost sharing assistance services are adherent with their HIV medical care and have documented evidence of attendance of HIV medical appointments in the client's primary record.	For clients with applicable data in ARIES or other data system used at the provider location, percentage of clients, regardless of age, with a diagnosis of HIV who had at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits. (HRSA HAB Measure) *or*	90%
Note: For clients who use HIPCSA to enable their use of medical care outside of the RW system: HIPCSA providers are required to maintain documentation of client's adherence to Primary Medical Care (e.g. proof of MD visits) during the previous 12 months.	For clients who use HIPCSA to enable their use of medical care outside of the RWHAP system: Percentage of clients with documentation of client's adherence to Primary Medical Care (e.g. proof of MD visits, insurance Explanation of Benefits, MD bill/invoice) during the previous 12 months.	90%
Viral Suppression: Clients receiving Health Insurance Premium and Cost-Sharing Assistance services have evidence of viral suppression as documented in viral load testing.	For clients with applicable data in ARIES or other data system used at the provider location, percentage of clients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year. (HRSA HAB Measure)	90%
Agency follows written guidelines, without exception, for all requests.	Provider assesses and documents client eligibility for alternative coverage of health insurance premium or cost sharing prior to RWHAP assistance.	90%
Client will be discharged according to provider's criteria for services. Client will be given adequate notice of any change in the level of services provided.	Provider has written plan for discharge and transition with written documentation that no eligible client is denied insurance assistance without discussing with the AA first (regardless of funding status).	90%

MEDICAL CASE MANAGEMENT (MCM)

Service Category Definition:

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

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

Medical Case Managers act as part of a multidisciplinary medical care team, with a specific role of assisting clients in following their medical treatment plan and assisting in the coordination and follow-up of the client's medical care between multiple providers.

The goals of this service are:

1. the development of knowledge and skills that allow clients to adhere to the medical treatment plan without the support and assistance of the staff providing Medical Case Management services and
2. to address needs for concrete services such as health care, public benefits and assistance, housing, and nutrition, as well as develop the relationship necessary to assist the client in addressing other issues including substance use, mental health, and domestic violence in the context of their family/close support system.

Core components of Medical Case Management services are:

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

Key activities include:

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

The following clients should be enrolled in Medical Case Management:

- Late to care / out of care / not in care / re-engaging in care
- Newly Diagnosed
- Homeless
- Recently released from incarceration

- Pregnant
- CD4 count below 200 or VL> 10,000 copies/ml
- Untreated mental illness (including substance use disorders)
- New to Antiretroviral therapy
- Non-adherence to HIV medication
- Unable to navigate System of Care due to language barriers
- Individuals who have complex medical needs and may require a more extensive time investment

Service Category Limitations:

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

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

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

Personnel Qualifications:

Qualification	Expected Practice
Part A Providers: Medical case management services must be provided by trained professionals, including both medically credentialed and other health care staff who provide a range of client-centered services that result in a coordinated care plan which links clients to medical care, psychosocial, and other services. They will meet the qualifications for the position as outlined in the Agency's job description. The minimum requirements are: 1. A bachelor's (required) or master's degree (preferred) in social work from a program accredited by the Texas State Board of Social Work Examiners (TSBSWE); OR 2. A bachelor's (required) or master's degree (preferred) in nursing (RN) currently licensed in Texas by the Board of Nurse Examiners (one year of paid experience will substitute for the degree); OR 3. One (1) year of paid post-degree experience in direct service to HIV target population.	Personnel files/resumes/applications for employment reflect requisite experience and education.

Part B Providers: All medical case managers shall be a licensed professional (e.g., RN, LBSW, LMSW). Programs providing medical case management that meet the requirements of this definition with experienced unlicensed staff may apply for a limited waiver of this provision. Regarding all future medical case management hires, providers shall seek to hire licensed professionals as outlined in HRSA policy notice 10-02.	Personnel files/resumes/applications for employment reflect requisite experience and education.
All case managers must complete (or have completed prior) the following within six (6) months of hire: • Effective Communication Tools for Healthcare Professionals 100: Addressing Health Literacy, Cultural Competency and Limited English Proficiency* • Texas HIV Medication Program 2013 Update* • HIV Case Management 101: A Foundation* • HIV Case Management 101: A Foundation Part Two (Module 1: HIV and Behavioral Risk; Module 2: Substance Use and HIV; Module 3: Mental Health and HIV)* All new case managers must complete (or have completed prior) the following within twelve (12) months: • STD Facts & Fallacies: Chlamydia, Gonorrhea & Pelvic Inflammatory Disease (PID)* • STD Facts & Fallacies: Syphilis* • Perinatal HIV Prevention Online Program* ***These courses are all available through the TRAIN (Training Finder Real-time Affiliate Integrated Network) Texas learning management system (www.tx.train.org)***	Personnel files reflect training log with documentation of subject matter and attendance.
A minimum of sixteen (16) additional hours of orientation training must cover orientation to the target population and the HIV service delivery system in the San Antonio TGA and HSDAs including but not limited to: • The full complement of HIV/AIDS services available within the TGA and HSDAs, including non-Ryan White funded agencies • How to access such services [including how to ensure that particular subpopulations are able to access services (i.e., undocumented individuals)] • Ryan White Standards of Care (Universal and Service Category Standards) • Education on applications for eligibility under entitlement and benefit programs other than Ryan White services will be included and periodically updated as changes occur	Personnel file reflects completion of orientation and signed job description.
Twenty-four (24) hours of annual training are required for all employees. The 24 hours shall include fifteen (15) hours of medical training, six (6) hours of psychosocial training and three (3) hours of quality management training.	Personnel files reflect training log with documentation of subject matter and attendance at twenty-four (24) hours of annual training.

The medical training shall cover the Texas Department of State Health Services (DSHS) required topics of Medical Adherence, HIV Disease Process, Oral Health, Risk Reduction/Prevention Strategies (including Substance Abuse Treatment) and Nutrition. A suggested additional topic may be End-of-Life issues. Medical training shall also include training on documentation. The psychosocial training shall include the topics of AIDS and the law, medically related federal and state benefits programs (e.g. Social Security, Medicare, Medicaid, Star +).	
Each medical case management agency must have and implement a written plan for supervision of all medical case management staff. Supervisors must review ten (10) percent or thirty (30) records, whichever is less, sample of each medical case manager's case records each month for completeness, compliance with these standards, and quality and timeliness of service delivery. Medical case managers must be evaluated at least annually by their supervisor according to written Agency policy on performance appraisals. Each medical case management agency must have and implement a written plan for supervision of all medical case management staff. Supervisors must review ten (10) percent or thirty (30) records, whichever is less, sample of each medical case manager's case records each month for completeness, compliance with these standards, and quality and timeliness of service delivery. Medical case managers must be evaluated at least annually by their supervisor according to written Agency policy on performance appraisals.	Agency has written plan for supervision of all medical case management staff. Agency will keep on file supervision logs demonstrating the review of random client files citing the date and outcome of chart reviews. Personnel files contain annual performance evaluations.
A medical case management supervisor must meet the *minimum* qualifications for education and experience listed below: 1. A bachelor's (required) or master's degree (preferred) in social work from a program accredited by the TSBSWE and two years of paid post degree experience in providing case management services; OR 2. A bachelor's (required) or master's degree (preferred) in nursing (RN) (one year of experience will substitute for the degree) and two years of paid post degree experience in providing case management services; OR 3. A bachelor's (required) or master's degree (preferred) in a human service related field which includes: psychology, education, counseling, social services, sociology, philosophy, family and consumer sciences, criminal justice, rehab services, child development, substance abuse, gerontology, and vocational rehabilitation and two years of paid post degree experience in providing case management services; OR 4. A bachelor's in liberal arts or general studies with concentration of at least sixteen (16) hours in one of the fields listed in item C of this part and two (2) years of paid post degree experience in providing medical case management services.	Personnel files/resumes/applications for employment reflect requisite experience and education.

Each supervisor must maintain a file on each medical case manager supervised and hold supervisory sessions on at least a monthly basis. The file on the medical case manager must include, at a minimum: 1. Date, time, and content of the supervisory sessions; and 2. Results of the supervisory case review addressing, at a minimum of completeness and accuracy of records, compliance with standards and effectiveness of service.	Documentation of supervision provided. Supervisors' files on each medical case manager reflect ongoing supervision, supervisory sessions and case review as described above.
A Medical Case Management Supervisor may supervise a maximum of eight (8) full-time medical case managers or a combination of full-time medical case managers and other professional-level human services staff. A supervisor *may* carry one-eighth of a caseload for each medical case manager supervised fewer than eight (8).	Caseloads are monitored to ensure that the maximum allowable standard is not exceeded.

Service Standards, Measures, and Goals:

Service Standard	*Outcome Measure*	*Goal*
Initial Comprehensive Assessment must be completed within 30 calendar days of the first appointment to access MCM services and includes at a minimum: 1. Client health history, health status and health-related needs, including but not limited to: • HIV disease progression • Tuberculosis • Hepatitis • STI history and/or history of screening • Other medical conditions • OB/GYN as appropriate, including pregnancy status • Routine health maintenance (ex. Well women exams, pap smears) • Medications and adherence • Allergies to medications • Complementary therapy • Current health care providers; engagement in and barriers to care • Oral health care • Vision care • Home health care and community-based services • Substance Use (validated and reliable substance use disorder screening tool must be used. See website for SAMISS) • Mental Health (validated and reliable substance use disorder screening tool must be used. See website for SAMISS) • Medical Nutritional Therapy • Clinical trials • Family Violence	Percentage of clients who access MCM services that have a completed initial comprehensive assessment within 30 calendar days of the first appointment to access MCM services and includes all required documentation in the primary client record system. Percentage of clients that received at least one face-to-face meeting with the MCM staff that conducted the initial comprehensive assessment. Percentage of clients with documentation of case closure due to non-responsiveness. Percentage of MCM clients with documented education on basic HIV information as needed (newly diagnosed, return to care), including explanation of viral load and viral suppression. Percentage of MCM clients with documented evidence of sexual health literacy and education provided on harm reduction, as needed.	90%

- Sexual health assessment and risk reduction counseling

2. Additional information
   - Client strengths and resources
   - Other agencies that serve client and household
   - Progress note of assessment session(s)
   - Supervisor signature and date, signifying review and approval, for medical case management staff during their probationary period

NOTE: The MCM team has the discretion to (1) determine priority need clients that should be enrolled in MCM and (2) enroll clients who have low acuity scores, but are high need and/or high-risk clients for disengaging in care. Clear and detailed documentation must be present in the client's primary record.

Clients who are no longer engaged in active case management services should have their cases closed based on the criteria and protocol outlined below. A closure summary usually outlines the progress toward meeting identified goals and services received to date. Common reasons for case closure include: • Client completed case management goals • Client is no longer in need of case management services (e.g. client is capable of resolving needs independent of case manager assistance) • Client is referred to another case management program • Client relocates outside of service area • Client chooses to terminate services • Client is no longer eligible for services due to not meeting eligibility requirements • Client is lost to care or does not engage in service • Client incarceration greater than 6 months in a correctional facility • Provider initiated termination due to behavioral violations • Client death Closed cases include documentation stating the reason for closure and a closure summary (brief narrative in progress notes and formal discharge summary) signed off by Supervisor (electronic review is acceptable). Client is considered non- compliant with care if 3 attempts to contact client (via phone, e-mail and/or written correspondence) are	Documentation of case closure and reason in client's record.	90%

unsuccessful and the client has been given 30 days from initial contact to respond. Discharge proceedings should be initiated by agency 30 days following the 3rd attempt. In accord with written policies and procedures established by each agency, the case manager notifies the client (through face-to-face meeting, telephone conversation or letter) explaining the reason(s) for discharge, the process to be followed if client elects to appeal the discharge from service, and information about reestablishment of services.		
Medical case managers shall ensure that, to the greatest extent possible, clients who leave care are linked with appropriate services to meet their needs.	Documentation in client's record indicating referrals or transition plan to other providers/agencies.	90%
The medical case manager conducts a face-to-face assessment of the client's needs.	Documentation of needs assessment in client chart.	90%
Within three (3) working days of enrollment, an intake shall be completed to evaluate the client's needs, including, but not limited to the following: • Medical history and current health/primary care status • Available financial resources (including insurance status) with emphasis on Medicaid, THMP, SSI and other resources. • Availability of food, shelter, and transportation • Available support system • Need for legal assistance • Substance abuse history and status • Emotional/mental health history and status	Client's chart contains documentation of each client's need for (or problems with) current medical status, financial resources, food, transportation, support system, substance abuse status and mental health status.	90%
The intake should be reviewed with the client as evidenced by the completed service plan and acuity score.	Documentation of service plan signed by client and case manager when reviewed in client file.	90%
Care Plans are re-assessed every 4-6 months for full eligibility, financial, and support services every 6 months. *(For stable clients with acuity score of >201, Care Plans should be reassessed every 6 months.) *see Acuity Scale below table.*	Documentation of reassessment of care plan in client files.	90%
An individual care plan will be completed within ten (10) working days of the first face-to-face meeting with the client.	Documentation of care plan in client file.	90%
The individual care plan will be a written comprehensive plan of intervention made up of goals and measurable objectives prepared with the participation of the client with the primary objective to include potential barriers to adherence to antiretrovirals or other therapies and continued medical follow-up	Documentation shall include client's problems and needs with treatment and medications, attempts made to solve the problems (including a timeframe and names of providers involved), and follow-up items to relay to the primary care provider.	90%
Medical case managers ensure that all client needs are identified by assessment and acuity, and prioritized so that the most important services for clients are made available as soon as possible.	Documentation in client file.	90%

Care Plans are signed and dated by the Medical Case Manager that developed the Plan and by the client.	Documentation of signature of Medical Case Manager and client in client files.	90%
Medical Case Managers will refer clients for necessary services in a timely manner.	Documented in client's file. Failure to follow-up on completion of a referral for any service will be documented in the progress notes of client file.	90%
Medical Case Managers will monitor client's progress to meeting established goals of care.	Documentation in client files.	90%
Medical case managers have documentation in client file of two (2) or more medical visits in the assessment year.	Documentation in client files.	90%

MEDICAL NUTRITION THERAPY

Service Category Definition:

Medical Nutrition Therapy services including nutritional supplements is provided outside of a primary care visit by a licensed Registered Dietitian; may include food provided pursuant to a physician's recommendation and based on a nutritional plan developed by a licensed Registered Dietitian.

Medical Nutrition Therapy includes:

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

All services performed under this service category must be pursuant to a medical provider's referral and based on a nutritional plan developed by the registered dietitian or other licensed nutrition professional. Services not provided by a registered/licensed dietitian should be considered Psychosocial Support Services under the RWHAP.
Note: In the State of Texas, the only allowable nutrition professional recognized for this service category is a licensed Registered Dietitian (RD).

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

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

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

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

Service Category Limitations:

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

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

Personnel Qualifications:

Qualification	Expected Practice
Staff and contracted workers have minimum qualifications, including licenses, certifications, and/or training expected and other experience related to the position.	Resume and documentation of training and orientations will be in personnel file.

Any person, who represents him/herself as a Registered/Licensed Dietitian shall conform to the National Monitoring Standards as a licensed Registered Dietitian and shall conform to the requirements of the Texas State Board of Examiners of Dietitians (TSBED).	Record in personnel file.
Staff and supervisors will know the requirements of their job description and service elements of the program.	Written job description provided to and signed by staff and kept in personnel file.
Staff will possess one year experience (preferred) in the nutrition assessment, counseling, evaluation and care plans of people living with HIV/AIDS.	Employee personnel file shall reflect appropriate education, expertise and experience appropriate to their area of practice as well as in the area of HIV/AIDS practice.
Registered/Licensed Dietitians are suggested to maintain membership in the Infectious Diseases Nutrition Dietetic Practice Group affiliate of the American Dietetic Association.	Record of membership in employee file.
Registered/Licensed Dietitians will meet all standards for Medical Nutrition Therapy (MNT) as described in the ADA standards for MNT.	ADA standards kept on file, and on the internet, and agency policies will reflect adherence to these guidelines.
Registered/Licensed Dietitians will maintain current professional education (CPE) units/hours, primarily in HIV nutrition and other related medical topics as approved by the Commission of Dietetic Registration.	Personnel files of staff must reflect 75 units of training over a five year period for the ADA certification and 6 units of training annually for the TSBED.
All MNT staff members shall receive training to enhance their basic knowledge about HIV and AIDS and the continuum of care for people living with HIV/AIDS.	Maintain copies of training verification in personnel file.

Service Standards, Measures, and Goals:

Service Standard	*Outcome Measure*	*Goal*
An initial MNT assessment will be conducted by an RD pursuant to a medical provider's referral.	Documentation of nutrition assessment on file in client's chart.	90%
MNT provider will contact the patient for the initial nutritional assessment within five (5) business days of the referral.	Percentage of clients accessing MNT with documentation of the medical provider's referral to MNT in the client's primary record. Percentage of clients accessing MNT with a documented completed MNT assessment conducted by an RD in the client's primary record.	90%
The initial MNT assessment must be completed within ten (10) business days of the initial appointment with the RD.	Percentage of clients accessing MNT with documentation of the medical provider's referral to MNT in the client's primary record. Percentage of clients accessing MNT with a documented completed MNT assessment conducted by an RD in the client's primary record.	90%
MNT provider collects and documents assessment history information with updates as medically appropriate prior to providing care. This information must be based on the Academy of Nutrition & Dietetics (AND) Evidence Based Guidelines that include, but not be limited to: • Anthropometrics: height and weight; pre-illness usual weight and goal weight; and body muscle and fat. • Clinical data: medical history. • Dietary data: individual's food preferences including ethnic and cultural food preferences and practices; information about allergies, food intolerances, and food avoidances; exercise frequency; food security.	Documentation of nutrition assessment completed in client's chart.	90%

- Biochemical: lab data from the primary medical care provider.

A nutritional plan will be developed appropriate for the client's health status, financial status, and individual preference. A Nutritional Plan is completed within ten (10) business days of Nutrition Assessment and includes, but is not limited to: • Nutritional diagnosis • Measurable goal • Date service is to be initiated • Recommended services and course of medical nutrition therapy to be provided to include the planned number and frequency of sessions • Types and amounts of nutritional supplements and food provisions. The plan will be signed by the RD developing the plan. The Nutrition Plan will be updated as necessary, but no less than at least twice per year, and will be shared with the client, the client's primary care provider, and other authorized personnel involved in the client's care.	Percentage of clients accessing MNT services have a documented nutrition plan developed in the client's primary record. Percentage of clients accessing MNT services have an updated nutrition plan at least twice per year as documented in the client's primary record.	90%
According to the American Dietetic Association's HIV related protocols in Medical Nutrition Therapy Across the Continuum of Care nutritional services will be provided. The frequency of contact with the RD will be based on the level of care needed per the initial assessment. Nutritional intervention will focus on set standards of medical nutrition therapy that targets measurable goals, recommended services, and course of medical nutrition therapy as outlined in the Nutrition Plan. Emerging problems such as lipodystrophy syndrome will be addressed and added to the nutrition plan as needed. Services will be documented in the patient's chart and signed by the RD providing care at each visit.	Percentage of clients accessing MNT services that have documentation in the client's primary record of frequency of contact with the RD to review the nutritional plan and goals as indicated in the initial assessment. Percentage of clients accessing MNT services with RD notes documented in the client's primary record of nutritional interventions and recommendations. Percentage of clients accessing MNT services show improvement in issues identified in the initial assessment as documented by the RD in the client's primary record.	90%
Nutritional supplements and food provisions deemed medically necessary may be provided per written orders from a prescribing physician. Upon receipt of the written referral by the primary medical care provider to the RD, clients may receive up to a 90-day supply of nutritional supplements at one time in accordance with their MNT developed nutritional plan. Nutritional supplements and food provisions must be outlined in the	Percentage of clients accessing MNT services that are prescribed nutritional supplements in accordance with the nutritional plan developed by the RD have documented evidence of supplements provided to the client in the client's primary record.	90%

written nutrition plan by the RD. The written nutritional plan must be communicated with the primary HIV prescribing provider.		
Patient nutritional health education will be offered to each patient a minimum of once a year that includes, but is not limited to: • Benefits of good nutrition • Special dietary needs of people with HIV/AIDS • Supplementation • Coping with complications	Percentage of clients accessing MNT services with documented evidence of nutritional health education provided in the client's primary record.	90%
At a minimum, patients will receive referrals to specialized health care providers/services as needed to augment MNT that includes, but is not limited to: • Other medical professionals such as social workers, mental health providers, or case managers • Community resources such as food pantries; SNAP/food stamps; • Women, Infants and Children Supplemental Food Program (WIC), etc. • Nutrition classes • Exercise facilities • Other education and economic resource groups MNT provider will document referral and outcome in the client's record.	Percentage of clients accessing MNT services that had documentation of referrals to other services as indicated in the client's primary record. Percentage of clients accessing MNT services have follow up documentation to the referral offered in the client's primary record.	90%
An individual is deemed no longer to be in need of MNT if one or more of these criteria is met: • Patient's medical condition improves and MNT services are no longer necessary • Patient deceased • Patient moves out of the service area Date of discharge, reason, and any recommendations for follow up shall be documented in the patient's record and the primary medical provider notified.	Percentage of clients accessing MNT with documentation of discharge noted in the client's primary record as applicable.	90%

MENTAL HEALTH SERVICES

Service Category Definition:

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

Mental health counseling services includes outpatient mental health therapy and counseling (individual and family) provided solely by Mental Health Practitioners licensed in the state of Texas.

Outpatient mental health services include:

- Mental Health Assessment
- Treatment Planning
- Treatment Provision
- Individual psychotherapy
- Family psychotherapy
- Conjoint psychotherapy
- Group psychotherapy
- Psychiatric medication assessment, prescription and monitoring
- Psychotropic medication management
- Drop-In Psychotherapy Groups
- Emergency/Crisis Intervention

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

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

Service Category Limitations:

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

Personnel Qualifications:

Qualification	Expected Practice
All staff providing direct mental health services to clients must be licensed and qualified within the laws of the State of Texas to provide mental health services in one of the following professions: 1. Licensed Clinical Social Worker 2. Licensed Master Social Worker (LMSW) who is employed by or volunteer for an agency not owned in total or part by the LMSW and who is under a clinical supervision plan	Current License/Certification will be maintained on file.

3. Marriage and family therapist 4. Licensed professional counselor 5. Psychologist 6. Psychiatrist 7. Psychiatric nurse 8. Psychotherapist 9. Counselor in Training (CIT) supervised by an appropriate licensed/certified professional	
At least two years of experience in HIV or another catastrophic illness preferred.	Personnel records/resumes/applications for employment reflect requisite experience/education.
A mental health supervisor must be a licensed clinical mental health practitioner.	Documentation of supervision during client interaction with Counselors In Training (CIT) or Interns as required by the Texas Department of State Health Services (TDSHS).
Provider shall have an established, detailed staff orientation process. Orientation must be provided to all staff providing direct services to patients within thirty (30) working days of employment, including at a minimum: 1. Crisis intervention procedures 2. Standards of Care 3. Confidentiality 4. Documentation in case records (ARIES training) 5. Consumer Rights and Responsibilities 6. Consumer abuse and neglect reporting policies and procedures 7. Professional Ethics 8. Emergency and safety procedures 9. Data Management and record keeping 10. Review of job description 11. Occupational Safety and Health Administration (OSHA) regulations pertaining to substance abuse in the workplace, and 12. The Americans With Disabilities Act As Amended (ADAAA)	Documentation of experience on file.
Staff participating in the direct provision of services to patients must satisfactorily complete all appropriate CEUs based on individual licensure requirements at a minimum, as per the license requirement for each licensed mental health practitioner.	Documentation of experience on file.
Each mental health service provider must have and implement a written plan for regular supervision of all licensed staff.	Current License/Certification will be maintained on file.
Notes of weekly supervisory conferences shall be maintained for such staff.	Personnel record reflects completion of orientation and signed job description.
Staff subject to formal supervision must be evaluated at least annually by their supervisor according to written provider policy on performance appraisals.	Contract providers will provide documentation of receiving such training.

Service Standards, Measures, and Goals:

Service Standard	*Outcome Measure*	*Goal*
An appointment will be scheduled within three (3) working days of a client's request for mental health services. In emergency circumstances, an appointment will be scheduled within twenty-four (24) hours. If service cannot be provided within these time frames, the Agency will offer to refer the client to another organization that can provide the requested services in a timelier manner.	Documentation in patient's file.	90%
A comprehensive assessment including the following will be completed within 10 days of intake or no later than and prior to the third counseling session: • Presenting Problem • Developmental/Social history • Social support and family relationships • Medical history • Substance abuse history • Psychiatric history • Complete mental status evaluation (including appearance and behavior, talk, mood, self-attitude, suicidal tendencies, perceptual disturbances, obsessions/compulsions, phobias, panic attacks) • Cognitive assessment (level of consciousness, orientation, memory and language) • Psychosocial history (Education and training, employment, Military service, Legal history, Family history and constellation, Physical, emotional and/or sexual abuse history, Sexual and relationship history and status, Leisure and recreational activities, General psychological functioning). • • Estimated end date or rationale for continuation with note of frequency of intervention plan.	Documentation in client record, which must include DSM-IV diagnosis or diagnoses, utilizing at least Axis I.	90%
A treatment plan shall be completed within 30 days that is specific to individual client needs. The treatment plan shall be prepared and documented for each client. Individual, and family case records will include documentation of the following: • Eligibility • Psychosocial assessment • Goals and objectives • Progress notes • Referrals • Discharge summary • Suggested number of sessions • Anticipated start and end date	Documentation in client's file.	90%

Progress notes are completed for every professional counseling session and must include: • Client name • Session date • Observations • Focus of session • Interventions • Assessment • Duration of session Counselor authentication, in accordance with current Joint Commission on Accreditation of Healthcare Organization (JCAHO) standards (www.jcaho.org).	Legible, signed and dated documentation in client record.	90%
Discharge planning is done with each client after 30 days without client contact or when treatment goals are met: • Circumstances of discharge • Summary of needs at admission • Summary of services provided • Goals completed during counseling • Discharge plan Counselor authentication, in accordance with current JCAHO standards	Documentation in client's record.	90%
Clients accessing Psychiatric care are medically adherent and are engaged in their psychiatric treatment plans.	Clients are assessed for psychiatric care and when engaged in psychiatric care, are medically adherent.	90%
Access to and maintenance in Medical Care: RW clients' ongoing participation in primary HIV medical care	Each client is assessed and verified for engagement in HIV medical care and assisted with establishing linkages to care if not currently receiving care. Assessed initially, then re-assessed and documented every 3 months.	90%

ORAL HEALTH CARE

Service Category Definition:

Oral Health Care includes diagnostic, preventative, and therapeutic dental care that is in compliance with dental practice laws, includes evidence-based clinical decisions that are informed by the American Dental Association Dental Practice Parameters, is based on an oral treatment plan, adheres to specified service caps, and is provided by licensed and certified dental professionals.

SERVICES:
Services will include routine dental examinations, prophylaxis, x-rays, fillings, endodontistry, prosthodontics, and basic oral surgery (simple extractions) and will be capped at $3,000.00 per unduplicated client per calendar year. Referral for specialized care should be completed if clinically indicated.

Emergency procedures will be treated on a walk-in basis as availability and provisions allow. All emergency costs will be added to the client's maximum allowable benefit. Funded Oral Health Care providers are permitted to provide necessary emergency care regardless of a client's annual benefit balance. Further non-emergency procedures will not be allowed once the cap has been reached. If provider cannot provide adequate services for emergency care, the patient will be referred to a hospital emergency room.

Service Category Limitations:

Cosmetic dentistry for cosmetic purposes only is prohibited

Personnel Qualifications:

Qualification	Expected Practice
Dentists must be licensed and accredited as specified by the Texas State Board of Dental Examiners (TSBDE).	Personnel files/resumes/applications for employment reflect requisite licensing and accreditation.
Dental hygienists must be licensed and accredited as specified by the TSBDE.	Personnel files/resumes/applications for employment reflect requisite licensing and accreditation.
Dental assistants must register with the TSBDE within one year if they administer x-rays.	Personnel files/resumes/applications for employment reflect requisite SBDE registration.
Staff Vaccinations: • Hepatitis B required as defined by the Texas State Department of Health Services (DSHS) • Tuberculosis tests at least every 12 months for all staff is strongly recommended • OSHA guidelines must be met to ensure staff and patient safety	Staff health records will be maintained at each agency to ensure that all vaccinations are obtained and precautions are met.
Service providers shall employ staff (i.e., receptionists, schedulers, file clerks, etc.) who are knowledgeable and experienced regarding their area of practice as well as in the area of HIV/AIDS. All staff without direct experience with HIV/AIDS shall be supervised by one who has such experience.	Agency will maintain documentation of unconditional staff certification and licensure in their particular area of practice, and will monitor the activities of staff to ensure that only qualified employees administer services.

Dental hygienists and assistants must perform all services to patients under supervision of a licensed dentist.	Copy of supervising dentist license on file.
Confidentiality statement signed by dental employees.	Signed confidentiality statements of staff on file (HIPAA compliance).
All health care workers should adhere to universal precautions as defined by Texas Health and Safety Code, Title 2, Subtitle D, Chapter 85.	It is strongly recommended that staff are aware of the following to ensure that all vaccinations are obtained and precautions are met: • Health care workers who perform exposure-prone procedures should know their HIV antibody status • Health care workers who perform exposure-prone procedures and who do not have serologic evidence of immunity to HBV from vaccination or from previous infection should know their HBsAg status and, if that is positive, should also know their HBeAg status. • Tuberculosis tests at least every 12 months for all staff. • OSHA guidelines must be met to ensure staff and patient safety.

Agency Qualifications:

Qualification	Expected Practice
Provider/Agency shall be accredited and/or licensed to deliver dental services.	Documentation of current unconditional license and/or certification is on file for each provider and for organization as a whole, where applicable.

Service Standards, Measures, and Goals:

Service Standard	*Outcome Measure*	*Goal*
Provider obtains and documents HIV primary care provider contact information for each patient.	Documentation of HIV primary care provider information in the patient's chart/file. At minimum, provider should obtain the clinic and/or physician's name and telephone number.	90%
Provider collects and documents health history information for each patient once per measurement year with updates as medically appropriate prior to providing care. This information should include, but not be limited to, the following: • A baseline current (within the last 6 months) CBC laboratory test results for all new patients and an annual update thereafter; • Current (within the last 6 months) Viral Load and CD4 laboratory test results, when medically necessary; • Patient's chief complaint, when necessary; • Current Medications; • Sexually transmitted diseases;	Documentation of health history information in patient's chart/file. Reasons for missing health history information are documented	90%

• HIV-associated illnesses; • Allergies and drug-sensitivities; • Alcohol use; • Recreational drug use; • Tobacco use; • Neurological diseases; • Hepatitis; • Usual oral hygiene; • Date of last dental examination; • Involuntary weight loss		
Patient must have an Initial comprehensive oral exam (ADA code D0150) and then periodic recall (ADA code D0120) oral evaluation at least twice each year to check any oral manifestations: linear gingival erythema (LGE) and necrotizing ulcerative periodontitis (NUP).	Documentation in patient chart/file of rate of oral manifestations: LGE and NUP.	90%
A comprehensive, multi-disciplinary Oral Health treatment plan will be developed in conjunction with the patient within 12 months of initial intake. This information should include, but not limited to: • Patient's primary reason for dental visit; • Patient strengths and limitations will be considered in development of treatment plan; • Treatment priority should be given to pain management, infection, traumatic injury or other emergency conditions. Treatment plan will be updated every six (6) months.	Treatment plan dated and signed by both provider and patient in patient chart/file. Updated treatment plan dated and signed by both provider and patient in patient's chart/file.	90%
The following elements are part of each patient's initial comprehensive oral and semi-annual exam hard/soft tissue examination: • Charting of caries; • X-rays; • Periodontal screening; • Written diagnoses, where applicable; • Treatment plan.	Documentation in patient's file/chart. Review of Agency's Policy and Procedures.	90%
Provider must provide patient oral health education once each year which includes the following: Caries prevention: • Fluoride (ADA code D1310) • Nutritional (ADA code D1310 • Smoking/tobacco cessation counseling (ADA code D1320), as indicated. Oral hygiene instructions (OHI) should be provided to each patient (ADA code 1330).	Documentation in patient's chart/file of rate of dental disease and oral pathology. Documentation in patient's chart/file of rate of smoking/tobacco cessation. Documentation of content of oral hygiene instructions in patient's chart/file.	90%

Clients with HIV infection will receive an oral exam by a dentist at least once during the grant year.	Documentation of oral exam by dentist in client file.	90%
HIV-infected oral health patients who had a periodontal screen or examination at least once in the grant year.	Documentation of periodontal screen or examination in client file.	90%
HIV-infected oral health patients with a Phase 1 treatment plan that is completed within 12 months.	Documentation of Phase 1 treatment plan in client file.	90%

OUTPATIENT/AMBULATORY HEALTH SERVICES (OAHS)

Service Category Definition:

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

Allowable activities include:

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

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

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

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

Telemedicine is an acceptable means of providing outpatient/ambulatory health services but must conform to the Texas Medical Board (TMB) guidelines for providing telemedicine, Texas Administrative Code, Texas Medical Board, Rules, Title 22, Part 9, Chapter 174, RULE §174.1 to §174.12 and the 2016 Texas Medicaid Provider TELECOMMUNICATION SERVICES HANDBOOK, Volume 2.

Limitations:

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

NOTE: Early Intervention Services provided by Ryan White Part C and Part D Programs should be included here under Outpatient Ambulatory Health Services.

Personnel Qualifications:

Qualification	Expected Practice
Individual clinicians shall have documented unconditional licensure/certification in his/her particular area of practice.	Appropriate licenses/certifications are maintained.
Service providers shall employ clinical staff who is knowledgeable and experienced regarding their area of clinical practice as well as in the area of HIV/AIDS clinical practice. All staff without direct experience with HIV/AIDS shall be supervised by one who has such experience.	Personnel records/resumes/applications for employment reflect requisite experience/education.
Staff participating in the direct provision of services to patients must satisfactorily complete all appropriate CEUs based on individual licensure requirements.	Provider will provide documentation of training received
Provider/Agency shall be accredited/licensed to deliver services.	Evidence of current unconditional license and /or certification is on record for each provider and for organization as a whole, where applicable.

Service Standards, Measures, and Goals:

Service Standard	Outcome Measure	Goal
Medical Evaluation/Assessment All HIV infected patients receiving medical care shall have a completed initial comprehensive medical evaluation/assessment and physical examination that adheres to the current U.S. Department of Health and Human Services (HHS) guidelines within 3 months of HIV diagnosis or within 15 business days of initial contact with patient who has been in care. Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the most current HHS treatment guidelines.	Percentage of patients who attended a routine HIV medical care visit within 3 months of HIV diagnosis. ***(HRSA HAB Measure – Linkage to Care)*** Percentage of existing patients (return to care and those in current medical care for more than one year) with a documented comprehensive assessment/evaluation completed by the MD, NP, CNS, or PA within 15 business days of initial contact with patient in accordance with professional and established HIV practice guidelines.	90%
Comprehensive HIV related history Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the most current HHS treatment guidelines. History shall include at a minimum, general medical history, a comprehensive HIV related history and psychosocial history to include: • Documented past medical and surgical history with regard to chronic diseases such as diabetes, high blood pressure, heart disease, cholesterol, asthma or emphysema, sickle cell disease, etc. per HHS guidelines. • Psychosocial history to include socio-cultural assessment, occupational history, hobbies (as applicable), travel history, mental health, and	Percentage of new patients with a documented comprehensive HIV related history that is inclusive of all components listed in the OAHS Standard as referenced in the HHS guidelines. Percentage of existing patients with a documented comprehensive HIV related history that is inclusive of all components listed in the OAHS Standard as referenced in the HHS guidelines.	90%

housing status. • Lifestyle including tobacco use, alcohol use, illicit substance use, exercise, travel history. • Sexual Health including partners, practices, past STIs, contraception use (past and present). • HIV-related health history including most recent CD4 and Viral Load results, current ART (if applicable), previous adverse ART drug reactions, history of HIV related illness and infections, HIV treatment history and staging.		
Physical examination Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the most current HHS treatment guidelines. Providers should perform a baseline and annual comprehensive physical examination, with particular attention to areas potentially affected by HIV. Physical examination will include the documentation from the complete review of systems as indicated within the comprehensive medical history. Examination of the oral cavity should be included in both the initial and interim physical examination of all HIV-infected patients.	Percentage of new patients with a documented annual physical examination including complete review of systems. Percentage of new patients with a diagnosis of HIV who received an oral exam by a dentist at least once during the measurement year (based on self-report or other documentation). ***(HRSA HAB Measure)*** Percentage of existing patients with a documented annual physical examination including documentation of completed review of systems conducting during the comprehensive medical history. Percentage of existing patients with a diagnosis of HIV who received an oral exam by a dentist at least once during the measurement year (based on self-report or other documentation). ***(HRSA HAB Measure)***	90%
Initial laboratory tests, as clinically indicated by licensed provider: Tests will include as clinically indicated: • HIV Antibody, if not documented previously; • CD4 Count and/or CD4 Percentage • Quantitative Plasma HIV RNA (HIV Viral Load) • Drug Resistance Testing (genotype, phenotype) • Co-receptor Tropism Test (if considering use of CCR5 co-receptor antagonist or for patients who exhibit virologic failure on a CCR5 antagonist) • HLA-B*5701 testing (only before initiating abacavir-containing regimen per guidelines) • Complete Blood Count (CBC) with Differential and Platelets • Chemistry Profile: Electrolytes, Creatinine, Blood Urea Nitrogen (BUN) • Liver Transaminases, Bilirubin (Total and Direct as medically indicated) Urinalysis with Urine Protein and Creatinine (per medical	Percentage of new patients with documented initial laboratory tests completed according the OAHS Standard and HHS treatment guidelines. Percentage of new patients with documented CD4 count (absolute). Percentage of new patients with documented HIV-RNA viral load. ***(HRSA HAB Measure)*** Percentage of new patients with documented drug resistance testing, as applicable.	90%

provider discretion) and/or cervical or urethral swabs as appropriate to body parts present • Lipid Profile (Total Cholesterol, LDL, HDL, Triglycerides); fasting • Glucose (preferably fasting) or hemoglobin A1C Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the most current HHS treatment guidelines.		
Other diagnostic testing Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the most current HHS treatment guidelines. Chest x-ray will be completed if pulmonary symptoms are present, after an initial positive QTF, after initial positive PPD, or annually if prior evidence of LTBI or pulmonary TB..	Percentage of new patients with documented chest x-ray completed if pulmonary symptoms were present or LTBI test was positive. Percentage of existing patients with documented chest x-ray completed if pulmonary symptoms were present, after an initial positive QTF, after initial positive PPD, or annually if prior evidence of LTBI or pulmonary TB.	90%
Initial Screenings/Assessments Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the most current HHS treatment guidelines. Patients should receive screening for opportunistic infections and assessment of psychosocial needs initially and annually according to the most current HHS guidelines. Screening should include at a minimum: • Quantitative HCV RNA viral load testing (for Hepatitis C positive patients who are candidates for treatment) • Hepatitis A total antibody, Hepatitis B surface antigen, core Ab, and surface antibody & Hepatitis C antibody screens at initial intake (providers should screen all HIV-infected patients for anti-HCV antibodies at baseline) • Mental health assessment that includes screening for clinical depression (PHQ 2 at a minimum) • Psychosocial assessment, including domestic violence and housing status • Substance use and abuse screening • Patients on ART receive lipid screening annually • Tobacco use screening • Pediatric patients (14 years and younger) will be screened for child abuse as defined in Chapter 261 of the Texas Family Code and DSHS	Percentage of new patients with documented initial medical screenings and assessments as indicated in the OAHS Standard and in accordance with HHS guidelines. Percentage of new female patients with a diagnosis of HIV who were screened for cervical cancer in the last three years. ***(HRSA HAB Measure)*** Percentage of new patients with a diagnosis of HIV at risk for sexually transmitted infections (STIs) who had a test for chlamydia within the measurement year. ***(HRSA HAB Measure)*** Percentage of new patients with a diagnosis of HIV at risk for sexually transmitted infections (STIs) who had a test for gonorrhea within the measurement year. ***(HRSA HAB Measure)*** Percentage of new adult patients with a diagnosis of HIV who had a test for syphilis performed within the measurement year. ***(HRSA HAB Measure)*** Percentage of new patients with documented serologic test for syphilis performed. ***(HRSA HAB Measure)*** Percentage of new patients aged 12 years and older screened for clinical depression on the date of the encounter using an age	90%

policy. Consider screening youth 14-17 for child abuse. • Oral health assessment and screening • Cervical Cancer Screen (at baseline, then every 3 years; consider annual screening if cd4<200, high risk HPV types, and/or abnormal cytology) • Tuberculosis (TB) Screening • Pregnancy Test (for female clients of childbearing potential) • Serum VDRL or RPR or treponemal antibody (Syphilis Screening) • Gonorrhea (GC) and Chlamydia (CT) Testing Additional screenings as medically indicated include: • Ophthalmology Screening • Toxoplasma gondii IgG • Trichomoniasis Testing (all HIV+ women as medically indicated). ***Anal Cancer (Dysplasia) Screening (pilot) as appropriate to each Region and the referral sources available:*** Consider Anal Pap tests *(1) as appropriate and when the referral sources (Anoscopy) are available, and/or (2) if anal pap screening/diagnostic resources are not available than a Digital Rectal Examination (DRE) by the HIV provider is an acceptable means of anal cancer screening. Anal cancer screening is recommended* for all HIV-infected regardless of age at baseline and as part of the annual physical.	appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen. ***(HRSA HAB Measure)*** Percentage of new patients with documented initial psychosocial assessment to include domestic violence and housing status. Percentage of new patients with a diagnosis of HIV who have been screened for substance use (alcohol & drugs) in the measurement year. ***(HRSA HAB Measure)*** Percentage of new patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user. ***(HRSA HAB Measure)*** Percentage of new patients, if applicable, with completed child abuse assessment (completed if patient aged 14 years and younger). Percentage of new patients aged 3 months and older with a diagnosis of HIV/AIDS, for whom there was documentation that a tuberculosis (TB) screening test was performed and results interpreted (for TB skin tests) as least once since the diagnosis of HIV infection. ***(HRSA HAB Measure)*** Percentage of new patients, regardless of age, for whom Hepatitis B screening was performed at least once since the diagnosis of HIV/AIDS or for whom there is documented infection or immunity. ***(HRSA HAB Measure)*** Percentage of new patients for whom Hepatitis C (HCV) screening was performed at least once since the diagnosis of HIV. ***(HRSA HAB Measure)***	
Immunizations/Antibiotic Treatment Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the most current HHS treatment guidelines. Immunizations/vaccinations will be given according to the most current HHS guidelines and the CDC's "2017 Adult Vaccination Schedule". Providers will initiate prophylaxis for specific opportunistic infections.	Percentage of patients with Tetanus, Diphtheria, and Pertussis current within 10 years, Td booster doses every 10 years thereafter, or documentation of refusal. Percentage of pediatric patients with HIV infection who have had at least one dose of Measles, Mumps & Rubella (MMR) vaccine administered between 12-24 months of age. (***HRSA HAB Measure for Pediatrics)***	90%

Patients will be offered vaccinations for the following (or have documentation of decline by patient): • Tetanus, Diphtheria, and Pertussis (Tdap) - initially; if potential exposure (wound); Td booster doses every 10 years thereafter • Measles, Mumps, Rubella (MMR) for pediatric patient; MMR titers at baseline and consider vaccination if negative titers AND CD4>250. • Influenza (inactivated vaccine)- annually during flu season October 1st - March 31st • Pneumococcal is recommended for all patients • Completion of hepatitis B (HBV) vaccines series, unless otherwise documented as immune • Completion of hepatitis A (HAV) vaccines series, unless otherwise documented as immune. • Varicella-Zoster (VZV), as medically indicated; Varicella titers at baseline, consider vaccination if negative titers and CD4>250 • Zoster vaccine (shingles vaccine) consideration if age >50 and CD4>250 • Human Papillomavirus (HPV)* • Meningococcal Antibiotic treatment for opportunistic infection will be initiated if active infection has been ruled out and positive for: • Mycobacterium avium complex (MAC) if CD4<50 cells/µL • Toxoplasmosis if CD4<100 cells/µL **HPV vaccine ideally given prior to sexual activity; indicated for females age 9-26 and males age 9-26. Three does through age 26.*	Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization. ***(HRSA HAB Measure)*** Percentage of patients with a diagnosis of HIV who completed the vaccination series for Hepatitis B. ***(HRSA HAB Measure)*** Percentage of patients with a diagnosis of HIV who ever received pneumococcal vaccine. ***(HRSA HAB Measure)*** Percentage of patients with a diagnosis of HIV who completed the vaccination series for Hepatitis A. Percentage of patients with diagnosis of HIV who received, or documented patient refusal, HPV.	
Antiretroviral Therapy and Pneumocystis jiroveci pneumonia (PCP) Prophylaxis Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the most current HHS treatment guidelines. Antiretroviral therapy will be prescribed in accordance with the HHS established guidelines. Patients who meet current guidelines for ART are offered and/or prescribed ART. PCP Prophylaxis will be completed adhering to the current HHS Guidelines.	Percentage of patients, regardless of age, with a diagnosis of HIV are prescribed antiretroviral therapy for the treatment of HIV infection during the measurement year. ***(HRSA HAB Measure)*** Patients aged 6 weeks or older with a diagnosed of HIV/AIDS, with CD4 counts of less than 200 cells/µL or a CD percentage below 15% will be prescribed PCP prophylaxis. ***(HRSA HAB Measure)***	90%

Drug Resistance Testing Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the most current HHS treatment guidelines. "HIV drug-resistance testing is recommended for persons with HIV infection at entry into care. Genotypic testing is recommended as the preferred resistance testing to guide therapy in ARV-naïve patients." Drug resistance testing must follow most recent, established resistance testing guidelines, including genotypic testing on all ARV-naïve patients. Counseling and education about drug resistance testing must be provided by the patient's medical practitioner, registered nurse and/or other appropriate licensed healthcare provider (if designated by the practitioner).	Percentage of patients, regardless of age, with a diagnosis of HIV who had an HIV drug resistance test performed before initiation of HIV antiretroviral therapy if therapy started during the measurement year. ***(HRSA HAB Measure)***	90%
Health Education/Risk Reduction Health education will adhere to the most current HHS guidelines. Providers will provide routine HIV risk-reduction counseling and behavioral health counseling for HIV-infected patients. Since patients' behaviors change over time as the course of their disease changes and their social situations vary, health education providers will tailor routine risk-reduction counseling and behavioral health counseling not only to the individual patient but also to the particular point in time in the patient's life. The following will be conducted initially and as needed: • Providers should discuss safer sexual practices so to decrease risk of transmitting HIV. • Providers should counsel HIV-infected patients about the risk of acquiring syphilis and other STIs from unprotected sexual contact, including all sites of possible transmission, such as anus, cervix, vagina, urethra, and oropharynx. • Providers should discuss family planning with patients • Contraception counseling/hormonal contraception • Drug interaction counseling • Providers should counsel patients on tobacco cessation annually for those patients that were screening and positive for smoking (or document decline of tobacco use) • When current alcohol or other substance use is identified, providers should discuss the possible effects of such use on the patient's	Percentage of patients with a diagnosis of HIV who received HIV risk counseling in the measurement year. ***(HRSA HAB Measure)*** Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user. ***(HRSA HAB Measure)*** Percentage of patients with documented counseling about family planning method appropriate to patient's status, as applicable. Percentage of patients with documented preconception counseling as appropriate. Percentage of patients with documented instruction regarding new medications, treatments, tests as appropriate. Percentage of patients with documented counseling regarding the importance of disclosure to partners.	90%

general health and HIV medications, as well as options for treatment if indicated. • Providers should routinely discuss with patients the importance of disclosure to partners. Patients should be educated about the options for voluntary partner notification. • Preconception care for HIV infected females of child-bearing age. • When HIV-infected patients are diagnosed with early syphilis (primary, secondary, or early latent), providers should intensify risk-reduction counseling, including discussions about the importance of condom use. • Nutritional Counseling regarding: o Quality and quantity of daily food and liquid intake o Exercise (as medically indicated)		
Treatment Adherence Assessment of treatment adherence and counseling will be provided that adheres to current HHS guidelines. Patients are assessed for treatment adherence and counseling at a minimum of twice a year. Those who are prescribed on-going ART regimen must receive adherence assessment and counseling on every HIV-related clinical encounter. If adherence issue is identified by another member of the healthcare team (MCM, MA, LVN, RN), there is documented evidence of adherence counseling and follow-up action. This adherence counseling documentation must be evident in the patient's medical record and clearly indicated that the prescribing provider was made aware of the adherence issue.	Percentage of patients with documented assessment for treatment adherence two or more times within the measurement year if patient is on ARV. Percentage of patients with documented adherence issue, received counseling for treatment adherence two or more times within the measurement year.	90%
Referrals Providers will refer to specialty care in accordance with current HHS guidelines. At a minimum, patients should receive referrals to specialized health care/providers/services ***as needed or medically indicated*** to augment medical care: • If CD4 count below 50, should be referred for ophthalmic examination by a trained retinal specialist. • AIDS Drug Assistance Program (ADAP) • Medication Assistance Programs • Medical care coordination	Percentage of patients, as medically indicated, who had documentation of referrals for: • Health maintenance • Adherence counseling • Mental Health and/or Substance Use • Oral Health • Ophthalmological services • Treatment Suitability (HCV treatment) • Child abuse if suspected abuse • Disease intervention specialist • Other specialty services.	90%

• Medical specialties
• Mental health and substance use services -Treatment education services
• Partner counseling and referral
• Annual oral hygiene and intraoral examinations, including dental caries and soft-tissue examinations.
• Medical Nutrition Therapy (MNT)
• Health maintenance, as medically indicated, such as:
  ○ Cervical Cancer Screening
  ○ Family Planning
  ○ Colorectal Screening
  ○ Mammogram
• Specialty medical care for any preexisting chronic diseases
• Case Management Services or a Disease Investigation Specialist (DIS) for follow-up if missing appointments.
 	
Providers/staff are expected to follow-up on each referral to assess attendance and outcomes.
	Percentage of patients with a documented referral in the measurement year, has a progress note in the patients chart regarding attendance and outcomes of the referral.	

Follow-up Visits Outpatient Ambulatory Health Services will adhere to the current HHS guidelines for on-going health care. Reassessment/reevaluation of health history, comprehensive physical examination, and annual laboratory testing should be documented in patient medical record. Ongoing lab tests for patients should include: • Annual: CBC, liver function tests, BUN, cholesterol, triglycerides (preferably fasting) • Every 3-6 months: CD4 counts and HIV-RNA viral loads monitored every 3-6 months based on compliance and medication adherence. Patients receiving ARV therapy should have follow- up visits scheduled every three to four months, except at the practitioner's discretion when a patient has demonstrated long-term stability and adherence. Patients on ART receive lipid screening annually. In accordance with HHS guidelines follow-up and ongoing lab tests for patients on ARV should include: < • CBC, liver function tests, BUN, creatinine, glucose, cholesterol, triglycerides (preferably fasting), CD4, HIV-RNA and Syphilis serology. • Urine and GC/Chlamydia (vaginal swabs recommended for persons with a vagina) should be offered for sexually active patients at increased risk.	Percentage of existing patients with documented initial medical screenings and assessments as indicated in the OAHS Standard and in accordance with HHS guidelines. Percentage of patients, regardless of age, with a diagnosis of HIV who had at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits. ***(HRSA HAB Measure)*** Percentage of patients, regardless of age, with a diagnosis of HIV who did not have a medical visit in the last 6 months of the measurement year. ***(HRSA HAB Measure)*** Percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year. ***(HRSA HAB Measure)*** Percentage of existing female patients with a diagnosis of HIV who were screened for cervical cancer in the last three years. ***(HRSA HAB Measure)*** Percentage of existing patients with a diagnosis of HIV at risk for sexually transmitted infections (STIs) who had a test for chlamydia within the measurement year. ***(HRSA HAB Measure)***	90%

Providers will continually evaluate patients for adverse outcomes and documents actions taken, outcomes, and follow-up.	Percentage of existing patients with a diagnosis of HIV at risk for sexually transmitted infections (STIs) who had a test for gonorrhea within the measurement year. ***(HRSA HAB Measure)*** Percentage of existing adult patients with a diagnosis of HIV who had a test for syphilis performed within the measurement year. ***(HRSA HAB Measure)*** Percentage of existing patients with documented serologic test for syphilis performed. ***(HRSA HAB Measure)*** Percentage of existing patients aged 12 years and older screened for clinical depression (annually) on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen. ***(HRSA HAB Measure)*** Percentage of existing patients with documented annual psychosocial assessment to include domestic violence and housing status. Percentage of existing patients with a diagnosis of HIV who have been screened for substance use (alcohol & drugs) in the measurement year. ***(HRSA HAB Measure)*** Percentage of existing patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user. ***(HRSA HAB Measure)*** Percentage of existing patients, if applicable, with completed child abuse assessment (completed if patient aged 14 years and younger). Percentage of existing patients aged 3 months and older with a diagnosis of HIV/AIDS, for whom there was documentation that a tuberculosis (TB) screening test was performed and results interpreted (for TB skin tests) as least once since the diagnosis of HIV infection***. (HRSA HAB Measure)***

	Percentage of existing patients, regardless of age, for whom Hepatitis B screening was performed at least once since the diagnosis of HIV/AIDS or for whom there is documented infection or immunity. ***(HRSA HAB Measure)*** Percentage of existing patients for whom Hepatitis C (HCV) screening was performed at least once since the diagnosis of HIV. ***(HRSA HAB Measure)*** Percentage of patients, regardless of age, with a diagnosis of HIV who were prescribed HIV antiretroviral therapy and who had a fasting lipid panel during the measurement year. ***(HRSA HAB Measure)***	
Documentation in Patients' Medical Chart Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the most current HHS treatment guidelines. Clinicians will develop/update plan of care at each visit. At a minimum, clinician will document/update the following at each visit: • Chief complaint • Vital signs • Assessment/diagnosis • Proposed treatment • Problem list • Medical plan of care in accordance with the current HHS treatment guidelines. • Current medications • Vaccinations • Referrals and recommendations • Any decline in services offered/referrals • Outreach efforts to bring patient who has missed appointments back into care. If a patient refuses a treatment, such as vaccinations, documentation of denial will be written in the patient's medical chart. The provider developing the plan will sign each entry.	Percentage of patient medical records with signed clinician entries. Percentage of flow sheets present and updated in the patient medical records. Percentage of problem lists present and updated in the patient medical records. Percentage of medication lists present and updated in the patient medical records.	90%
Documentation of missed patient appointments and efforts to bring the patient into care.	Percentage of patient medical records with documentation of a minimum of 3 different contacts (email, phone, mail, emergency contact, home visit by DIS) when patient has missed 3 scheduled appointments in a 3-month period.	90%

Provider and/or staff will conduct the following: • Contact patients who have missed appointments using at least 3 different forms of contact (email, phone, mail, emergency contact, phone call, referral to DIS for home visit) • Address any specific barriers to accessing services • Documentation includes number of missed patients appointments and efforts to bring the patient into care.	Percentage of patient medical records with documentation of any specific barriers and efforts made to address missed appointments.

SUBSTANCE ABUSE OUTPATIENT CARE

Service Category Definition:

Substance Abuse Outpatient Care is the provision of medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) provided in an outpatient setting, rendered by a physician or under the supervision of a physician, or by other qualified personnel.

Provision of treatment and/or counseling addresses substance abuse and addiction/dependency for alcohol and other drugs. Services consist of outpatient treatment, counseling, social detoxification and/or referral to medical detoxification (including methadone treatment) when necessary as appropriate to the client. A goal of the continuum of substance abuse treatment is to encourage individuals to access primary medical care and adhere to HAART as well as other treatments indicated. All treatment providers will have specific knowledge, experience, and services regarding the needs of persons with HIV/AIDS.

Examples of services include regular, ongoing substance abuse treatment and counseling on an individual and/or group basis by a state-licensed provider. Services must include provision of or links to the following: social and/or medical detoxification when necessary, recovery readiness, harm reduction, 12-step model, rational recovery approach model, aftercare, mental health counseling to reduce depression, anxiety and other disorders associated with substance abuse, medical treatment for addiction, and drug-free treatment and counseling. These services will include women with children and persons with disabilities.

Referring provider will ensure collaboration across the various groups that work with the substance abuse population and those at risk and that share the best practices to overcome philosophical barriers.

Service Category Limitations:

Services limited to the services below as stated in the HRSA National Monitoring Standards. No use of RWHAP funds shall be used to carry out any program of distributing sterile needles or syringes for the hypodermic injection of any illegal drugs. Please reference http://www.statutes.legis.state.tx.us/Docs/HS/htm/HS.481.htm

Personnel Qualifications:

Qualification	Expected Practice
All staff providing direct substance abuse counseling or treatment services to clients will meet the qualifications for the position as outlined in the agency's job description and shall include the following: • Licensed by the State of Texas to provide substance abuse counseling (e.g., LPC, LCSW, LMSW, LMFT, LCDC, CDAC, licensed clinical psychologist), or a Counselor in Training (CIT) supervised by an appropriate licensed/certified professional, *AND* • Two years of experience in HIV or other catastrophic illness and continuing education in HIV, *AND* • One year experience in family counseling as pertaining to substance abuse, *AND* • Non-violent crisis intervention training, *AND* • Professional liability coverage for individuals and for the agency, *AND* • At least three (3) hours annually of cultural competency training as required in the Universal Standards of Care regarding populations who have an incidence of HIV infection in the TGA (e.g., ethnic, gay/lesbian/bisexual/transgender, women, homeless, adolescents, sex trade workers, deaf/hard of hearing, drug cultures, *AND* • Training in mental health issues and knowing when to refer a client to a mental health program/counselor, *AND* • Supervision as required by licensure.	Personnel files/resumes/applications for employment reflect requisite licenses, certifications, experience and training. Documentation of supervision during client interaction with Counselors In Training (CIT) or Interns as required by the Texas Department of State Health Services (DSHS).

Substance abuse treatment supervisor shall, at a minimum, be a Master's level professional (e.g., LPC, LMSW, or Licensed Clinical Psychologist) licensed by the State of Texas and qualified to provide supervision per applicable licensing rules.	Proof of licenses and certifications indicated in personnel file.
Orientation shall be provided to all staff within ten (10) working days of employment, including at a minimum: • Crisis intervention procedures • DSHS Administrative Code for Substance Abuse • Standards of Care • Confidentiality • Documentation in case records (ARIES training) • Consumer Rights and Responsibilities • Consumer abuse and neglect reporting policies and procedures • Professional Ethics • Emergency and safety procedures • Data Management and record keeping • Infection Control and universal precautions • Review of job description • Occupational Safety and Health Administration (OSHA) regulations pertaining to substance abuse in the workplace, and • The Americans With Disabilities Act as Amended (ADAAA)	Orientation program educates staff on required subject matters. Personnel file reflects completion of orientation and signed job description.
Continuing education/in-service training. In accordance with DSHS and state licensing and credentialing boards, all direct care staff must satisfactorily complete the required hours in continuing education training.	Documentation to include in the employee file that reflects date of training, contents, name of trainer, topic, length of training and signature of employee.
Each substance abuse treatment provider must have and implement a written plan for regular supervision of all staff by a licensed supervisor/Qualified Credentialed Counselor (QCC) in accordance with all applicable laws and regulations.	Agency has written plan for supervision of all staff on site.
Notes of weekly supervisory conferences shall be maintained for such staff.	Supervisor's files reflect notes of weekly supervisory conferences.
Staff must be evaluated at least annually by their supervisor according to written provider policy on performance appraisals.	Personnel files contain annual performance evaluations.

Agency Qualifications:

Qualification	Expected Practice
The provider agency must be a licensed hospital or a licensed facility with outpatient treatment designation and must comply with the rules and standards established by DSHS' Substance Abuse Facility Licensing Group.	Documentation of current facility licensing on site.
Provider agency must be in compliance with the Americans with Disabilities Act as Amended (ADAAA) to indicate full accessibility by all clients. If not in compliance at the time of funding, agency must demonstrate a plan, including timeline, to become compliant within the funding period.	Evidence of ADAAA compliance or plan and timeline for compliance on file at provider agency.

Provider agency must have at least one person on staff with current certification in CPR and first aid on the premises at all times services are rendered (RN and MD can be substituted for first aid).	Documentation of CPR-certified staff and evidence of first aid capability at site
Provider agency must develop and implement policies and procedures for handling crisis situations and psychiatric emergencies, which include, but are not limited to, the following: • Verbal Intervention • Non-violent physical intervention • Emergency medical contact information • Incident reporting • Voluntary and involuntary patient admission • Follow-up contacts • Continuity of services in the event of a facility emergency	Documentation of client and staff safety policies and procedures on site.

Service Standards, Measures, and Goals:

Service Standard	*Outcome Measure*	*Goal*
Case conferences with members of the client's multi-disciplinary team shall be held as appropriate.	Client records include documentation of multi-disciplinary case conferences, as appropriate.	90%
An appointment will be scheduled within three (3) working days of a client requesting substance abuse treatment services. In emergency circumstances, appointments will be scheduled within one (1) working day. If services cannot be provided within these time frames, the agency will offer to refer the clients to another organization to provide the requested services in a timelier manner.	Client chart contains documentation of each item listed above.	90%
The intake process will include: • Screening for substance abuse and/or dependency for alcohol and other drugs using SAMISS • Verification of Medicaid/Medicare eligibility • Client's demographic information • Client's address • Client's phone number(s)/e-mail address • Client's housing status • Client's employment and income status • Client's alcohol and drug history and current usage • Client's physical health • List of current medications • Presenting problems • Suicide and homicide assessment	Documentation of intake information in client's file and in ARIES.	90%

Initial assessment protocols shall provide for screening individuals to determine level of need and appropriate service plan. The initial assessment shall include, but not be limited to, the following: • The presenting problem • Substance abuse history • Medical and psychiatric history • Treatment history • Psychological history and current status • Complete mental status evaluation (including appearance and behavior, talk, mood, self-attitude, suicidal tendencies, perceptual disturbances, obsessions/compulsions, phobias, panic attacks) • Cognitive assessment (level of consciousness, orientation, memory and language) • Social support and family relationships • Strengths and Weaknesses Specific assessment tools such as the Addiction Severity Index (ASI) could be used for substance abuse and sexual history, the Substance Abuse and Mental Illness Symptoms Screener (SAMISS) for substance abuse and mental illness symptoms and the Mini Mental State Examination (MMSE) for cognitive assessment. A copy of the assessment(s) will be provided to the client.	Client's chart contains documentation of each assessment item listed and documentation that a copy was given to the client.	90%
A psychosocial history will be completed and must include: • Education and Training • Employment • Military Service • Legal History • Family history and constellation • Physical, emotional and/or sexual abuse history • Sexual and relationship history and status • Leisure and recreational activities • General psychological functioning	Client's chart contains documentation.	90%
Treatment Plan: A treatment plan shall be completed within 30 calendar days of completed comprehensive psychosocial assessment specific to individual client needs. The treatment plan shall be prepared and documented for each client. Treatment planning will be a collaborative process through which the provider and client develop desired treatment outcomes and identify the strategies for achieving them.	Percentage of client charts that have documentation of treatment plans completed within 30 calendar days of the completed comprehensive assessment. Percentage of client charts with documented evidence of treatment plans reviewed/modified at a minimum midway through the number of determined sessions agreed upon for frequency of modality in the client's primary record.	90%

Individual, and family case records will include documentation of the following: • Identification of the identified substance use disorder • Goals and objectives • Treatment modality (group or individual) • Start date for substance use counseling • Recommended number of sessions • Date for reassessment • Projected treatment end date • Any recommendations for follow up Treatment, as appropriate, will include counseling about (at minimum): • Prevention and transmission risk behaviors, including root causes and underlying issues related to increased HIV transmission behaviors • Treatment adherence • Development of social support systems • Community resources • Maximizing social and adaptive functioning • The role of spirituality and religion in a client's life, disability, death and dying and exploration of future goals The treatment plan will be signed by the substance use counselor rendering service.		
In accordance with DSHS's Administrative Code on Substance Abuse, the treatment plan shall be reviewed at a minimum midway through treatment or at least every 12 sessions and must reflect ongoing reassessment of client's problems, needs and response to therapy. The treatment plan duration, review interval and process must be stated in the agency policies and procedures and must follow criteria outlined in the Administrative Code.	Documentation of treatment plan review in client's file and agency treatment review policies and procedures on file at site.	90%
Client and family participation in service planning should be maximized.	Documentation on site.	90%
Progress Notes: Services will be provided according to the individual's treatment plan and documented in the client's record. Progress notes are completed for every professional counseling session and include: • Client name • Session date • Clinical observations • Focus of session • Interventions	Percentage of client charts with documented progress notes for each counseling session as indicated.	90%

• Assessment • Duration of session • Newly identified issues/goals • Client's responses to interventions and referrals • HIV medication adherence • Substance use treatment adherence • Counselor authentication, in accordance with current TAC Standards of Care for Substance Abuse Services.		
A client may be discharged from substance abuse services through a systematic process that includes a discharge or case closure summary in the client's record. The discharge/case closure summary will include:: • Circumstances of discharge • Summary of needs at admission • Summary of services provided • Goals and objectives completed during counseling • Referral after completing substance use treatment to case manager and/or primary care provider, as appropriate • A transition plan to other services or provider agencies, if applicable • Consent for discharge follow-up • Counselor signature and credentials and date, in accordance with TAC Standards and the counselor licensure requirements.	Documentation of case closure in client's record. Documentation of reason for discharge/case closure (e.g., case closure summary).	90%
In all cases, providers/case managers shall ensure that, to the greatest extent possible, clients who leave care are linked with appropriate services to meet their needs. For example, if a client were moving to another area, the provider/case manager would ideally refer the client to an appropriate provider in that area; or if the client has to be discharged from services, the provider/case manager may, as is appropriate to the circumstance, provide the client with a list of alternative resources.	Documentation in client's record indicating referrals or transition plan to other providers/agencies.	90%
Clients demonstrate decreased drug use frequency or maintenance of decreased drug use in a 6 month time frame through urine or blood drug screens or self-report.	Decreased use of drugs and alcohol frequency or maintenance of decreased drug use.	90%

EMERGENCY FINANCIAL ASSISTANCE (EFA)

Service Category Definition:

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

NOTE: Part A and Part B programs must be allocated, tracked, and reported by type of assistance.

Part A EFA programs in the TGA cover limited financial assistance to pay only medication not in formulary, essential utilities (to include electricity, gas, water/sewerage and propane gas), housing, and food (including groceries, food vouchers, and food stamps). Utilities are not to exceed $500 per unduplicated client per grant year; medications not subject to a cap and for short term use only. Short term is defined as up to 60 days.

Part B EFA programs in the HSDA will cover services in the following categories:

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

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

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

- The agency must set priorities, delineate and monitor what part of the overall allocation for emergency assistance is obligated for each subcategory. Careful monitoring of expenditures within a subcategory of "emergency assistance" is necessary to assure that planned amounts for specific services are being implemented, and to determine when reallocations may be necessary.
- Limitations on the provision of emergency assistance to eligible individuals/households should be delineated and consistently applied to all clients. It is expected that all other sources of funding in the community for emergency assistance will be effectively used and that any allocation of EFA funding for these purposes will be the payer-of-last-resort, and for limited amounts, limited use, and limited periods of time.

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

- Assistance is provided only for the following essential services/subcategories:
    - Utilities such as household utilities including gas, electricity, propane, water, and all required fees
    - Housing such as rent or temporary shelter. EFA can only be used if HOPWA assistance isn't available
    - Food such as groceries and food vouchers
    - Prescription medication assistance such as short term, one-time assistance for any medication and associated dispensing fee as a result or component of a primary medical visit (not to exceed a 30-day supply)

Emergency Financial Assistance (EFA) Part A/B programs may be used to dispense medications as:

- A result or component of a primary medical visit
- A single occurrence of short duration (an emergency)

- Vouchers to clients on an emergency basis

Applicants must demonstrate that an unexpected financial hardship has occurred, which prevents them from meeting the expense of medications, prescription eyeglasses, and/or utility bills due to one or more of the following:

- The notice of disconnection of service
- A significant increase in bills
- A recent decrease in income
- High unexpected expenses on essential items
- The cost of their shelter is more than 30% of the household income
- The cost of their utility consumption is more than 10% of the household income
- They are unable to obtain credit necessary to provide for basic needs and shelter
- A failure to provide emergency financial assistance will result in danger to the physical health of client or dependent children
- Other emergency needs as deemed appropriate by the agency

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

Service Category Limitations:

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

Personnel Qualifications:

Qualification	Expected Practice
Bachelor's degree preferred. Minimum qualifications for position as described in the Agency position description. A minimum of one year paid work experience with persons with HIV/AIDS or other catastrophic illness. Extensive knowledge of community resources and services.	Personnel files/resumes/applications for employment reflect requisite experience and education. Documentation may include, but is not limited to, transcripts, diplomas, certifications, and/or licensure.
Misappropriation of funds or use of assistance funds for a purpose other than that for which the funds were requested constitutes abuse. Any abuse of emergency financial assistance services shall result in the denial of all future assistance.	Documentation of misuse in monitoring report.
Appeals of denials of funding may be made using the emergency financial assistance provider's grievance procedure, or, if referral to emergency financial assistance is denied by the Primary case manager, using the Case Management provider's grievance procedure.	Agency written agreement procedure.

The invoice/bill which is to be paid with emergency financial assistance funds must be in the client's name. An exception may be made only in instances where it is documented that, although the service (e.g. utility) is in another person's name, it directly benefits the client. The agency has a procedure to protect client confidentiality when making payments for assistance, (e.g., checks that do not identify the agency as an HIV/AIDS agency).	As documented in file. • Copy of invoice/bill paid. • Copy of check for payment.

Agency Qualifications:

Qualification	Expected Practice
Agency providing emergency financial assistance shall have protocols in place to ensure that funds are distributed fairly and consistently. The agency has a procedure to monitor/manage expenditures of emergency assistance that ensures funding will be available throughout the program year.	Agency written protocol.

Service Standards, Measures, and Goals:

Service Standard	*Outcome Measure*	*Goal*
Service provider will conduct an assessment of the presenting problems/needs of the client with HIV-related emergency financial issue.	Documentation of the client's need for EFA.	90%
Client will be assessed for ongoing status and outcome of the emergency assistance plan.	Documentation of resolution of the emergency status and referrals made with outcome results in client files.	90%
Emergency financial assistance payment is made out to the appropriate vendor in the exact amount listed on bill and is authorized for pick up by the client or the client's primary case manager. No payment may be made directly to clients, family or household members.	Documentation of payment in client's file with copy of check/voucher in client's file.	90%
All completed requests for assistance shall be approved or denied within three (3) working days. A check shall be issued in response to an essential need (as identified by Primary case manager and Agency) within five (5) working days of approval of request.	Documentation of client receipt of payment within five (5) days of approved request.	90%

FOOD BANK /HOME-DELIVERED MEALS

Service Category Definition:

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

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

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

1. *Food Bank:*
   Food Bank services are the provision of actual food and personal care items in a food bank setting.
2. *On-site/Home Delivered Meals:*
   On-site/Home-Delivered Meals are the provision of prepared meals or food vouchers for prepared meals, in either a congregate dining setting or delivered to clients who are homebound and cannot shop for or prepare their own food. When a client is banned from a facility, he or she may designate in writing an alternate person who will be authorized to pick up the "to go" meal. It is the client's responsibility to ensure that the authorization is accurate and current. Meals "to go" will not be provided to unauthorized persons.

Service Category Limitations:

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

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

Personnel Qualifications:

Qualification	Expected Practice
Semi-annual training of staff must be conducted by a Licensed Dietitian, specializing in the special needs of HIV+ clients, including the nutrition/caloric needs and dietary issues of HIV+ clients.	Signed Memorandum of Understanding between provider and Licensed Dietitian, specializing in HIV, must be on file, acknowledging that Licensed Dietitian will provide training, at least semi-annually to dietary staff of food service agency.
Food preparation staff must attend at least quarterly scheduled trainings provided by consultant Dietitian on such topics as food handling, safety in the kitchen, HIV nutrition, food temperature, proper sanitation, food packaging, etc.	Documentation in food preparation staff member's personnel file.
Director of meal program must complete and pass Service Safety certification every 3 years.	Current Service Safety certification posted in food preparation area.

Agency shall establish an orientation for new staff and volunteers addressing, as applicable, topics pertinent to the task at hand, such as: 1. Safe food handling procedures 2. Confidentiality issues for delivery personnel 3. Sensitivity to the HIV/AIDS Client 4. HIV nutrition, based on American Dietetic Association guidelines 5. Cultural competency	Personnel files reflect completion of applicable orientation.
All drivers delivering meals must hold a valid Texas driver's license and automobile insurance consistent with state minimum requirements.	Personnel files of paid and volunteer drivers contain documentation that each is licensed to drive.

Agency Qualifications:

Qualification	Expected Practice
A Memorandum of Understanding must be established with an agency providing consultation of a Licensed Dietitian, specializing in HIV, regarding special needs of clients. The Dietitian will make recommendations based on the American Dietetic Association's standards and be available to educate and evaluate clients and their needs. Dietary staff refers to staff working in food bank and in/onsite/home-delivered meals.	Proof of qualification of Licensed Dietitian, specializing in HIV, must be on file with the Dietitian's agency, such as: 1. Copy of License 2. Resume or Curriculum Vitae
Provider must maintain all licenses and permits required by city, county, state, and federal law to operate the particular food services program(s) involved.	Current provider licenses should be on display at site.

Service Standards, Measures, and Goals:

Service Standard	*Outcome Measure*	*Goal*
A written record of meal/food bank distribution will be maintained. Attempts should be made on a regular basis to provide choices on food items that meet individual nutrition needs of HIV+ persons, including the foods that fall into the recognized categories for good nutrition identified in the Food and Drug Administration or American Dietetic Association standard food and nutrition pyramid 13.2.7 Client Satisfaction. There must be a method to regularly obtain client input about food preference and satisfaction. Such input shall be used to make program changes with appropriate reporting to the Administrative Agency.	Written log will be maintained to back-up information entered into ARIES. Provider has written policies and procedures for obtaining client input on food choices on a regular basis.	90%
Service provider assists clients in seeking alternate sources to obtain food bank/home-delivered meals.	Planning sessions occur with clients regarding alternate source investigation for food bank/home-delivered meals.	90%
Clients accessing food vouchers have same-day HIV/AIDS related appointment.	Clients show access to HIV/AIDS related services and retention of care.	90%
Clients receiving meals/pantry have at least one (1) documented medical visit within 6 month period of measurement year.	Clients show medical visit and retention of medical care.	90%

MEDICAL TRANSPORTATION SERVICES

Service Category Definition:

Medical Transportation Services enable an eligible individual to access HIV-related health and support services, including services needed to maintain the client in HIV medical care, either through direct transportation services, vouchers, or tokens.

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

Services may be provided through:

- Contracts with providers of transportation services
- Voucher or token system
- System of mileage reimbursement that does not exceed the federal per-mile reimbursement rates
- System of volunteer drivers, where insurance and other liability issues are addressed
- Purchase or lease of organizational vehicles for client transportation, with prior approval from HRSA/HAB for the purchase

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

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

Service Category Limitations:

Purchase or lease of organizational vehicles for client transportation requires prior approval from HRSA/HAB.

Reimbursement methods may not involve cash payments to clients.

Mileage reimbursement rates will not exceed the federal reimbursement rate.

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

Personnel Qualifications:

Qualification	Expected Practice
Drivers for agency conveyance will have received training in universal precautions and infection control appropriate to their duties. All drivers have current Texas driver's licenses for the type of vehicle driven as well as levels of liability insurance required by state law and funding sources Drivers must have verified driving records, receive a drug screen and background check.	Personnel files/resumes/applications for employment reflect requisite experience, education, and licensure, required testing and background checks.

A signed statement from the drivers agreeing to safe driving practices is on file. This statement is to include the consequences of violating the agreement.	
Staff Supervision	Each agency must have and implement a written plan for supervision of all staff. Supervisors must review monthly transportation logs for completeness, compliance with these standards, and quality and timeliness of service delivery. Staff must be evaluated at least annually by their supervisor according to written Agency policy on performance appraisals.

Agency Qualifications:

Qualification	Expected Practice

Agency Policies and Procedures	The agency shall have policies/procedures for each of the following:
	• Client rights and responsibilities, including confidentiality guidelines
	• Client grievance policies and procedures
	• Client eligibility requirements
	• Data collection procedures and forms, including data reporting
	• Guidelines for language accessibility
	• Policy on staff performance appraisals
	• Conducting background check for drivers
	• Agency response to drivers who receive moving violations while transporting clients
	• Emergency procedures, such as automobile crashes, client's behavior placing driver/others at risk:
	  ○ Written procedures are developed and implemented to handle emergencies
	  ○ Each driver will be instructed in how to handle emergencies before commencing service
	  ○ Each driver will receive in-service training annually
	• Required use of seat belts by drivers and passengers
	• Proper boarding/unloading assistance of passengers and manipulation of wheelchair and other durable medical equipment/health devices
	• No smoking policy while transporting clients
	• No drug tolerance policy for any drugs that may impair the ability to drive
	• Distribution of vouchers/tokens/bus passes
	• Wait times:
	  ○ There is no more than a two (2) hour wait time for vehicles and vans so that appointments are kept
	• System abuse by clients:
	  ○ If an agency has verified that a client has falsified the existence of an appointment in order to access transportation, the client can be removed from the agency roster

	○ If a client cancels van/vehicle transportation appointments in excess of three (3) times per month, the client may be removed from the van/vehicle roster for 30 days ○ Agency must have published rules regarding the consequences to the client in situations of system abuse ○ If client is removed from the roster, he or she must be referred to other transportation services. One additional "no show" and the client can be suspended from service for up to six (6) months • Notification system/procedure to clients and providers in case of delay or cancellation of transportation. Agency has a policy on file that addresses the following at a minimum: • Protocol for addressing Traffic, Parking, and Moving Violations • Grounds for termination • Must state that Ryan White Funding cannot be used to pay for such violations.
Direct Transportation: Agency staff and volunteers providing medical transportation through direct transportation will maintain appropriate insurance, liability, licenses, and training per the HRSA National Monitoring Standards.	Agency maintains correct level of liability insurance for all drivers as required by State of Texas. All drivers have appropriate current Texas driver's licenses for the type of vehicle driven. • Usually a Class C according to: http://www.txdps.state.tx.us/DriverLicense/dlClasses.htm Drivers must have verified driving records, receive a drug screen and background check. • Driver has maintained a clean driving record for the past year ○ Less than 3 convicted traffic moving violations ○ DUI Staff and Drivers for agency conveyance will have received training in universal precautions and infection control appropriate to their duties. Each driver will sign a statement agreeing to maintain confidentiality and safe driving practices.
Vehicle Maintenance and Insurance	Routine maintenance records and other repair information are available. • A file will be maintained on each agency vehicle and shall include, but not be limited to: ○ Description of vehicle including year, make, model ○ General condition ○ Service and state inspection records ○ Inspections of vehicle(s) should be routine and documented Agency maintains documentation of all agency-owned vehicles insurance coverage as required by State of Texas.

	Seat belts/restraint systems must be operational. • When in place, child car seats must be operational and installed according to manufacturer specifications. Transportation services must be handicap accessible in accordance with the Americans with Disabilities Act (ADA) regulations. All lights and turn signals must be operational, brakes must be in good working order, tires must be in good condition, and air conditioning/heating system must be fully operational. All vehicles will be equipped with a fire extinguisher, first aid kit, and CPR kit. Driver must have radio or cell phone capability, including the ability for hands-free operation while vehicle is in motion if required locally. A log/form for collection of mileage is maintained by the driver(s) and is reviewed per agency policy but no less than at least quarterly by supervisor.

Service Standards, Measures, and Goals:

Service Standard	*Outcome Measure*	*Goal*
Voucher/Token/Bus Pass System	Procedures are in place regarding use and distribution of vouchers or bus passes. A system is in place to account for the purchase and distribution of vouchers and bus passes. A security system is in place for storage of and access to vouchers, bus passes and fees collected. All fees are reported as program income as appropriate.	90%
Intake and Service Eligibility: According to the HRSA HIV National Monitoring Standards, eligibility for services must be determined.	Agency will receive referrals from a broad range of HIV/AIDS service providers. Eligibility information will be obtained from the referral source and will include: • Contact and identifying information (name, address, phone, birth date, etc.) • Language(s) spoken • Literacy level (client self-report) • Demographics	90%

	• Emergency contact • Household members • Pertinent releases of information • Insurance status if applicable • Income (including a "zero income" statement) if applicable • State residency • Proof of HIV infection • Acknowledgement of client's rights The client's eligibility must be recertified for this service every six (6) months. Before assistance is provided, there should be written documentation in the client's file that Ryan White/State Services funding is being used as the payor of last resort.	

Documentation	Documentation that medical transportation services are used only to enable an eligible individual to access HIV-related health and support services.
	• Transportation Provider must ensure:
	  ○ Follow-up verification between transportation provider and destination service program confirming use of eligible service(s)
	  ○ Receipt of proof of service documenting use of eligible services at destination agency on the date of transportation or scheduling of transportation services by receiving agency's case manager or transportation coordinator. Documentation completed by agency/case manager who has verified that transportation used for eligible services is acceptable.
	  ○ Agency is allowed to provide one (1) round trip per client per year without proof of service documentation.
	
	Agency must document daily transportation services on the Transportation Log.
	
	No shows should be documented in the log and the client's case manager notified.
	
	Documentation that services were provided:
	• Contracted services
	  ○ Contract that clearly identifies allowable services and method of transportation
	  ○ Tracking of service provided and the purpose (transport
		90%

	to medical appointment; transport to food bank, etc.).
	• Voucher, token, or bus pass system
	  o Document the amount of the voucher or number of tokens/passes given to client for each trip.
	• Mileage reimbursement
	  o Agency must document the mileage between Trip Origin and Trip Destination (e.g. where client is transported to access eligible service) per a standard Internet based mapping program (e.g. Yahoo Maps, Map Quest, Google Maps) or odometer reading for all clients receiving van-based transportation services.
	• Volunteer drivers
	  o Insurance and other liabilities have been addressed
	  o Contract that clearly identifies allowable services and method of transportation
	  o Tracking of service provided and the purpose (transport to medical appointment; transport to food bank, etc.)
	• Purchase or lease of agency vehicles
	  o Proof of prior approval from HRSA/HAB to lease or purchase vehicle
	  o Contract that clearly identifies allowable services and method of transportation
	  o Tracking of service provided and the purpose (transport to medical appointment; transport to food bank, etc.)
	
	Program will maintain documentation related to:
	• Client eligibility
	• Reason for the transportation and its relation to accessing HIV-related core/support services
	• Method used to meet the transportation need
	• Trip origin and destination
	• Cost per trip
	• Level or service/number of trips provided	

The agency provides clients with information on transportation limitations, clients' responsibilities for accessing transportation, and the agency's responsibilities for providing transportation.	Documentation in client record.	90%
Screening for other transportation resources are documented, i.e., Medicaid eligible clients using DSHS Medicaid transportation program, Medicare eligible clients utilizing half fare VIA Cards, VIA Trans, etc.	Documentation in client record.	90%

Accommodation will be provided for related/affected individuals and/or caregivers as necessary for the benefit of the client.	Documentation in client record. Agency Policies and Procedures	90%
A signed statement from client agreeing to safe and proper conduct in the vehicle is on file. This statement is to include the consequences of violating the agreement.	Documentation in client's record.	90%
Agency conveyance usage shows acuity score and qualifiers for clients accessing services. (Clients have NO other means to access their medical care.)	Documentation in client's record.	90%
"No Shows" are documented in a Transportation log and case managers are notified.	Transportation logs document no-shows and case manager notification	90%
Transportation increases access and maintenance in medical care, mental health & substance abuse services.	Maintenance in medical care &/or mental health and substance abuse services documented.	90%

NON-MEDICAL CASE MANAGEMENT (NMCM)

Service Category Definition:

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

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

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

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

Service Category Limitations:

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

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

Personnel Qualifications:

Qualification	Expected Practice
All case managers will meet the qualifications for the position as outlined in the Agency's job description. The minimum requirements are: 1. A minimum of an Associate's Degree from an accredited college or university or equivalent (in education or experience); **and** 2. A minimum of one year paid work experience with persons with HIV/AIDS or other catastrophic illness preferred; **and/or** 3. State or National certification from a recognized state/national certification	Personnel files/resumes/applications for employment reflect requisite experience and education.

organization and/or licensing organization preferred (i.e. LBSW, LMSW, LCSW, LPC, LMFT, LCDC, etc,); **or** 4. Case managers employed prior to March 1, 2009 and who did not meet the minimum qualifications listed above may be granted a waiver from these qualifications by the Administrative Agency; **and** 5. Knowledge and training in assessment of needs, formulation of care plans, monitoring of care plans and evaluation of case pro files; **and** 6. Extensive knowledge of community resources and services.	
Each agency staff person who provides direct services to clients shall be properly trained in case management. Supervisors will be a degreed or licensed individual (by the State of Texas) in the fields of health, social services, mental health, or a related area, preferably Master's Level.	Personnel files/resumes/applications for employment reflect requisite experience and education.
All case managers must complete (or have completed prior) the following within the first six (6) months: 1. Effective Communication Tools for Healthcare Professionals 100: Addressing Health Literacy, Cultural Competency and Limited English Proficiency* 2. Texas HIV Medication Program 2013 Update* 3. HIV Case Management 101: A Foundation* 4. HIV Case Management 101: A Foundation Part Two (Module 1: HIV and Behavioral Risk; Module 2: Substance Use and HIV; Module 3: Mental Health and HIV)* **These courses are all available through the TRAIN (Training Finder Real-time Affiliate Integrated Network) Texas learning management system (www.tx.train.org)*	Personnel files reflect training log with documentation of subject matter, attendance, and supervisor signature.
A minimum of sixteen (16) additional hours of orientation training must cover orientation to the target population and the HIV service delivery system in the San Antonio Transitional Grant Area (TGA) and HSDAs, including but not limited to: 1. The full complement of HIV/AIDS services available within the TGA, HSDA 2. How to access such services [including how to ensure that particular subpopulations are able to access services (i.e., undocumented individuals)] 3. Ryan White Standards of Care (Universal and Service Category Standards) 4. Education on applications for eligibility under entitlement and benefit programs other than Ryan White services will be included and periodically updated as changes occur.	Personnel file reflects completion of orientation and signed job description.
Twenty-four (24) hours of annual training are required for all employees. The 24 hours shall include fifteen (15) hours of medical training, six (6) hours of psychosocial training and three (3) hours of quality management training. The medical training shall cover the Texas Department of State Health Services (DSHS) required topics of Medical Adherence, HIV Disease Process, Oral Health, Risk Reduction/Prevention Strategies (including Substance Abuse Treatment) and Nutrition. A suggested additional topic may be End of Life Issues. Medical training shall also include training on documentation. The psychosocial training shall include the topics of AIDS and the law, medically	Personnel files reflect training log with documentation of subject matter and attendance at twenty-four (24) hour comprehensive educational program annually.

related federal and state benefits programs (e.g. Social Security, Medicare, Medicaid, Star +).	
Case managers and case management supervisors must satisfactorily complete continuing education as required by state licensing boards.	Documented in personnel file or training log.
Each case management agency must have and implement a written plan for supervision of all case management staff.	Agency has written plan for supervision of all case management staff.
Supervisors must review a 10 percent sample of each case manager's case records each month for completeness, compliance with these standards, and quality and timeliness of service delivery.	Agency will keep on file supervision logs demonstrating the review of random client files citing the date and outcome of chart reviews.
Case managers must be evaluated at least annually by their supervisor according to written Agency policy on performance appraisals.	Personnel files contain annual performance evaluations.
Each supervisor must maintain a file on each case manager supervised and hold supervisory sessions on at least a monthly basis. The file on the case manager must include, at a minimum: 1. Date, time, and content of the supervisory sessions 2. Results of the supervisory case review addressing, at a minimum of completeness and accuracy of records, compliance with standards and effectiveness of service.	3. Documentation of supervision provided 4. Supervisors' files on each case manager reflect ongoing supervision, supervisory sessions and case review as described above.

Service Standards, Measures, and Goals:

Service Standard	*Outcome Measure*	*Goal*
The objectives of the enrollment process are: • Inform the client of: o all services available AND o all Ryan White funded case management agencies in the area o what client can expect if s/he enrolls in case management services; • Establish client eligibility for services; • Establish acuity score using scale to determine needs of client; • Collect required state/federal client data for reporting purposes; • Completion of a complete AIDS Regional Information Evaluation System (ARIES) Intake.	Documentation in client's chart and in ARIES.	90%
Funded Non-Medical Case Management agencies must be able to: • Make initial contact with client and/or referring agent within five (5) working days of receiving request for services. • Provide enrollment within ten (10) working days of initial contact; • Schedule an appointment at the client's convenience; • Refer the client to another agency in the event of a waiting list or any capacity constraints prohibiting an agency from serving a client immediately. •	Agency policy and procedures reflect the availability of walk-in services. Documented referral kept on file at the agency.	90%

The Initial Assessment is required for clients who are enrolled in Non-Medical Case Management (NMCM) services. It expands upon the information gathered during the intake phase to provide the broader base of knowledge needed to address complex, longer-standing access and/or barriers to medical and/or psychosocial needs. The 30 day completion time permits the initiation of case management activities to meet immediate needs and allows for a more thorough collection of assessment information: a) Client's support service status and needs related to: • Nutrition/Food bank • Financial resources and entitlements • Housing • Transportation • Support systems • Partner Services and HIV disclosure • Identification of vulnerable populations in the home (i.e. children, elderly and/or disabled) and assessment of need (e.g. food, shelter, education, medical, safety (CPS/APS referral as indicated) • Family Violence • Legal needs (ex. Health care proxy, living will, guardianship arrangements, landlord/tenant disputes, SSDI applications) • Linguistic Services, including interpretation and translation needs • Activities of daily living • Knowledge, attitudes and beliefs about HIV disease • Sexual health assessment and risk reduction counseling • Employment/Education b) Additional information • Client strengths and resources • Other agencies that serve client and household • Brief narrative summary of assessment session(s)	Percentage of clients who access NMCM services that have a completed assessment within 30 calendar days of the first appointment to access NMCM services and includes all required documentation. Percentage of clients that received at least one face-to-face meeting with the NMCM staff that conducted the initial assessment. Percentage of clients who have documented Initial Assessment in the primary client record system.	90%

The client and the case manager will actively work together to develop and implement the care plan. Care plans include at a minimum:
 	
• Problem Statement (Need)
• Goal(s) – suggest no more than three goals
• Intervention
  ○ Task(s)
  ○ Assistance in accessing services (types of
	Percentage of non-medical case management clients, regardless of age, with a diagnosis of HIV who had a non-medical case management care plan developed and/or updated two or more times in the measurement year. ***(DSHS Performance Measure)***
	
	Percentage of client records with documented follow up for issues presented in the care plan.
		90%

assistance) ○ Service Deliveries • Individuals responsible for the activity (case management staff, client, other team member, family) • Anticipated time for each task • Client acknowledgment ***The care plan is updated with outcomes and revised or amended in response to changes in access to care and services at a minimum every six (6) months.*** Tasks, types of assistance in accessing services, and services should be updated as they are identified or completed – not at set intervals.	Percentage of Care Plans documented in the primary client record system.	
Case management staff will work with the client to determine barriers to accessing services and will provide assistance in accessing needed services. Case management staff will ensure that clients are accessing needed services, and will identify and resolve any barriers clients may have in following through with their Care Plan. When clients are provided assistance for services elsewhere, case notes include documentation of follow-up.	Percentage of NMCM clients with documented types of assistance provided that was initiated upon identification of client needs and with the agreement of the client. Assistance denied by the client should also be documented in the primary client record system. Percentage of NMCM clients with assistance provided have documentation of follow up to the type of assistance provided.	90%
Clients who are no longer engaged in active case management services should have their cases closed based on the criteria and protocol outlined below. Common reasons for case closure include: • Client is referred to another case management program • Client relocates outside of service area • Client chooses to terminate services • Client is no longer eligible for services due to not meeting eligibility requirements • Client is lost to care or does not engage in service • Client incarceration greater than six (6) months in a correctional facility • Provider initiated termination due to behavioral violations • Client death Graduation criteria: • Client completed case management goals for increased access to services/care needs • Client is no longer in need of case management services (e.g. client is capable of resolving needs independent of case	Percentage of N-MCM clients with closed cases includes documentation stating the reason for closure and a closure summary (brief narrative in progress notes and formal discharge summary). Percentage of closed cases with documentation of supervisor signature/approval on closure summary (electronic review is acceptable). Percentage of clients notified (through face-to-face meeting, telephone conversation, or letter) of plans to discharge the client from case management services. Percentage of client with written documentation explaining the reason(s) for discharge and the process to be followed if client elects to appeal the discharge from service. Percentage of clients with information about reestablishment shared with the client and documented in primary client record system.	90%

management assistance) Client is considered non-compliant with care if three (3) attempts to contact client (via phone, e-mail and/or written correspondence) are unsuccessful and the client has been given 30 days from initial contact to respond. Discharge proceedings should be initiated by agency 30 days following the 3rd attempt. Make sure appropriate *Releases of Information and consents are signed by the client and meet requirements of HB 300 regarding electronic dissemination of protected health information (PHI).* Staff should utilize multiple methods of contact (phone, text, e-mail, certified letter) when trying to re-engage a client, as appropriate. Agencies must ensure that they have releases of information and consent forms that meet the requirements of HB 300	Percentage of clients provided with contact information and process for reestablishment as documented in primary client record system. Percentage of clients with documented Case Closure/Graduation in the primary client record system.	
In all cases, case managers shall ensure that, to the greatest extent possible, clients who leave care are linked with appropriate services to meet their needs. For example, if a client were moving to another area, the case manager would ideally refer the client to an appropriate provider in that area; or if the client has to be discharged from services, the case manager may, as is appropriate to the circumstance, provide the client with a list of alternative resources.	Documentation in client's record indicating referrals or transition plan to other providers/agencies.	90%

APPENDIX

STATEMENT OF CONSUMER RESPONSIBILITIES

1. RESPECT, COURTESY, AND CONFIDENTIALITY – YOU HAVE THE RESPONSIBILITY
To treat health and social service providers and staff with respect and courtesy at all times.

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

3. SEEKING FACTS ABOUT YOUR CARE – YOU HAVE THE RESPONSIBILITY
To ask questions about the care you are receiving if you do not completely understand it. This means that you should know about the risks, benefits and financial aspects of your care. You also have the right to have advocate/s ask about this information.

4. FOLLOWING THE TREATMENT PLAN – YOU HAVE THE RESPONSIBILITY
To follow treatment plans that you and your provider/s have agreed upon. You have the responsibility to tell your provider right away if you decide to stop treatment or go against your provider's advice. You are responsible for what happens to you.

5. SCHEDULED APPOINTMENTS – YOU HAVE THE RESPONSIBILITY
To keep appointments that you and your providers have scheduled. If you have to cancel, you are responsible for telling your provider that you will not be there.

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

7. RULES AND REGULATIONS OF SERVICE PROVIDER ORGANIZATIONS – YOU HAVE THE RESPONSIBILITY
To follow the rules and regulations of your providers and their agencies/facilities**.**

8. VOICING COMPLAINTS AND GRIEVANCES – YOU HAVE THE RESPONSIBILITY
To voice complaints and present grievances in an appropriate and timely manner. You should do this by following the providers' grievance policies and procedures and you may ask for help in doing this if you need it.

9. CONTINUING CARE – YOU HAVE THE RESPONSIBILITY
To ask when and where to go for more treatment and follow-up services whenever you leave a providers' facility or care.

10. AN ADVANCED DIRECTIVE FOR CARE - YOU HAVE THE RESPONSIBILITY
To make formal decisions about your care that can be used if you are not able to speak for yourself if you become ill. These include living wills, health care proxies, and durable powers of attorney for health and social services.

11. ACCESS TO FINANCIAL INFORMATION – YOU HAVE THE RESPONSIBILITY

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

12. A CONSUMER GRIEVANCE PROCEDURE – YOU HAVE THE RESPONSIBILITY

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

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

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

STATEMENT OF CONSUMER RIGHTS

1. RESPECT, COURTESY, AND PRIVACY – YOU HAVE THE RIGHT

To be treated at all times with respect and courtesy within a setting, this provides you with the highest degree of privacy possible.

2. FREEDOM FROM DISCRIMINATION – YOU HAVE THE RIGHT

To freedom from discrimination because of age, ethnicity, gender, religion, sexual orientation, values and beliefs, marital status, medical condition, or any other arbitrary criteria.

3. ACCESS TO HIV/AIDS SERVICE INFORMATION – YOU HAVE THE RIGHT

To be informed by your healthcare and/or social service provider about the full range of available HIV/AIDS treatments and about related available social and support services.

To be advised of the risks and to discuss benefits of any proposed treatments. You have the right to give your informed consent to any treatments or services before they are provided.

4. IDENTITY AND PROVIDER CREDENTIALS – YOU HAVE THE RIGHT

To know the names, titles, specialties, and affiliation of all health and social service providers and anyone else involved in your care. To know about the health or social service organization's policies and procedures.

5. CULTURALLY SENSITIVE SHARING OF INFORMATION – YOU HAVE THE RIGHT

To have information shared with you in a respectful manner and in a way that is easy to understand, which takes into account the differences in each person's background, culture, and preferences.

6. CONSENT AND THE CARE PLAN – YOU HAVE THE RIGHT

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

7. CHOICE AND ACCESS TO SERVICE – YOU HAVE THE RIGHT

To be informed of all available services upon intake. To choose and access all treatment/services for which you qualify.

8. DECLINING SERVICE – YOU HAVE THE RIGHT

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

9. NAMING AN ADVOCATE – YOU HAVE THE RIGHT

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

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

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

11. ACCESS TO FINANCIAL INFORMATION – YOU HAVE THE RIGHT

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

12. A CONSUMER GRIEVANCE PROCEDURE – YOU HAVE THE RIGHT

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

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

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

14. FREEDOM FROM CONSTRAINTS – YOU HAVE THE RIGHT

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

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

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