University Health Ryan White Part B Service Delivery, State Funds, & State Services Programs:

Standards of Care

Health Resources and Services Administration funded HIV Core Medical and Supportive Health Services

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

Table of Contents

INTRODUCTION

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

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

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

The SoC are designed for HIV/AIDS Core Medical and Supportive Health Service Categories that are funded by Ryan White Part B Service Delivery, State Funds, and State Services Programs in the following jurisdictions:

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

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

- HRSA Service Category Description
- Program Guidance
- Limitations
- Services
- Statement of Need (if applicable)
- Service Standards & Monitoring Indicators
- References
- Notes

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

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

The Texas Department of State Health Services HIV Care Services Program and University Health Ryan White Administration Staff continually monitor, 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 University Health Ryan White Program Administration.

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Note: The Service Descriptions and Definitions can be found in Appendix A; this is the DSHS issued Ryan White Data System Taxonomy.

UNIVERSAL STANDARDS: ADMINISTRATIVE AGENCY REQUIREMENTS

A. Staff Requirements	
Monitoring Standards	Monitoring Indicators
Staff Screening (Pre-Employment) Staff providing services to clients shall be screened for appropriateness by provider agency as follows: • Personal/Professional references • Personal interview • Written application	Documentation in Agency's Policies and Procedures Manual. Documentation in personnel and/or volunteer files.
Criminal background checks, if required by Agency Policy, must be conducted prior to employment and thereafter for all staff and/or volunteers per Agency policy.	Documentation in Agency's Policies and Procedures Manual. Documentation in personnel and/or volunteer files.
Staff Performance Evaluation Agency will perform annual staff performance evaluation.	Completed annual performance evaluation kept in employee's file. Signed and dated by employee and supervisor (includes electronic signature).

B. Effective Management Practices	
Monitoring Standards	Monitoring Indicators
Subcontractor Monitoring Agency that utilizes a subcontractor in delivery of service, must have established policies and procedures on subcontractor monitoring that include: • Fiscal monitoring • Program • Quality of care • Compliance with guidelines and standards Reviewed Annually	Documentation of subcontractor monitoring. Documentation in Agency's Policies and Procedures Manual.

Staff Guidelines Agency develops written guidelines for staff, which include, at a minimum, agency-specific policies and procedures (staff selection, resignation and termination process, and position descriptions); client confidentiality; health and safety requirements; complaint and grievance procedures; emergency procedures; and statement of client rights; staff must review these guidelines annually	Personnel file contains a signed statement acknowledging that staff guidelines were reviewed and that the employee understands agency policies and procedures
Work Conditions Staff/volunteers have the necessary tools, supplies, equipment and space to accomplish their work.	Documentation in Agency's Policies and Procedures Manual. Inspection of tools and/or equipment indicates that these are in good working order and in sufficient supply.
Professional Behavior Staff must comply with written standards of professional behavior.	Staff guidelines include standards of professional behavior. Documentation in Agency's Policies and Procedures Manual. Documentation in personnel files indicates compliance. Review of agency's complaint and grievance files.
Communication There are procedures in place regarding regular communication with staff about the program and general agency issues.	Documentation in Agency's Policies and Procedures Manual. Documentation of regular staff meetings.
Accountability There is a system in place to document staff work time.	Staff time sheets or other documentation.
Staff Availability Staff are present to answer incoming calls during agency's normal operating hours.	Published documentation of agency operating hours. Staff time sheets or other documentation indicate compliance.

References:

HRSA/HAB HIV/AIDS Programs National Monitoring Standards for Ryan White Part A and Part B Grantees: Universal – Part A and B (Covers Both Fiscal and Program Requirements)

Ryan White HIV/AIDS Program Manuals – Part A 2013 (PDF)

Ryan White HIV/AIDS Program Manuals – Part B (Revised 2015) (PDF)

UNIVERSAL STANDARDS: POLICIES AND PROCEDURES

A. Access to Care	
Services Standard	**Monitoring Indicators**
Structured and ongoing efforts to obtain input from clients in the design and delivery of services.	Maintain documentation of at least one of the following efforts to obtain client input regarding the design and delivery of services: 1. Documentation of Consumer Advisory Board (CAB) and public meetings – minutes, and/or 2. Documentation of existence and appropriateness of a suggestion box or other client input mechanism, and/or 3. Documentation of content, use, and confidentiality of a client satisfaction survey or focus groups conducted at least annually.
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.
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: 1. permit denial of services due to preexisting conditions; 2. permit denial of services due to non HIV-related conditions (primary care); or 3. provide any other barrier to care due to a person's past or present health condition.
Provision of services in a setting accessible to low-income individuals with HIV disease.	A facility that is handicapped accessible, accessible by public transportation. Policies and procedures that provide, by referral or vouchers, transportation if facility is not accessible to public transportation. No policies that may act as a barrier to care for low-income individuals.

Efforts to inform low-income individuals of the availability of HIV-related services and how to access them.	Availability of informational materials about sub-recipient's services and eligibility requirements such as: newsletters; brochures; posters; community bulletins; and/or any other types of promotional materials.

B. Eligibility Determination	
Services Standard	**Monitoring Indicators**
Eligibility determination and reassessment of clients to determine eligibility as specified by the jurisdiction (in this case State) or ADAP.	Document that the process and timelines for establishing initial client eligibility, assessment, and recertification takes place at a minimum of every six months. Document that all staff involved in eligibility determination have participated in required training.
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 "payor of last resort".
Payor of Last Resort (PoLR) Ensure that RWHAP Part B and State Services funds distributed by DSHS are used as PoLR for eligible services and eligible clients.	Agencies have written policies and/or protocols for ensuring RWHAP Part B and State Services funds are used as PoLR for eligible services and eligible clients.

C. Anti-Kickback Statute	
Services Standard	**Monitoring Indicators**
Demonstrated structured and ongoing efforts to avoid fraud, waste, and abuse (mismanagement) in any federally funded program.	Employee Code of Ethics including: • 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.

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.

D. Quality Management	
Services Standard	**Monitoring Indicators**
Implementation of a Clinical Quality Management (CQM) Program.	Documentation that the Part B Program has in place a Clinical Quality Management Program that includes, at a minimum: • A Quality Management Plan • Quality expectations for providers and services • A method to report and track expected outcomes • Monitoring of provider compliance with HHS treatment guidelines and the • Part B Program's approved service category definition for each funded service.

E. Other Service Requirements	
Services Standard	**Monitoring Indicators**
Referral relationships with key points of entry Requirement that Part B service providers maintain appropriate referral relationships with entities that constitute key points of entry.	Documentation that written referral relationships exist between Part B service providers and key points of entry.

F. Prohibition on Certain Activities	
Services Standard	**Monitoring Indicators**
Purchase of Vehicles without Approval No use of Ryan White funds by recipients or sub-recipients for the purchase of vehicles without written approval of HRSA Grants Management Officer (GMO).	No use of Ryan White funds by recipients or sub-recipients for the purchase of vehicles without written approval of HRSA Grants Management Officer (GMO). Where vehicles were purchased, review of files for written permission from GMO.

Lobbying Activities Prohibition on the use of Ryan White funds for influencing or attempting to influence members of Congress and other Federal personnel.	Prohibition on the use of Ryan White funds for influencing or attempting to influence members of Congress and other Federal personnel. Include in personnel manual and employee orientation information on regulations that forbid lobbying with federal funds.
Direct Cash Payments No use of Ryan White program funds to make direct payments of cash to service recipients.	Review of Service Standards and other policies and procedures for service categories involving payments made on behalf of individuals to ensure that no direct payments are made to individuals (e.g., emergency financial assistance, transportation, health insurance premiums, medical or medication copays and deductibles, food and nutrition).
Employment and Employment-Readiness Services Prohibition on the use of Ryan White program funds to support employment, vocational, or employment-readiness services.	Prohibition on the use of Ryan White program funds to support employment, vocational, or employment- readiness services.
Maintenance of Privately Owned Vehicle No use of Ryan White funds for direct maintenance expenses (tires, repairs, etc.) of a privately owned vehicle or any other costs associated with a vehicle, such as lease or loan payments, insurance, or license and registration fees.	Documentation that Ryan White funds are not being used for direct maintenance expenses or any other costs associated with privately owned vehicles, such as lease or loan payments, insurance, or license and registration fees – except for vehicles operated by organizations for program purposes.
Syringe Services No use of Ryan White funds shall be used to carry out any program of distributing sterile needles or syringes for the hypodermic injection of any illegal drugs.	Documentation that Ryan White funds are not being used for programs related to sterile needles or syringe exchange for injection drug use.

G. General HIV Policies and Procedures	
Services Standard	Monitoring Indicators
Grievance Policies	Agency has a policy and/or procedure for handling client grievances.
Delivery of Client Services	Agency has written procedures to deal with clients who may be disruptive or uncooperative. Agency has written procedures to deal with clients who are violent or exhibit threatening behavior.

Non-Discrimination Policy	Agency has comprehensive non-discrimination policies, which prohibits discrimination on the basis of race, color, national origin, religion, sex, sexual orientation, age, disability, gender-identity, and any other non-discrimination provision in specific statures under which application for federal or state assistance is being made.
Confidentiality Regarding Patient Information	All staff, management, and volunteers have completed a signed confidentiality agreement annually affirming the individuals' responsibility for keeping client information and data confidential. All staff, management, and volunteers have successfully completed confidentiality and security training.
Breach of Confidentiality	Agency has detailed policies outlining how to address negligent or purposeful release of confidential client information in accordance with the Texas Health and Safety Code and HIPAA regulations.
Child Abuse Reporting	Agencies will have detailed policies outlining how to address suspected child abuse in accordance with Texas law and the DSHS policy. Agencies have documented evidence of training provided to all staff on reporting child abuse.
Incarcerated Persons in Community Facilities	Agency has policies in place ensuring RWHAP and State Services funding is not utilized in paying for medical care or medications when incarcerated persons in community facilities are receiving services in local service provider locations.
Conflict of Interest *Appendix B*	Agency has written conflict of interest policies and procedures. All employees and board members of the agency have completed and signed an annual Conflict of Interest Disclosure Form, which contains, at a minimum, the content in the sample provided by DSHS.

Personnel Policies and Procedures	Personnel and human resources policies are available that address new staff orientation, ongoing training plan and development, employee performance evaluations, and employee/staff grievances.
Required Training	Agency maintains documented evidence of staff trainings, conferences, and meetings to ensure program compliance. Providers shall complete cultural competency training to include cultural awareness of youth and the aging population and/or relevant local priority populations based on epidemiological data and service priorities.
Code of Ethics	Agency has written policies and procedures on file for the following: • Provision of services without discrimination • Provision of services with confidentiality and respect • Provision of a grievance procedure
Consumer Rights and Responsibilities *Appendix C & D*	Documentation in client files of signed statement: • Provision of Statement of Consumer Rights and Responsibilities • Provision of informed consent

H. Ryan White Data System	
Services Standard	Monitoring Indicators
Ryan White Data System Security Policy	Policies are in place at all agency locations that are funded in the state of Texas with RWHAP Part B and State Services funds that ensure Ryan White Data System information is protected and maintained to ensure client confidentiality.
Ryan White Data System Data Managers Core Competencies	Agency has local policies and procedures in place relating to Ryan White Data System and the data collected through Ryan White Data System.

I. Additional Policies and Procedures: Core Services	
Services Standard	Monitoring Indicators
Outpatient/Ambulatory Health Services	Ensure that client medical records document services provided, the dates and frequency of services provided, that services are for the treatment of HIV infection.

	Include clinician notes in client records that are signed by the licensed provider of services. Maintain professional certifications and licensure documents and make them available to the Recipient on request. Standing Delegation Orders are available to staff and are reviewed annually, dated and signed. Service providers shall employ clinical staff who are experienced regarding their area of clinical practice as well as knowledgeable in the area of HIV/AIDS clinical practice. Personnel records/resumes/applications for employment will reflect requisite experience/education. All staff without experience with HIV/AIDS shall be supervised by an employee with at least one (1) year of experience. Reviewers will look for evidence of: 1. a policy that states the supervision requirements; 2. language in contracts/MOUs stating that this will occur; or 3. A verification process of staff and staff supervisors in personnel files.
Local AIDS Pharmaceutical Assistance Program (LPAP)	Agency has an LPAP policy that meets HRSA/HAB requirements. Only authorized personnel dispense/ provide prescription medication. Medications and supplies are secured in a locked area and stored appropriately. Agency has a system for drug therapy management, if applicable. Policy for timeliness of services. MOUs ensuring cost efficient methods are in place.

	MOUs ensure dispensing fees are established and implemented. Pharmacy technicians and other personnel authorized to dispense medications are under the supervision of a licensed pharmacist. Active pharmacy license is onsite and is renewed every two years. Documentation on file that pharmacy owner if not a Texas licensed pharmacist, is consulting with a pharmacist in charge (PIC) or with another licensed pharmacist.
Oral Health Care	Oral health services are provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries and meet current dental care guidelines. Oral health professionals providing the services have appropriate and valid licensure and certification, based on State and local laws. Services fall within specified service caps, expressed by dollar amount, type of procedure, limitations on the procedures, or a combination of any of the above, as determined by the State and/or local communities.
Early Intervention Services	Documentation that Part B funds are used for HV testing only where existing federal, state, and local funds are not adequate, and RW funds will supplement, and not supplant, existing funds for testing. Documentation that individuals who test positive are referred for and linked to health care and supportive services. Documentation that health education and literacy training is provided that enables clients to navigate the HIV system. Documentation that EIS is provided at or in coordination with documented key points of entry.

	Documentation that EIS services are coordinated with HIV prevention efforts and programs.
Health Insurance Premium and Cost-sharing Assistance	Agency has policy that outlines caps on assistance/payment limits and adheres to DSHS Policy 270.001 (Calculation of Estimated Expenditures on Covered Clinical Services). Agency has policy that details the expectation for client contribution and tracks these contributions under client charges. Agency has policy that requires referral relationships with organizations or individuals who can provide expert assistance to clients on their health insurance coverage options and available cost reductions. Agency has policies and procedures detailing process to make premium and out-of-pocket payments or IRS payments.
Mental Health Services	Obtain and have on file and available for Recipient review appropriate and valid licensure and certification of mental health professionals, including supervision of licensed staff. MOUs are available for referral needs. Policies/procedures in place. If mental health services are provided in-house, agency has a policy for regular supervision of all licensed staff. If mental health services are provided in-house, agency has a policy stating agency staff will conduct monthly multidisciplinary discussions of selected clients. Agency/Provider has a discharge policy and procedure.
Medical Nutrition Therapy	Maintain and make available copies of the dietitian's license and registration.

	Staff has the knowledge, skills, and experience appropriate to providing food or nutritional counseling/education services. Personnel records/resumes/applications for employment will reflect requisite education, skills, and experience. Licensed Registered Dietitians will maintain current professional education (CPE) units/hours, including HIV nutrition and other related medical topics approved by the Commission of Dietetic Registration. Documentation in personnel records of professional education. Agency has a policy and procedure for determining frequency of contact with the licensed Registered Dietitian based on the level of care needed. Agency has a policy and procedure on obtaining, tracking inventory, storing, and administering supplemental nutrition products, if applicable. Agency has a policy and procedure on discharging a patient from medical nutrition therapy and the process for discharge/referral.
Medical Case Management, including Treatment Adherence	Maintain documentation showing that MCM services are provided by trained professionals who are either medically credentialed or trained health care staff and operate as part of the clinical care team. Policies and procedures are in place for conducting MCM services, including data collection procedures and forms, data reporting. Staff Qualifications: Minimum qualifications for Medical Case Management supervisors: degreed or licensed in the fields of health, social services, mental health or a related area (preferably Masters' level). Additionally, case manager supervisors must have 3 years' experience providing case management

	services, or other similar experience in a health or social services related field (preferably with 1 year of supervisory or clinical experience). Required MCM trainings are documented in personnel files. The agency shall have policies/procedures for: • Initial Comprehensive Assessment. • MCM Case Management Acuity Level and Client contact. • Care Planning. • Viral Suppression/Treatment Adherence. • Referral and Follow-up. • Case Closure/Graduation. • Case Conferencing. • Caseload Management. • Case Transfer (internal/external). • Probationary Period (new hire). • Staff Supervision. • Staff Training, including agency specific training.
Substance Abuse Outpatient Care	Maintain and provide provider licensure or certifications as required by the state of Texas. If applicable, facilities providing substance abuse treatment services will be licensed by the Texas Department of State Health Services (Department) or be registered as a faith-based exempt program. If applicable, agency will have documentation on site that license is current for the physical location of the treatment facility. Documentation of supervision during client interaction with Counselors In Training (CIT) or Interns as required by the Texas Department of State Health Services (DSHS). Documentation of professional liability for all staff and agency.

	Provider agency must develop and implement policies and procedures for handling crisis situations and psychiatric emergencies, which include, but are not limited to, the following: • Verbal Intervention • Non-violent physical intervention • Emergency medical contact information • Incident reporting • Voluntary and involuntary patient admission • Follow-up contacts • Continuity of services in the event of a facility emergency Agency will have a policy and procedure for clients to follow if they need after-hours assistance. There will be written policies and procedures for staff to follow in psychiatric or medical emergencies. Policies and procedures define emergency situations, and the responsibilities of key staff are identified.

J. Additional Policies and Procedures: Support Services	
Services Standard	Monitoring Indicators
Non-Medical Case Management	Maintain client records that include the required elements as detailed by the Recipient. Provide assurances that any transitional case management for incarcerated persons meets contract requirements. Policies and procedures are in place for conducting NMCM services. Non-medical case managers will complete annual trainings per DSHS.
Emergency Financial Assistance	Agency has a policy for documenting client eligibility, types of EFA provided, dates of EFA, and method of providing EFA.

	Policies include medication purchase limitations. Agencies providing EFA medications must develop policies and procedures to pursue all feasible alternative revenues systems (e.g., pharmaceutical company patient assistance programs) before requesting reimbursement through EFA.
Food Bank/Home-Delivered Meals	Maintain documentation of: • Services provided by type • Amount and use of funds for purchase of non-food items • Compliance with all federal, state, and local laws regarding the provision of food bank, home-delivered meals and food voucher programs, including any required licensure and/or certifications. • Assurance that RW funds were used only for allowable purposes and RW was the payor of last resort. • Records of local health department food handling/food safety inspection are maintained on file. Food pantry program will meet regulations on Food Service Sanitation as set forth by Texas Department of State Health Services, Regulatory Licensing Unit, and / or local city or county health regulating agencies. Current license(s) will be on display at site. Records of local health department food handling/food safety inspection are maintained on file. Agency will be licensed for non-profit salvage by the Texas Department of State Health Services Regulatory Licensing Unit and/or local city or county health regulating agencies.

	Food Pantry must display "And Justice for All" posters that inform people how to report discrimination. There must be a method to regularly obtain client input about food preference and satisfaction. Such input shall be used to make program changes. Director of meal program must complete and pass Service Safety certification every three (3) years. An application form is completed for each volunteer. Each staff and volunteer position has written job descriptions. Staff/Volunteer Education - Personnel files reflect completion of applicable trainings and orientation.
Medical Transportation Services	Maintain program files. Maintain documentation that the provider is meeting stated contract requirements with regard to methods of providing transportation. Collection and maintenance of data documenting that funds are used only for transportation designed to help eligible individuals remain in medical care by enabling them to access medical and support services. Obtain HRSA and State approval prior to purchasing or leasing a vehicle(s). Maintains voucher or token system(s)
Referral for Health Care/Supportive Services	Maintains program files. Maintains client records that include required elements as detailed by the State.

	Maintains documentation demonstrating that services and circumstances of referral services meet contract requirements.

References:

Public Health Service (PHS) Act Title XXVI (PDF)

Ryan White HIV/AIDS Program Legislation (PDF) Part of PHS Act Title XXVI

Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards 45 CFR 75 (PDF) Amended 10/25/2021

HRSA/HAB HIV/AIDS Programs National Monitoring Standards for Ryan White Part A and Part B Grantees: Universal – Part A and B (Covers Both Fiscal and Program Requirements)

Ryan White HIV/AIDS Program Manuals – Part A 2013 (PDF)

Ryan White HIV/AIDS Program Manuals – Part B (Revised 2015) (PDF)

HRSA/HAB Division of Metropolitan HIV/AIDS Programs National Program Monitoring Standards – Part A April 2013 (PDF)

HRSA/HAB Division of State HIV/AIDS Programs National Program Monitoring Standards – Program Part B April 2013 (PDF)

HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Notices and Program Letters, Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02 (PDF) (Revised 10/22/2018)

HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Notices and Program Letters, Ryan White HIV/AIDS Program Services: Determining Client Eligibility & Payor of Last Resort in the Ryan White HIV/AIDS Program Policy Clarification Notice (PCN) #21-02 (PDF)

UNIVERSAL STANDARDS: FISCAL AND ADMINISTRATIVE

A. Recipient Accountability	
Services Standard	**Monitoring Indicators**
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
Recipient accountability for the expenditure of funds it shares with lead agencies (usually health departments), sub-recipients.	A copy of each contract. Fiscal, program site visit reports and action plans. Audit reports. Documented reports that track funds by formula, supplemental, service categories. Documented reports that track unobligated balance and carryover funds. Documented reallocation process. Report of total number of funded sub-recipients/contractors. Sub-recipient A-133 or single audit conducted annually and made available to the State every year an audit is conducted. (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 conducted). Auditor management letter.

Business management systems that meet the requirements of the Office of Management and Budget code of federal regulations, programmatic expectations outlined in the Grantee (Recipient) assurances, and the Notice of Grant Award.	Review of subrecipient contracts. Fiscal and program site visit reports and action plans. Policies and Procedures that outline compliance with federal and Ryan White programmatic requirements. Independent audits. Auditor management letter.
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.

B. Reporting	
Services Standard	Monitoring Indicators
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

C. Monitoring	
Services Standard	Monitoring Indicators
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.
Monitoring activities expected to include annual site visits of all Provider/Subrecipients.	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
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
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.	Identification and description of individual employee salary expenditures to ensure that salaries are within the HRSA Executive Salary Limit. Determine whether individual staff receive additional HRSA income through other sub-awards or subcontracts.
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.
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, and/or sponsored technical assistance.	Review corrective action plans. Review resolution of issues identified in corrective action plan. Policies that describe actions to be taken when issues are not resolved in a timely manner.

D. Quality Management	
Services Standard	Monitoring Indicators
Implementation of a Clinical Quality Management (CQM) Program.	Review of CQM program to ensure that both the recipient and providers are carrying out necessary CQM activities and reporting CQM performance data. Develop and monitor own Service Standards as part of CQM Program.

E. Prohibition on Certain Activities	
Services Standard	Monitoring Indicators
Broad Scope Awareness Activities No use of Ryan White funds for broad scope awareness activities about HIV services that target the general public.	Review of program plans, budgets, and budget narratives for marketing, promotions, and advertising efforts, to determine whether they are appropriately targeted to geographic areas and/or disproportionately affected populations rather than targeting the general public.
Additional Prohibitions No use of Ryan White Funds for the following activities or to purchase these items: • Clothing • Funeral, burial, cremation or related expenses • Local or State personal property taxes (for residential property, private automobiles, or any other personal property against which taxes may be levied) • Household appliances • Pet foods or other non-essential products • Off-premises social/recreational activities or payments for a client's gym membership • Purchase or improve land, or to purchase, construct, or permanently improve (other than minor remodeling) any building or other facility • Pre-exposure prophylaxis	Review and monitoring of recipient and sub-recipient activities and expenditures to ensure that Ryan White funds are not being used for any of the prohibited activities.

F. Data Reporting Requirements	
Services Standard	Monitoring Indicators
Submission of the online service providers report of the Ryan White HIV/AIDS Program Services Report (RSR).	Documentation that all service providers have submitted their sections of the online service providers report.
Submission of the online client report.	Documentation that all service providers have submitted their sections of the online client report.

G. Additional Policies and Procedures: Core Services	
Services Standard	Monitoring Indicators
Health Insurance Premium and Cost-sharing Assistance	Where premiums are covered by RW funds, agency will provide proof that the insurance policy provides comprehensive primary care and a formulary with a full range of HIV medications. Agency will provide documentation, when appropriate, that demonstrates that funds were not used to cover costs associated with the creation, capitalization, or administration of a liability risk pool, or social security costs.

References:

Public Health Service (PHS) Act Title XXVI (PDF)

Ryan White HIV/AIDS Program Legislation (PDF) Part of PHS Act Title XXVI

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HRSA/HAB Division of Metropolitan HIV/AIDS Programs National Program Monitoring Standards – Part A April 2013 (PDF)

HRSA/HAB Division of State HIV/AIDS Programs National Program Monitoring Standards – Program Part B April 2013 (PDF)

HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Notices and Program Letters, Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02 (PDF) (Revised 10/22/2018)

HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Notices and Program Letters, Ryan White HIV/AIDS Program Services: Determining Client Eligibility & Payor of Last Resort in the Ryan White HIV/AIDS Program Policy Clarification Notice (PCN) #21-02 (PDF)

FISCAL STANDARDS

A. Limitation on Uses of Ryan White funding	
Services Standard	**Monitoring Indicators**
Aggregated subrecipient administrative expenses total not more than 10% of Part B service dollars.	Prepare project budget and track expenses with sufficient detail to allow identification of administrative expenses.
Appropriate subrecipient assignment of Ryan White Part B administrative expenses, with administrative costs to include: • Usual and recognized overhead activities, including rent, utilities, and facility costs • Costs of management oversight of specific programs funded under this title, including program coordination; clerical, financial, and management staff not directly related to patient care; program evaluation; liability insurance; audits; computer hardware/ software not directly related to patient care	Prepare project budget that meets administrative cost guidelines. Provide expense reports that track administrative expenses with sufficient detail to permit review of administrative cost elements.
Inclusion of Indirect costs (capped at 10%) only where the recipient has a certified HHS- negotiated indirect cost rate using the Certification of Cost Allocation Plan or Certificate of Indirect Costs, which has been reviewed by the HRSA/HAB Project Officer.	If using indirect cost as part or all of its 10% administration costs, obtain and keep on file a federally approved HHS-negotiated Certificate of Cost Allocation Plan or Certificate of Indirect Costs. Submit a current copy of the Certificate to the recipient.
Expenditure of not less than 75% of service dollars on core medical services, unless a waiver has been obtained from HRSA (Service dollars are those grant funds remaining after removal of administrative and clinical quality management funds).	Report to the recipient expenses by service category.
Total expenditures for support services limited to no more than 25% of service dollars. Support services are those services, subject to approval of the Secretary of Health and Human Services,	Report to the recipient expenses by service category.

that are needed for individuals with HIV/AIDS to achieve their medical outcomes.	Document that support service funds are contributing to positive medical outcomes for clients.

B. Unallowable Costs	
Services Standard	Monitoring Indicators
The recipient shall provide to all Part B subrecipients definitions of unallowable costs.	Maintain a file with signed subrecipient agreement, assurances, and/or certifications that specify unallowable costs. Ensure that budgets do not include unallowable costs. Ensure that expenditures do not include unallowable costs. Provide budgets and financial expense reports to the recipient with sufficient detail to document that they do not include unallowable costs.
No use of Part B funds to purchase or improve land, or to purchase, construct, or permanently improve any building or other facility (other than minor remodeling).	Documentation that no Part B Funds were used to o purchase or improve land, or to purchase, construct, or permanently improve any building or other facility (other than minor remodeling).
No use of Part B funds for: • Non-targeted marketing promotions or advertising about HIV services that target the general public (poster campaigns for display on public transit, TV or radio public service announcements, etc.) • Broad-scope awareness activities about HIV services that target the general public	Documentation that no Part B funds are used for: • Non-targeted marketing promotions or advertising about HIV services that target the general public (poster campaigns for display on public transit, TV or radio public service announcements, etc.) • Broad-scope awareness activities about HIV services that target the general public. Prepare a detailed program plan and budget narrative that describe planned use of any advertising or marketing activities.
No use of Part B funds for outreach activities that have HIV prevention education as their exclusive purpose.	Documentation that no Part B funds are used for outreach activities that have HIV prevention education as their exclusive purpose.

	Provide a detailed program plan of outreach activities that demonstrates how the outreach goes beyond HIV prevention education to include testing and early entry into care.
No use of Part B funds for foreign travel.	Documentation that no Part B funds are used for foreign travel. Maintain a file documenting all travel expenses paid by Part B funds.

C. Payor of Last Resort	
Services Standard	Monitoring Indicators
Use of Part B and other funding sources to maximize program income from third party sources and ensure that Ryan White is the payer of last resort. Third party funding sources include: • Medicaid • State Children's Health Insurance Programs (SCHIP) • Medicare (including the Part D prescription drug benefit) and • Private insurance	Have policies and staff training on the requirement that Ryan White be the payer of last resort and how that requirement is met. Require that each client be screened for insurance coverage and eligibility for third party programs, and helped to apply for such coverage, with documentation of this in client records. Carry out internal reviews of files and billing system to ensure that Ryan White resources are used only when a third party payer is not available. Establish and maintain medical practice management systems for billing.
Ensure billing and collection from third-party payers, including Medicare and Medicaid, so that payer of last resort requirements are met.	Billing and collection policies and procedures. Billing and collection process and/or electronic system. Documentation of accounts receivable.
Ensure subrecipient participation in Medicaid and certification to receive Medicaid payments.	Document and maintain file information on recipient or individual provider agency Medicaid status. Maintain file of contracts with Medicaid insurance companies. If no Medicaid certification, document current efforts to obtain such certification, if

	certification is not feasible, request a waiver where appropriate.

D. Program Income	
Services Standard	Monitoring Indicators
Ensure billing, tracking, and reporting of program income by recipient and subrecipient.	Bill, track, and report to the recipient all program billed and obtained.
Ensure service provider retention of program income derived from Ryan White-funded services and use of such funds in one or more of the following ways: • Funds added to resources committed to the project or program, and used to further eligible project or program objectives • Funds used to cover program costs	Document billing and collection of program income. Report program income documented by charges, collections, and adjustment reports or by the application of a revenue allocation formula.

E. Imposition & Assessment of Client Charges	
Services Standard	Monitoring Indicators
Ensure recipient and subrecipient policies and procedures require a publicly posted schedule of charges (e.g. sliding fee scale) to clients for services, which may include a documented decision to impose only a nominal charge.	Establish, document, and have available for review: • policy for a schedule of charges Current schedule of charges • Client eligibility determination in client records • Fees charged by the provider and the payments made to that provider by clients • Process for obtaining, and documenting client charges and payments through an accounting system, manual or electronic
No charges imposed on clients with incomes below 100% of the Federal Poverty Level (FPL).	Document that: • policy for schedule of charges does not allow clients below 100% of FPL to be charged for services • Personnel are aware of and consistently following the policy for schedule of charges • Policy for schedule of charges must be publically posted

Charges to clients with incomes greater than 100% of poverty are determined by the schedule of charges. Annual limitation on amounts of charge (i.e. caps on charges) for Ryan White services are based on the percent of client's annual income, as follows: • 5% for clients with incomes between 100% and 200% of FPL • 7% for clients with incomes between 200% and 300% of FPL • 10% for clients with incomes greater than 300% of FPL	Establish and maintain a schedule of charges policy that includes a cap on charges and the following: • Responsibility for client eligibility determination to establish individual fees and caps • Tracking of Part B charges or medical expenses inclusive of enrollment fees, deductibles, co- payments, etc. • A process for alerting the billing system that the client has reached the cap and should not be further charged for the remainder of the year. • Personnel are aware of and consistently following the policy for schedule of charges and cap on charges.

F. Financial Management	
Services Standard	Monitoring Indicators
Compliance by recipient with all the established requirements in the Code of Federal Regulations (CFR) for (a) state and local governments; and (b) non-profit organizations, hospitals, commercial organizations and institutions of higher education. Included are for: • Payments for services • Program income • Revision of budget and program plans • Non-federal audits • Property standards, including insurance coverage, equipment, supplies, and other expendable property • Procurement standards, including recipient responsibilities, codes of conduct, competition, procurement procedures, cost and price analysis, and procurement records. • Reports and records, including monitoring and reporting, program performance, financial reports, and retention and access requirements	Provide recipient personnel access to: • Accounting systems, electronic spreadsheets, general ledger, balance sheets, income and expense reports and all other financial activity reports of the subrecipient • All financial policies and procedures, including billing and collection policies and purchasing and procurement policies • Accounts payable systems and policies

• Termination and enforcement and closeout procedures	
Comprehensive recipient and subrecipient budgets and reports with sufficient detail to account for Ryan White funds by service category, subrecipient, administrative costs, and (75/25 rule) core medical and support services rules, and to delineate between multiple funding sources and show program income.	Ensure adequacy of agency fiscal systems to generate needed budgets and expenditure reports, including: • Accounting policies and procedures • Budgets • Accounting system and reports
Line-item subrecipient budgets.	Submit a line-item budget with sufficient detail to permit review and assessment of proposed use of funds for the management and delivery of the proposed services.
Revisions to approved budget of federal funds that involve significant modifications of project costs made by the recipient only after approval from the recipient.	Document all requests for and approvals of budget revisions.
Provider subrecipients agreements and other contracts meet all applicable federal and local statutes and regulations governing subrecipient/contract award and performance.	Establish policies and procedures to ensure compliance with contract provisions. Document and report on compliance as specified by the recipient.

G. Property Standards	
Services Standard	Monitoring Indicators
Subrecipient tracking of and reporting on tangible nonexpendable personal property, including exempt property, purchased directly with Ryan White Part B funds and having: • A useful life of more than one year, and • An acquisition cost of $5,000 or more per unit (Lower limits may be established, consistent with recipient policies)	Develop and maintain a current, complete, and accurate asset inventory list and a depreciation schedule that lists purchases of equipment by funding source. Make the list and schedule available to the recipient upon request.
Implementation of adequate safeguards for all capital assets that assure that they are used solely for authorized purposes.	Documentation of the implementation of adequate safeguards for all capital assets that assure that they are used solely for authorized purposes.

H. Cost Principles	
Services Standard	Monitoring Indicators
Payments made to subrecipients for services need to be cost based and relate to Ryan White administrative, quality management, and programmatic costs in accordance with standards cited under OMB Circulars or the Code of Federal Regulations.	Ensure that budgets and expenses conform to federal cost principles. Ensure fiscal staff familiarity with applicable federal regulations.
Payments made for services to be reasonable, not exceeding costs that would be incurred by a prudent person under the circumstances prevailing at the time the decision was made to incur the costs.	Make available to the recipient very detailed information on the allocation and costing of expenses for services provided. Calculate unit costs based on historical data. Reconcile projected unit costs with actual unit costs on a yearly or quarterly basis.
Written subrecipient procedures for determining the reasonableness of costs, the process for allocations, and the policies for allowable costs, in accordance with the provisions of applicable Federal cost principles and the terms and conditions of the award.	Have in place policies and procedures to determine allowable and reasonable costs. Have in place reasonable methodologies for allocating costs among different funding sources and Ryan White categories. Make available policies, procedures, and calculations to the recipient on request.
Calculate unit costs by subrecipients based on an evaluation of reasonable cost of services; financial data must relate to performance data and include development of unit cost information whenever practical.	Have in place systems that can provide expenses and client utilization data in sufficient detail to determine reasonableness of unit costs.
Requirements to be met in determining the unit cost of a service: • Unit cost not to exceed the actual cost of providing the service • Unit cost to include only expenses that are allowable under Ryan White requirements • Calculation of unit cost to use a formula of allowable administrative costs plus allowable program costs divided by number of units to be provided	Have in place systems that can provide expenses and client utilization data in sufficient detail to calculate unit cost. Have unit cost calculations available for recipient review.

I. Auditing Requirements	
Services Standard	Monitoring Indicators
Subrecipients of Ryan White funds that are institutions of higher education or other non- profit organizations (including hospitals) are subject to the audit requirements contained in the Single Audit Act Amendments of 1996 (31 USC 7501–7507) and revised OMB Circular A-133, with A-133 audits required for all recipients and subrecipients receiving more than $500,000 per year in federal grants.	Conduct a timely annual audit (an agency audit or an A-133 audit, depending on amount of federal funds). Request a management letter from the auditor. Submit the audit and management letter to the recipient. Prepare and provide auditor with income and expense reports that include payer of last resort verification.
Based on criteria established by the recipient, subrecipients of Ryan White funds that are small programs (i.e. receive less than $500,000 per year in federal grants) may be subject to audit as a major program (i.e. a program that receives more than $500,000 in aggregate federal funding) pursuant to OMB Circular 1-133, Section .215 c).	Prepare and provide auditor with financial and other documents required to conduct a major program audit (e.g. income and expense reports that include payer of last resort verification, timesheets, general ledger, etc.). Comply with contract audit requirements on a timely basis.
Selection of auditor to be based on Audit Committee for Board of Directors (if non-profit)policy and process.	Have in place financial policies and procedures that guide selection of an auditor. Make the policies and procedures available to recipient on request.
Review of audited financial statements to verify financial stability of organization.	Comply with contract audit requirements on a timely basis. Provide audit to recipient on a timely basis.
A-133 audits to include statements of conformance with financial requirements and other federal expectations.	Comply with contract audit requirements on a timely basis. Provide audit to recipient on a timely basis.
Subrecipients expected to note reportable conditions from the audit and provide a resolution.	Comply with contract audit requirements on a timely basis. Provide recipient the agency response to any reportable conditions.

J. Fiscal Procedures	
Services Standard	Monitoring Indicators
Subrecipient policies and procedures in place for handling revenues from the Ryan White grant, including program income.	Establish policies and procedures for handling Ryan White revenue including program income. Prepare a detailed chart of accounts and general ledger that provide for the tracking of Part B revenue. Make the policies and process available for recipient review upon request.
Advances of federal funds not to exceed 30 days and to be limited to the actual, immediate cash requirements of the program.	Document reconciliation of advances to actual expenses.
Right of the awarding agency to inspect and review records and documents that detail the programmatic and financial activities of subrecipients in the use of Ryan White funds.	Have in place policies and procedures that allow the recipient as funding agency prompt and full access to financial, program, and management records and documents as needed for program and fiscal monitoring and oversight.
Awarding agency not to withhold payments for proper charges incurred by recipient unless the subrecipient has failed to comply with grant award conditions or is indebted to the United States; recipient not to withhold subrecipient payments unless subrecipient has failed to comply with grant award conditions.	Provide timely, properly documented invoices. Comply with contract conditions.
Awarding agency to make payment within 30 days after receipt of a billing, unless the billing is improperly presented or lacks documentation.	Submit invoices on time monthly, with complete documentation. Maintain data documenting reimbursement period, including monthly bank reconciliation reports and receivables aging report.
Employee time and effort to be documented, with charges for the salaries and wages of hourly employees to: • Be supported by documented payrolls approved by the responsible official • Reflect the distribution of activity of each employee	Maintain payroll records for specified employees. Establish and consistently use allocation methodology for employee expenditures where employees are engaged in activities supported by several funding sources.

• Be supported by records indicating the total number of hours worked each day	Make payroll records and allocation methodology available to recipient upon request.
Subrecipient fiscal staff are responsible for: • Ensuring adequate reporting, reconciliation, and tracking of program expenditures • Coordinating fiscal activities with program activities (For example, the program and fiscal staff's meeting schedule and how fiscal staff share information with program staff regarding contractor expenditures, formula and supplemental unobligated balances, and program income) • Having an organizational and communications chart for the fiscal department	Review the following: • Program and fiscal staff resumes and job descriptions • Staffing Plan and recipient budget and budget justification • Subrecipient organizational chart. Provide information to the recipient upon request.

K. Unobligated Balances	
Services Standard	Monitoring Indicators
Demonstration of its ability to expend fund efficiently by expending 95% of funds in any grant year.	Report monthly expenditures to date to the recipient. Inform the recipient of variances in expenditures.
Annual unobligated balance for formula dollars of no more than 5% reported to HRSA/HAB in recipient's Federal Financial Report (FFR).	Provide timely reporting of unspent funds, position vacancies, etc. to the recipient. Establish and implement a process for tracking unspent Part B funds and providing accurate and timely reporting to the recipient. Be an active participant in the re-allocation process by informing the recipient on a timely basis of funds not spent or funds spent too quickly.

Recognition of consequences of unobligated balances and evidence of plans to avoid a reduction of services, if any of the following penalties is applied: a. Future year award is offset by the amount of the unobligated balance less any approved carry over b. Future year award is reduced by amount of unobligated balance less the amount of approved carry over c. The recipient is not eligible for a future year supplemental award.	Report any unspent funds to the recipient. Carry out monthly monitoring of expenses to detect and implement cost- saving strategies.

References:

Public Health Service (PHS) Act Title XXVI (PDF)

Ryan White HIV/AIDS Program Legislation (PDF) Part of PHS Act Title XXVI

Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards 45 CFR 75 (PDF) Amended 10/25/2021

HRSA/HAB HIV/AIDS Programs National Monitoring Standards for Ryan White Part A and Part B Grantees: Universal – Part A and B (Covers Both Fiscal and Program Requirements)

Ryan White HIV/AIDS Program Manuals – Part A 2013 (PDF)

Ryan White HIV/AIDS Program Manuals – Part B (Revised 2015) (PDF)

HRSA/HAB Division of Metropolitan HIV/AIDS Programs National Fiscal Monitoring Standards – Part A 2013 (PDF)

HRSA/HAB Division of Metropolitan HIV/AIDS Programs National Fiscal Monitoring Standards – Part B 2013 (PDF)

ELIGIBILITY STANDARDS

Clients must be screened for program eligibility every six months

- Initial Determination
    - Only needs to happen once initially, unless the birth month is 2+ months after initial date
    - Required Documentation needed:
        - HIV/AIDS diagnosis
        - Proof of Residence
        - Proof of Low Income
        - Proof of Insurance
- 6-month Self-Attestation
    - Must be completed no later than the last day of the clients' half birth month
    - Required Documentation needed
        - Proof of Residence
        - Proof of Low Income
        - Proof of Insurance
- 12-month Recertification
    - Must be completed no later than the last day of the clients' birth month or as client circumstances change.
    - Required Documentation needed
        - Proof of Residence
        - Proof of Low Income
        - Proof of Insurance

Allowable Forms of Required Documentation:

- HIV/AIDS diagnosis
    - Only needed once at initial Determination
    - Documentation in client's file:
        - HIV Lab result; or
            - Positive result from HIV screening test (HIV 1/2 Combo Ab/Ag enzyme immunoassay [EIA]);
            - Positive result from an HIV 1 RNA qualitative virologic test such as a HIV 1 Nucleic Acid Amplification Test (NAAT); or
            - Detectable quantity from an HIV 1 RNA quantitative virologic test (e.g. viral load test)
        - A signed statement from an entity with prescriptive authority attesting to the HIV-positive status of the person.
- Proof of Residence
    - Must be a resident of Atascosa, Bandera, Bexar, Comal, Frio, Gillespie, Guadalupe, Karnes, Kendall, Kerr, Medina, or Wilson Counties in order to receive Part B, State Funds, and State Services-funded services
    - Documentation in client's file:
        - Valid (unexpired) Texas Driver's License noting Texas address;
        - Texas State identification card (including identification from criminal justice systems);

  - IRS Tax Return Transcript, Verification of Non-Filing, W2, or 1099;
  - Current employment records (pay stub);
  - Benefits Award letter in name of client showing address;
  - Voter registration;
  - Mortgage or official rental lease agreement in the client's name;
  - Rent or utility receipts for one month prior to the month of application in the client's name;
  - Post office records;
  - Official state mail;
  - Letter of identification and verification of residency from a verifiable homeless shelter or community center serving homeless individuals; or
  - Statement/attestation (does not require notarization) with client's signature declaring that client has no resources for housing or shelter.
- Proof of Low Income
  - Not more than 500% of FPL for Part B, State Services, and State Rebate
  - Documentation in client's file:
    - Pay stubs (30 continuous days of payment within the last 60 days);
    - Supporter statement;
    - Employer statement;
    - Agency letter;
    - Social Security Income (SSI) Award Letter;
    - Social Security Disability Income (SSDI) Award Letter; or
    - Other income documentation
    - Texas Workforce Commission unemployment benefits letter; or
    - Prison release paper within 30 days of release date
- Proof of Insurance
  - 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

A. Eligibility Determination	
Services Standard	Monitoring Indicators
Eligibility determination and reassessment of clients to determine eligibility as specified by the jurisdiction or ADAP	Percentage of clients with documentation in the client file of completion of initial and/or annual eligibility determination. Documentation must include: • HIV/AIDS diagnosis (at initial determination) • Proof of residence • Proof of low income

	Percentage of clients with documented evidence of recertification (minimum of every six months): • HIV/AIDS diagnosis (at initial determination) • Proof of residence • Proof of low income *Note*: At 6-month recertification one of the following is acceptable: full application and documentation, self-attestation of no change, or self-attestation of change with documentation. Percentage of clients with proof of overall compliance with eligibility determination as defined by the State (percentage of UDC fully compliant with both the annual and 6-month eligibility recertification periods.)

B. Verification of Payer of Last Resort	
Services Standard	Monitoring Indicators
Verification of Payer of Last Resort Funds may not be used for payments for any item or service to the extent that payment has been made, or reasonably can be expected to be made, with respect to that item or service under any state compensation program, insurance policy, federal or state health benefits program or by an entity that provides health services on a prepaid basis (except for a program administered by or providing the services of the Indian Health Services).	Percentage of clients with income calculation worksheet. Percentage of clients with insurance verification Six month percentage of clients with insurance verification

References:

HRSA/HAB HIV/AIDS Programs National Monitoring Standards for Ryan White Part A and Part B Grantees: Universal – Part A and B (Covers Both Fiscal and Program Requirements)

Ryan White HIV/AIDS Program Manuals – Part A 2013 (PDF)

Ryan White HIV/AIDS Program Manuals – Part B (Revised 2015) (PDF)

HRSA/HAB Division of Metropolitan HIV/AIDS Programs National Program Monitoring Standards – Part A April 2013 (PDF)

HRSA/HAB Division of State HIV/AIDS Programs National Program Monitoring Standards – Program Part B April 2013 (PDF)

HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Notices and Program Letters, Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02 (PDF) (Revised 10/22/2018)

Program Standards: Core Medical Services

EARLY INTERVENTION SERVICES (EIS)

HRSA Service Category Description:

Support of Early Intervention Services (EIS) that include identification of individuals at points of entry and access to services and must include the following four components:

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

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

Program Guidance:

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

Limitations:

Ryan White HIV/AIDS Program (RWHAP) Part B funds are used for HIV testing only where existing federal, state, and local funds are not adequate and RWHAP funds will supplement, **not supplant**, existing funds for testing.

Services:

EIS services are limited to counseling and HIV testing, referral to appropriate services based on HIV status, linkage to care, and education and health literacy training for clients to help them navigate the HIV care system. EIS services require coordination with providers of prevention services and should be provided at specific points of entry.

Counseling, testing, and referral activities are designed to bring individuals with HIV into Outpatient/Ambulatory Health Services (OAHS). The goal of EIS is to decrease the number of underserved individuals with HIV by increasing access to care. EIS also provides the added benefit of educating and motivating clients on the importance and benefits of getting into care. Individuals found not to have HIV should be referred to appropriate prevention services.

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

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

Service Standards & Monitoring Indicators:

The following Service Standards and Monitoring Indicators are guides to improving healthcare outcomes for people living with HIV throughout the Service Delivery Area within the Part B Service Delivery, State Funds, and State Services Programs.

A. HIV Testing and Results Counseling	
Service Standard	**Monitoring Indicators**
Agencies providing HIV testing will ensure the following: • Staff will be familiar with the DSHS HIV/STD Policy 2013.02; • At a minimum, ensure that HIV testing is performed through the use of blood samples (either finger stick or venipuncture); • Maintain records of number of HIV tests conducted in each measurement year; and • Maintain records of test results with documentation that indicates whether the client was informed of their status. State Services funds may be used to purchase CLIA-approved in-home testing kits.	Percentage of HIV positive tests in the measurement year. (HRSA HAB Measure) Percentage of individuals who test positive for HIV who are given their HIV-antibody test results in the measurement year. (HRSA HAB Measure) Percentage of agencies that have documented evidence of CLIA- approved testing kits purchased and logs to track use of these testing kits.

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

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

C. EIS Care Planning	
Service Standard	**Monitoring Indicators**

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

D. Progress Notes	
Service Standard	**Monitoring Indicators**
Progress notes will be maintained in each client's primary record with documentation of the assistance the EIS staff provided to the client to help achieve the goal of a successful linkage to OAHS services.	Percentage of clients accessing EIS services that have documented progress notes showing assistance provided to the client in the primary client record.

E. Referral and Follow-Up	
Service Standard	Monitoring Indicators
EIS staff will assist the clients with referrals to necessary services to achieve successful linkage to care. Referrals will be documented in the client's primary record and, at a minimum, should include referrals for services such as: • OAHS • MCM • Medical transportation, as applicable • Mental Health, as applicable • Substance Use Treatment, as applicable • Any additional services necessary to help clients engage in their medical care All referrals made will have documentation of follow-up to the referral in the client's primary record. Follow-up documentation should include the result of the referral made (successful or otherwise) and any additional assistance the EIS staff offered to the client.	Percentage of clients accessing EIS services with documented referrals in the primary client record initiated in a timely manner with client agreed participation upon identification of client needs. Percentage of clients with documented referrals declined by the client in the primary client record. Percentage of clients accessing EIS services that have documentation of follow-up to the referral including appointment attended and the result of the referral in the primary client record.

F. Transition/Case Closure	
Service Standard	Monitoring Indicators
Clients who are successfully linked to active MCM services and/or OAHS must have their cases closed with a case closure summary narrative documented on the criteria and protocol outlined below. Common reasons for case closure, as applicable, include: • Client is referred and successfully linked to MCM services; • Client relocates outside of the service area; • Client chooses to terminate services; • Client is lost to care or does not engage in services;	Percentage of EIS clients with closed cases that include documentation stating the reason for closure and a closure summary (brief narrative in progress notes and formal case closure/graduation summary) in the primary client record system. Percentage of closed cases with documentation of supervisor signature/approval on closure summary (electronic review is acceptable).

• Client incarceration is greater than six (6) months in a correctional facility; • Client death. Transition criteria: • Client has completed EIS goals and has been successfully linked to MCM services • Client is no longer in need of EIS services (client declines EIS assistance). Client is considered non-adherent with care if three (3) attempts to contact client (via phone, text, home visit, email, and/or written correspondence) are unsuccessful and the client has been given 30 days from initial contact to respond. Case closure proceedings should be initiated by the agency 30 days following the 3rd attempt. *Make sure appropriate Releases of Information and consents are signed by the client and meet requirements of Texas Medical Record Privacy Act HB 300 regarding electronic dissemination of protected health information (PHI).* Staff should utilize multiple methods of contact (phone, text, email, certified letter) when trying to re-engage a client, as appropriate. Agencies must ensure that they have releases of information and consent forms that meet the requirements of Texas Medical Record Privacy Act HB 300 regarding the electronic dissemination of PHI.	

References:

DSHS HIV/STD Policy 2013.02, The Use of Testing Technology to Detect HIV Infection. Revision date September 3, 2014. Accessed on October 12, 2020.

HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A April 2013. p. 10-11. (PDF) Accessed on October 12, 2020.

HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B April, 2013. P. 10-11. (PDF) Accessed October 12, 2020.

HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Notices and Program Letters, Policy Clarification Notice 16-02 Accessed on October 12, 2020.

Interim Guidance for the Use of Telemedicine and Telehealth for HIV Core and Support Services, March 2020

Interim Guidance for the Use of Telemedicine and Telehealth for HIV Core and Support Services – Users Guide and FAQs, March 2020

Notes:

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

HEALTH INSURANCE PREMIUM AND COST-SHARING ASSISTANCE (HIPCSA)

HRSA Service Category Description:

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. For purposes of this service category, health insurance also includes standalone dental insurance. The service provision consists of the following:

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

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

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

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

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

Program Guidance:

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

- DSHS Policy 260.002 (Revised 11/2/2015): Health Insurance Assistance
- DSHS HIV/STD Ryan White Part B Program Universal Standards: Health Insurance Premium and Cost Sharing Assistance
- PCN 14-01 (PDF) (Revised 4/3/2015): Clarifications Regarding the Ryan White HIV/AIDS Program and Reconciliation of Premium Tax Credits under the Affordable Care Act;

- PCN 16-02 (PDF): Eligible Individuals & Allowable Uses of Funds and FAQ for Standalone Dental Insurance.
- PCN 18-01 (PDF): Clarifications Regarding the Use of Ryan White HIV/AIDS Program Funds for Health Care Coverage Premium and Cost Sharing Assistance

Limitations:

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.

Per HRSA/DSHS directive, CareLink is not an allowable service under HIPCSA.

For clients enrolled after 9/1/17 and all new or returning HIPCSA clients, the annual cap for Health Insurance is $10,500.00 per calendar year and for stand-alone Oral Health Insurance is $2,500.00.[1] This includes monthly premiums, deductibles, co-pays, and co-insurance. There is no cap for HIPCSA clients who have been continuously enrolled in HIPCSA services since 09/01/2017 or earlier.

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.

Services:

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

[1] CAP set by DSHS policy 207.001

The cost of insurance plans must be lower than the cost of providing health services through grant-supported direct delivery (be "cost-effective"), including costs for participation in the Texas AIDS Drug Assistance Program (ADAP). Please refer to Texas Department of State Health Services (DSHS) Policy 270.001 (Calculation of Estimated Expenditures on Covered Clinical Services) for further clarification and guidance. Additionally, an annual cost effective analysis can be located as an attachment to the aforementioned policy.

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

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 (PDF), including the FAQ;
- Paying co-pays (including co-pays for prescription eyewear for conditions related to HIV), deductibles, and co-insurance for medical and dental plans on behalf of the client;
- Providing funds to contribute to a client's Medicare Part D true out-of-pocket (TrOOP) costs; and/or
- Certain tax liabilities.

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

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

Service Standards & Monitoring Indicators:

The following Service Standards and Monitoring Indicators are guides to improving healthcare outcomes for people living with HIV throughout the Service Delivery Area within the Part B Service Delivery, State Funds, and State Services Programs.

A. Health Insurance Plans	
Service Standard	Monitoring Indicators
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) and Oral Health Care 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 and Oral Health Care services that meet the requirements of the ACA law for essential health benefits as indicated in the client's primary record.

B. Co-payments, Premiums, Deductibles, and Co-insurance	
Service Standard	Monitoring Indicators
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.

C. Cost Sharing Education	
Service Standard	Monitoring Indicators
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.	Percentage of clients with documented evidence of education provided regarding cost sharing reductions as applicable, as indicated in the client's primary record.

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.	

D. Premium Tax Credits Education	
Service Standard	Monitoring Indicators
Agencies have documented evidence in the client's primary record of the enrollment in a QHP in the Marketplace, as applicable to the individual (clients that are between 100-400% FPL without access to minimum essential coverage). Education provided to the client regarding tax credits and the requirement to file income tax returns must be documented in the client's primary record. Clients must be provided education on the importance of reconciling any Advanced Premium Tax Credit (APTC) well before the IRS tax filing deadline.	Percentage of clients with documented evidence of education provided regarding premium tax credits as indicated in the client's primary record.

E. Prescription Eyewear	
Service Standard	Monitoring Indicators
Agency must keep documentation from physician stating that the eye condition is related to the client's HIV 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 as indicated in the client's primary record.

F. Medical Visits	
Service Standard	Monitoring Indicators
Clients accessing health insurance premium and cost sharing assistance services are adherent with their HIV medical or dental care and have documented evidence of attendance of HIV medical or dental appointments in the client's primary record. *Note*: For clients who use HIPCSA to enable their use of medical or dental 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 with applicable data in Ryan White Data System 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 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. * *For clients who use HIA for OAHS at RWHAP-funded providers and therefore have visit and lab data in Ryan White Data System or other data system.*

G. Viral Suppression	
Service Standard	Monitoring Indicators
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 Ryan White Data System 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)

References:

HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A April 2013. p. 33-36. (PDF) Accessed on October 12, 2020.

HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B April 2013. p. 31-35. (PDF) Accessed October 12, 2020.

HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Notices and Program Letters, Policy Clarification Notice 16-02. Accessed on October 12, 2020.

HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Notices and Program Letters, Ryan White HIV/AIDS Program Services: Clarifications Regarding the use of Ryan White HIV/AIDS Program Funds for Health Care Coverage Premium and Cost Sharing Assistance Policy Clarification Notice (PCN) #18-01 (PDF) (revised 8/30/2018).

HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Notices and Program Letters, Policy Change Notice 14-01

HRSA/HAB, Ryan White Program & Grants Management, Recipient Resources. Policy Notices and Program Letters, Frequently Asked Questions (FAQ) for Standalone Dental Insurance (PDF)

Interim Guidance for the Use of Telemedicine and Telehealth for HIV Core and Support Services, March 2020

Interim Guidance for the Use of Telemedicine and Telehealth for HIV Core and Support Services - Users Guide and FAQs, March 2020

DSHS HIV/STD Ryan White Program Policies. DSHS Funds as Payment of Last Resort (Policy 590.001)

DSHS HIV/STD Ryan White Part B Program Universal Standards (pg. 30-31)

DSHS HIV/STD Prevention and Care Branch, Policy 260.002. Health Insurance Assistance

LOCAL AIDS PHARMACEUTICAL ASSISTANCE (LPAP)

HRSA Service Category Description:

Local Pharmaceutical Assistance (LPAP) is operated by a HRSA Ryan White HIV/AIDS Program (RWHAP) Part B (non-ADAP) recipient or subrecipient as a supplemental means of providing ongoing medication assistance when a HRSA RWHAP AIDS Drug Assistance Program (ADAP) has a restricted formulary, waiting list, and/or restricted financial eligibility criteria.

Program Guidance:

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

Limitations:

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

- Local pharmacy assistance programs are not funded with ADAP earmark funding.
- LPAPs are not to take the place of the ADAP program.
- Clients cannot be enrolled in another medication assistance program for the same medication, excluding co-payment discounts.
- Funds may not be used to make direct payments of cash/vouchers to a client.
- No charges may be imposed on clients with incomes below 100% of the Federal Poverty Level (FPL).
- LPAPs do not dispense medications as:
    - A result or component of a primary medical visit;
    - A single occurrence of short duration (an emergency);
    - Vouchers to clients on an emergency basis.
      (Emergency Financial Assistance service category funds should be used for the above situations)

Services:

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

- Uniform benefits for all enrolled clients throughout the service area;
- A recordkeeping system for distributed medications;
- A LPAP advisory board;
- A drug formulary that is
    - approved by the local advisory committee/board, and
    - consists of HIV-related medications not otherwise available to the clients due to the elements mentioned above;
- A drug distribution system;

- A client enrollment and eligibility determination process that includes screening for HRSA RWHAP ADAP and LPAP eligibility with rescreening at a minimum of every six months;
- Coordination with the State's RWHAP Part B ADAP (a statement of need should specify restrictions of the state ADAP and the need for the LPAP); and
- Implementation in accordance with requirements of the HRSA 340B Drug Pricing Program and the Prime Vendor Program.

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

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

Statement of Need:

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

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

- The LPAP may not duplicate services available through the TX ADAP program.
- Clients needing long-term assistance with prescription medications shall be assisted with completing a TX ADAP application and, when applicable, PAP applications.
- If the medication is not on the TX ADAP formulary and is not available through assistance programs, the client may be served with LPAP funds if the medication is on the LPAP formulary.
- If short-term medication assistance is required and a client is eligible, this need may be met with Emergency Financial Assistance funds.
- Clients with insurance and other third-party payer sources are not eligible for LPAP assistance unless there is documentation on file that the medication is not covered by their prescription benefits.

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

- Consistent with the most current HIV/AIDS Treatment Guidelines;
- Coordinated with the State's Part B Texas HIV Medication Program (THMP) of which the TX ADAP is part of; and/or
- Implemented in accordance with requirements of the 340B Drug Pricing Program and the Prime Vendor Program.

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

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

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

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

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

Service Standards & Monitoring Indicators:

The following Service Standards and Monitoring Indicators are guides to improving healthcare outcomes for people living with HIV throughout the Service Delivery Area within the Part B Service Delivery, State Funds, and State Services Programs.

A. LPAP Prescriptions	
Service Standard	Monitoring Indicators
Providers may use funding to assist eligible clients with purchasing medications that are over the Medicaid monthly allotment or that the THMP program does not cover. A copy of the client's prescription from the prescribing provider is on file with the agency. The prescription must include: • Name of the client • Date of Birth • Medication • Dose • Signature of prescribing medical provider	Percentage of client charts that have the documented prescriptions funded through LPAP assistance with name of client; date of birth; medication; dose; and signature of prescribing medical provider.

B. Timeliness of Services	
Service Standard	Monitoring Indicators
Agencies must have a system for clients to access prescriptions. Prescriptions should be available and approved for LPAP assistance within two (2) business days. Otherwise eligible clients shall have ongoing access to medications prescribed by a qualified prescribing medical provider through the local area's LPAP program so long as the medication is on the LPAP formulary and allocations permit.	Percentage of clients accessing services under LPAP have access to their prescribed medication(s) that are not on the State Formulary within two (2) business days of approved LPAP-funding.

C. Prescribed Over the Counter (OTC) Medications	
Service Standard	Monitoring Indicators
LPAP can assist clients with their OTC medications if the provider has prescribed the medication and has deemed the medication is needed for prevention and treatment of opportunistic infections or to prevent the serious deterioration of the client's health AND the medication is on the LPAP formulary.	Percentage of client files with prescribed OTC medications paid through LPAP funding have documented evidence of medical necessity from prescribing provider.

D. Medication Adherence Counseling	
Service Standard	Monitoring Indicators
Clients are offered counseling on medication adherence when assistance is requested.	Percentage of clients who have documented evidence of adherence counseling offered at the time of assistance request.

E. Viral Suppression	
Service Standard	Monitoring Indicators
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 antiviral medication assistance for long-term (more than 60 days) have documented evidence of viral suppression within the measurement year.

References:

HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A April 2013, p. 6-7 (PDF)

HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B April, 2013, p. 6-7 (PDF)

HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Notices and Program Letters, Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02 (PDF) (Revised 10/22/18)

HRSA HAB Local Pharmaceutical Assistance Program (LPAP) FAQs · LPAP Policy Clarification Memo. August 29, 2013 (PDF)

Interim Guidance for the Use of Telemedicine and Telehealth for HIV Core and Support Services, March 2020

Interim Guidance for the Use of Telemedicine and Telehealth for HIV Core and Support Services – Users Guide and FAQs, March 2020

Texas Administrative Code Title 22; Chapter 15, 291.6

DSHS HIV/STD Program Policies. Payer of Last Resort (Policy 590.001)

DSHS HIV/STD Program Policies Purchasing Prescription or Over-The-Counter Medications and Vitamins not Covered by a Third-Party Payer. (Policy 220.101)

DSHS HIV/STD Program Policies HIV/STD Medication Program Pharmacy Eligibility Criteria. (Policy 700.003)

Notes:

In the event that TX ADAP income eligibility changes, this policy will comply with the revised TX ADAP income eligibility/percentage of FPL.

MEDICAL CASE MANAGEMENT (MCM)

HRSA Service Category Description:

Medical Case Management (MCM) is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum. Activities provided under this service category may be provided 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).

In addition to providing the medically oriented activities above, 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).

Program Guidance:

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

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 only 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 during a case management visit (medical and non-medical) should be reported in the appropriate case management service category (i.e., Medical Case Management or Non-Medical Case Management).

Services:

Staff providing MCM services 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, 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, and 3) Client specific advocacy and/or review of utilization of services provided and needed by client.

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 treatments.to achieve and maintain viral suppression.

Key activities include:

- Initial assessment of case management 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

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

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

The HAB performance measures for Medical Case Management Services can be located on the HRSA website.

Service Standards & Monitoring Indicators:

The following Service Standards and Monitoring Indicators are guides to improving healthcare outcomes for people living with HIV throughout the Service Delivery Area within the Part B Service Delivery, State Funds, and State Services Programs.

A. Initial Comprehensive Assessment	
Service Standard	Monitoring Indicators
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	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.

• 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, including 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 mental health screening tool must be used) • Medical Nutritional Therapy • Clinical trials • Family Violence • 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 staff providing medical case management staff during their probationary period.	Percentage of clients who access MCM services that received at least one face-to-face meeting with staff providing MCM services that conducted the initial comprehensive assessment. Percentage of clients who access MCM services with documented education on basic HIV information as needed (newly diagnosed, return to care), including explanation of viral load and viral suppression. Percentage of clients who access MCM services with documented evidence of sexual health literacy and education provided on harm reduction, as needed.

B. Medical Case Management Acuity Level and Client Contact	
Service Standard	**Monitoring Indicators**
Clients who access MCM services have a documented acuity level using an approved acuity scoring tool with the comprehensive assessment. Each interaction with a client has the potential to change acuity scores in specific categories. Any changes in a client's acuity should be documented appropriately. Acuity and frequency of contact is documented in the primary client record system. *NOTE*: *The team providing MCM services has the discretion to (1) determine priority need clients that should be enrolled in MCM services and (2) clients who have low acuity scores but are high need and/or high-risk clients for falling out of care. Clear and detailed documentation must be present in the client's primary record.*	Percentage of clients who access MCM services who have a completed acuity level documented using an approved acuity scale with the comprehensive assessment and documented in the client primary record system. Percentage of clients who access MCM services that have documented evidence of review of acuity, minimum every three (3) months, to ensure acuity is still appropriate level for the client's needs. Percentage of clients who access MCM services with documented decreased acuity during the measurement year. Percentage of clients who access MCM services with documented evidence of acuity and frequency of contact by staff matches acuity level in the primary client record system.

C. Care Planning	
Service Standard	**Monitoring Indicators**

The client and the staff providing MCM services will actively work together to develop and implement the medical case management care plan. This is not a nursing care plan. Care plans include at a minimum:
• Problem Statement (Need)
• Goal(s) – suggest no more than three goals
• Intervention
  ○ Task(s)
  ○ Referral(s)
  ○ Service Deliveries
• Individuals responsible for the activity (staff providing MCM services, client, other team member, family)
• Anticipated time for each task
	Percentage of clients who access MCM services, regardless of age, with a diagnosis of HIV who had a medical case management care plan developed and/or updated two or more times in the measurement year. (HRSA HAB Measure-DSHS language clarification)
	
	Percentage of client records with documented issues noted in the care plans that have ongoing case notes that match the stated need and the progress towards meeting the goal identified, as indicated in the primary client record system.

The care plan is updated with outcomes and revised or amended in response to changes in client life circumstances or goals, at a minimum, every six (6) months. Tasks, referrals and services should be updated as they are identified or completed – not at set intervals.	

D. Viral Suppression/Treatment Adherence	
Service Standard	**Monitoring Indicators**
An assessment of treatment adherence support needs and client education should begin as soon as clients access MCM services and should continue as long as a client continues to access MCM services. Medical Case Management services should involve an individually tailored adherence intervention program, *and staff providing medical case management services should reinforce treatment adherence at every contact whether it is during face-to-face contact or telephone contact.* The following criteria are recommendations that can help staff providing medical case management services and clients examine the client's current and historical adherence to both medical care and treatment regimens: • *Medication and Treatment Adherence:* Relates to current level of adherence to ARV medication regimen and client ability to take medications as prescribed. Staff providing MCM services will use any available treatment adherence tool to promote adherence for clients who demonstrate challenges with adherence (e.g., not taking ARV medications as prescribed, missing appointments, etc.) • *Appointments:* Relates to current level of completion of appointments for	Percentage of clients who access MCM services with documented education about the goals of HIV treatment. Percentage of clients who access MCM services who were provided treatment counseling as indicated for those clients who demonstrate challenges with adherence (not taking their medications as prescribed, missing doses) with education documented in the primary client record system. Percentage of clients who access MCM services who were provided education on treatment adherence as determined necessary for clients who demonstrate challenges with adherence and education is documented in the primary client record system. Percentage of clients who access MCM services, regardless of age, with a diagnosis of HIV who did not have a medical visit in the last 6 months of the measurement year (that is documented in the medical case management record). (HRSA HAB measure – DSHS language clarification) Percentage of clients who access MCM services, 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 – DSHS language clarification)

core medical services and understanding of the importance of regular attendance at medical and non- medical appointments in order to achieve positive health outcomes. • *ARV Medication Side Effects:* Relates to potential adverse side effects associated with ARV treatment and the impact on functioning and adherence. Staff providing MCM services will discuss side effects of medications as challenges and barriers to treatment adherence. • *Knowledge of HIV Medications:* Relates to client understanding of prescribed ARV regimen, the role of medications in achieving positive health outcomes and techniques to manage side effects (e.g., providing education to client on importance and relation of adherence to ARV to achieve and maintain viral suppression, thus preventing onward transmission). • *Treatment Support:* Relates to client relationship with family, friends, and/or community support systems, which may either promote or hinder client adherence to treatment protocols.	Percentage of clients who access MCM services, 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 – DSHS language clarification)

E. Referral and Follow-up	
Service Standard	Monitoring Indicators
Staff providing MCM services will work with the client to determine barriers to referrals and facilitate access to referrals. Staff providing MCM services will ensure that clients are accessing needed referrals and services, and will identify and resolve any barriers clients may have in following through with their Care Plan. When clients are referred for services elsewhere, case notes include	Percentage of clients who access MCM services with documented referrals initiated immediately with client agreed participation upon identification of client needs. Percentage of clients who access MCM services with documented referrals declined by the client in the primary client record system. Percentage of clients who access MCM services with referrals that have

documentation of the completed referral with outcome of the referral in the primary client record system.	documentation of follow up to the referral including appointment attended and the result of the referral. Percentage of agencies providing MCM services with documented evidence of a referral tracking mechanism to monitor completion of all medical case management referrals.

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

independent of medical case management assistance) Client is considered to be "out of 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. Case closure proceedings should be initiated by agency 30 days following the 3rd attempt. *Make sure appropriate Releases of Information and consents are signed by the client and meet requirements of HB 300 regarding electronic dissemination of protected health information (PHI).* Staff should utilize multiple methods of contact (phone, text, e-mail, certified letter) when trying to re-engage a client, as appropriate. Agencies must ensure that they have releases of information and consent forms that meet the requirements of HB 300 regarding the electric dissemination of protected health information (PHI).	Percentage of clients who access MCM services that are provided with contact information and process for reestablishment as documented in primary client record system.

References:

HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A April 2013. p. 21-23. (PDF) Accessed on October 12, 2020.

HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B, April, 2013. P. 20-22. (PDF) Accessed October 12, 2020.

HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Notices and Program Letters, Policy Clarification Notice 16-02 Accessed on October 12, 2020.

Interim Guidance for the Use of Telemedicine and Telehealth for HIV Core and Support Services, March 2020

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Notes:

Probationary period is determined by the agency and should be noted in agency case management procedures.

MEDICAL NUTRITION THERAPY (MNT)

HRSA Service Category Description:

Medical Nutrition Therapy (MNT) includes:

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

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

Program Guidance:

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 (RD) or other licensed nutrition professional.

Services not provided by a registered/licensed dietitian should be considered Psychosocial Support Services under the Ryan White HIV/AIDS Program (RWHAP).

In the State of Texas, the only allowable nutrition professional recognized for Medical Nutrition Therapy service category is a licensed Registered Dietitian.

Limitations:

Services must be provided by a Registered Dietitian 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.

Services:

The application of MNT 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 living with HIV through the continuum of care.

MNT 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 a RD.

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.

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

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

Service Standards & Monitoring Indicators:

The following Service Standards and Monitoring Indicators are guides to improving healthcare outcomes for people living with HIV throughout the Service Delivery Area within the Part B Service Delivery, State Funds, and State Services Programs.

A. Medical Nutrition Therapy Assessment	
Service Standard	**Monitoring Indicators**
An initial MNT assessment will be conducted by an RD pursuant to a medical provider's referral. MNT provider will contact the patient for the initial nutritional assessment within five (5) business days of the referral. The initial MNT assessment must be completed within ten (10) business days of the initial appointment with the RD. MNT provider obtains and documents HIV primary medical care provider contact information for each patient. MNT services must be provided in consultation with the medical care provider for medical coordination.	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.

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. • *Biochemical*: lab data from the primary medical care provider.	

B. Nutrition Plan	
Service Standard	Monitoring Indicators
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,	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.

the client's primary care provider, and other authorized personnel involved in the client's care.	

C. Services Provided	
Service Standard	Monitoring Indicators
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.

D. Provision of Nutritional Supplements and Food Provisions	
Service Standard	Monitoring Indicators
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 written nutrition plan by the RD. The written nutritional plan must	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.

be communicated with the primary HIV prescribing provider.	

E. Nutrition Education	
Service Standard	Monitoring Indicators
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.

F. Referrals	
Service Standard	Monitoring Indicators
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.

G. Discharge	
Service Standard	Monitoring Indicators
An individual is deemed no longer to need 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	Percentage of clients accessing MNT with documentation of discharge noted in the client's primary record as applicable.

Date of discharge, reason, and any recommendations for follow up shall be documented in the patient's record and the primary medical provider notified.	

References:

Agency for Healthcare Research and Quality. HIV/AIDS evidence-based nutrition practice guideline

HRSA/HAB Division of Service Systems Program Monitoring Standards – Part A April, 2013, page 19- 20. (PDF) Accessed on October 12, 2020.

HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B April, 2013, page 19-20. (PDF) Accessed on October 12, 2020

Living well with HIV/AIDS. A manual on nutritional care and support for people living with HIV/AIDS

The American Dietetic Association. Medical Nutrition Therapy Across the Continuum of Care, Second Edition, October, 1998.

The American Dietetic Association. HIV/AIDS evidence-based nutrition practice guideline. Chicago (IL): American Dietetic Association; December, 2010. (PDF)

HRSA Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02 (PDF) (Revised 10/22/2018).

Interim Guidance for the Use of Telemedicine and Telehealth for HIV Core and Support Services, March 2020

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MENTAL HEALTH SERVICES (MH)

HRSA Service Category Description:

Mental Health (MH) 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, advanced practice nurses, psychologists, licensed professional counselors, and licensed clinical social workers.

Limitations:

Mental Health Services *are allowable only for people living with HIV* who are eligible for HRSA Ryan White HIV/AIDS Program (RWHAP) services.

Services:

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

Mental health services include:

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

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

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

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

Mental health services that are provided via telehealth must be in accordance with State of Texas mental health provider practice requirements, see Texas Occupations Code, Title 3 Health Professions and chapter 111 for Telehealth & Telemedicine and Texas Administrative Code, Title 22 Examining Boards, Part 9 Texas Medical Board, Chapter 174 Telemedicine, Subchapter B Mental Health Services.

When psychiatry is provided as a mental health service via telehealth then the provider must follow guidelines for telemedicine as noted in 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.

Service Standards & Monitoring Indicators:

The following Service Standards and Monitoring Indicators are guides to improving healthcare outcomes for people living with HIV throughout the Service Delivery Area within the Part B Service Delivery, State Funds, and State Services Programs.

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

• Behavior that is considered unacceptable and the agency's progressive action for suspension of services, see DSHS Policies 530.003 and 530.002	

B. Mental Health Assessment	
Service Standard	**Monitoring Indicators**

All clients referred to the program will receive a mental health assessment by licensed mental health professionals. A mental health assessment should be completed no later than the third counseling session and should include, at a minimum, the following as guided by licensure requirements:
• Presenting problems
• Completed mental status evaluation (including appearance and behavior, self-attitude, speech, psychomotor activity, mood, insight, judgment, suicidal ideation, homicidal ideation, perceptual disturbances, obsessions/compulsions, phobias, panic attacks)
• Cognitive assessment (level of consciousness, orientation, memory, and language)
• Current risk of danger to self and others
• Living situation
• Social support and family relationships, including client strengths/challenges, coping mechanisms and self-help strategies
• Medical history
• Current medications
• Substance use history
• Psychosocial history to include:
  ○ Education and employment history, including military service
  ○ Sexual and relationship history and status
	Percentage of clients with documented mental health assessment completed by the 3rd counseling session, unless otherwise noted, in the client's primary record.

○ Physical, emotional, and/or sexual abuse history ○ Domestic violence assessment ○ Trauma assessment ○ Legal history ○ Leisure and recreational activities Clients are assessed for care coordination needs and referrals are made to case management programs, as appropriate. If pressing mental health needs emerge during the mental health assessment requiring immediate attention that results in the assessment not being finalized by the third session, this must be documented in the client's primary record.	

C. Treatment Plan	
Service Standard	Monitoring Indicators
All eligible client files should have documented evidence of a detailed treatment plan and documentation of services provided within the client's primary record. A treatment plan shall be completed within 30 days from the Mental Health Assessment. The treatment plan should include: • Diagnosed mental health issue • Goals and objectives • Treatment type (individual, group) • Start date for mental health services • Recommended number of sessions • Date for reassessment • Projected treatment end date (estimated) • Any recommendations for follow up Treatment, as clinically appropriate, should include counseling regarding: • Risk reduction and health promotion • Substance use disorder • Treatment adherence • Development of social support systems	Percentage of clients with documented detailed treatment plan and documentation of services provided within the client's primary record. Percentage of clients with treatment plans completed and signed by the licensed mental health professional rendering services in the client's primary record. Percentage of clients with documented evidence of treatment plans reviewed/modified at a minimum midway through the number of determined sessions agreed upon for frequency of modality in the client's primary record.

• Community resources • Maximizing social and adaptive functioning • The role of spirituality and religion in a client's life, disability, death and dying and exploration of future goals The treatment plan must be signed by the mental health professional rendering service and developed in conjunction with the client. Electronic signatures are acceptable. Treatment plans are reviewed and modified at a minimum, midway through the number of determined sessions agreed upon for frequency of modality, or more frequently as clinically indicated.	

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

E. Psychotropic Medication Management	
Service Standard	Monitoring Indicators
Psychotropic medication management services are available for all clients either directly or through referral as appropriate. Pharm Ds can provide psychotropic medication management services. Mental health professional will discuss the client's concerns with the client about prescribed medications (side effects, dosage, interactions with HIV medications, etc.). Mental health professional will encourage the client to discuss concerns about prescribed medications with their HIV-prescribing clinician (if the mental health professional is not the prescribing clinician) so that medications can be managed effectively.	Percentage of clients accessing medication management services with documented evidence in the client's primary record of education regarding medications. Percentage of clients with changes to psychotropic/psychoactive medications with documented evidence of this change shared with the HIV-prescribing provider, as permitted by the client's signed consent to share information, in the client's primary record.

Mental health providers with prescriptive authority will follow all regulations required for prescribing of psychoactive medications as outlined by the Texas Administrative Code, Title 25, Part1, Chapter 415, Subchapter A, Rule 415.10.	

F. Provision of Services	
Service Standard	**Monitoring Indicators**
Services will be provided according to the individual's treatment plan and documented in the client's primary record. Progress notes are completed according to the agency's standardized format for each session and will include: • Client name • Session date • Focus of session • Interventions • Progress on treatment goals • Newly identified issues/goals • Counselor signature and authentication (credentials). In urgent, non-life-threatening circumstances, an appointment will be made within one (1) business day. If an agency cannot provide the needed services, the agency will offer to refer the client to another organization that can provide the services. The referral must be made within one (1) business day for urgent, non-life threatening situation(s).	Percentage of clients with documented evidence of progress notes completed and signed in accordance with the individual's treatment plan in the client's primary record.

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

referrals are in place for clients who need to improve adherence (e.g. behavioral contracts). There is evidence of consultation with medical care/psychiatric/pharmacist as appropriate regarding medication management, interactions, and treatment adherence.	

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

I. Discharge Planning	
Service Standard	**Monitoring Indicators**
Discharge planning will be done with each client when treatment goals are met or when client has discontinued therapy either by initiating closure or as evidenced by non-attendance of scheduled appointments, as applicable. Documentation for discharge planning will include, as applicable: • Circumstances of discharge • Summary of needs at admission • Summary of services provided • Goals and objectives completed during counseling • Discharge plan • Counselor authentication, in accordance with current licensure requirements	Percentage of clients with documentation of discharge planning when treatment goals being met as evidenced in the client's primary record. Percentage of clients with documentation of case closure per agency non-attendance policy as evidenced in the client's primary record.

References:

American Psychiatric Association. The Practice Guideline for Treatment of Patients with HIV/AIDS , Washington, DC, 2001. (PDF)

American Psychiatric Association. Guideline Watch: Practice Guideline for the Treatment of Patients with HIV/AIDS, Washington, DC, 2006. (PDF)

HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A April, 2013, page 17-18. (PDF)

HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B April, 2013, page 17-18. (PDF)

HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Notices and Program Letters, Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02 (PDF) (Revised 10/22/18)

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New York State Department of Health, Mental Health Standards of Care, Delivery of Care

ORAL HEALTH CARE (OH)

HRSA Service Category Description:

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

Limitations:

Cosmetic dentistry for cosmetic purposes only is prohibited. At the current time, teledentistry is not approved by the Texas Dental Board.

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

In the cases of emergency need and/or where extensive care is needed, the maximum amount may exceed the above cap. Dental providers are required to document the reason for exceeding the yearly maximum amount and must have documented approval from the local Administrative Agency.

Services:

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

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

Service Standards & Monitoring Indicators:

The following Service Standards and Monitoring Indicators are guides to improving healthcare outcomes for people living with HIV throughout the Service Delivery Area within the Part B Service Delivery, State Funds, and State Services Programs.

A. Services	
Service Standard	Monitoring Indicators
In order to provide equitable, allowable Oral Health services to all eligible clients for successful completion of their individualized dental treatment plans, expenditure caps may be sent with additional limitations so long as the criteria are applied equitably and	Percentage of oral health patients with documented evidence that oral health care services provided met the specific limitations or caps as set forth for dollar amount and any additional limitations as set regionally for type of procedure, limits on number of procedures or combination of these.

limitations do not restrict eligible individuals from receiving needed oral health services. In the cases of emergency need and/or where extensive care is needed, the maximum amount may exceed the above ($3,000/client/calendar year) cap. Dental providers are required to document the reason for exceeding the yearly maximum amount and must have documented approval from the local Administrative Agency (AA) for the purposes of funds only, but not the appropriateness of the clinical procedure.	Percentage of oral health patients with documented evidence *if* the cost of dental care exceeded the annual maximum amount for Ryan White/State Services funding, reason is documented in the patient's oral health care record.

B. Medical/Dental History/Screening	
Service Standard	Monitoring Indicators
To develop an appropriate treatment plan, the oral health care provider shall obtain complete information about the patient's health and medication status. As per the Texas Board of Dental Examiners, at minimum, a medical history and limited physical evaluation should be obtained and reviewed at the initial appointment and updated annually. This information shall include, but not be limited to, the following: • The client's HIV-prescribing primary medical care provider name and phone number; • Pregnancy status as applicable; • Coagulants; • Patient's chief complaint; • Current Medications, including any osteoporotic medications; • Allergies and drug sensitivities; • Recreational drug and alcohol use; • Tobacco use; • Neurological diseases; • Usual oral hygiene; and • Date of last dental examination.	Percentage of oral health patients who had a dental and medical health history (initial or updated) at least once in the measurement year. (HRSA HAB Measure)

C. Limited Physical Examination	
Service Standard	**Monitoring Indicators**
The oral health provider is responsible for completing an initial limited physical examination in accordance with the Texas Board of Dental Examiners that shall include, but not be limited to: • Blood Pressure; • Pulse/Heart Rate; and • Basic vital signs. Dental practitioner shall also record blood pressure and pulse heart rate as indicated for invasive procedures involving sedation and anesthesia. If the dental practitioner is unable to obtain a patient's vital signs, the dental practitioner must document in the patient's oral health care record why the attempt to obtain vital signs was unsuccessful.	Percentage of oral health patients with a documented limited physical examination completed in the primary client oral health record.

D. Oral Examination	
Service Standard	**Monitoring Indicators**
Clinical oral evaluations include evaluation, diagnosis and treatment planning. Patient must have either an initial comprehensive oral exam or a periodic recall oral evaluation once per year such as: • Comprehensive oral evaluation, to include bitewing x-rays, new or established patient; • Periodic Oral Evaluation to include bitewing x-rays, established patient; • Detailed and Extensive Oral Evaluation, problem focused by report; • Re-evaluation, limited, problem focused (established patient; not post-operative visit); or • Comprehensive Periodontal Evaluation, new or established patient. Source: ada.org ADA Oral Health Topic: HIV.	Percentage of oral health patients with a documented oral examination completed within the measurement year in the client's primary oral health record.

E. Periodontal Screening or Examination	
Service Standard	Monitoring Indicators
A periodontal screen shall include the assessment of medical and dental histories, the quantity and quality of attached gingival, bleeding, tooth mobility, and radiological review of the status of the periodontium and dental implants. A comprehensive periodontal examination includes: • Evaluation of periodontal conditions; • Evaluation and recording of dental caries; • Evaluation and recording of missing or unerupted teeth; • Evaluation and recording of restorations; • Evaluation and recording of occlusal relationships; • Evaluation of oral cancer; • Probing and charting; • Evaluation and recording of the patient's dental and medical history; and • General health assessment. Some forms of periodontal disease may be more severe in individuals affected with immune system disorders. Patients with HIV may have especially severe forms of periodontal disease. The incidence of necrotizing periodontal diseases may increase with patients with acquired immune deficiency syndrome.	Percentage of oral health patients who had a periodontal screen or examination as least once in the measurement year. (HRSA HAB Measure)

F. Treatment Plan	
Service Standard	Monitoring Indicators
Dental Treatment Plan A dental treatment plan that includes preventive care, maintenance, and elimination of oral pathology shall be developed and discussed with the patient.	Percentage of oral health patients who had a dental treatment plan developed and/or updated at least once in the measurement year. (HRSA HAB Measure)

Various treatment options shall be discussed and developed in collaboration with the patient. A treatment plan appropriate for the patient's health status, financial status, and individual preference must include as clinically indicated: • Provision for the relief of pain; • Elimination of infection; • Preventive plan component; • Periodontal treatment plan if necessary; • Elimination of caries; • Replacement or maintenance of tooth space or function; • Consultation or referral for conditions where treatment is beyond the scope of services offered; • Determination of adequate recall interval; • Invasive Procedure Risk Assessment (prior to oral surgery, extraction, or other invasive procedure); • Dental treatment plan will be signed by the oral care health professional providing the services. (*Electronic signatures are acceptable*)	
Phase 1 Treatment Plan Phase 1 treatment includes prevention, maintenance, and/or elimination of oral pathology that results from dental caries or periodontal disease. This includes: • Restorative treatment; • Basic periodontal therapy (nonsurgical); • Basic oral surgery that includes extractions and biopsy; • Non-surgical endodontic therapy; and • Space maintenance and tooth eruption guidance for transitional dentition.	Percentage of oral health patients with a Phase 1 treatment plan that is completed within 12 months. (HRSA HAB Measure)

A Phase 1 treatment plan will be established and updated annually to include diagnostic, preventative, and therapeutic services that will be provided. The Phase 1 treatment plan, if the care was completed on schedule, is completed within 12 months of initiating treatment.	

G. Oral Health Education	
Service Standard	Monitoring Indicators
Oral health education must be provided and can be documented by either a licensed dentist, dental hygienist, dental assistant, or dental case manager and shall include: • Oral hygiene instruction; • Daily brushing and flossing (or other interproximal cleaning) and/or prosthetic care to remove plaque; • Daily use of over-the-counter fluorides to prevent or reduce cavities when appropriate and applicable to the patient. If deemed appropriate, the reason is stated in the patient's oral health record; and • Smoking/tobacco cessation counseling as indicated. Additional areas for instruction may include Nutrition. For pediatric patients, oral health education shall be provided to parents and caregivers and be age-appropriate for pediatric patients. Source: ada.org or the ADA's website for patient education information.	Percentage of oral health patients who received oral health education at least once in the measurement year. (HRSA HAB Measure)

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

follow-up documentation regarding the referral.	

References:

HRSA/HAB Division of Service Systems Program Monitoring Standards – Part A April 2011, page 9-10. (PDF) Accessed on October 12, 2020.

HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B April 2013, page 9-10. (PDF) Accessed October 12, 2020.

Texas Administrative Code. Title 22, Part 5 State Board of Dental Examiners. Chapter 108, Subchapter A, Rule §108.7 Minimal Standards of Care, General

Texas Administrative Code. Title 22, Part 5, State Board of Dental Examiners, Chapter 108, Subchapter A, Rule §108.8, Records of the Dentist

Texas Health and Safety Code, Title 2, Subtitle D, Chapter 85. Acquired Immune Deficiency Syndrome and Human Immunodeficiency Virus Infection

HRSA/HAB Clinical Care & Quality Management. HAB Oral Health Performance Measures Accessed January 11, 2018.

HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Notices and Program Letters, Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02 (PDF) (Revised 10/22/2018)

New York State Department of Health AIDS Institute, Management of Periodontal Disease Accessed October 14, 2020

New York State Department of Health AIDS Institute, Oral Health Complications Accessed October 14, 2020

Notes:

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

OUTPATIENT AMBULATORY HEALTH SERVICES (OAHS)

HRSA Service Category Description:

Outpatient/Ambulatory Health Services (OAHS) provide diagnostic and therapeutic-related activities directly to a client by a licensed healthcare provider in an outpatient medical setting. Outpatient medical settings may include: clinics, medical offices, mobile vans, using telehealth technology, and urgent care facilities for HIV-related visits.

Program Guidance:

Treatment adherence activities provided during an OAHS visit are considered OAHS services, whereas treatment adherence activities provided during a medical case management visit are considered medical case management services.

Limitations:

Non-HIV related visits to urgent care facilities are not allowable costs under OAHS per HRSA RWHAP PCN 16-02. Emergency room visits are not allowable costs within the OAHS category.

Services:

Allowable activities include:

- Medical history taking
- Physical examination
- Diagnostic testing(including HIV confirmatory and viral load testing), as well as 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
- Education and counseling on health and prevention issues
- Referral to and provision of specialty care related to HIV diagnosis, including audiology and ophthalmology

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

Diagnostic laboratory testing includes all indicated medical diagnostic testing, including all tests considered integral to treatment of HIV. Funded tests must meet the following conditions:

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

- Tests must be (1) ordered by a registered, certified, or licensed medical provider, and (2) necessary and appropriate based on established clinical practice standards and professional clinical judgment.

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

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

Service Standards & Monitoring Indicators:

The following Service Standards and Monitoring Indicators are guides to improving healthcare outcomes for people living with HIV throughout the Service Delivery Area within the Part B Service Delivery, State Funds, and State Services Programs.

A. Comprehensive HIV-related history	
Service Standard	**Monitoring Indicators**
Primary medical care for the treatment of HIV includes the provision of care that is consistent with the most current HHS treatment guidelines. Providers should document a comprehensive HIV-related history that is inclusive of all components listed in the OAHS Standard as referenced in the HHS guidelines. This can be completed during the initial visit or divided over the course of two or three early visits. History shall consist of, at a minimum, general medical history, a comprehensive HIV related history, and psychosocial history to include: • Documented past medical and surgical history with regard to chronic diseases such as diabetes, high blood pressure, heart disease, cholesterol, asthma or emphysema, sickle cell disease, etc. per HHS guidelines.	Percentage of 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.

• Psychosocial history to include socio-cultural assessment, occupational history, hobbies (as applicable), travel history, mental health, and housing status. • Lifestyle including tobacco use, alcohol use, illicit substance use, exercise, travel history. • Sexual Health including partners, practices, past sexually transmitted infections (STIs), contraception use (past and present). • HIV-related health history including most recent CD4 and Viral Load results, current ART (if applicable), previous adverse ART drug reactions, history of HIV-related illness and infections, HIV treatment history and staging. Source: Guide for HIV/AIDS Clinical Care Page 61-70 (PDF)	

B. Physical examination	
Service Standard	Monitoring Indicators
Primary medical care for the treatment of HIV includes the provision of care that is consistent with the most current HHS treatment guidelines. Providers should perform a baseline and annual comprehensive physical examination, with 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. Source: Guide for HIV/AIDS Clinical Care Page 73-77 (PDF)	Percentage of patients with a documented annual physical examination. Percentage of patients with a diagnosis of HIV who received an oral cavity exam during the physical exam as documented in the patient's primary record.

C. Laboratory tests, as clinically indicated by licensed provider	
Service Standard	**Monitoring Indicators**
Primary medical care for the treatment of HIV includes the provision of care that is consistent with the most current HHS treatment guidelines. 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) • HIV Viral Load Suppression • Standard genotypic drug-resistance testing Refer to Table 3 in the "Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents Living with HIV" for guidance on other scenarios where genotype testing is recommended • Coreceptor Tropism Test (if considering use of CCR5 co-receptor antagonist or for patients who exhibit virologic failure on a CCR5 antagonist) • HLA-B*5701 testing (only before initiating abacavir-containing regimen per guidelines) • Complete Blood Count (CBC) with Differential and Platelets • Chemistry Profile: Electrolytes, Creatinine, Blood Urea Nitrogen (BUN) • Liver Transaminases, Bilirubin (Total and Direct) • Urinalysis with Urine Protein and Creatinine • Lipid Profile – random or non-fasting (Total Cholesterol, LDL, HDL, Triglycerides) • Glucose (random or non-fasting) or hemoglobin A1C • Hepatitis A antibody, Hepatitis B surface antigen, core Ab, and surface antibody & Hepatitis C antibody screens at initial intake (providers	Percentage of patients with documented laboratory tests completed according to the OAHS Standard and HHS treatment guidelines. Percentage of patients with documented CD4 count (absolute). Percentage of patients with documented HIV-RNA viral load. 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 patients, regardless of age, with a diagnosis of HIV who had an HIV drug resistance test performed before initiation of HIV ART if therapy started during the measurement year. (HRSA HAB Measure) Percentage of patients, regardless of age, with a diagnosis of HIV who were prescribed HIV ART and who had a random or fasting lipid panel during the measurement year. (HRSA HAB Measure) Percentage of patients with a diagnosis of HIV at risk for STIs who had a test for chlamydia within the measurement year. (HRSA HAB Measure) Percentage of patients with a diagnosis of HIV at risk for STIs who had a test for gonorrhea within the measurement year. (HRSA HAB Measure) Percentage of adult patients with a diagnosis of HIV who had a test for syphilis performed within the measurement year. (HRSA HAB Measure)

should screen all HIV-infected patients for anti-HCV antibodies at baseline) ○ Quantitative HCV RNA viral load testing (for Hepatitis C (HCV) positive patients who are candidates for treatment) • Toxoplasma gondii IgG • Pregnancy Test (for female clients of childbearing potential) • RPR or treponemal antibody (Syphilis Screening) • Gonorrhea (GC) and Chlamydia (CT) Testing • Trichomoniasis Testing Source: Guide for HIV/AIDS Clinical Care Page 79-89 (PDF)	Hepatitis B screening was performed at least once since the diagnosis of HIV or for whom there is documented infection or immunity. (HRSA HAB Measure) Percentage of patients for whom HCV screening was performed at least once since the diagnosis of HIV. (HRSA HAB Measure) Percentage of patients with a Hepatitis C RNA viral load test, as applicable, completed within the measurement year.

D. Other diagnostic testing	
Service Standard	Monitoring Indicators
Primary medical care for the treatment of HIV includes the provision of care that is consistent with the most current HHS treatment guidelines. Chest x-ray will be completed if pulmonary symptoms are present; if positive LTBI test (either TST or Interferon Gamma Release Assay (IGRA)); or if prior evidence of LTBI or pulmonary TB (perform annually). Source: Guide for HIV/AIDS Clinical Care Page 85 (PDF)	Percentage of patients with documented chest x-ray completed if pulmonary symptoms were present, after an initial positive QTF, after initial positive TST, or annually if prior evidence of LTBI or pulmonary TB.

E. Screenings/Assessments	
Service Standard	Monitoring Indicators
Primary medical care for the treatment of HIV includes the provision of care that is consistent with the most current HHS treatment guidelines. Patients should receive screening for opportunistic infections and assessment of psychosocial needs initially and annually	Percentage of patients with documented medical screenings and assessments as indicated in the OAHS Standard and in accordance with HHS guidelines. Percentage of female patients with a diagnosis of HIV who were screened for

according to the most current HHS guidelines.
 	
Screening should include at a minimum:
• Mental health assessment that includes screening for clinical depression (PHQ 2 at a minimum)
• Psychosocial assessment, including domestic violence and housing status (housing status noted as: stable housing, unstable housing, or homeless)
• Substance use and abuse screening
• Tobacco use screening
• Pediatric patients (14 years and younger) will be screened for child abuse as defined in Chapter 261 of the Texas Family Code and DSHS policy. Consider screening youth 14-17 for child abuse.
• Oral health exam and assessment
• Tuberculosis (TB) Screening
• Cervical Cancer Screen (*following the most current clinical recommendations*)
  ○ *Women Aged <30 Years with HIV:*
  ▪ If younger than age 21, known to have HIV or newly diagnosed with HIV, and sexually active, Pap test should be performed within one (1) year of onset of sexual activity regardless of mode of HIV transmission.
  ○ *Women Aged >30 Years with HIV*
  ▪ Pap test should be done at baseline and every 12 months. If results of three (3) consecutive Pap tests are normal, follow-up Pap tests can be performed every three (3) years.
	cervical cancer in the last three years. (HRSA HAB Measure)
	
	Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool. (DSHS revised - HRSA HAB Measure)
	
	Percentage of patients aged 12 years and older with positive clinical depression screen with follow-up plan documented on the date of the positive screen. (DSHS revised - HRSA HAB Measure)
	
	Percentage of patients with documented psychosocial assessment to include domestic violence and housing status.
	
	Percentage of patients with a diagnosis of HIV who have been screened for substance use (alcohol & drugs) 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. (DSHS Revised - HRSA HAB Measure)
	
	Percentage of patients, if applicable, with completed child abuse assessment (completed if patient aged 14 years and younger).
	
	Percentage of patients aged three months and older with a diagnosis of HIV, for whom there was documentation that a tuberculosis (TB) screening test was performed and results interpreted (for TB skin tests) as least once since the diagnosis of HIV. (HRSA HAB Measure)

Additional screenings as medically indicated include: • Dilated eye exam every 6 to 12 months if the CD4 <50 by an ophthalmologist *Anal Cancer (Dysplasia) Screening* The Anal Cancer (Dysplasia) Screening Guidelines recommend, at a minimum, annual digital examination to detect masses on palpation that could be anal cancer. However, performing the digital exam alone as a screening procedure for anal dysplasia or cancer will miss many lesions. Anal cancer screening using a Pap test can improve sensitivity for detecting anal dysplasia or cancer. Cytology combined with high-resolution anoscope (HRA) is considered the best strategy for screening of precancerous lesions. If anal Pap is performed, clinicians should refer patients with abnormal anal cytology for HRA. In communities where HRA is not available, clinicians should consider referring patients with abnormal anal cytology to a surgeon for evaluation. Source: Guide for HIV/AIDS Clinical Care Page 6-7, 83-89, 127 (PDF) Recommended: Guide for HIV/AIDS Clinical Care Psychosocial Assessment Questions: page 65 (PDF) Cervical Cancer Screen	

F. Immunizations	
Service Standard	Monitoring Indicators
Primary medical care for the treatment of HIV includes the provision of care that is consistent with the most current HHS treatment guidelines. Immunizations/vaccinations will be given according to the most current HHS guidelines and the CDC's "Table 2: Recommended Adult	Percentage of patients with Tetanus, Diphtheria, and Pertussis current within 10 years, Td booster doses every 10 years thereafter, or documentation of refusal. Percentage of patients aged six months and older seen for a visit between October 1 and March 31 who received an influenza

Immunization Schedule by Medical Condition and Other Indications, US 2020." Providers will initiate prophylaxis for specific opportunistic infections. Patients will be offered vaccinations for the following: • Tetanus, Diphtheria, and Pertussis (Tdap) per recommended treatment guidelines for immunizations • Measles, Mumps, Rubella (MMR) per recommended treatment guidelines for immunizations. *Adults and adolescents with a CD4 cell count <200 cells/uL should not receive MMR*. • Influenza (inactivated vaccine)- annually during flu season October 1st - March 31st • Pneumococcal is recommended for all patients, two separate vaccines are recommended; ○ Receive a dose of PCV13, (Prevnar 13), followed by a dose of PPV23 (Pneumovax) at least eight (8) weeks later. • Completion of Hepatitis B (HBV) vaccines series, unless otherwise documented as immune, vaccinated patients should be tested for HBsAb response 1–2 months after completed the series or at the next scheduled clinic visits after completing the series. • Completion of Hepatitis A (HAV) vaccines series, unless otherwise documented as immune. • Varicella-Zoster (VZV): Please reference current treatment guidelines for VZV. **This vaccination is contraindicated in persons with HIV and CD4 count <200*. * HPV vaccine: The 2019 Advisory Committee on Immunization Practices (ACIP) recommends and DHHS states: "because of	immunization OR who reported previous receipt of an influenza immunization OR documentation of refusal. (DSHS Revised - HRSA HAB Measure) Percentage of patients with a diagnosis of HIV who completed the vaccination series for Hepatitis B, or documentation of refusal. Percentage of patients with a diagnosis of HIV who ever received pneumococcal vaccine, or documentation of refusal. Percentage of patients with a diagnosis of HIV who completed the vaccination series for Hepatitis A, or documentation of refusal. Percentage of patients with a diagnosis of HIV and are age >50 with a CD4>200 who ever received the Zoster vaccine, or documentation of refusal. Percentage of patients with a diagnosis of HIV between the ages of 11 and 26 years (can be initiated as early as 9 years of age) who completed the series for HPV, or documentation of refusal.

the potential benefit in preventing HPV-associated disease and cancer in this population, HPV vaccination is recommended for HIV infected males and females aged 11 through 26, but can be initiated as early as 9 years of age. For persons 27-45, ACIP recommends a conversation between provider and client regarding vaccine for this age group	

G. Anti-retroviral Therapy (ART)	
Service Standard	**Monitoring Indicators**
Primary medical care for the treatment of HIV includes the provision of care that is consistent with the most current HHS treatment guidelines. ART will be prescribed in accordance with the HHS established guidelines. Patients who meet current guidelines for ART are offered and/or prescribed ART. Source: Guide for HIV/AIDS Clinical Care (ARV) Page 207-220 (PDF)	Percentage of patients, regardless of age, with a diagnosis of HIV are prescribed antiretroviral therapy (ART) for the treatment of HIV during the measurement year. (HRSA HAB Measure)

H. Health Education/Risk Reduction	
Service Standard	**Monitoring Indicators**
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 point in time in the patient's life.	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 received cessation counseling intervention if identified as a tobacco user. (DSHS Revised - HRSA HAB Measure) Percentage of patients with documented counseling about family planning method appropriate to patient's status, as applicable, to include preconception counseling.

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

Source: Guide for HIV/AIDS Clinical Care (Smoking Cessation) page 189-196 (PDF) Source: Guide for HIV/AIDS Clinical Care (Patient Education) Page 57-59, 89, 102, 107, 111, 126, 143-154 (PDF) Source: Guide for HIV/AIDS Clinical Care (Nutrition) Page 197-202 (PDF)	

I. Treatment Adherence	
Service Standard	**Monitoring Indicators**
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. Source: Guide for HIV/AIDS Clinical Care Page 273 (PDF)	Percentage of patients with documented assessment for treatment adherence two or more times within the measurement year if patient is on ART. Percentage of patients with documented adherence issues who received counseling for treatment adherence two or more times within the measurement year. 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)

J. Referrals	
Service Standard	**Monitoring Indicators**
Providers will refer to specialty care or other systems as appropriate in accordance with current HHS guidelines.	Percentage of patients, as medically indicated, who had documentation of referrals for: • Mental Health and/or Substance Use

At a minimum, patients should receive referrals to specialized health care/providers/services *as needed or medically indicated* to augment medical care:
• AIDS Drug Assistance Program (ADAP)
• Medication Assistance Programs
• Medical care coordination
• 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 cancer screening
  ○ Breast cancer screening
• Specialty medical care for any preexisting chronic diseases
• Case Management Services or a Disease Investigation Specialist (DIS) for follow-up if missing appointments.
• Vision Care
• Audiology
 	
Providers/staff are expected to follow-up on each referral to assess attendance and outcomes. For specific details regarding screening modalities and timeframes see The United States Preventive Services Task Force.
 	
Source: Guide for HIV/AIDS Clinical Care Page 73 (PDF)
	• Oral Health
	• Ophthalmological services
	• Child abuse if suspected abuse
	• Disease intervention specialist
	• Other specialty services.
	
	Percentage of patients with a documented referral in the measurement year, has a progress note in the patient's chart regarding attendance, and outcomes of the referral.

K. Documentation in Patients' Medical Chart	
Service Standard	Monitoring Indicators
Primary medical care for the treatment of HIV includes the provision of care that is consistent with the most current HHS treatment guidelines. Clinicians (included but not limited to Providers with prescriptive authority, PharmD, PhD, LCSW, LCDC, RN, LVN, MA or MCM) will develop/ update plan of care at each visit. If a patient refuses a treatment, such as vaccinations, documentation of denial will be written in the patient's medical chart. The provider developing the plan will sign each entry, an electronic signature is allowable. Source: Guide for HIV/AIDS Clinical Care See Section 2, Page 77 (PDF)	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.

L. Documentation of missed patient appointments & efforts to bring them into care	
Service Standard	Monitoring Indicators
Provider and/or staff will conduct the following: • Contact patients who have missed appointments, using at least 3 different forms of contact (phone, mail, emergency contact, phone call, referral to DIS for home visit) prior to determining they are lost to follow-up; • Address any specific barriers to accessing services; • Document number of missed patient appointments and efforts to bring the patient into care. Source: Guide for HIV/AIDS Clinical Care Page 1 (PDF)	Percentage of patient medical records with documentation of any specific barriers and efforts made to address missed appointments.

M. Perinatally Exposed Infants Neonatal Zidovudine (ZDV) Prophylaxis	
Service Standard	Monitoring Indicators
All newborns perinatally exposed to HIV should receive postpartum antiretroviral (ARV) drugs to reduce the risk of perinatal transmission of HIV. Newborn ARV regimens—at gestational-age-appropriate doses—should be initiated as close to the time of birth as possible, preferably within 6 to 12 hours of delivery. The selection of a newborn ARV regimen should be determined based on maternal and infant factors that influence risk of perinatal transmission of HIV. The uses of ARV Regiments in Newborns include: • *ARV Prophylaxis:* The administration of one or more ARV drugs to a newborn without documented HIV infection to reduce the risk of perinatal acquisition of HIV. • *Empiric HIV Therapy:* The administration of a three-drug ARV regimen to newborns at highest risk of perinatal acquisition of HIV. Empiric HIV therapy is intended to be preliminary treatment for a newborn who is later documented to have HIV but also serves as prophylaxis against HIV acquisition for those newborns who are exposed to HIV in utero, during the birthing process, or during breastfeeding and who do not acquire HIV. • *HIV Therapy:* The administration of a three-drug ARV regimen at treatment dosages (antiretroviral therapy [ART]) to newborns with documented HIV infection. Providers with questions about ARV management of perinatal HIV exposure should consult the National Perinatal HIV	Percentage of infants born to HIV + women who were prescribed ZDV prophylaxis for HIV within 12 hours of birth during the measurement year. (HRSA HAB Measure)

Hotline (1-888-448-8765), which provides free clinical consultation on all aspects of perinatal HIV, including newborn care. All newborns with perinatal exposure to HIV should receive antiretroviral (ARV) drugs in the neonatal period to reduce perinatal transmission of HIV, with selection of the appropriate ARV regimen guided by the level of transmission risk. • The most important factors that influence the risk of HIV transmission to a newborn exposed to HIV are whether the mother has received antepartum/intrapartum antiretroviral therapy (ART) and her viral load • The risk of transmission is increased in the absence of maternal ART or if maternal antepartum/intrapartum treatment was started after early pregnancy or was ineffective in producing virologic suppression; higher maternal viral load, especially in later pregnancy, correlates with higher risk of transmission. There is a spectrum of transmission risk that depends on these and other maternal and infant factors, including mode of delivery, gestational age at delivery, and maternal health status. HIV transmission can occur in utero, intrapartum, or during breastfeeding. Drug selection and dosing considerations are related to the age and gestational age of the newborn. Consultation is available through the National Perinatal HIV Hotline (888-448-8765).	

N. Diagnostic Testing to Exclude HIV Infection in Exposed Infants	
Service Standard	Monitoring Indicators
Newborns Born to Mothers Who Received Antepartum/Intrapartum Antiretroviral Drugs with Effective Viral Suppression: According to US Department of Health and Human Services, (DHHS) the risk of HIV acquisition in newborns born to women who received ART regimens during pregnancy and labor and had undetectable viral loads at delivery is <1%. DHHS recommends a 4-week neonatal zidovudine prophylaxis regimen for newborns if the mother has received ART during pregnancy with viral suppression (usually defined as confirmed HIV RNA level below the lower limits of detection of an ultrasensitive assay) at or after 36 weeks' gestation, and there are no concerns related to maternal adherence. *Newborns Born to Mothers with Unknown HIV Status at Presentation in Labor* • Expedited HIV testing is recommended during labor for women with unknown HIV status and, if not performed during labor, as soon as possible after birth for the mothers and/or their newborns (see Identification of Perinatal Exposure). Expedited test results should be available within 60 minutes. • If maternal or infant expedited testing is positive, the newborn *should be immediately initiated on a multi-drug ARV prophylaxis regimen or empiric HIV therapy*, without waiting for the results of supplemental tests • Expedited HIV testing should be available on a 24-hour basis at all facilities with a maternity service and/or neonatal intensive care unit or special care or newborn nursery	Percentage of infants born to HIV + women who received recommended virologic diagnostic testing for exclusion of HIV infection in the measurement year. (HRSA HAB Measure)

• A nursing mother who is suspected of having HIV based on an initial positive antibody or antibody/antigen test result should stop breastfeeding until HIV is confirmed or ruled out • Breastfeeding is not recommended for women with confirmed HIV in the United States, including those receiving ART *Newborns Born to Mothers with Antiretroviral Drug-Resistant Virus* • The optimal ARV regimen for newborns delivered by women with ARV drug-resistant virus is unknown. The ARV regimen for newborns born to mothers with known or suspected drug resistance should be determined in consultation with a pediatric HIV specialist before delivery or through consultation via the National Perinatal HIV Hotline (888-448-8765) • Data exist to provide dosing recommendations appropriate for the treatment of HIV in neonates For comprehensive guidance please see Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Infection	

References:

American College of Obstetricians and Gynecologists (ACOG); 2011 Aug. 11 p. (ACOG practice bulletin; no. 122) Accessed October 15, 2020.

HIV Clinical Guidelines

U.S. Department of Health and Human Services, Health Resources and Services Administration, Guide for HIV/AIDS Clinical Care – 2014 Edition. Rockville, MD: U.S. Department of Health and Human Services, 2014 (PDF)

MMWR (January 31, 2014 / 63(04); 69-72) CDC Grand Rounds: Reducing the Burden of HPV-Associated Cancer and Disease

New York State Recommendations on Anal Pap Smears

Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV. Department of Health and Human Services (PDF) Accessed October 2020.

Panel on Antiretroviral Therapy and Medical Management of Children Living with HIV. Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Infection (PDF) Accessed October 2020.

Panel on Treatment of Pregnant Women with HIV Infection and Prevention of Perinatal Transmission. Recommendations for the Use of Antiretroviral Drugs in Pregnant Women with HIV Infection and Interventions to Reduce Perinatal HIV Transmission in the United States (PDF) Accessed October 2020.

Panel on Guidelines for the Prevention and Treatment of Opportunistic Infections in Adults and Adolescents with HIV. Guidelines for the Prevention and Treatment of Opportunistic Infections in HIV-infected Adults and Adolescents: Recommendations from the Centers for Disease Control and Prevention, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. (PDF) Accessed October 2020.

Panel on Opportunistic Infections in HIV-Exposed and HIV-Infected Children. Guidelines for the Prevention and Treatment of Opportunistic Infections in HIV-Exposed and HIV-Infected Children. Department of Health and Human Services (PDF) Accessed October 2020.

Preexposure prophylaxis for the prevention of HIV infection in the United States-Update (2014). Department of Health and Human Services (PDF)

Texas Administrative Code, Title 22, Part 9, Chapter 193, Rule §193.1

U.S. Department of Health and Human Services, Health Resources and Services. A Guide to the Clinical Care of Women with HIV – 2013 Edition. Rockville, Maryland: U.S. Department of Health and Human Services, 2013 (PDF)

U.S. Department of Health and Human Services, Health Resources and Services Administration, Guide for HIV/AIDS Clinical Care – 2014 Edition. Rockville, MD: U.S. Department of Health and Human Services, page 81, 85. (PDF)

Primary Care Guidelines for Management of HIV. CID 2014:58 (1 January)

Recommended Immunization Schedule for Adults Aged 19 Years or Older. United States. 2020 Advisory Commission on Immunization Practices (ACIP), Table 1

Guidelines for the prevention and treatment of opportunistic infections in HIV-infected adults and adolescents. DHHS, 2020

HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Notices and Program Letters, Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02 (PDF) (Revised 10/22/2018)

Interim Guidance for the Use of Telemedicine and Telehealth for HIV Core and Support Services, March 2020

Interim Guidance for the Use of Telemedicine and Telehealth for HIV Core and Support Services – Users Guide and FAQs, March 2020

SUBSTANCE ABUSE – OUTPATIENT SERVICES (SA-O)

HRSA Service Category Description:

Substance Abuse Outpatient Care (SA-O) is the provision of outpatient services for the treatment of drug or alcohol use disorders.

Program Guidance:

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

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

Limitations:

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

Services:

Services include:

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

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

DSHS HIV Care Services requires that for Ryan White Part B or SS funded services providers must use features to protect ePHI transmission between client and providers. RW Providers

must use a telehealth vendor that provides assurances to protect ePHI that includes the vendor signing a business associate agreement (BAA). Ryan White Providers using telehealth must also follow DSHS HIV Care Services guidelines for telehealth and telemedicine outlined in DSHS Telemedicine Guidance.

Service Standards & Monitoring Indicators:

The following Service Standards and Monitoring Indicators are guides to improving healthcare outcomes for people living with HIV throughout the Service Delivery Area within the Part B Service Delivery, State Funds, and State Services Programs.

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

Department of Insurance criteria per TAC standards. The screening process shall collect information necessary to determine the type of services that are required to meet the client's needs.	

2. Comprehensive Psychosocial Assessmen	
Service Standard	**Monitoring Indicators**
All clients referred to the program will receive a Comprehensive Psychosocial Assessment (in accordance with TAC Standards) by a licensed substance use counselor. Initial comprehensive psychosocial assessment protocols shall provide for screening individuals to determine level of need and appropriate development of treatment plan. A comprehensive psychosocial assessment will be completed prior to the third counseling session* and will include the following: • Presenting problems resulting in need; • Alcohol and other substance use; • Psychiatric and chemical dependency treatment; • Medical history and current health status, to include an assessment of Tuberculosis (TB), HIV, and other sexually transmitted infections (STI) risk behaviors as permitted by law; • Relationships with family including domestic/intimate partner violence; • History of trauma/related events; • Stigma; • Housing stability, expelled from home; • Treatment adherences (e.g. HIV meds); • Social and leisure activities; • Education and vocational training; • Employment history; • Legal issues; • Mental/emotional functioning; and • Strengths and challenges.	Percentage of client charts that have documentation of initial comprehensive assessments completed as indicated. Percentage of client charts with documented use of assessment tools as indicated for substance use and sexual history. Percentage of client charts with documented use of assessment tool as indicated for cognitive assessment.

Texas Administrative Code, Title 25, Part 1, Chapter 448, Subchapter H, Rule §448.801, Screening The assessment shall result in a diagnosed substance use issue, as allowed by the license and scope of practice of the counselor. **Note*: Clients are assessed for care coordination needs, and referrals are made to other case management programs as appropriate. If pressing needs emerge during the assessment requiring immediate attention that results in the assessment not finalized by the third session, this must be documented in the client's primary record. Specific assessment tools such as the Substance Abuse and Mental Illness Symptoms Screener (SAMISS) (PDF) and Addiction Severity Index (ASI) may be used for substance use and sexual history, and the Mini Mental State Examination (MMSE) may be used for cognitive assessment. A copy of the assessment(s) will be offered/provided to the client.	

3. Treatment Modalities	
Service Standard	Monitoring Indicators
Providers must discuss treatment options with clients who use substances and should ask which treatment options they prefer. Providers should inquire about use of multiple substances and should consider the full spectrum of the client's drug use when discussing treatment options with the client. Providers must discuss alternative treatment modalities with the client that are targeted toward the substance(s) that the client is still using.	Percentage of client charts with documentation of discussion of treatment modalities with the client. Percentage of client charts, for clients on medication-assisted therapies, with documentation of contact with client's medical provider within 72 hours of treatment initiation or the client's refusal to authorize the communication. Percentage of clients with acupuncture services rendered with documented evidence of a physician's order.

Providers must rely on the Patient Placement Criteria of the American Society of Addiction Medicine (ASAM) for guidance on selecting the best treatment alternatives for specific clients. Medical treatment for substance use must adhere to current HIV Clinical Guidelines. For medication-assisted therapies (e.g. methadone, suboxone) treatment, client charts will document contact with the client's medical provider within 72 hours of initiation of methadone/suboxone to inform the medical provider of the new prescription or client refusal to authorize this communication. Treatment for non-pharmacologic treatment modalities may include, but are not limited to, Twelve-Step Programs and Acupuncture. All acupuncture services will be performed in accordance with the Acupuncture Act § 205.001(2)(A) and TAC Title 22, Chapter 9, §183.1.	

4. Treatment Plan	
Service Standard	Monitoring Indicators
A treatment plan shall be completed within 30 calendar days of completed comprehensive psychosocial assessment specific to individual client needs. The treatment plan shall be prepared and documented for each client. Treatment planning will be a collaborative process through which the provider and client develop desired treatment outcomes and identify the strategies for achieving them. Individual, and family case records will include documentation of the following: • Identification of the identified substance use disorder	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 minimum midway through the number of determined sessions agreed upon for frequency of modality in the client's primary record.

• 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 TAC on Substance Abuse, the treatment plan shall be reviewed at a minimum midway through the number of determined sessions agreed upon for frequency of modality and must reflect ongoing reassessment of client's problems, needs and response to therapy.	

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

6. Referrals	
Service Standard	Monitoring Indicators
Agency will make appropriate referrals out when necessary.	Percentage of client charts, as applicable, with documented referrals made based on need demonstrated in the assessment and/or progress notes.

7. Discharge Planning	
Service Standard	Monitoring Indicators
Discharge planning will be done with each client when treatment goals are met and include: • Circumstances of discharge • Summary of needs at admission • Summary of services provided • Goals and objectives completed during counseling • Referral after completing substance use treatment to case manager and/or primary care provider, as appropriate	Percentage of client charts with documentation, as applicable, of discharge planning with the client prior to case closure.

• Discharge plan • Counselor authentication, in accordance with TAC Standards and the counselor licensure requirements. In all cases, providers/case managers shall ensure that, to the greatest extent possible clients who leave care are linked with appropriate services to meet their needs.	

8. Discharge Summary	
Service Standard	Monitoring Indicators
Services may be discontinued when the client has: • Reached goals and objectives in their treatment plan • Missed three (3) consecutive appointments in a six (6) month period. • Continued non-adherence to treatment plan • Chooses to terminate services • Unacceptable client behavior • Deceased Completed discharge summary, in accordance with TAC Standards (§448.805), as applicable.	Percentage of client charts with documentation of case closure (discharge) and reason for discharge, or discharge summary if applicable. *Proposed System Level Outcome Measure:* Percentage of clients who demonstrate improved viral suppression after completing Substance Use Outpatient Treatment Plan objectives.

References:

Department of State Health Services Substance Abuse Treatment Facilities

HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A April 2013. p. 17-18. (PDF) Accessed on October 12, 2020.

HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B April, 2013. p. 17-18. (PDF) Accessed on October 12, 2020.

HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Notices and Program Letters, Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02 (PDF) (Revised 10/22/2018)

AIDS Institute, Clinical Guidelines Program, Substance Use Accessed on October 14, 2020.

Texas Administrative Code, Title 22, Part 30, Chapter 681 - Texas Board of Examiners of Professional Counselors

Texas Administrative Code, Title 25, Part 1, Chapter 448

Food, Drugs, Alcohol, and Hazardous Substances, Subtitle B. Alcohol and Substance Programs, Chapter 464

Texas Administrative Code, Title 25. Part 1, Chapter 448 Standards of Care, Subchapter H Screening and Assessment

Interim Guidance for the Use of Telemedicine and Telehealth for HIV Core and Support Services, March 2020

Interim Guidance for the Use of Telemedicine and Telehealth for HIV Core and Support Services – Users Guide and FAQs, March 2020

Notes:
Texas Administrative Code, Title 25, Part 1, Chapter 448, Subchapter H, Rule §448.801, Screening

Texas Administrative Code, Title 22, Part 8, Chapter 193, Acupuncture

Texas Administrative Code, Title 25, Part 1, Chapter 448, Subchapter H, Rule §448.805, Discharge

Program Standards: Support Services

EMERGENCY FINANCIAL ASSISTANCE (EFA)

HRSA Service Category Description:

Emergency Financial Assistance (EFA) provides limited one-time or short-term payments to assist a HRSA Ryan White HIV/AIDS Program (RWHAP) client with an urgent need for essential items or services necessary to improve health outcomes, including: utilities, housing, food (including groceries and food vouchers), transportation, medication not covered by an AIDS Drug Assistance Program (ADAP) or AIDS Pharmaceutical Assistance Program (LPAP), or another HRSA RWHAP-allowable cost needed to improve health outcomes. Emergency financial assistance must occur as a direct payment to an agency or through a voucher program.

Program Guidance:

It is expected that all other sources of funding in the community for EFA will be effectively used and that any allocation of RWHAP funds for these purposes will be as the payer-of-last-resort, and for limited amounts, uses, and periods of time. EFA funds used to pay for otherwise allowable HRSA RWHAP services must be accounted for under the EFA category.

Limitations:

Direct cash payments to clients are not permitted. Continuous provision of an allowable service to a client must not be funded through EFA.

Services:

RWHAP Part B/State Services funds may be used to provide services in the following categories:

1. ADAP eligibility determination period; and
2. 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 provides funding through:

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

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

EFA funds used to pay for otherwise allowable RWHAP services must be accounted for under the EFA category.

EFA funds may be used on the following essential items or services.

- Utilities (may include household utilities such as gas, electricity, propane, water, and all required fees).
- Housing (may include as rent or temporary shelter. EFA can only be used if HOPWA assistance is not available or if client is not eligible for HOPWA services).
- Food (groceries or food vouchers)
- Transportation
- 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)
- Other RWHAP allowable costs needed to improve health outcomes

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

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

Service Standards & Monitoring Indicators:

The following Service Standards and Monitoring Indicators are guides to improving healthcare outcomes for people living with HIV throughout the Service Delivery Area within the Part B Service Delivery, State Funds, and State Services Programs.

A. Assisting Clients during ADAP eligibility determination period	
Service Standard	Monitoring Indicators
RWHAP-eligible clients with documented evidence of emergency need of HIV medications are able to receive short-term medication assistance (30-day supply) with limited use of EFA for no more than 60 days (2 months or less).	Percentage of clients that have documented evidence in the client primary record of short-term HIV medication assistance provided during ADAP application period.

B. Assisting Clients with Short-Term Medications	
Service Standard	Monitoring Indicators
RWHAP-eligible clients with documented evidence of pending health insurance medication plan approval are able to receive short-term HIV medication assistance through EFA.	Percentage of clients that have documented evidence in the client primary record of short-term HIV medication assistance provided during health insurance application period.

C. Client Determination for Emergency Financial Assistance	
Service Standard	Monitoring Indicators
Applicants must demonstrate an urgent need resulting in their inability to pay their utility bills or prescriptions without financial assistance for essential items or services necessary to improve health outcomes. For example, demonstrated need may be demonstrated by but not limited to the following: • A significant increase in bills • A recent decrease in income • High unexpected expenses on essential items • They are unable to provide for basic needs and shelter • A failure to provide EFA will result in danger to the physical health of client or dependent children • Other emergency needs as deemed appropriate by the agency Agency staff will conduct an assessment of the presenting problems/needs of the client with the emergency financial issue.	Percentage of clients with documented evidence of determination of EFA need noted in client's primary record. Percentage of clients with documented service plan for EFA in the client's primary record that indicates emergent need, other resources pursued, and outcome of EFA provided. Percentage of clients with documented evidence of resolution of the emergency status and referrals made (as applicable) with outcome results in client's primary record.

A service plan will be developed documenting client's emergent need resulting in their inability to pay bills/prescriptions without assistance, and other resources pursued noted prior to using EFA funding for assistance. Client will be assessed for ongoing status and outcome of the emergency assistance. Referrals for services, as applicable, will be documented in the client file. Resolution of the emergency status will be documented in the client record.	

D. Emergency Financial Assistance Provided	
Service Standard	**Monitoring Indicators**
Short-term assistance will only be provided for: • Utilities • Housing • Food (groceries and food vouchers) • Transportation • Prescription medication assistance • Other RWHAP-allowable costs needed to improve health outcomes All completed requests for assistance shall be approved or denied within three (3) business days. Assistance shall be issued in response to an essential need (as identified by the staff person providing EFA) within three (3) business days of approval of request. Payment for assistance made to service providers will protect client confidentiality. • Use of checks and envelopes that de-identify agency as an HIV/AIDS provider to protect client confidentiality.	Percentage of clients with documented evidence of payments made by agency for resolution of emergency status. (*copies of checks/vouchers available*)

References:

HRSA/HAB Division of Service Systems Program Monitoring Standards – Part A April, 2013, page 29-30. (PDF) Accessed on October 12, 2020.

HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B April, 2013, page 29-30. (PDF) Accessed on October 12, 2020.

HRSA Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02 (PDF) (Revised 10/22/2018)

DSHS HIV/STD Program Policies Payer of Last Resort (Policy 590.001)

Interim Guidance for the Use of Telemedicine and Telehealth for HIV Core and Support Services, March 2020

Interim Guidance for the Use of Telemedicine and Telehealth for HIV Core and Support Services – Users Guide and FAQs, March 2020

FOOD BANK/HOME-DELIVERED MEALS (FB)

HRSA Service Category Description:

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.

Program Guidance:

Unallowable costs include household appliances, pet foods, and other non-essential products. Nutritional services and nutritional supplements provided by a registered dietitian are considered a core medical service under the Ryan White HIV/AIDS program (RWHAP) and if offered, should be funded under the core medical service medical nutritional therapy.

Limitations:

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

Services:

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

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

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

Service Standards & Monitoring Indicators:

The following Service Standards and Monitoring Indicators are guides to improving healthcare outcomes for people living with HIV throughout the Service Delivery Area within the Part B Service Delivery, State Funds, and State Services Programs.

A. Provision of Services	
Service Standard	Monitoring Indicators
1. Food Distribution: Clients referred to, or otherwise accessing food bank without a referral, must be screened for other eligible resources such as	Percentage of clients with documentation in the client's primary record of other food resources accessed prior to clients accessing food bank.

Supplemental Nutrition Assistance Program (SNAP) as evidence in their primary record. Clients accessing food bank have documentation in the client primary record of reason/need assessed. Assessment of client's immediate or ongoing need for food bank services is documented in the client's primary record.	Percentage of clients with documentation in the client's primary record of the assessment of need for food resources.

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

C. Home Cooked/Hot Meals	
Service Standard	Monitoring Indicators
Clients assessed for food security and offered home-cooked meals/hot meal programs have evidence of the need documented in the client's primary record. Clients provided vouchers for hot meal programs have an increase in food security.	Percentage of clients accessing hot meal programs, have documented evidence of assessment of need in the client's primary record. *PILOT*: Percentage of clients accessing hot meal programs have increase in food security as documented in the client's primary record.

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

References:

HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A April 2013. p. 30-32. (PDF) Accessed on October 12, 2020.

HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B April, 2013. p. 36-37. (PDF) Accessed on October 12, 2020.

Texas Department of State Health Services HIV Food Services Standards located within the Program Operating Policies, Chapter 13.

HRSA/HAB Ryan White & Global HIV/AIDS Programs, Program & Grants Management, Policy Notices and Program Letters, Policy Change Notice 16-02

MEDICAL TRANSPORTATION SERVICES (MT)

HRSA Service Category Description:

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

Program Guidance:

Medical Transportation may be provided through:

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

Limitations:

Unallowable costs include:

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

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

Services:

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

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

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

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

Service Standards & Monitoring Indicators:

The following Service Standards and Monitoring Indicators are guides to improving healthcare outcomes for people living with HIV throughout the Service Delivery Area within the Part B Service Delivery, State Funds, and State Services Programs.

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

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

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

D. Use of Agency Vehicles	
Service Standard	Monitoring Indicators
When Agency Conveyance is used for medical transportation, clients and agencies are made aware of problems immediately (e.g. vehicle breakdown) and notification documented. The Agency shall ensure that the transportation program has the capability to provide alternate transportation (e.g. taxi,	Percentage of clients accessing Medical Transportation services that have documented evidence, as applicable, of issue reported to the client and other arrangements are made to accommodate the client need in the primary client record.

ride share) to eligible clients in, at a minimum, the following situations: • Service is unavailable due to primary transportation vehicle breakdown, driver unavailability, or inclement weather; • Client's non-emergency medical need requires immediate transport; • Scheduling conflicts; and/or • Other locally determined events where missing an appointment may impose significant hardship upon a client (e.g. missing a Social Security Disability hearing).	

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

F. Access to Care	
Service Standard	Monitoring Indicators
lients accessing Medical Transportation services have evidence of attendance to their core and/or support services where Medical Transportation services were required to access and retain a client in care.	Percentage of clients who access Medical Transportation services have documentation of evidence of access and retention in medical care, other core services, and/or support services in the primary client record.

References:

American with Disabilities Act (ADA)

HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A April 2013. p. 38-40. (PDF) Accessed on October 12, 2020.

HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B April, 2013. p. 38-39. (PDF) Accessed on October 12, 2020.

State of Texas Transportation Code Title 7, Subtitle C, Chapter 545. Operation and movement of Vehicles

Texas Department of Public Safety. Classes of Drivers Licenses

HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Clarification Notice 16-02 Accessed October 12, 2020.

Interim Guidance for the Use of Telemedicine and Telehealth for HIV Core and Support Services, March 2020

Interim Guidance for the Use of Telemedicine and Telehealth for HIV Core and Support Services – Users Guide and FAQs, March 2020

NON-MEDICAL CASE MANAGEMENT (NMCM)

HRSA Service Category Description:

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

Program Guidance:

NMCM Services have as their objective providing coordination, guidance and assistance in improving access to and retention in needed medical and support services to mitigate and eliminate barriers to HIV care services, whereas Medical Case Management Services have as their objective improving health care outcomes.

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

Limitations:

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

Non-Medical Case Management is a service based on need, and is not appropriate or necessary for every client accessing services. Non-Medical Case Management is designed to serve individuals who are unable to access, and maintain in, systems of care on their own (medical and social). Non-Medical Case Management should not be used as the only access point for medical care and other agency services. Clients who do not need guidance and assistance in improving/gaining access to needed services should not be enrolled in NMCM services. When clients can 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.

Services:

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

Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Client-specific advocacy and/or review of utilization of services
- 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).

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

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

Service Standards & Monitoring Indicators:

The following Service Standards and Monitoring Indicators are guides to improving healthcare outcomes for people living with HIV throughout the Service Delivery Area within the Part B Service Delivery, State Funds, and State Services Programs.

A. Initial Assessment	
Service Standard	**Monitoring Indicators**
The Initial Assessment is required for clients who are enrolled in Non-Medical Case Management (N-MCM) services. It expands upon the information gathered during the intake phase to provide the broader base of knowledge needed to address complex, longer-standing access and/or barriers to medical and/or psychosocial needs. The 30 day completion time permits the initiation of case management activities to meet immediate needs and allows for a more thorough collection of assessment information: 1. Client's support service status and needs related to: • Nutrition/Food bank • Financial resources and entitlements • Housing • Transportation • Support systems • Partner services and HIV disclosure • Identification of vulnerable populations in the home (i.e. children, elderly and/or disabled) and assessment of need (e.g. food, shelter, education, medical, safety (Texas Department of Family Protective Services (TDFPS) Child Protective	Percentage of clients who access N-MCM services that have a completed assessment within 30 calendar days of the first appointment to access N-MCM services and includes all required documentation. Percentage of clients that received at least one face-to-face meeting with the N-MCM staff that conducted the initial assessment. Percentage of clients who have a documented initial assessment in the primary client record system.

Services CPS/TDFPS Adult Protective Services (APS) referral as indicated) • Family violence • Legal needs (ex. Health care proxy, living will, guardianship arrangements, landlord/tenant disputes, Social Security Disability Insurance (SSDI)/Supplemental Security Income (SSI) applications) • Linguistic services, including interpretation and translation needs • Activities of daily living • Knowledge, attitudes and beliefs about HIV disease • Sexual health assessment and risk reduction counseling • Employment/Education 2. Additional information • Client strengths and resources • Other agencies that serve client and household • Brief narrative summary of assessment session(s)	

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

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.	

C. Assistance in Accessing Services and Follow-Up	
Service Standard	**Monitoring Indicators**
Case management staff will work with the client to determine barriers to accessing services and will aid 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 aided with services elsewhere (outside of the agency providing NMCM services), case notes include documentation of follow-up.	Percentage of N-MCM 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 N-MCM clients with assistance provided have documentation of follow up to the type of assistance provided.

D. Case Closure/Graduation	
Service Standard	**Monitoring Indicators**
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 no longer needs non-medical case management services • 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	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.

• 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 can resolving needs independent of case management assistance) Client is considered non-compliant with care if three (3) attempts to contact client (via phone, email 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, email, certified letter) when trying to re-engage a client, as appropriate. Agencies must ensure that they have releases of information and consent forms that meet the requirements of HB 300 regarding the electronic dissemination of protected health information (PHI).	Percentage of clients 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. 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.

References:

HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A April 2013. P. 25-26. (PDF)

HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B April 2013. P. 24-26. (PDF)

HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Notices and Program Letters, Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02 (PDF) (Revised 10/22/2018)

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REFERRAL FOR HEALTH CARE SERVICES (RHCS)

HRSA Service Category Description:

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

Program Guidance:

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

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

RWHAP Part B and State Services funds can be used to provide transitional social services to establish or re-establish linkages to the community. Case management that links a soon-to-be-released inmate with primary care is an example of appropriate transitional social services.

Transitional social services should NOT exceed 180 days. (Source: DSHS Policy 591.00 Limitations on Ryan White and State Service Funds for Incarcerated Persons in Community Facilities, Section 5.3).

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

Limitations:

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

Services:

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

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

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

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

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

Service Standards & Monitoring Indicators:

The following Service Standards and Monitoring Indicators are guides to improving healthcare outcomes for people living with HIV throughout the Service Delivery Area within the Part B Service Delivery, State Funds, and State Services Programs.

A. Benefits Counseling	
Service Standard	**Monitoring Indicators**
Activities should be client-centered facilitating access to and maintenance of health and disability benefits and services. It is the primary responsibility of staff to ensure clients are receiving all needed public and/or private benefits and/or resources for which they are eligible. Staff will educate clients about available benefit programs, assess eligibility, assist with applications, provide advocacy with appeals and denials, assist with re-certifications and provide advocacy in other areas relevant to maintaining benefits/resources. Staff will explore the following as possible options for clients, as appropriate: • AIDS Drug Assistance Program (ADAP) • Health Insurance Plans/Payment Options (CARE/ HIPP, COBRA, OBRA, State Health Insurance Assistance Plans (SHIPs), Medicaid, Medicare, Private, ACA/Marketplace) • SNAP • Pharmaceutical Patient Assistance Programs (PAPS) • Social Security Programs (Social Security Income (SSI), Social Security Disability Insurance (SSDI)) • Temporary Aid to Needy Families (TANF) • Veteran's Administration Benefits (VA) • Women, Infants and Children (WIC) • Other public/private benefits programs • Other professional services Staff will assist eligible clients with completion of benefits application(s) as appropriate within 14 business days of the eligibility determination date.	Percentage of clients with documented evidence of education provided on other public and/or private benefit programs in the primary client record. Percentage of clients with documented evidence of other public and/or private benefit applications completed as appropriate within 14 business days of the eligibility determination date in the primary client record. Percentage of eligible clients with documented evidence of the follow-up and result(s) to a completed benefit application in the primary client record.

Conduct a follow-up within 90 days of completed application to determine if additional and/or ongoing needs are present.	

B. Health Care Services	
Service Standard	Monitoring Indicators
Clients should be assisted in accessing health insurance or Marketplace plans to assist with engagement in the health care system and HIV Continuum of Care, including medication payment plans or programs. Eligible clients are referred to Health Insurance Premium and Cost-Sharing Assistance (HIPCSA) to assist clients in accessing health insurance or Marketplace plans within one (1) week of the referral for health care and support services intake. Eligible clients are referred to other core services (outside of a medical, MCM, or NMCM appointment), as applicable to the client's needs, with education provided to the client on how to access these services. Eligible clients are referred to additional support services (outside of a medical, MCM, NMCM appointment), as applicable to the client's needs, with education provided to the client on how to access these services. Staff will follow-up within 10 business days of a referral provided to HIA to determine if the client accessed HIA services. Staff will follow-up within 10 business days of a referral provided to any core services to ensure the client accessed the service. Staff will follow up within 10 business days of a referral provided to support services to ensure the client accessed the service.	Percentage of clients with documented evidence of assistance provided to access health insurance or Marketplace plans in the primary client record. Percentage of clients who received a referral for other core services who have documented evidence of the education provided to the client on how to access these services in the primary client record. Percentage of clients who received a referral for other support services who have documented evidence of the education provided to the client on how to access these services in the primary client record. Percentage of clients with documented evidence of referrals provided for HIPCSA assistance that had follow-up documentation within 10 business days of the referral in the primary client record. Percentage of clients with documented evidence of referrals provided to any core services that had follow-up documentation within 10 business days of the referral in the primary client record. Percentage of clients with documented evidence of referrals provided to any support services that had follow-up documentation within 10 business days of the referral in the primary client record.

C. Case Closure Summary	
Service Standard	Monitoring Indicators
Clients who are no longer in need of assistance through Referral for Health Care and Support Services must have their cases closed with a case closure summary narrative documented in the client primary record. The case closure summary must include a brief synopsis of all services provided and the result of those services documented as 'completed' and/or 'not completed.' A supervisor must sign the case closure summary.	Percentage of clients who are no longer in need of assistance through Referral for Health Care and Support Services that have a documented case closure summary in the primary client record.

References:

HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A April 2013. p. 43-44. (PDF) Accessed on October 12, 2020.

HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B April 2013. p. 42-43. (PDF) Accessed October 12, 2020.

HRSA/HAB Ryan White Program & Grants Management, Recipient Resources. Policy Notices and Program Letters, Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02 (PDF) (Revised 10/22/2018)

DSHS Policy 591.000, Section 5.3 regarding Transitional Social Service linkage

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APPENDIX A RYAN WHITE DATA SYSTEM TAXONOMY

Service Descriptions and Definitions – Core Services

Early Intervention Services (EIS) Service Descriptions and Definitions

Service Category	Subcategories	Service Units
Early Intervention Services (EIS)	Early Intervention Service	Per encounter with client previously unlinked to care

Health Insurance Premium and Cost-Sharing Assistance (HIPCSA) Service Descriptions and Definitions

Service Category	Subcategories	Service Units
Outpatient / Ambulatory Medical Care[2] Co-payments for Outpatient / Ambulatory Medical Care Services when a client has private insurance.	Ambulatory/Outpatient Medical Care	Per payment
Outpatient / Ambulatory Medical Care Co-payments for Outpatient / Ambulatory Medical Care Services when a client has private insurance.	Dermatology	Per payment
Outpatient / Ambulatory Medical Care Co-payments for Outpatient / Ambulatory Medical Care Services when a client has private insurance.	Infectious Disease	Per payment
Outpatient / Ambulatory Medical Care Co-payments for Outpatient / Ambulatory Medical Care Services when a client has private insurance.	Neurology	Per payment
Outpatient / Ambulatory Medical Care Co-payments for Outpatient / Ambulatory Medical Care Services when a client has private insurance.	Ob/Gyn	Per payment

[2] DSHS Revised March 31, 20217

Outpatient / Ambulatory Medical Care Co-payments for Outpatient / Ambulatory Medical Care Services when a client has private insurance.	Oncology	Per payment
Outpatient / Ambulatory Medical Care Co-payments for Outpatient / Ambulatory Medical Care Services when a client has private insurance.	Opthamaology	Per payment
Outpatient / Ambulatory Medical Care Co-payments for Outpatient / Ambulatory Medical Care Services when a client has private insurance.	Other Specialty	Per payment
Outpatient / Ambulatory Medical Care Co-payments for Outpatient / Ambulatory Medical Care Services when a client has private insurance.	Radiology	Per payment
Outpatient / Ambulatory Medical Care Co-payments for Outpatient / Ambulatory Medical Care Services when a client has private insurance.	Laboratory - Service	Per payment
Outpatient / Ambulatory Medical Care Co-payments for Outpatient / Ambulatory Medical Care Services when a client has private insurance.	CD-4 T-Cell Count	Per payment
Outpatient / Ambulatory Medical Care Co-payments for Outpatient / Ambulatory Medical Care Services when a client has private insurance.	Viral Load Test	Per payment

Insurance – Medical Premium and deductible payments for a client's medical insurance with a private insurance provider. Do not report payments to public payers (e.g. Medicare/Medicaid) here.	Deductible Payment	Per payment
Insurance – Medical Premium and deductible payments for a client's medical insurance with a private insurance provider. Do not report payments to public payers (e.g. Medicare/Medicaid) here.	Premium Payment	Per month
Oral Health Care Co-payments for Oral Health Care when a client has private dental insurance.	Routine Treatment	Per payment
Oral Health Care Co-payments for Oral Health Care when a client has private dental insurance.	Prophylaxis	Per payment
Oral Health Care Co-payments for Oral Health Care when a client has private dental insurance.	Specialty	Per payment
Insurance – Oral Health Care Premium and deductible payments to a private insurer for dental insurance.	Deductible Payment	Per payment
Insurance – Oral Health Care Premium and deductible payments to a private insurer for dental insurance.	Premium Payment	Per month
AIDS Pharmaceutical Assistance (Local) (not Medicare, Medicaid or Part D) Co-payments for a client's medications when a client has drug coverage from a private insurer.	Co-Payment	Per prescription

Insurance - Prescription Drugs (not Medicare, Medicaid or Part D) Premium and deductible payments for prescription drug benefits with a private insurer.	Deductible Payment	Per payment
Insurance - Prescription Drugs (not Medicare, Medicaid or Part D) Premium and deductible payments for prescription drug benefits with a private insurer.	Premium Payment	Per month
Medicare/Medicaid Supplement Premium, deductible or co-payments to Medicare/Medicaid.	Deductible Payment	Per payment
Medicare/Medicaid Supplement Premium, deductible or co-payments to Medicare/Medicaid.	Co-Payment	Per payment
Medicare/Medicaid Supplement Premium, deductible or co-payments to Medicare/Medicaid.	Premium Payment	Per month
Medicare/Medicaid Supplement Premium, deductible or co-payments to Medicare/Medicaid.	Deductible Payment – Part D	Per payment
Medicare/Medicaid Supplement Premium, deductible or co-payments to Medicare/Medicaid.	Co-Payment – Part D	Per payment
Medicare/Medicaid Supplement Premium, deductible or co-payments to Medicare/Medicaid.	Premium Payment – Part D	Per month

Other Health Insurance Premium, deductible or co-payments to other health insurers.	Deductible Payment	Per payment
Other Health Insurance Premium, deductible or co-payments to other health insurers.	Co-Payment	Per payment
Other Health Insurance Premium, deductible or co-payments to other health insurers.	Premium Payment	Per month

Local AIDS Pharmaceutical Assistance (LPAP) Service Descriptions and Definitions

Service Category	Subcategories	Service Units
AIDS Pharmaceutical Assistance (Local) {LPAP}	Local Drug Reimbursement	Per prescription (not pill or dose)

Medical Case Management (MCM) Service Descriptions and Definitions

Service Category	Subcategories	Service Units
Medical Case Management, including Treatment Adherence Services (MCM)	Medical Case Management	Per 15 minutes

Medical Nutrition Therapy (MNT) Service Descriptions and Definitions

Service Category	Subcategories	Service Units
Medical Nutrition Therapy	Medical Nutrition Therapy - Counseling	Per 15 minutes
Medical Nutrition Therapy	Medical Nutrition Therapy - Supplements (Supplements recommended by someone other than a licensed dietitian should be funded and recorded under Food Pantry/Voucher with Nutritional Supplements.)	Per transaction

Mental Health Services (MH) Service Descriptions and Definitions

Service Category	Subcategories	Service Units
Mental Health Services	Mental Health Services – Individual	Per visit
Mental Health Services	Mental Health Services - Group	Per visit

Mental Health Services	Mental Health Services – Psychiatric Evaluation	Per visit
Mental Health Services	Mental Health Services – Psychiatric Follow-up	Per visit

Oral Health Care (OH) Service Descriptions and Definitions

Service Category	Subcategories	Service Units
Oral Health Care	Oral Health Care - Routine Treatment	Per visit
Oral Health Care	Oral Health Care - Prophylaxis	Per visit
Oral Health Care	Oral Health Care - Specialty	Per visit

Outpatient Ambulatory Health Services (OAHS) Service Descriptions and Definitions

Service Category	Subcategories	Service Units
Outpatient/Ambulatory Health Services (OAHS)	Outpatient/Ambulatory Health Services	Per visit
Outpatient/Ambulatory Health Services (OAHS)	Dermatology	Per visit
Outpatient/Ambulatory Health Services (OAHS)	Infectious Disease	Per visit
Outpatient/Ambulatory Health Services (OAHS)	Neurology	Per visit
Outpatient/Ambulatory Health Services (OAHS)	Ob/Gyn	Per visit
Outpatient/Ambulatory Health Services (OAHS)	Oncology	Per visit
Outpatient/Ambulatory Health Services (OAHS)	Ophthalmology	Per visit
Outpatient/Ambulatory Health Services (OAHS)	Other Specialty	Per visit
Outpatient/Ambulatory Health Services (OAHS)	Radiology	Per visit
Outpatient/Ambulatory Health Services (OAHS)	Laboratory - Service (and test except CD4 and VRLD)	Per test
Outpatient/Ambulatory Health Services (OAHS)	CD-4 T-Cell Count	Per test
Outpatient/Ambulatory Health Services (OAHS)	Viral Load Test	Per test

Substance Abuse – Outpatient Services (SA-O) Service Descriptions and Definitions

Service Category	Subcategories	Service Units
Substance Abuse Outpatient Care	Substance Abuse Services – Outpatient-Individual Counseling	Per visit
Substance Abuse Outpatient Care	Substance Abuse Services – Outpatient-Group Counseling	Per visit
Substance Abuse Outpatient Care	Substance Abuse – Intake *Includes but not limited to intake into methadone or other medication-assisted treatment. May include substance abuse assessments (SASSI) by appropriately qualified personnel, although technically, a person is not in outpatient or any form of treatment at the time of the assessment.*	Per visit
Substance Abuse Outpatient Care	Medication-Assisted Detox *Includes medications such as Methadone, Subut (buprenorphine hydrochloride) and Suboxone (buprenorphine hydrochloride and naloxone hydrochloride), ORLAAM, etc.*	Per visit
Substance Abuse Outpatient Care	Substance Abuse Medication Maintenance	Per visit

Service Descriptions and Definitions – Support Services

Emergency Financial Assistance (EFA) Service Descriptions and Definitions

Service Category	Subcategories	Service Units
Emergency Financial Assistance (EFA)	Emergency Assistance - Prescription	Per prescription
Emergency Financial Assistance (EFA)	Emergency Assistance – Utilities	Per transaction
Emergency Financial Assistance (EFA)	Emergency Assistance – Food	Per visit

Food Bank/Home Delivered Meals (FB) Service Descriptions and Definitions

Service Category	Subcategories	Service Units
Food Bank/Home Delivered Meals	Food Pantry/Voucher Visit Without Nutritional Supplements	Per visit
Food Bank/Home Delivered Meals	Food Pantry/Voucher Visit with Nutritional Supplements (Supplements ordered by a licensed dietician should be funded and recorded under Medical Nutritional Therapy)	Per visit
Food Bank/Home Delivered Meals	Meals - Home-Delivered	Per person per meal
Food Bank/Home Delivered Meals	Meals - Congregate	Per person per meal

Medical Transportation Services (MT) Service Descriptions and Definitions

Service Category	Subcategories	Service Units
Medical Transportation	Medical Transportation Services	Per one way trip

Non-Medical Case Management (NMCM) Service Descriptions and Definitions

Service Category	Subcategories	Service Units
Non-Medical Case Management Services (NMCM)	Case Management – Non Medical	Per 15 minutes

Referral for Health Care Services (RHCS) Service Descriptions and Definitions

Service Category	Subcategories	Service Units
Referral for Health Care and Support Services	Referral to health care/supportive services	Per referral

APPENDIX B CONFLICT OF INTEREST

Conflict of Interest Disclosure Form

Ryan White Program

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

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

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

To the best of my knowledge:

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

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

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

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

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

(Attach additional sheets if necessary.)

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

_____
Printed Name

_____
Board Member/Employee Signature

_____
Date

cc: Personnel File

APPENDIX C STATEMENT OF CONSUMER RESPONSIBILITIES

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

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

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

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

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

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

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

8. VOICING COMPLAINTS AND GRIEVANCES – YOU HAVE THE RESPONSIBILITY

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

9. CONTINUING CARE – YOU HAVE THE RESPONSIBILITY

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

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

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

11. ACCESS TO FINANCIAL INFORMATION – YOU HAVE THE RESPONSIBILITY

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

12. A CONSUMER GRIEVANCE PROCEDURE – YOU HAVE THE RESPONSIBILITY

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

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

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

APPENDIX D 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.