BEXAR COUNTY
DEPARTMENT OF COMMUNITY RESOURCES

FY 2016-2017
SAN ANTONIO TRANSITIONAL GRANT AREA/HEALTH SERVICE DELIVERY AREA

STANDARDS OF CARE FOR HIV/AIDS SERVICES

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

San Antonio Area HIV Health Services Planning Council

Revised by:

COLLABORATIVE RESEARCH

Specializing in Consulting Services for Ryan White CARE Act Entities

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

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STANDARDS OF CARE INTRODUCTION

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

Universal Standards

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

Service Category Specific Standards

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

It is important to note that the Standards of Care (SOC) is a living document and will evolve based on 1) Federal Law updates, changes, or modifications, 2) changing needs and realities of the infected and affected communities within the service delivery areas, and 3) the capacity of the service delivery areas. The CPCC committee, the San Antonio Planning Council, and Support Staff of the Administrative Agency (Bexar County Department of Community Resources) continually propose revisions and update the SOC as needed.

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

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

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

UNIVERSAL STANDARDS

CODE OF ETHICS

OBJECTIVE(S): To ensure that the best interests of the client govern the provision of services in a supportive and non-discriminatory manner; eliminate conflicts of interests; and establish a conflict resolution forum to address ethical concerns and client grievances related to the provision of services and compliance with these standards.

#	Standard	Measure
1.0	Services will be provided to all Ryan White qualified individuals without discrimination on the basis of HIV infection, race, ethnicity, creed, color, age, sex, gender, gender identity or expression, marital or parental status, sexual orientation, religion, ancestry, national origin, physical or mental handicap (including substance abuse), immigrant status, political affiliation or belief, ex-offender status, unfavorable military discharge, membership in an activist organization, or any basis prohibited by law.	Agency has statement/policy onsite.
2.0	All services provided under the Ryan White Treatment Extension act of 2009 will serve the best interests of the client/consumer/patient emphasizing confidentiality, respect for the client's rights and protect the client's dignity and self-esteem.	Agency has statement/policy onsite.
3.0	Services will be provided without interference by conflicts of interest. A potential conflict of interest exists where relationships might allow a party to influence the delivery of services for personal and/or professional gain for an individual or organization. All potential conflicts will be disclosed in writing to the parties involved. The Agency will monitor the provision of services in a potential conflict situation to ensure that services are provided in an equitable manner and decisions are not influenced by the relationship creating the potential conflict.	Agency has statement/policy onsite.
4.0	All Agencies shall maintain a grievance procedure, which provides for the objective review of client grievances and alleged violations of universal and service standards. Clients will be routinely informed about and assisted in utilizing this procedure and shall not be discriminated against for doing so.	Agency has statement/policy onsite.
5.0	Some service categories may have additional code of ethics to which providers must adhere.	Each provider maintains a Code of Ethics on file, as appropriate.

VERIFICATION OF ELIGIBILITY

OBJECTIVE(S): To ensure appropriate use of funds designated for those infected/affected by HIV disease.

#	Standard	Measure
1.0	Policies and procedures shall exist to ensure compliance with program requirements including all requirements communicated by the Bexar County Department of Community Resources, Division of Community Health, also known as the Administrative Agency (AA), and the Standards of Care (SOC).	Agency's written policies will be kept on file to ensure compliance with program requirements as communicated by AA and the Standards of Care.
2.0	Each Provider shall verify a client's HIV Status at initial eligibility determination. Verification of HIV+ status shall be in a written form. Each Provider shall verify the eligibility for services under Ryan White Treatment Extension Act of 2009 at a minimum, every six (6) months: • **Income:** Client must meet financial eligibility requirements as defined by the San Antonio Area HIV Health Services Planning Council, which is currently up to 300% of the federal poverty level. There is no financial eligibility requirement for case management services (medical and non-medical). • **Residency:** To receive services funded by Part A, client should reside in the San Antonio TGA, which includes the following counties: Bexar, Comal, Guadalupe, and Wilson. (However, service providers should not turn away any clients who live outside the TGA. Provider must report to the AA reasons for patient seeking services outside of their TGA/EMA). • **Insurance Status:** Contractors are responsible for doing routine screening for third party payers to see if the client is enrolled in other health coverage. Clients will have either documentation of insurance coverage OR signed attestation that they are ineligible to use the ACA marketplace in their files. **Part B funding eligibility is State residency.** **Citizenship is not a requirement to access services.** **Ryan White HIV/AIDS Program grantees may not deny services, including prescription drugs, to a veteran who is otherwise eligible for Ryan White HIV/AIDS Program services.**	Each provider maintains a completed standardized ARIES Client Eligibility and Review Verification form and all current supporting documentation for each client on file. Standardized Payer of Last Resort Screening Tool in client files. For **proof of positivity**, one of the following documents must be in client's file: Documentation in client's file: • HIV Lab result; or • Written statement from a physician or medical record, pending confirmatory testing within 3 months of receipt of statement or record. For **proof of income**, one of the following documents must be in the client's file: • benefit award letter; • pay stubs; • standardized declaration of income statement; • standardized supporter statement; • standardized statement of no income; • tax forms (i.e. W2, tax returns); • Texas Workforce Commission unemployment benefits letter; or • Prison release paper within 30 days of release date.

		For **proof of residency**, one of the following documents must be in the client's file: • Current government-issued ID or Driver's license noting Texas address; • Utility bills; • Benefits Award letter in name of client showing address; • Voter registration; • Lease or mortgage in clients name; • Notarized Affidavit; or • Verification, on letterhead, from Residential programs (e.g., nursing homes, treatment centers, halfway houses, hospice);. or • For homeless and/or undocumented, temporary affidavit signed and dated by the client which must be updated every 90 days.
2.1	All Ryan White Providers are responsible for ensuring that eligibility documents are entered into ARIES in a timely fashion. All providers are required to verify the following documents for clients are entered into ARIES: Agency Consent Form, ARIES Consent Form, Release of Information, Client Confidentiality Form, Proof of Residency, HIV Letter of Diagnosis, Proof of Income, and Picture ID. As a note, if a referral is received from another Ryan White agency, the referring agency is required to have all eligibility documents entered into ARIES with the correct date of document expiration. Agencies receiving referrals are required to verify that this information has been entered into ARIES. If this information has been entered in ARIES there will be no further action required of the receiving agency. If eligibility information has not been entered into ARIES then the receiving agency can either enter the documents with an expiration date which is reflected on the documents or contact the referring agency to have documents entered into ARIES.	Current Documentation in ARIES: Every 6 Months: • Proof of Residency • Proof of Income Annually: • Agency Consent Form • ARIES Consent Form • Release of Information • Client Confidentiality Form • Picture ID Once: • HIV Letter of Diagnosis • Proof of Positivity
3.0	Services to individuals not infected with HIV (affected persons) may be provided in the following circumstances only: a. The primary purpose of the service is to enable the affected individual to participate in the care of someone living with HIV or AIDS. Examples include support groups and individual mental health counseling. b. The service directly enables an infected individual to receive needed medical or	Client's chart documents relationship to an infected Ryan White client.

	support services by removing an identified barrier to care. The service promotes family stability in coping with the unique challenges posed by HIV/AIDS. Examples include mental health services and substance abuse services, which focus on equipping affected family members and caregivers to manage the stress and loss associated with HIV.	

ORIENTATION/TRAINING OF STAFF/VOLUNTEERS

OBJECTIVE(S): To ensure each agency has an established, detailed staff orientation process for new and/or existing personnel.

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

CONFIDENTIALITY OF CLIENT INFORMATION

OBJECTIVE(S): To protect the release of client information regarding HIV status, behavioral risk factors, or use of services.

#	Standard	Measure
1.0	Each agency will protect client confidentiality in accordance with state and federal laws including the Health Insurance Portability and Accountability Act (HIPAA) and will have a system for the safeguarding of client information.	Agency Policy and Procedures Manual on file. All client records belong to the Bexar County Department of Community Resources.
2.0	Agency employees and volunteers shall sign a confidentiality statement following completion of staff training on the subject of confidentiality.	Personnel files have documentation of training in confidentiality of client information.
3.0	Clients will be informed of their right to confidentiality and provided with a document that expressly describes under what circumstances client information can be released.	Each provider maintains documentation in the client's file that the client has been informed and received a copy of their rights and responsibilities regarding release of information to include the ARIES consent form.

CONSUMER RIGHTS & RESPONSIBILITIES

OBJECTIVE(S): To ensure that providers inform clients regarding their rights and responsibilities as recipients of Ryan White services.

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

COLLABORATIVE HIV SERVICE DELIVERY

OBJECTIVE(S): To effectively and efficiently provide comprehensive, coordinated, high quality services to Ryan White eligible individuals.

#	Standard	Measure
1.0	Providers must have available a full range of service referrals. To establish this base of	Agency has linkage agreements with service

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

CULTURAL COMPETENCY

OBJECTIVE(S): To ensure that services are delivered to individuals in an atmosphere of sensitivity to cultural difference and in an equitable and non-judgmental manner.

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

USE OF VOLUNTEERS

OBJECTIVE(S): To ensure that programs have established a range of appropriate activities that can be offered through volunteers that enhances the quality of life of clients and promotes access to care. Agencies utilizing volunteers are expected to comply with the Universal Standards of Care, as well as these additional standards.

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

QUALITY MANAGEMENT

OBJECTIVE(S): To ensure that clients receive quality services through client-level, agency-level and system-level monitoring activities.

#	Standard	Measure
1.0	Agencies will participate in local, State, and Federal planning and monitoring projects as requested by the AA.	The AA will monitor participation in planning projects as requested by the AA.
2.0	Agencies will provide data as requested by the AA for monitoring purposes.	Provision of data as requested by the AA.
3.0	Agency shall monitor for programmatic compliance on a quarterly basis.	Provider has documentation of self-monitoring for programmatic compliance. AA to track this quarterly.
4.0	Provider's physical plant will comply with appropriate building, zoning, health and safety codes, be clean, well-ventilated, properly lighted, heated, air conditioned, maintained and handicap accessible as required by City, State and Federal Law.	Agency will maintain documentation of certificate of occupancy, appropriate licenses and inspection approvals of all physical plant issues, including compliance with zoning, building, health and safety codes, lighting, heating and air conditioning, as well as accessibility to handicapped persons.
5.0	All agencies are required to have a written quality management plan. The quality management	Documented plan on file.

#	Standard	Measure
	plan must include: a. A mechanism for consumers to express their level of satisfaction with services; agencies are expected to collect, analyze and report client satisfaction data. b. A grievance procedure, which provides for the objective review of client grievances and alleged violations of universal and service standards. Clients will be informed about and assisted in utilizing this procedure and shall not be subject to retaliation for doing so. c. Quality assurance and continuous quality improvement activities designed to check the quality of services delivered to the client, documentation of services, and the degree to which the client is satisfied with the services received. d. It is recommended that quality management plans include monitoring of client-level health outcomes.	a. Each provider maintains a written client satisfaction plan that addresses an annual assessment of consumer satisfaction, including the administration of a client satisfaction survey. b. Each provider maintains a written grievance plan that addresses an annual assessment of consumer grievance procedure. c. Completed satisfaction survey d. Documentation in quality management plan
6.0	Staff will be trained on the agency Quality Management (QM) plan and related activities.	The agency documents self-audit for compliance with the SOC semiannually.
7.0	Agency will self-monitor compliance with these SOC on a semiannual basis. Provider must have a single point of contact (SPOC) on staff to account for compliance.	Staff personnel files reflect training in QM as appropriate and written identification of SPOC on site.

ACCESS TO CARE

#	Standard	Measure
1.0	Agencies will have structured and ongoing efforts to obtain input from clients in the design and delivery of services.	Documentation of Consumer Advisory Board and public meetings – minutes and/or Documentation of existence and appropriateness of a suggestion box or other client input mechanism and/or Documentation of content, use and confidentiality of a client satisfaction survey or focus groups conducted at least annually.
2.0	Agencies will provide services regardless of an individual's ability to pay for the service	Provider has policies and procedures that do

#	Standard	Measure
		not: a. Deny services for non-payment b. Deny payment for inability to produce income documentation c. Require full payment prior to service d. Include any other procedure that denies services for non-payment.
3.0	Agencies will provide services regardless of the current or past health condition of the individual to be served.	Documentation of eligibility determination and provider policies to ensure that they do not: a. Permit denial of services due to pre-existing conditions. b. Permit denial of services due to non-HIV-related conditions (primary care) c. Provide any other barrier to care due to a person's past or present health condition.
4.0	Agencies will provide services in a setting accessible to low-income individuals with HIV disease.	Agency will maintain a facility that is accessible. Agency will have policies and procedures that provide, by referral or vouchers, transportation if facility is not accessible to public transportation policies that may act as a barrier to care for low-income individuals.
5.0	Agencies will conduct outreach to inform low-income individuals of the availability of HIV-related services and how to access them.	Availability of informational materials about provider's services and eligibility requirements, such as: a. Newsletters b. Brochures c. Posters d. Community Bulletins e. Any other types of promotional materials.

ANTI-KICKBACK STATUTE

#	Standard	Measure
1.0	Agencies will have structured and ongoing efforts to avoid fraud, waste and abuse (mismanagement) in any federally funded program.	Documentation of Agency's Employee Code of Ethics, which includes: a. Conflict of Interest b. Prohibition on use of property, information or position without approval or to advance personal interest c. Fair dealing – engaged in fair and open competition d. Confidentiality e. Protection and use of company assets f. Compliance with laws, rules and regulations g. Timely and truthful disclosure of significant accounting deficiencies h. Timely and truthful disclosure of non-compliance
2.0	Agencies will prohibit 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.	Documentation required by the Compliance Plan or employee conduct standards that prohibit employees from receiving payments in kind or cash from suppliers and contractors of goods or services.

AIDS PHARMACEUTICAL ASSISTANCE (LOCAL)

DEFINITION:

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

LIMITATIONS:

Local pharmacy assistance programs (LPAP) are not funded with AIDS Drug Assistance Program (ADAP) earmark funding.

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

SERVICES:

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

Local AIDS Pharmaceutical Programs provide:

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

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

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

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

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

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

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

This program does not pay for medications as:

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

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

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

PERSONNEL:

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

SUB RECIPIENT STANDARDS:
AIDS Pharmaceutical Assistance (Local) providers will be responsible for monitoring sub recipient standards, including but not limited to the following standards. These standards will be reflected in either the contract or a Memorandum of Agreement.

Standard	Measure
Service providers dispensing medications shall adhere to all local, state and federal regulations and maintain current licenses required to operate as a medication dispensary in the State of Texas.	Pharmacy license is on site. 340B certification current and on file within Agency records.
In addition to licensing requirements, pharmacist and pharmacy will adhere to:	
Each prescription is dispensed/delivered within two (2) working days (including mail orders).	Prescription log shows date and time each prescription was submitted and filled.
Available label descriptions in Spanish when necessary.	Labels are available in Spanish upon request.
A procedure to voice complaints or grievances with service. Grievances must be maintained as required by licensure.	Pharmacy has a means to receive and address client complaints.
Confidentiality statement signed by pharmacy employees.	Signed confidentiality statements of staff on file.

QUALITY MANAGEMENT:

Program Outcomes: Number of clients successfully transferring to a sustainable funding source as result of accessing Drug Reimbursement at 6 months & 12 months

Indicator: Number of clients who report an improved health status as measured by virologic suppression (HIV RNA Viral Load).

Service Unit(s):
- Successful completed application request
- Number of clients utilizing LPAP funds
- Filled prescriptions using LPAP (enumerate by script)

Standard of Care	*Outcome Measure*	*Numerator*	*Denominator*	*Data Source*	*Goal/Benchmark*
I. Process					
Provider will ensure that all feasible alternative revenue systems (e.g. pharmaceutical company patient assistance programs) have been explored	Documentation of patient assistance programs (PAP) was explored prior to request for LPAP.	Number of clients screened for PAP	Number of clients access LPAP	ARIES Data, Client Charts	100% of clients are screened for PAP prior to request fo r LPAP.

before request for LPAP.					
The client is assessed for eligibility of Texas HIV Medication Program (THMP).	Applications submitted to THMP within 2 weeks of client assessment.	Number of clients with complete applications submitted to THMP within 2 weeks .	Total number of clients eligible for THMP.	ARIES Client Level Data	75% of eligible client files have documentation of completed applications submitted to THMP within 2 weeks of assessment.
Provider will utilize the most affordable/cost efficient form of medication accessible.	Prescriptions filled are the most cost-efficient medications provided by pharmacy dispensing	Number of charts with most cost efficient documentation (receipts)	Number of charts	Client Charts	75% of prescriptions are filled with the most cost efficient medications provided.
A copy of the client's prescription from a medical provider is on file.	Charts document prescriptions with: • Name of the client • Date of birth • Medication • Dose • Prescribing medical provider	Number of prescriptions with information listed	Number of prescriptions	Client Charts	75% of charts document prescriptions with: • Name of the client • Date of birth • Medication • Dose • Prescribing medical provider
II. Outcomes					
Clients are offered counseling on medication adherence.	Clients are screened for medication adherence and counseled if not adherent.	Number of clients screened for adherence. Number of clients counseled.	Number of clients Number of screened clients	Client Charts	75% of clients are screened for medication adherence. 75% of clients screened to have adherence issues are counseled.

EARLY INTERVENTION SERVICES (EIS)

DEFINITION:

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

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

LIMITATIONS:

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

SERVICES:

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

Benefits counseling, referrals, and linkages to care may include enrollment in Medicaid, Medicare, or private insurance plans through the health insurance marketplace established under the Affordable Care Act.

Counseling, testing, case finding, outreach and referral activities are designed to bring HIV positive individuals into Ambulatory/Outpatient Medical Care and may be provided by Ryan White Part B or State Services funds. The goal of EIS is to decrease the number of underserved individuals with HIV/AIDS by increasing access to care. EIS also provides the added benefit of educating and motivating clients on the importance and benefits of getting into care. Individuals found to be HIV negative should be referred to appropriate prevention services.

PERSONNEL:

Staff Qualification	Expected Practice
Staff providing care and/or counseling services to clients participating in the Early Intervention program must be trained to provide these services to recently diagnosed HIV/AIDS clients and to PLWHAs who know their status and are not in care. They also must receive supervision by a senior member with experience and skill in the field. All agency staff that provide direct-care services shall possess: • Texas Department of State Health Services current certification as an HIV Prevention counselor, or advanced training/experience in the area of HIV/infectious disease specialty; • HIV early intervention skills and abilities as evidenced by training, certification, and/or licensure, and documented competency assessment; and • The skills necessary to work with a variety of health care professionals, medical case managers, and interdisciplinary personnel. • Phlebotomy certification, if required.	Personnel files/resumes/applications for employment reflect requisite experience and education.
Each agency staff person who provides direct services to clients shall be properly trained in case management. Supervisors will be a degreed or licensed individual (by the State of Texas) in the fields of health, social services, mental health, or a related area, preferably Master's Level.	Personnel files/resumes/applications for employment reflect requisite experience and education.
Within three (3) months of hire, all staff must complete a minimum of sixteen (16) hours of training regarding the target population and the HIV service delivery system in the San Antonio TGA/HSDA, including but not limited to: a. The full complement of HIV/AIDS services available within the TGA b. How to access such services [including how to ensure that particular subpopulations are able to access services (i.e., undocumented individuals)] c. Ryan White Standards of Care (Universal and Service Category Standards) d. Education on applications for eligibility under entitlement and benefit programs other than Ryan White services will be included and periodically updated as changes occur.	Personnel file reflects completion of orientation and signed job description.
Twenty-four (24) hours of annual training are required for all employees. The 4 hours shall include fifteen (15) hours of medical training, six (6) hours of psychosocial training and three (3) hours of quality management training. The medical training shall cover the Texas Department of State Health Services	Personnel files reflect training log with documentation of subject matter and attendance at twenty-four (24) hour comprehensive educational program annually.

(DSHS) required topics of Medical Adherence, HIV Disease Process, Oral Health, Risk Reduction/Prevention Strategies (including Substance Abuse Treatment) and Nutrition. A suggested additional topic may be End of Life Issues. Medical training shall also include training on documentation. The psychosocial training shall include the topics of AIDS and the law, medically related federal and state benefits programs (e.g. Social Security, Medicare, Medicaid, Star +).	
EIS Specialists/Case Managers and EIS Specialists/Case supervisors must satisfactorily complete continuing education as required by state licensing boards.	Documented in personnel file or training log.
Each EIS Specialists/Case Management Agency must have and implement a written plan for supervision of all EIS Specialists/Case Management staff. Supervisors must review a 10 percent sample of each EIS Specialist's/Case Manager's case records each month for completeness, compliance with these standards, and quality and timeliness of service delivery. EIS Specialists/Case Managers must be evaluated at least annually by their supervisor according to written Agency policy on performance appraisals.	Agency has written plan for supervision of all EIS Specialists/Case Management staff. Agency will keep on file supervision logs demonstrating the review of random client files citing the date and outcome of chart reviews Personnel files contain annual performance evaluations.
Each supervisor must maintain a file on each EIS Specialist/Case Manager supervised and hold supervisory sessions on at least a monthly basis. The file on the case manager must include, at a minimum: a. Date, time, and content of the supervisory sessions b. Results of the supervisory case review addressing, at a minimum of completeness and accuracy of records, compliance with standards and effectiveness of service.	Documentation of supervision provided Supervisors' files on each EIS Specialists/Case Managers reflect ongoing supervision, supervisory sessions and case review as described above.

QUALITY MANAGEMENT:

Program outcome: The goal of EIS is to decrease the number of underserved individuals with HIV/AIDS by increasing access to care.

Indicators:

- Number of clients brought into care
- Number of clients returned to care

Service Unit(s): Face to face visit and/or documented phone conversation in ARIES

Standard of Care	*Outcome Measure*	*Numerator*	*Denominator*	*Data Source*	*Goal/Benchmark*
I. Outcomes					
Service Provider shall provide physical examination and assessment to identify urgent health issues/need.	Documentation of physical examination in client files.	Number of newly enrolled clients	Number of EIS clients	Client Charts ARIES	75% of newly enrolled EIS clients will have documentation in their files of a physical examination.
Service Provider shall provide client education concerning the HIV disease process, risk reduction, maintenance of the immune system and literacy training that enable clients to navigate the HIV system of care.	Documentation of client education in client files.	Number of newly enrolled clients	Number of EIS clients	Client Charts ARIES	75% of newly enrolled EIS clients will have documentation of education given regarding HIV disease process, risk reduction, and maintenance of the immune system.
Service Provider shall develop an initial care plan in direct cooperation and agreement with the client that identifies client needs, resources, goals, and planned course of action to meet immediate needs, and revise the plan as necessary.	Documentation of Care Plan and follow up reassessment of care plan as indicated, in client files.	Number of newly enrolled clients	Number of EIS clients	Client Charts ARIES	75% of newly enrolled EIS clients will have documentation of a Care Plan and follow up reassessment of the care plan as indicated, in client files.
Service Provider shall maintain and coordinate care plan to enable transfer to primary medical case management.	Documentation of Care Plan coordination and referral to Primary Medical Case Management.	Number of newly enrolled clients	Number of EIS clients	Client Charts ARIES	75% of newly enrolled EIS clients will have documented care plans with coordination and referral to Primary Medical Case Management.
EIS programs will ensure that clients are connected to Primary Medical Care within 30 Days of initial intake.	Documentation of first medical visit within 30 days of EIS intake in client files.	Number of newly enrolled clients	Number of EIS clients	Client Charts ARIES	75% of newly enrolled EIS clients will have their first medical visit within 30 days of their EIS intake in their client files.
EIS programs will make available mental health and psychosocial support services performed by a master's level social worker and/or other appropriate licensed healthcare provider or counselor. Services will be provided in accordance with the National Association of Social Workers'	Documentation of mental health and psychosocial support services screening and/or assessment in client files.	Number of newly enrolled clients	Number of EIS clients	Client Charts ARIES	75% of newly enrolled EIS clients will have documentation of mental health and psychosocial support services screening and/or assessment in client files.

Code of Ethics. Mental health and psychosocial services will include (but not be limited to): • Comprehensive psychosocial assessment of all new clients including: • Mental health or substance use issues • Client's adjustment to HIV disease and illness • Client's understanding of diagnosis and treatment • Recommended treatment • Barriers to treatment adherence • History of client's family background, education, vocational experience, and housing status. • Development of an individualized psychosocial treatment plan.					
Individual, group, couple, family and/or counseling and crisis intervention services may also be offered for those clients who are experiencing acute or ongoing psychological stress. Such services will usually be provided on a regularly-scheduled basis with special arrangements made for non-scheduled visits at the time of crisis. All mental health services will be provided in accordance with the approved Mental Health and Substance Abuse Services-Outpatient Standards of Care.	Documentation of referral to Mental Health and Substance Abuse Services-Outpatient as indicated in client files.	Number of newly enrolled clients	Number of EIS clients	Client Charts ARIES	75% of newly enrolled EIS clients will have a documented referral where indicated for Mental Health and Substance Abuse Services-Outpatient in their client files.
Counseling and Crisis intervention services will be offered as needed and provided in accordance with current approved standards of care.	Documentation of agency policy and protocol for counseling and crisis intervention services.	Number of agencies with counseling services	Number of contracted EIS agencies	Agency Policy and Procedure Manual	75% of newly enrolled EIS clients will have access, as indicated, to counseling and crisis intervention services.
EIS programs are encouraged to work in partnership with clients to develop and track health self-management goals in such critical areas as:	Documentation of self-management goals in client files.	Number of newly enrolled clients	Number of EIS clients	Client Charts ARIES	75% of newly enrolled EIS clients will have documented self-management goals in client

• Adherence • Exercise • Substance abuse • Sexual risk management • Nutrition • Oral Health					files.

EMERGENCY FINANCIAL ASSISTANCE

DEFINITION:

Emergency Financial Assistance (EFA) is the support for essential services including utilities, housing, food (including groceries, food vouchers), or prescriptions (including prescription eyeglasses) provided to clients with limited frequency and for a limited period of time. The intent of these funds are to support a client for a short duration.

NOTE: Part A and Part B programs must be allocated and tracked. Report these funds under specific service categories as described under 2.6 in Texas Department of State Health Services (DSHS) Program Policy Guidance No. 2 (formally Policy No. 97-02).

SERVICES:

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

Part B EFA programs in the TGA/HSDA will cover:

- Utilities such as household utilities including gas, electricity, propane, water, and all required fees
- Housing such as rent, mortgage payment, or temporary shelter. EFA can only be used if HOPWA assistance isn't available
- Food such as groceries and food vouchers
- Prescription assistance such as short term, one time assistance for any medication and associated dispensing fee (excluding ADAP dispensing fees) as a result or component of a primary medical visit (30-day supply) and the cost of corrective prescription eye wear

Part B EFA shall not exceed $500 per unduplicated client, with the exception of medications which are not subject to a cap and for short term use only. Short term is defined as up to 60 days.

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

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

Direct cash payments to clients are not permitted

No funds may be used for any expenses associated with the ownership or maintenance of a privately owned motor vehicle.

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

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

PERSONNEL:

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

where it is documented that, although the service (e.g. utility) is in another person's name, it directly benefits the client. The agency has a procedure to protect client confidentiality when making payments for assistance, (e.g., checks that do not identify the agency as an HIV/AIDS agency).	• Copy of check for payment.

AGENCY:

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

QUALITY MANAGEMENT:

Program outcome:

- Clients stabilized at 3 and 6 month intervals that do NOT have future EFA requests.
- 75% of clients will show improved and/or stabilized living situation as result of accessing EFA at 6 months and 12 months.

Indicator: Number of stabilized clients (determined by decreased need for EFA, stable housing, reduced number of requests)

Service Unit(s): ARIES units of successful processing of payment

Standard of Care	***Outcome Measure***	***Numerator***	***Denominator***	***Data Source***	***Goal/Benchmark***
I. Process					
Service provider will conduct an assessment of the presenting problems/needs of the client with HIV-related emergency financial issue.	Documentation of the client's need for EFA.	Number of EFA charts with documentation of assessment	Number of total client files for EFA	Client Files ARIES	75% of client files have documentation of need for EFA.
Client will be assessed for ongoing status and outcome of the emergency assistance plan.	Documentation of resolution of the emergency status and referrals made with outcome results in client files.	Number of EFA charts with documentation of assessment	Number of total client files for EFA	Client Files ARIES	75% of client files have documentation of resolution of the emergency status and referrals made with outcome results in client files.
Emergency financial assistance payment is made	Documentation of payment in client's file with copy of	Number of EFA charts with documentation of	Number of total client files	Client Files	75% of client files have documentation of payment with copy

out to the appropriate vendor in the *exact* amount listed on bill and is authorized for pick up by the client or the client's primary case manager. No payment may be made directly to clients, family or household members.	check/voucher in client's file.	payment	for EFA	ARIES	of check/voucher.
II. Outcomes					
All completed requests for assistance shall be approved or denied within five (5) working days. A check shall be issued in response to an essential need (as identified by Primary case manager and Agency) within five (5) working days of approval of request.	Documentation of client receipt of payment within five (5) days of approved request.	Number of EFA clients receiving payment within five (5) days of approved request	Number of EFA clients	Client Files ARIES	75% of client files have documented payment within five (5) working days of approved request.

FOOD BANK /HOME-DELIVERED MEALS

DEFINITION:

Food Bank/Home-Delivered Meals include the provision of actual food or meals. This includes vouchers or gift cards to purchase prepared food or meals.

The provision of essential household supplies such as hygiene items and household cleaning supplies are allowable in this service category.

Water filtration/purification systems, such as faucet/pitcher/refrigerator in communities where issues with water purity exist are allowable in this service category.

LIMITATIONS:

No funds can be used for:

- Household Appliances
- Pet Foods
- Other non-essential products

Food vouchers/gift cards are to be restricted from the purchase of tobacco or alcohol products.

No direct payments to clients to purchase food is allowed.

SERVICES:

This category includes the provision of actual food, prepared meals, or food vouchers to purchase prepared meals (as distinguished from money to purchase same, which is not available). This category also includes the provision of fruit, vegetables, dairy, canned meat, staples, and personal care products in a food bank setting. Food vouchers/gift cards are to be restricted from the purchase of tobacco or alcohol products.

a. **Food Bank**:
Food Bank services are the provision of actual food and personal care items in a food bank setting. Provision of fruit (fresh preferred), vegetables (fresh preferred), nutritional balanced supplements and nutritional products (not inclusive of vitamin and mineral products) and

staples in a food bank setting in a cost-effective way. No direct payment to clients to purchase food, including the provision of grocery store gift cards, is allowed.

b. **On-site/Home Delivered Meals**:
Provision of prepared meals, food vouchers, or gift cards for prepared meals, either in a congregate dining setting, delivered to those who are homebound due to HIV illness, provided at the location of a medical visit, or at a dining hall or restaurant or under special circumstances may be taken "to go", e.g., a medical condition documented by a health care professional that would preclude a person from interacting with the public, or in situations when a client is banned from a facility, but still eligible for the service. When a client is banned from a facility, he or she may designate in writing an alternate person who will be authorized to pick up the "to go" meal. It is the client's responsibility to ensure that the authorization is accurate and current. Meals "to go" will not be provided to unauthorized persons.

PERSONNEL:

Staff Qualification	Expected Practice
A Memorandum of Understanding must be established with an agency providing consultation of a Licensed Dietitian, specializing in HIV, regarding special needs of clients. The Dietitian will make recommendations based on the American Dietetic Association's standards and be available to educate and evaluate clients and their needs. Dietary staff refers to staff working in food bank and in/onsite/home-delivered meals.	Proof of qualification of Licensed Dietitian, specializing in HIV, must be on file with the Dietitian's agency, such as: a. Copy of License b. Resume or Curriculum Vitae
Semi-annual training of staff must be conducted by a Licensed Dietitian, specializing in the special needs of HIV+ clients, including the nutrition/caloric needs and dietary issues of HIV+ clients. Food preparation staff must attend at least quarterly scheduled trainings provided by consultant Dietitian on such topics as food handling, safety in the kitchen, HIV nutrition, food temperature, proper sanitation, food packaging, etc.	Signed Memorandum of Understanding between provider and Licensed Dietitian, specializing in HIV, must be on file, acknowledging that Licensed Dietitian will provide training, at least semi-annually to dietary staff of food service agency. Documentation in food preparation staff member's personnel file.
Director of meal program must complete and pass Service Safety certification every 3 years.	Current Service Safety certification posted in food preparation area.
Agency shall establish an orientation for new staff and volunteers addressing, as applicable, topics pertinent to the task at hand, such as: a. Safe food handling procedures b. Confidentiality issues for delivery personnel c. Sensitivity to the HIV/AIDS Client d. HIV nutrition, based on American Dietetic Association guidelines e. Cultural competency	Personnel files reflect completion of applicable orientation.

Provider must maintain all licenses and permits required by city, county, state, and federal law to operate the particular food services program(s) involved.	Current provider licenses should be on display at site.
All drivers delivering meals must hold a valid Texas driver's license and automobile insurance consistent with state minimum requirements.	Personnel files of paid and volunteer drivers contain documentation that each is licensed to drive.
A written record of meal/food bank distribution will be maintained. Attempts should be made on a regular basis to provide choices on food items that meet individual nutrition needs of HIV+ persons, including the foods that fall into the recognized categories for good nutrition identified in the Food and Drug Administration or American Dietetic Association standard food and nutrition pyramid *13.2.7* *Client Satisfaction.* There must be a method to regularly obtain client input about food preference and satisfaction. Such input shall be used to make program changes with appropriate reporting to the Administrative Agency.	Written log will be maintained to back-up information entered into ARIES. Provider has written policies and procedures for obtaining client input on food choices on a regular basis.

QUALITY MANAGEMENT:

Program outcome: Clients show improved access to medical care as a result of increased nutritional status at 6 and 12 months.

Indicators:

- Number of requests completed for food bank/home-delivered meals
- Number of requests at reduced urgency (emergency need, frequency)

Service Unit(s): Number and dollar amount of filled requests in ARIES

Standard of Care	***Outcome Measure***	***Numerator***	***Denominator***	***Data Source***	***Goal/Benchmark***
I. Process					
Service provider assists clients in seeking alternate sources to obtain food bank/home-delivered meals.	Planning sessions occur with clients regarding alternate source investigation for food bank/home-delivered meals.	Number of clients with alternate food sources session	Number of food clients	Client Chart ARIES	75% of charts document planning sessions with client regarding food source investigation.
II. Outcomes					
Clients accessing food vouchers have same-day HIV/AIDS related appointment.	Clients show access to HIV/AIDS related services and retention of care	Number of clients with same day HIV/AIDS related appointment.	Number of clients	Client Chart ARIES	75% of clients accessing food vouchers have same- HIV/AIDS related appointment.
Clients receiving meals/pantry	Clients show medical visit and	Number of clients with	Number of	Client Chart	75% of clients receiving meals/pantry

have at least one (1) documented medical visit within 6 month period of measurement year.	retention of medical care	documented medical visit within 6 month pd of measurement year	clients	ARIES	have at least one (1) documented medical visit within 6 month period of measurement year.

HEALTH EDUCATION/RISK REDUCTION (HE/RR)

DEFINITION:

Health Education/Risk Reduction is the provision of services that educate clients with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes the provision of information; including information dissemination about medical and psychosocial support services and counseling to help clients with HIV improve their health status.

SERVICES:

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

a. Providing information dissemination about medical services, psychosocial support and counseling services to help HIV-positive individuals and/or those at risk of contracting HIV access services.
b. Providing education on HIV Disease, Transmission, Treatment and Adherence

PERSONNEL:

Staff Qualification	Expected Practice
Health Education/Risk Reduction staff shall be proficient with appropriate computer applications, and shall have had at least six (6) months of relevant experience in the areas of outreach work, community service, supportive work with families and individuals, supportive work with youth, corrections, public relations or customer service. All staff and volunteers involved in the production and/or distribution of the HIV Resource Guide shall possess: the ability to work productively with HIV/AIDS service providers and knowledge of community resources available to clients, so that appropriate, effective sources of HIV services will be included in the Resource Guide.	Personnel files/resumes/applications for employment reflect requisite experience and education.
Supervisors will be a degreed or licensed individual (by the State of Texas) in the fields of health, social services, mental health, or a related area, preferably Master's Level.	Personnel files/resumes/applications for employment reflect requisite experience and education.
A minimum of eight (8) additional hours of orientation training must cover orientation to the target population and the HIV service delivery system in the San Antonio TGA, including but not limited to: a. The full complement of HIV/AIDS services available within the TGA	Personnel file reflects completion of orientation and signed job description.

b. How to access such services [including how to ensure that particular subpopulations are able to access services (i.e., undocumented individuals)] c. Ryan White Standards of Care (Universal and Service Category Standards)	
Within the first (3) months of hire, HE/RR staff must complete training that includes, at minimum, the following criteria: **HIV / AIDS Training;** • HIV Basics (i.e., getting tested, transmission, disease stages) • Understanding Laboratory results (i.e., reading lab results, understanding lab values) • Medication and Side Effects (i.e., understanding drug resistance, side effects and the goals of medications) • Adherence (i.e., adherence strategies) **Communication Skills;** • Active Listening • Asking Tough Questions • Non-Verbal Communication • Responding to Conflict • Culture and Cultural Competency • Boundaries disclosure **Substance Use and Mental Health Recognition and Referral** **Risk reduction counseling** Annual training of staff shall include updates for -Full complement of HIV/AIDS services within the area. How clients access such services [including how to ensure that particular subpopulations are able to access services (i.e., undocumented individuals).	Personnel records will reflect completion of training.
Each agency must have and implement a written plan for supervision of all staff. Supervisors must review a 10 percent sample of each staff member's case records each month for completeness, compliance with these standards, and quality and timeliness of service delivery. Staff must be evaluated at least annually by their supervisor according to written Agency policy on performance appraisals.	Agency has written plan for supervision of all staff. Agency will keep on file supervision logs demonstrating the review of random client files citing the date and outcome of chart reviews. Personnel files contain annual performance evaluations.
Each supervisor must maintain a file on each staff member supervised and hold	Documentation of supervision provided.

supervisory sessions on at least a weekly basis. The file on the staff member must include, at a minimum: a. Date, time, and content of the supervisory sessions b. Results of the supervisory case review addressing, at a minimum of completeness and accuracy of records, compliance with standards and effectiveness of service.	Supervisors' files on each case manager reflect ongoing supervision, supervisory sessions and case review as described above.
The Agency shall maintain the Resource Guide as an accurate, up-to-date database of community resources available to all PLWHA, including detailed information about individual service providers; and The Agency shall collaborate with other services providers, as is required, to ensure that the most current information is included in the Resource Guide, and for purposes of its distribution.	Documented in the program's policy.

QUALITY MANAGEMENT:

Program outcome: To improve client understanding of HIV Disease, Transmission, Treatment and Adherence.

Indicators:

- Number of clients with increased knowledge
- Number of clients with decreased risk behaviors associated with HIV Transmission
- Number of clients reporting reduced barriers to care

Service Unit(s): Face to face visits in ARIES

Standard of Care	***Outcome Measure***	***Numerator***	***Denominator***	***Data Source***	***Goal/Benchmark***
I. Process					
HE/RR Staff will provide educational sessions using the following topics (at a minimum): • HIV and the Disease Process • Medical Adherence • Risk Reduction and Prevention • Oral Health • Nutrition	Agency has documentation of educational sessions available.	Number of agencies with guidelines	Number of contracted HE/RR agencies	Agency Policy and Procedure Manual ARIES Client Charts	75% of agencies funded for HE/RR have documentation of educational sessions made available using the addressed topics.
HE/RR Staff will have the client complete a brief program	Agency has client evaluation forms available after each	Number of agencies with evaluation form	Number of contracted HE/RR	Agency Policy and Procedure	75% of all educational sessions have documented evaluation forms by clients

evaluation after each session. *These evaluations must be turned into the HE/RR Supervisor.*	educational session.		agencies	Manual	attending.
II. Outcomes					
HE/RR staff will complete a Health/HIV Educational Assessment and a service plan that will indicate how the client's educational needs will be met. A checklist will also be completed to verify that all necessary documents have been completed. After assessments and service plans are completed with the client, they must be reviewed and approved by the HE/RR Supervisor.	Documented in client files of educational assessment and service plan.	Number of new clients with educational assessment and service plan	Number of clients in HE/RR	Client Files ARIES	75% of all clients will have documentation in their files of an educational assessment and service plan.

HEALTH INSURANCE PREMIUM AND COST SHARING ASSISTANCE

DEFINITION:

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

SERVICES:

Part A:

The HIPCSA program is intended to help HIV positive individuals continue medical care without gaps in health insurance coverage or disruption of treatment. Continued insurance coverage allows clients to obtain care not limited to HIV treatment, therefore resulting in greater overall client health outcomes. Continued coverage also reduces the burden on publicly-funded medical care systems.

Ryan White funds for the HIPCSA program can be used toward co-payments (including co-pays for prescription eyewear for conditions related to HIV infection), co-insurance, deductibles and premiums for individual policies and group policies provided by employers. Funds can be used for assistance with payments under the local government cost sharing programs (i.e. Carelink program of the Bexar County University Health System). Such assistance shall be limited to those clients paying their cost sharing assistance bills and must be evidenced by documentation showing the client has a current account which is not past due or in default status.

No Ryan White funds can be used toward co-payments associated with hospitalization and/or emergency room care.

No Ryan White Part A funds will be used to pay out-of-network costs.

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

If a client is receiving tax credits or subsidies through the Affordable Care Act to purchase insurance, the client must apply the subsidy or credit to monthly premiums. Ryan White funds will not be used to pay that portion of the cost of insurance.

Ryan White funds can only be used to purchase insurance plans whose drug benefits are equivalent to those provided by the DSHS' HIV Medication Program.

Part B:

HIV Health Insurance Assistance funds can be used to pay the following for eligible individuals:

- Premiums
- Deductibles
- Co-Payments
- Co-Insurance
- Supplemental Insurance

Ryan White (RW) and/or State Services (SS) funds may not be used towards:

- Co-payments, co-insurance, or deductible costs associated with hospitalization and/or emergency room care
- No Ryan White Part B funds will be used to pay out-of-network costs.
- Ryan White Part B funds can only be used to purchase silver-level plans.
- Ryan White funds can only be used to purchase insurance plans whose drug benefits are equivalent to those provided by the DSHS' HIV Medication Program
- If a client is receiving tax credits or subsidies through the Affordable Care Act to purchase insurance, the client must apply the subsidy or credit to monthly premiums. Ryan White funds will not be used to pay that portion of the cost of insurance.

These funds must be the payer of last resort and the client's inability to cover these expenses would result in the client losing health insurance coverage. Clients are expected to contribute to individual health insurance costs as they are able.
Individuals participating in the following programs can receive assistance with eligible associated insurance costs:

Medicare
Assistance with premiums, deductibles, co-insurance and co-payments can be provided to eligible clients with Medicare.

Individual Policy
Assistance with premiums, deductibles, co-insurance and co-payments can be provided to eligible clients with individual policies (both established and new policies).

Portion of Family/Group Policy
Assistance with premiums, deductibles, co-insurance and co-payments can be provided to eligible clients who are covered under a family/group health insurance policy. Assistance is provided to cover the HIV-positive client's portion of the family/group health insurance plan.

It is only allowable to assist an eligible client with the costs associated with the entire family/group policy when the inability to cover these expenses would result in the eligible client losing health insurance coverage. ***In such circumstances, providers are instructed to consult with their Administrative Agency to assure appropriate use of funds.***

Supplemental Insurance

Assistance with premiums, deductibles, co-insurance and co-payments can be provided to eligible clients enrolled in a supplemental insurance policy. (As long as a client's supplemental policy's primary purpose is to assist with HIV related outpatient care).

Maximum Allowable Assistance

Part B providers must adhere to the latest DSHS guidelines regarding HIPACSA maximum allowable expenditures.

Co-Payments, Co-Insurance Payments

There is no limit on the amount of assistance an individual may receive under the HIPACSA program for costs associated with co-payments or co-insurance benefits. If the AA determines the need to restrict co-payment or co-insurance assistance or to restrict premium or deductible assistance more than allowed by DSHS, the AA must request permission to do so by submitting the restriction guidelines with justification to DSHS for approval.

Local Government Cost Sharing Assistance Programs

Provider may assist eligible individuals who receive financial assistance through local government sponsored cost sharing assistance programs (eg., the CareLink program of the Bexar County University Health System). Such assistance shall be limited to those clients who are not in default paying their cost sharing assistance bills and must be evidenced by documentation showing the client has a current account which is not in default.
Ryan White funds may NOT be used to cover a client's Medicare Part D "true out-of-pocket" (i.e. TrOOP or donut hole) costs.

I. ELIGIBILITY

Per requirements of Eligibility in the Universal Standards of Care for All Ryan White Services section, except that the financial eligibility requirement shall be evidence of an annual gross earned and/or unearned income not greater than 500% of the federal poverty guidelines according to family size

PERSONNEL:

Staff Qualification	Expected Practice
Service providers shall employ staff who have at least a Bachelor's degree and a minimum of six (6) months experience providing services in this or a related field. A total of three (3) years of relevant experience in this or a related field can be substituted for the education requirement. Staff must be able to comprehend the different scenarios involving health insurance and have a	Personnel files/resumes/applications for employment reflect requisite experience/education/knowledge and understanding.

working knowledge of the COBRA and OBRA insurance programs and various private insurance programs and policies, including eligibility requirements, benefits, applicable deductibles and co-pays, Parts A, B and D of Medicare, Medicaid, the Children's Health Insurance Program (CHIP), Medicare Savings Programs, Medicare Advantage Plans, Veterans Administration (VA) benefits, CareLink, Texas HIV Medication Program (THMP), State Pharmaceutical Assistance Program (SPAP) and other health insurance, financial assistance and medication assistance programs and have a general understanding of the system of health care delivery within the TGA and surrounding HSDAs.	
HIPACSA providers must maintain individual files which document client demographics, eligibility, services provided, other agencies contacted, and benefits programs accessed.	Documentation in client's file and in ARIES.
Cash payments to clients are prohibited.	Documentation of policy and procedures in agency manuals that addresses prohibition of cash payments to clients.

QUALITY MANAGEMENT:

Program outcome: Medically related co-payments, co-insurance, premiums and/or deductibles for health insurance

Indicators: 100% of clients access HIV-related primary medical care supported by co-payment/co-insurance/premium/deductible assistance

Service Unit(s):

- Number of successful co-payments/co-insurance/premium/deductible
- Billed physician visits

Standard of Care	***Outcome Measure***	***Numerator***	***Denominator***	***Data Source***	***Goal/Benchmark***
I. Process					
Agency follows written guidelines, without exception, for all requests.	Provider assesses and documents client eligibility for alternative coverage of health insurance premium (e.g. Part B) or cost sharing (Carelink) prior to Ryan White Part A assistance.	Number of charts documenting assistance	Number of HIPCSA clients	Client Chart ARIES	75% of charts document client eligibility for Part A assistance.
Client will be discharged according to provider's criteria for services. Client will be given adequate notice of any change in the level of services provided.	Provider has written plan for discharge and transition with written documentation that no eligible client is denied insurance assistance without discussing with the	Number of clients with discharge documentation	Number of HIPCSA clients	Client Chart ARIES	75% of agencies have documented criteria for discharge plan.

	AA first (regardless of funding status).				
II. Outcomes					
Provider agency pays timely payment of premiums to avoid gaps in health insurance coverage and/or disruption of medical care.	Client insurance or payment plan receives payment within five (5) business days of approved request.	Number of insurance or payment plan receipts	Number of HIPCSA clients	Client Chart ARIES	75% of client charts document payment within five (5) business days of approved request to the approved insurance or payment plan.

For further information: HRSA Policy Notice 10-02
Texas Insurance Code 1506.153
HIV/STD Policy 260.002

HOME HEALTH CARE

DEFINITION:

Home Health Care includes the provision of services in the home by licensed health care workers such as nurses and the administration of intravenous and aerosolized treatment, parenteral feeding, diagnostic testing, and other medical therapies.

SERVICES:

Home health services are therapeutic, supportive and/or compensatory health services provided by a licensed/certified home health agency in a home or community-based setting in accordance with a written, individualized plan of care established by a licensed physician. Home health services include the following:

- **Para–professional care** is the provision of services by a home health aide, personal caretaker, or attendant caretaker. This definition also includes non–medical, non–nursing assistance with cooking and cleaning activities to help disabled patients remain in their homes.
- **Professional care** is the provision of services in the home by licensed health care workers such as nurses.
- **Specialized care** is the provision of services that include intravenous and aerosolized treatment, parenteral feeding, diagnostic testing, and other high–tech therapies.

The provision of home health services has shown in research to significantly reduce the number of hospital admissions, emergency room visits, and improve the quality of life for HIV-infected individuals.

Home health provides for the availability of the following services: skilled nursing, home health aides, personal care attendants, physical therapy, social worker services, supplies, and the purchase or rental of non-motorized durable medical equipment.

Home Health Care is funded through Part B and State Services only.

PERSONNEL:

Staff Qualification	Expected Practice
All nursing staff, home health aides, personal care attendants, physical therapists, and social workers and others that require licensure or certification will meet the appropriate licensure requirements set forth by the State of Texas.	Personnel files/resumes/applications for employment reflect requisite education
Home health providers must be appropriately licensed by the State of Texas and	Evidence of current unconditional license and /or certification is on file for each

able to bill Medicare, Medicaid, private insurance and/or other third party payers.	provider and for organization as a whole.
Home health providers must have one full year of experience providing home health services.	License on file.

QUALITY MANAGEMENT:

Program outcome: 75% of clients accessing Home Health Care have increase in activities of daily living.

Indicators: Number of requests for Home Health Care services

Service Unit(s): Face to Face visits as documented in ARIES

Standard of Care	***Outcome Measure***	***Numerator***	***Denominator***	***Data Source***	***Goal/Benchmark***
I. Structure					
Home health services will begin within 72 hours after the receipt of the physician's referral, unless otherwise specified.	Documentation of services date reflects 72 hours from date of referral.	Number of new clients referred to Home Health Care	Number of clients accessing Home Health Care	Client Charts ARIES	75% of client charts have documentation of services beginning within 72 hours of referral date.
The home health agency may elect to refuse a referral for the following reasons only: • Based on the agency's perception of the referred patient's condition, the patient requires a higher level of care than would be considered reasonable in a home setting. The agency must document the situation in writing and immediately contact the patient's physician. • The agency has attempted to complete an initial assessment and the referred patient has been away from home on three occasions. The agency must document the situation in writing and immediately contact the referring physician.	Documentation in client files reflects the agency's decision and written communication to the physician and appropriate monitoring entity.	Number of referrals refused	Number of clients accessing Home Health Care	Client charts ARIES Agency Policy and Procedure Manual	75% of client files have documentation of refusal of a referral reflecting agency's decision and written communication to the physician and appropriate monitoring entity.
The agency may discontinue services in only the following circumstances:	Documentation of discharge/transition plan in	Number of discharge clients	Number of clients accessing	Client Charts	75% of client files have documentation of discharge/transition plan.

• The patient is determined ineligible financially; • The patient is determined to have assets greater than the allowable eligibility requirements; • The patient is not stable enough to be cared for outside of the acute care setting as determined by the agency and the patient's physician; • The patient moves from Texas; • The patient no longer has a stable home environment appropriate for the provision of home health services as determined by the agency; • The patient no longer desires home health care; • The patient no longer medically requires home health care as determined by the agency or the physician; • An employee of the agency has experienced a real or perceived threat to his/her safety during a visit to a patient's home, in the company of an escort or not. The agency may discontinue services or refuse the patient for as long as the threat is ongoing. Any assaults, verbal or physical, must be reported to the monitoring entity within 24 hours and followed by a written report. A copy of the police report is sufficient, if applicable. All services discontinued under above circumstances must be accompanied by a referral to an appropriate service provider agency.	client file.		Home Health Care	ARIES Agency Policy and Procedure Manual	
II. Process					

Only physicians can refer patients to home health services. The referring physician must provide orders verbally and in writing to the agency prior to the initiation of care, act as that patient's primary care physician, maintain a consistent plan, and communicate changes from the initial plan directly to the agency. (In the event that this is not possible, the physician must be willing to transfer the client to the care of a willing physician.)	Documentation of physician orders in client chart.	Number of new clients	Number of clients	Client Chart ARIES	75% of client charts have documentation of physician orders for Home Health Care.
The home health agency must conduct a first visit with the referred patient and develop a written plan of treatment. Progress notes will be kept and the patient's eligibility must be recertified for the program every 12 months. Home health care providers will update the plan of treatment (HCFA Form 485) at least every sixty (60) days. The agency will maintain ongoing communication with the physician and case manager in compliance with Texas Medicaid and Medicare Guidelines.	Documentation of plan of treatment, progress notes, and communication logs in client chart.	Number of new clients	Number of clients	Client Chart ARIES	75% of client charts have documentation of plan of treatment, progress notes, and communication log.
The home health agency will certify upon intake, and throughout the course of the treatment plan, the patient is not in need of acute care.	Documentation of continuous assessment of client in client chart.	Number of clients with assessments	Number of clients	Client Chart ARIES	75% of client charts have documentation of continuous assessments to ensure client does not need acute care.
III. Outcomes					
Agency shall continuously monitor and evaluate a patient's care throughout the course of a treatment plan, while making changes when appropriate and informing the patient's physician of such changes.	Client's file reflects case conferencing, progress notes, and appropriate chart audit documentation.	Number of agencies with guidelines	Number of contracted Home Health Care agencies	Client Chart ARIES Agency Policy and Procedure Manual	75% of client charts have documentation reflecting case conferencing, progress notes, and appropriate chart auditing.

HOSPICE SERVICES

DEFINITION:

Hospice services include room, board, nursing care, counseling, physician services, and palliative therapeutics provided to clients in the terminal stages of illness in a residential setting, including a non-acute-care section of a hospital that has been designated and staffed to provide hospice services for terminal clients.

LIMITATIONS:

Ryan White/State Service funds may not be used for funeral, burial, cremation, or related expenses. Funds may not be used for nutritional services, durable medical equipment and medical supplies or case management services.

SERVICES:

Hospice services include, but are not limited to, the palliation and management of the terminal illness and conditions related to the terminal illness. Allowable Ryan White/State Services funded services are:

- Room
- Board
- Nursing care
- Mental health counseling, to include bereavement counseling
- Physician services
- Palliative therapeutics (Palliative therapy is care designed to relieve or reduce intensity of uncomfortable symptoms but not to produce a cure.)

PERSONNEL:

Staff Qualification	Expected Practice
All hospice care staff who provide direct-care services and who require licensure or certification, must be properly licensed or certified by the State of Texas.	Personnel files/resumes/applications for employment reflect requisite licensure and certification (e.g., R.Ns, LVNs, CNAs).
Provider must provide a criminal background check for any applicant whom the provider anticipates hiring to provide direct-care services.	Personnel files reflect completion of criminal background checks.
Staff participating in the direct provisions of services to patients must	Materials for staff training and continuing education are on file.

satisfactorily complete a minimum of eight (8) additional hours of training in HIV/AIDS and clinically-related issues. The training shall include psychosocial issues and end-of-life issues. Additionally, opportunities are to be provided for licensed/certified staff to take relevant, outside courses to both improve their skills and earn CEUs sufficient to maintain licensure or certification.	
Hospice services must be provided under the supervision of a physician and/or registered nurse.	Copy of supervisory physician or registered nurse license is on file.
Provider is a licensed hospital or has and maintains a valid State license with a residential AIDS Hospice designation.	Documentation of license and/or certification is available at the site where services are provided to patients.

QUALITY MANAGEMENT:

Program outcome: 75% of clients have improved quality of end-of-life treatment.

Indicators: Number of Hospice Clients

Service Unit(s): Face to face visits in ARIES

Standard of Care	***Outcome Measure***	***Numerator***	***Denominator***	***Data Source***	***Goal/Benchmark***
I. Structure					
Physician must certify that a client is terminal, defined under Medicaid hospice regulations as having a life expectancy of 6 months or less.	Documentation of physician certification in client chart.	Number of new clients referred to Hospice	Number of clients in Hospice	Client Chart ARIES	75% of client charts have documentation of physician certification of terminal state, as defined under Medicaid hospice regulations.
The referring physician must provide orders verbally and in writing to the provider prior to the initiation of care and act as that patient's primary care physician.	Documentation in client's chart reflects written and verbal physician's order including any updates.	Number of new clients referred to Hospice	Number of clients in Hospice	Client Chart ARIES	75% of client charts have documentation of written and verbal physician's orders.
The hospice provider may elect to refuse a referral for reasons which include, but are not limited to, the following: • There are no beds available • Level of patient's acuity and staffing limitations	Provider's office log indicates reason for refusal.	Number of clients refused	Number of clients in Hospice	Client Chart ARIES	75% of Hospice provider logs indicate reason for refusal.

• Patient is aggressive and a danger to the staff • Patient is a "no show"					
An individual is deemed no longer to be in need of hospice services if one or more of these criteria is met: • Patient expires; • Patient's medical condition improves and hospice care is no longer necessary; • Patient is transferred out of provider's facility.	Documentation of discharge/transfer in client's chart/file.	Number of clients discharged	Number of clients	Client Chart ARIES	75% of client charts will have documentation of discharge/transfer plans as indicated.
II. Process					
A comprehensive health assessment is completed for each client within 48 hours of admission.	Documentation in client's chart/file.	Number of clients with comprehensive health assessment	Number of clients	Client Chart ARIES	75% of client charts have documentation of comprehensive health assessment.
A written Plan of Care is completed for each client within 7 days of admission and reviewed monthly.	Documentation in client's chart/file.	Number of clients with written plan of care	Number of clients	Client Chart ARIES	75% of client charts have documentation of plan of care.
Provider documents each client's scheduled medications, including dosage and frequency.	Documentation in client's chart/file with client's name, route and initials of staff.	Number of clients with scheduled medications	Number of clients	Client Chart ARIES	75% of client charts have documentation of scheduled medications, including dosage and frequency.
Provider documents each client's as needed (PRN) medications, including client's name, dose, route, reason, result and signature and title of staff.	Documentation in client's chart/file.	Number of clients with PRN medications	Number of clients	Client Chart ARIES	75% of client charts have documentation of as needed (PRN) medications, including client name, dose, route, reason, result and signature and title of staff.
Physician orders are transcribed and noted by attending nurse.	Documentation in client's chart/file.	Number of clients with physician orders	Number of clients	Client Chart ARIES	75% of client charts have documentation of physician orders.
The need for bereavement and counseling services for family members must be consistent with definition of Mental Health counseling.	Documentation in client's chart/file.	Number of clients' families with bereavement and counseling needs	Number of clients	Client Chart ARIES	75% of client charts have documentation of need for bereavement and counseling services for family members consistent with definition of Mental Health counseling.
III. Outcomes					
Provider will maintain consistent plan of care and communicate changes from the initial plan to the referring provider.	Documentation of plan of care and communication to the referring provider for changes to plan.	Number of clients with plan of care	Number of clients	Client Chart ARIES	75% of client charts have documentation of plan of care and communication to the referring provider for changes to plan.

HOUSING SERVICES

DEFINITION:

Housing Services are the provision of short-term assistance to support emergency, temporary or transitional housing to enable an individual or family to gain or maintain medical care. Housing related referral services include assessment, search, placement, advocacy, and the fees associated with them. Eligible housing can include both housing that does not provide direct medical or supportive services and housing that provides some type of medical or supportive services, such as residential mental health services, foster care, or assisted living residential services.

SERVICES:

Housing referral services, short-term temporary housing, and emergency rental assistance will be transitional in nature and are for the purpose of maintaining an individual or family in a long-term, stable living situation. The housing strategy plan will be conducted at intake to identify, assist in relocation, and/or ensure the individual or family is moved to, or capable of maintaining a long-term stable living situation.

Short-term assistance is limited to four continuous months of assistance within a contract year. The maximum amount of assistance for short-term assistance is $2,400 per contract year.

Emergency assistance is limited to one month of rental assistance within a contract year. The maximum amount of emergency assistance is $600.

There is a 24 month cumulative period of eligibility per household for housing services provided by Ryan White funds.

Housing Services are funded through Part B and State Services only.

PERSONNEL:

Staff Qualification	Expected Practice
Service providers shall employ staff who are able to comprehend various housing assistance available in the TGA and HSDAs with a general understanding of the system of health care delivery within the TGA and HSDAs.	Personnel files/resumes/applications for employment reflect requisite experience and education.
Staff and residents of short-term, temporary/transitional housing programs shall be oriented, at a minimum, to the following subjects upon employment with or	Personnel files reflect completion of applicable orientation.

admission to the program: a. Emergency and safety procedures b. Infection control and universal precautions c. Confidentiality	
Provider must specify criteria, policies, and procedures for utilization of housing assistance services.	Provider's policies and procedures reflect specified requirements.
Provider must maintain all licenses and permits required by law to operate the particular housing program(s) involved.	Provider has all licenses required to operate.

QUALITY MANAGEMENT:

Program outcome:

- 75% of clients who report stable living arrangements reported on a quarterly basis
- Number of referred clients into program
- Number of people receiving housing assistance

Indicators:

- Number of clients enrolled in stable living arrangements
- Number of clients with documentation of housing as a stable/permanent, temporary, unstable or unknown

Service Unit(s):

- Successful completed application as documented in ARIES
- Face to face or phone contacts
- Number of clients placed in stable housing by type: Permanent, Transitional, Group, Skilled Nursing Facility

Standard of Care	***Outcome Measure***	***Numerator***	***Denominator***	***Data Source***	***Goal/Benchmark***
I. Structure					
Providers offering short-term, temporary/transitional housing shall have the capacity to provide access/referrals to the following services for residents: • Case management • Social services • Personal care assistance	Agency has staff or demonstrated linkages to provide the listed services to clients. Client files reflect receipt of a broad range of services tailored to individual needs.	Number of enrolled clients with referrals to services	Number of clients receiving Housing Assistance	Client Files ARIES Agency Letters of Agreement	75% of all client files have documentation of access/referrals to other services.

• Transportation • Independent living skills • Assistance with adherence to medication schedules • Nutritionally balanced meals, with accommodations for special diets • Access for home health and hospice workers in accordance with physician's orders					
Funds in this category are limited to four (4) continuous months of assistance within a contract year. The maximum amount of assistance for short-term assistance is $2,400. Ryan White funds will not pay more than the Fair Market Rent (FMR) in assistance.	Documentation in client's file.	Number of clients receiving Housing Assistance funds	Number of clients receiving Housing Assistance	Client Files ARIES	75% of client charts have documentation of funds to clients upon approved request.
Funds for short term lodging are intended to assist people who require specialty care, exclusive of clinical trials, that is not available in the HSDA and have to travel out of the area to access services, up to $100/night for a maximum of two nights. Any expenses over and above $100 will be borne by the client. Ryan White funds will NOT cover all incidental charges such as food and beverages, telephone, liquor, tobacco products, movies and entertainment.	Documentation in client's file, includes but not limited to: • valid paid receipt from hotel/motel; or • documentation of prepayment by provider to hotel/motel. Client must produce written verification of attendance at the medical appointment signed by treating medical provider.	Number of clients receiving short term lodging assistance funds	Number of clients receiving Housing assistance	Client Files ARIES	75% of client charts have documentation of short term funds to clients and/or hotel/motel upon approved request.
Provider will have a written plan regarding discharge and/or transition of client from services.	Written discharge/transition plan on file.	Number of clients discharged/transitioned from Housing Assistance	Number of clients receiving Housing Assistance	Client Files ARIES	75% of client charts have documentation of written discharge/transition plan.
II. Process					
Initial assessment protocols shall provide screening of individuals to determine needs and appropriate service plan.	Documentation of individual client service plan.	Number of clients with individual service plan assessment	Number of clients	Client Files ARIES	75% of client charts have documentation of individual client service plan.
Clients who discontinue the program may be required to re-establish eligibility before resuming service. After clients have exhausted 12-month	Documentation is maintained on eligibility verification.	Number of clients who have exhausted services	Number of clients	Client Files ARIES	75% of client charts have documentation of eligibility verification for services discontinued.

calendar year, a 6-month waiting period is required before re-applying for services. Clients, who have not exhausted a cumulative 24 months of services, will not have to re-apply for services.					
Each client will be informed of third party payer application requirements. If applicable, clients must apply for Texas Medicaid – or have a documented denial from Medicaid dated within the prior twelve (12) months.	Client's central file reflects Texas Medicaid application requirements or contains prior denial documentation.	Number of clients with completed applications or denial documentation	Number of clients	Client Files ARIES	75% of client charts have documentation of Texas Medicaid application or prior denial documentation.
A service plan shall be completed within thirty (30) days that is specific to individual client needs. The service plan shall be prepared and documented for each client. Individual and family case records will include documentation of the following: • Eligibility • Housing or emergency financial assessment of needs • Referrals • Discharge summary	Documentation in client's file.	Number of clients with service plans	Number of clients	Client Files ARIES	75% of client charts have documentation of service plans.
A service plan identifying clear, time-measured objectives evaluated on a quarterly basis will be on file at provider agency and case management agency.	Documentation of service plan identifying clear, time measured objectives evaluated on a quarterly basis will be on file at provider agency and case management agency.	Number of clients with service plans re-evaluated	Number of clients	Client Files ARIES	75% of client charts have documentation of service plan with re-evaluation on a quarterly basis.
II. Outcomes					
Emergency rental assistance payment is made out to the appropriate vendor and authorized for pick up by the client or the client's case manager. No payment may be made directly to clients, family or household members.	The Agency providing emergency rental assistance must maintain the following documents in each client's case file, in addition to any other documentation which may be required by the Standards of Care: • Copy of invoice/bill paid; • Copy of check for payment; • Copy of documentation of application for other assistance, if applicable; and	Number of clients receiving Housing Assistance payments	Number of clients	Client Files ARIES	75% of client charts have documentation of rental assistance payments made to appropriate vendor.

	• Letter documenting need and attempts at locating other available resources signed by case manager.				
All completed requests for assistance shall be approved or denied within one (1) working day. A check shall be issued within seven (7) working days of approval of request.	Documentation in client's file of Housing assistance funds to clients within 7 working days of approved request.	Number of clients receiving Housing Assistance funds within 7 working days	Number of Housing Assistance funds requests	Client Files ARIES	75% of client charts document funds to clients within 7 working days of approved request.

LINGUISTIC SERVICES

DEFINITION:

Linguistic Services include the provision of interpretation and translation services, both oral and written.

SERVICES:

This program will provide for interpretation and translation services, to include American Sign Language, to clients and/or affected family members/caregivers during Ryan White core funded services.

PERSONNEL:

Staff Qualification	Expected Practice
• Certification by the Certification Commission for Healthcare Interpreters (CCHI) or the National Board of Certification for Medical Interpreters (NBCMI), • Or all of the following: o Age 18 o High school education o Fluency in English and a language other than English o Experience as a translator or interpreter in a health care setting o Training in: ▪ Interpreting Skills: Consecutive Interpreting; Sight Translation; and Protocols (managing a session) ▪ Code of Ethics for Health Care Interpreters ▪ Standards of Practice for Health Care Interpreters ▪ Roles of Health Care Interpreter ▪ Cultural Awareness ▪ Legislation and Regulations (Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act, Title VI of Civil Rights Act, Health Information Portability and Accountability Act (HIPAA), Health Information Technology for Economic and Clinical Health Act (HITECH), National Standards on Culturally and Linguistically Appropriate Services (CLAS)) ▪ General medical knowledge on the following topics:	Personnel files/resumes/applications for employment reflect requisite experience and education

- Anatomical Terms for Major Body Systems - Medical Tests and Diagnostics - Common Specialties and Medications (including physical and mental health) - Acronyms and Abbreviations - Routine Medical Equipment - Infection Control - Onsite Mentoring - Mental/Behavioral Health: • Common disorders of adults, children/adolescents • Common medications • Psychiatric tests and diagnostics • Treatment plans • Acronyms and Abbreviations • Legal status (voluntary, Peace Officer Emergency Commitment (POEC), Order of Protective Custody (OPC))[3] • Staff and volunteers who provide American Sign Language services MUST hold a certification from the Board of Evaluation of Interpreters (BEI), the Registry of Interpreters for the Deaf (RID), or the National Interpreter Certification (NIC) at a level recommended by the Texas Department of Assistive and Rehabilitative Services (DARS) Office for Deaf and Hard of Hearing Services. This level will vary based on the core Ryan White Service the interpreter is provided for.	

SUB RECIPIENT STANDARDS:

Linguistic Services providers will be responsible for monitoring sub recipient standards, including but not limited to the following Standards. These standards will be reflected in either the contract or a Memorandum of Agreement.

[3] Advisory Committee on Qualifications for Health Care Translators and Interpreters. (2012). "Recommendations in Response to the 2010 Qualifications for Health Care Translators and Interpreters Legislative Charge." Report to the 83rd Legislature, Regular Session, 2013. Austin, TX.

Access

Standard	Measure
The agency shall provide access to its interpretation/translation services within seventy-two (72) hours of receipt of a request.	Agency has written policy on file
The agency shall ensure that its interpretation/translation/sign language staff persons, speaking in a neutral language and tone, present an objective interpretation of information to be provided, in the language most easily understood by the client, capturing the content and spirit intended by the provider.	Agency has written policy on file
Instruct its interpretation/translation/sign language staff to provide no advice or personal opinion, and to avoid direct conversation with the agency provider while rendering services	Agency has written policy on file
Ensure that its interpretation/translation/sign language staff, in rendering services, takes into account client age, any history of impaired comprehension, substance abuse, mental health problems, literacy difficulties, and medical condition.	Agency has written policy on file

QUALITY MANAGEMENT:

Program outcome:

75% of clients who received this service remained in medical care

Indicators:
Number of clients who requested linguistic services in medical care
Number of clients who maintain medical care at the end of 6 months and 12 months.
Number of clients who report increased satisfaction with core medical services.

Service Unit(s):

- Per 15 minutes of interpersonal (face to face) interpretation/translation.
- Per transaction of document interpretation/translation.

Standard of Care	*Outcome Measure*	*Numerator*	*Denominator*	*Data Source*	*Goal/Benchmark*
I. Outcomes					
Clients accessing Linguistic Services have same day core medical appointment.	Clients show access to core medical appointment and retention in care.	Number of clients with same day core medical appointment.	Number of clients	Client Chart ARIES	100% of clients accessing Linguistic Services have same-day core medical care.
Clients receiving Linguistic	Clients show medical visit	Number of clients with	Number of	Client Chart	75% of clients receiving Linguistic Services

Services have at least one (1) documented medical visit within 6 month period of measurement year.	and retention of medical care	documented medical visit within 6 month pd of measurement year	clients	ARIES	have at least one (1) documented medical visit within 6 month period of measurement year.
Clients receiving Linguistic Services have increased satisfaction with their medical care	Clients show increased satisfaction with their medical care.	Number of clients with documented medical visit within 6 month pd of measurement year	Number of Client	Client Chart, Client Satisfaction Survey	75% of clients receiving Linguistic Services will have increased satisfaction with their medical care.

MEDICAL CASE MANAGEMENT

DEFINITION:

Medical Case Management (including treatment adherence) are a range of client–centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care through ongoing assessment of the client and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact and any other forms of communication.

Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized service plan
- Coordination of services required to implement the plan
- Continuous client monitoring to assess the efficacy of the plan
- Periodic re-evaluation and adaptation of the plan as necessary over the life of the client.
- Benefits and entitlements counseling, with respect to the Affordable Care Act

SERVICES:

Medical Case Management (including treatment adherence). Provision of services focused on maintaining HIV-infected persons in systems of primary medical care to improve HIV-related health outcomes. Medical Case Managers act as part of a multidisciplinary medical team, with a specific role of assisting clients in following their medical treatment plan. Medical Case Managers should not serve as gatekeepers or access points into medical care, as the goal of this service is the development of knowledge and skills that allow clients to adhere to the medical treatment plan without the support and assistance of the Medical Case Manager. The Medical Case Manager should be a licensed professional (e.g., RN, LMSW). Programs providing Medical Case Management (MCM) that meet the requirements of this definition with experienced unlicensed staff may apply for a limited waiver of this provision.

MCM must include a comprehensive assessment of need, the development of a service plan to address client needs, client referral to appropriate providers based on need and service plan, interventions to address client issues such as medication compliance, adherence and risk reduction, as well as patient education.

Active, intensive medical case management services are home and community-based. Medical case managers will encounter clients in their environment, which may include a residence, a public facility, in the streets, or in the facilities of the medical case management service provider agency. Medical case management shall provide for face-to-face or phone contact and a home visit, as determined by client need.

The following clients should be enrolled in Medical Case Management:

- Late to care / out of care / not in care / re-engaging in care
- Newly Diagnosed
- Homeless
- Recently released from incarceration
- Pregnant
- CD4 count below 200 or VL> 10,000 copies/ml
- Untreated mental illness (including substance use disorders)
- New to Antiretroviral therapy
- Non-adherence to HIV medication
- Unable to navigate System of Care due to language barriers
- Individuals who have complex medical needs and may require a more extensive time investment

PERSONNEL:

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

meet the requirements of this definition with experienced unlicensed staff may apply for a limited waiver of this provision. Regarding all future medical case management hires, providers shall seek to hire licensed professionals as outlined in HRSA policy notice 10-02.	
A medical case management supervisor must meet the *minimum* qualifications for education and experience listed below: a. A bachelor's (required) or master's degree (preferred) in social work from a program accredited by the TSBSWE and two years of paid post degree experience in providing case management services; OR b. A bachelor's (required) or master's degree (preferred) in nursing (RN) (one year of experience will substitute for the degree) and two years of paid post degree experience in providing case management services; OR c. A bachelor's (required) or master's degree (preferred) in a human service related field which includes: psychology, education, counseling, social services, sociology, philosophy, family and consumer sciences, criminal justice, rehab services, child development, substance abuse, gerontology, and vocational rehabilitation and two years of paid post degree experience in providing case management services; OR d. A bachelor's in liberal arts or general studies with concentration of at least sixteen (16) hours in one of the fields listed in item C of this part and two (2) years of paid post degree experience in providing medical case management services.	Personnel files/resumes/applications for employment reflect requisite experience and education.
A minimum of sixteen (16) additional hours of orientation training must cover orientation to the target population and the HIV service delivery system in the San Antonio TGA and HSDAs including but not limited to: a. The full complement of HIV/AIDS services available within the TGA and HSDAs, including non-Ryan White funded agencies b. How to access such services [including how to ensure that particular subpopulations are able to access services (i.e., undocumented individuals)] c. Ryan White Standards of Care (Universal and Service Category Standards) d. Education on applications for eligibility under entitlement and benefit programs other than Ryan White services will be included and periodically updated as changes occur	Personnel file reflects completion of orientation and signed job description.
All case managers must complete (or have completed prior) the following within six (6) months of hire: • Effective Communication Tools for Healthcare Professionals 100: Addressing Health Literacy, Cultural Competency and Limited English Proficiency* • Texas HIV Medication Program 2013 Update*	Personnel files reflect training log with documentation of subject matter and attendance.

• HIV Case Management 101: A Foundation* • HIV Case Management 101: A Foundation Part Two (Module 1: HIV and Behavioral Risk; Module 2: Substance Use and HIV; Module 3: Mental Health and HIV)* All new case managers must complete (or have completed prior) the following within twelve (12) months: • STD Facts & Fallacies: Chlamydia, Gonorrhea & Pelvic Inflammatory Disease (PID)* • STD Facts & Fallacies: Syphilis* • Perinatal HIV Prevention Online Program* ***These courses are all available through the TRAIN (Training Finder Real-time Affiliate Integrated Network) Texas learning management system (www.tx.train.org)***	
Twenty-four (24) hours of annual training are required for all employees. The 24 hours shall include fifteen (15) hours of medical training, six (6) hours of psychosocial training and three (3) hours of quality management training. The medical training shall cover the Texas Department of State Health Services (DSHS) required topics of Medical Adherence, HIV Disease Process, Oral Health, Risk Reduction/Prevention Strategies (including Substance Abuse Treatment) and Nutrition. A suggested additional topic may be End-of-Life issues. Medical training shall also include training on documentation. The psychosocial training shall include the topics of AIDS and the law, medically related federal and state benefits programs (e.g. Social Security, Medicare, Medicaid, Star +).	Personnel files reflect training log with documentation of subject matter and attendance at twenty-four (24) hours of annual training.
Each medical case management agency must have and implement a written plan for supervision of all medical case management staff. Supervisors must review ten (10) percent or thirty (30) records, whichever is less, sample of each medical case manager's case records each month for completeness, compliance with these standards, and quality and timeliness of service delivery. Medical case managers must be evaluated at least annually by their supervisor according to written Agency policy on performance appraisals.	Agency has written plan for supervision of all medical case management staff. Agency will keep on file supervision logs demonstrating the review of random client files citing the date and outcome of chart reviews. Personnel files contain annual performance evaluations.
Each supervisor must maintain a file on each medical case manager supervised	Documentation of supervision provided. Supervisors' files on each medical

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

QUALITY MANAGEMENT:

Program outcome:

- 75% of clients will maintain Medical Care after accessing Medical Case Management services as reported every 6 months or as determined through use of an Acuity Scale
- % of clients retained in care (total number clients retained/total number clients)
- % of clients entering care (total number of new clients/total number clients)

Indicators:

- Care plan details client's short and long-term goals with associated tasks to achieve them. Care plan is updated every 6 months.
- Clients are successfully linked to Primary Medical Care as evidenced by initial visit and then documentation of visit every 6 months.
- The number of client charts with accurate risk/exposure group via documentation of updated risk factors twice a year

Service Unit(s): Face to Face Clinic (office) visit or Face to Face (home) visit

Standard of Care	***Outcome Measure***	***Numerator***	***Denominator***	***Data Source***	***Goal/Benchmark***
I. Structure					
Clients who are no longer engaged in active case management services should have their cases closed based on the criteria and protocol outlined below. A closure summary usually outlines the progress toward meeting identified goals and services received to date.	Documentation of case closure and reason in client's record.	Number of clients discharged from MCM	Number of clients	Client Files ARIES	75% of discharged clients have documentation of case closure and reason in client files.

Common reasons for case closure include: • Client completed case management goals • Client is no longer in need of case management services (e.g. client is capable of resolving needs independent of case manager assistance) • Client is referred to another case management program • Client relocates outside of service area • Client chooses to terminate services • Client is no longer eligible for services due to not meeting eligibility requirements • Client is lost to care or does not engage in service • Client incarceration greater than 6 months in a correctional facility • Provider initiated termination due to behavioral violations • Client death Closed cases include documentation stating the reason for closure and a closure summary (brief narrative in progress notes and formal discharge summary) signed off by Supervisor (electronic review is acceptable). Client is considered non-compliant with care if 3 attempts to contact client (via phone, e-mail and/or written correspondence) are unsuccessful and the client has been given 30 days from initial contact to respond. Discharge					

proceedings should be initiated by agency 30 days following the 3rd attempt. In accord with written policies and procedures established by each agency, the case manager notifies the client (through face-to-face meeting, telephone conversation or letter) explaining the reason(s) for discharge, the process to be followed if client elects to appeal the discharge from service, and information about reestablishment of services.					
Medical case managers shall ensure that, to the greatest extent possible, clients who leave care are linked with appropriate services to meet their needs.	Documentation in client's record indicating referrals or transition plan to other providers/agencies.	Number of clients leaving MCM	Number of clients	Client Files ARIES	75% of clients leaving MCM have documentation or referrals or transition plan to other providers/agencies in their file.
I. Process					
The medical case manager conducts a face-to-face assessment of the client's needs.	Documentation of needs assessment in client chart.	Number of MCM clients	Number of clients	Client Files ARIES	75% of all MCM client files have documentation of face to face assessment completed.
Within three (3) working days of enrollment, an intake shall be completed to evaluate the client's needs, including, but not limited to the following: • Medical history and current health/primary care status • Available financial resources (including insurance status) with emphasis on Medicaid, THMP, SSI and other resources. • Availability of food, shelter, and transportation • Available support system • Need for legal assistance • Substance abuse history and status • Emotional/mental health	Client's chart contains documentation of each client's need for (or problems with) current medical status, financial resources, food, transportation, support system, substance abuse status and mental health status.	Number of MCM clients with intake	Number of clients	Client Files ARIES	75% of all MCM client files have documentation of an intake.

history and status					
The intake should be reviewed with the client as evidenced by the completed service plan and acuity score.	Documentation of service plan signed by client and case manager when reviewed in client file.	Number of MCM clients with signed plan Number of MCM clients with acuity score	Number of clients	Client Files	75% of all MCM clients have documentation of a signed service plan by both client and case manager. 75% of all MCM clients have documentation of acuity score in ARIES.
Care Plans are re-assessed every 4-6 months for full eligibility, financial, and support services every 6 months. *(For stable clients with acuity score of >201, Care Plans should be reassessed every 6 months.) *see Acuity Scale below table.*	Documentation of reassessment of care plan in client files.	Number of clients with documented review of Care Plan at least twice a year, with at least five months between the first and last reviews.	Number of clients	Client Files ARIES	75% of client files document Care Plan review at least twice, with at least five months between the first and last reviews.
III. Care Plan					
An individual care plan will be completed within ten (10) working days of the first face-to-face meeting with the client.	Documentation of care plan in client file.	Number of clients with Care Plan	Number of clients	Client Files ARIES	75% of clients have a comprehensive Care Plan within 10 days of the first face-to-face meeting.
The individual care plan will be a written comprehensive plan of intervention made up of goals and measurable objectives prepared with the participation of the client with the primary objective to include potential barriers to adherence to antiretrovirals or other therapies and continued medical follow-up[4].	Documentation shall include client's problems and needs with treatment and medications, attempts made to solve the problems (including a timeframe and names of providers involved), and follow-up items to relay to the primary care provider.	Number of clients with Care Plan	Number of clients	Client Files ARIES	75% of clients have a comprehensive Care Plan with documented needs of clients in client file.
Medical case managers ensure that all client needs are identified by assessment and acuity, and prioritized so that the most important services for clients are made available as soon as possible.	Documentation in client file.	Number of assessments that identify and prioritize client needs	Number of clients	Client Files ARIES	75% of client assessments show documentation of clients needs identified and prioritized.

[4] Data collected regarding clients' treatment adherence is for information gathering only and will not be used to deny services to clients for non-adherence issues.

Care Plans are signed and dated by the Medical Case Manager that developed the Plan and by the client.	Documentation of signature of Medical Case Manager and client in client files.	Number of Care Plans signed and dated by MCM and client	Number of clients	Client Files ARIES	75% of Care Plans are signed and dated by MCM and clients.
Medical Case Managers will refer clients for necessary services in a timely manner.	Documented in client's file. Failure to follow-up on completion of a referral for any service will be documented in the progress notes of client file.	Number of clients with referrals	Number of clients	Client Files ARIES	75% of clients have documentation on file of referrals for necessary services.
Medical Case Managers will monitor client's progress to meeting established goals of care.	Documentation in client files.	Number of client records with goals and updated care plans	Number of clients	Client Files ARIES	75% of client records contain established goals and updated care plans.
II. Outcomes					
Medical case managers have documentation in client file of two (2) or more medical visits in the assessment year.	Documentation in client files.	Number of clients with at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between the first medical visit in the prior 6-month period and the last medical visit in the subsequent 6-month period. Number of clients with a medical visit in the last 6 months.	Number of clients	Client Files ARIES	75% of clients accessing Medical Case Management have documentation of at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between the first medical visit in the prior 6-month period and the last medical visit in the subsequent 6-month period. 75% of clients accessing Medical Case Management have a medical visit in the last 6 months.

MEDICAL NUTRITION THERAPY

DEFINITION:

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

SERVICES:

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

Medical Nutrition Therapy includes:

- Performing a comprehensive nutrition assessment determining the nutrition diagnosis;
- Planning and implementing a nutrition intervention using evidence-based nutrition practice guidelines;
- Monitoring and evaluating an individual's progress over subsequent visits with the Registered Dietitian (RD).

A 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.

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

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

Nutritional services and nutritional supplements not provided by a licensed Registered Dietitian shall be considered a support service (psychosocial support).

Food provisions not provided pursuant to a physician's recommendation and a nutritional plan developed by a licensed Registered Dietitian also shall be considered a support service (food bank).

PERSONNEL:

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

QUALITY MANAGEMENT:

Program outcomes:

- 75% of clients will have at least one Medical Nutritional Therapy assessment per year
- 75% of clients enrolled in Medical Nutritional Therapy (number of clients in MNT/number of clients)
- 75% of clients who show improved BMI's (number of clients with improved BMI's/number of clients)

Indicators:

- Nutritional plans detail client goals in nutrition in relation to their medical treatment needs
- Number of nutritional care plans updated to enhance medical care

Service Unit(s): Face to Face visits in ARIES

Standard of Care	***Outcome Measure***	***Numerator***	***Denominator***	***Data Source***	***Goal/Benchmark***
I. Process					
An initial MNT assessment will be conducted by a Registered/Licensed Dietitian to ensure appropriateness of service.	Documentation of nutrition assessment on file in client's chart.	Number of nutrition assessments completed in client files	Number of clients	Client Files ARIES	75% of client files have nutritional assessments documented.
MNT provider collects and documents assessment history information with updates as medically appropriate prior to providing care. This information should be based on the Academy of Nutrition & Dietetics (AND) Evidence Based Guidelines.	Documentation of nutrition assessment completed in client's chart.	Number of nutrition assessments completed in client files.	Number of MNT clients	Client Files ARIES	75% of client files have nutritional assessments completed and documented
The nutrition care process will include: • Nutritional assessment • Nutritional diagnosis • Nutrition intervention • Nutrition monitoring and evaluation	Signed, dated nutritional plan including measurable goal oriented strategies on file in client records.	Number of signed/dated nutritional plans	Number of clients	Client Files ARIES	75% of client files have signed/dated nutritional plans documented.
Nutrition care plan will be updated as necessary, at least annually, and may be shared with client's primary care provider and/or other personnel involved in client's care.	Updated, signed plan on file in client's record.	Number of updated nutritional plans	Number of clients	Client Files ARIES	75% of client files have documentation of updated signed nutritional plans at least annually.
II. Outcomes					
Nutritional care plan will assess client's weight, Body	Documentation in client file.	Number of nutritional care plans.	Number of clients.	Client Files	75% of client files have documentation of care plan

Mass Index (BMI), and dietary intake.				ARIES	assessment including client weight, BMI and dietary intake.
Nutritional care plan will be individualized by client assessing clients' needs medically.	Documentation in client file.	Number of nutritional care plans	Number of clients	Client Files ARIES	75% of client files have documentation of individualized nutritional care plans addressing client's needs medically.
Patient nutritional health education should be offered to each patient a minimum of once a year that includes but not limited to: • Benefits of good nutrition • Special eating needs of people with HIV/AIDS • Supplementation • Coping with complications	Documentation in client file.	Number of patient nutritional health education	Number of MNT client	Client Files ARIES	75% of client files have documentation of patient nutritional health education.

MEDICAL TRANSPORTATION SERVICES

DEFINITION:

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

LIMITATIONS:

Reimbursement methods may not involve cash payments to the client.

Mileage reimbursement will not exceed the federal reimbursement rate.

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 defined core services and/or medical and health related care services.

Activities of Medical Transportation include:

a) Agency Conveyance
b) Bus Passes/Tokens
c) Hardship circumstances assessed on a case-by-case basis with documented justification

TRANSPORTATION OBJECTIVE: Medical transportation is classified as a support service and is used to provide transportation for eligible Ryan White HIV/AIDS Program clients to core medical services and support services. Medical Transportation must be reported as a support service in all cases, regardless of whether the client is transported to a medical core service or to a support service

PERSONNEL:

Staff Qualification	Expected Practice
Drivers for agency conveyance will have received training in universal precautions and infection control appropriate to their duties. All drivers have current Texas driver's licenses for the type of vehicle driven as well as levels of liability insurance required by state law and funding sources Drivers must have verified driving records, receive a drug screen and background check. A signed statement from the drivers agreeing to safe driving practices is on file. This statement is to include the consequences of violating the agreement.	Personnel files/resumes/applications for employment reflect requisite experience, education, and licensure, required testing and background checks.
Agency Vehicle Requirements	
A file will be maintained on each agency vehicle and shall include, but not be limited to: description of vehicle including year, make, model, general condition, service records (and) inspections of vehicle(s) should be routine and documented Agency maintains documentation of all agency owned vehicles insurance coverage as required by State of Texas. Routine maintenance records and other repair information are available. Seat belts/restraint systems must be operational. When in place, child car seats must be operational and installed according to manufacturer specifications Agency maintains documentation of current insurance coverage as required by state law and funding sources for all agency owned vehicles. Agency has a policy on file that addresses the following at a minimum: • Protocol for addressing Traffic, Parking, and Moving Violations • Grounds for termination • Must state that Ryan White Funding cannot be used to pay for such	Vehicle records file. A written policy on file.

violations. Vehicle License and inspection are current. A log/form for collection of mileage is maintained by the driver(s) and is reviewed at least quarterly by supervisor. Transportation services must be handicap accessible in accordance with the Americans with Disabilities Act (ADA) regulations.	
Each agency must have and implement a written plan for supervision of all staff. Supervisors must review a ten (10) percent sample of each staff's case records each month for completeness, compliance with these standards, and quality and timeliness of service delivery. Staff must be evaluated at least annually by their supervisor according to written Agency policy on performance appraisals.	Agency has written plan for supervision of all staff. Agency will keep on file supervision logs demonstrating the review of random client files citing the date and outcome of chart reviews. Personnel files contain annual performance evaluations.
Procedures are in place regarding use and distribution of vouchers or bus passes. A system is in place to account for the purchase and distribution of vouchers and bus passes. A security system is in place for storage of and access to vouchers, bus passes and fees collected. All fees are reported as program income as appropriate.	Agency Policies and Procedures. Distribution logs, client records, and financial documentation.
Agency does not provide direct transportation services to clients in need of emergency medical care and there is a policy in place to address this.	Agency Policies and Procedures

QUALITY MANAGEMENT:

Program outcome: 75% of clients will arrive at core services as a result of accessing transportation.

Indicators: The number of clients who arrived at core service appointments as a result of Transportation Services.

Service Unit(s): Successful completed transport to Core Services via Bus Pass/Voucher

Standard of Care	*Outcome Measure*	*Numerator*	*Denominator*	*Data Source*	*Goal/Benchmark*
I. Process					
The agency provides clients with information on transportation limitations, clients' responsibilities for accessing transportation, and the agency's responsibilities for providing transportation.	Documentation in client record.	Number of clients accessing medical transportation services	Number of clients	Client Files ARIES	75% of client files have documentation of policies for accessing medical transportation as explained to the client.
Screening for other transportation resources are documented, i.e., Medicaid eligible clients using DSHS Medicaid transportation program, Medicare eligible clients utilizing half fare VIA Cards, VIA Trans, etc.	Documentation in client record.	Number of clients screened	Number of clients	Client Files ARIES	75% of clients accessing Medical Transportation Services are screened for eligibility of other transportation services available.
Accommodation will be provided for related/affected individuals and/or caregivers as necessary for the benefit of the client.	Documentation in client record. Agency Policies and Procedures	Number of affected/related individuals accessing MTS	Number of clients	Client Files ARIES	75% of client files have documentation of accommodations made for related/affected individuals and/or caregivers for the benefit of the client.
A signed statement from client agreeing to safe and proper conduct in the vehicle is on file. This statement is to include the consequences of violating the agreement.	Documentation in client's record.	Number of signed statements	Number of clients	Client Files ARIES	75% of client files have documentation of signed statement from client agreeing to safe and proper conduct.
II. Outcomes					
Agency conveyance usage shows acuity score and qualifiers for clients accessing services. (Clients have NO other means to access their medical care.)	Documentation in client's record.	Number of acuity score and qualifiers	Number of clients	Client Files ARIES	75% of agencies with agency conveyance will have documentation of acuity scores and qualifiers for client accessing services.
"No Shows" are documented in a Transportation log and case managers are notified.	Transportation logs document no-shows and case manager notification	Number of "no-shows"	Number of clients	Client Files ARIES	75% of agencies have documentation of transportation log for "no shows" with case manager notification.
Transportation increases access and maintenance in medical care, mental health & substance abuse services.	Maintenance in medical care &/or mental health and substance abuse services documented.	Number of clients accessing medical care, mental health, substance abuse services	Number of clients	Client Files ARIES	75% of clients accessing Medical Transportation Services have increase in access to medical care, mental health, and substance abuse services.

MENTAL HEALTH SERVICES

DEFINITION:

Mental Health Services include outpatient psychological and psychiatric treatment and counseling services offered to individuals with a diagnosed mental illness, conducted in a group or individual setting, based on a detailed treatment plan, and provided by a mental health professional licensed or authorized within the State to render such services. This typically includes psychiatrists, psychologists, and licensed clinical social workers.

SERVICES:

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

Outpatient mental health services include:

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

General outpatient mental health therapy, counseling and short-term (based on mental health professionals judgement) bereavement support is available for non-HIV infected family members or significant others.

All mental health interventions must be based on proven clinical methods and in accordance with legal and ethical standards.

PERSONNEL:

Staff Qualification	Expected Practice
All staff providing direct mental health services to clients must be licensed and qualified within the laws of the State of Texas to provide mental health services in one of the following professions: a. Licensed Clinical Social Worker b. Licensed Master Social Worker (LMSW) who is employed by or volunteer for an agency not owned in total or part by the LMSW and who is under a clinical supervision plan c. Marriage and family therapist d. Licensed professional counselor e. Psychologist f. Psychiatrist g. Psychiatric nurse h. Psychotherapist i. Counselor in Training (CIT) supervised by an appropriate licensed/certified professional	Current License/Certification will be maintained on file. Personnel records/resumes/applications for employment reflect requisite experience/education. Documentation of supervision during client interaction with Counselors In Training (CIT) or Interns as required by the Texas Department of State Health Services (DSHS).
At least two years of experience in HIV or another catastrophic illness preferred.	Documentation of experience on file.
A mental health supervisor must be a licensed clinical mental health practitioner.	Current License/Certification will be maintained on file.
Provider shall have an established, detailed staff orientation process. Orientation must be provided to all staff providing direct services to patients within thirty (30) working days of employment, including at a minimum: a. Crisis intervention procedures b. Standards of Care c. Confidentiality d. Documentation in case records (ARIES training) e. Consumer Rights and Responsibilities f. Consumer abuse and neglect reporting policies and procedures g. Professional Ethics h. Emergency and safety procedures i. Data Management and record keeping j. Review of job description k. Occupational Safety and Health Administration (OSHA) regulations pertaining to substance abuse in the workplace, and l. The Americans With Disabilities Act As Amended (ADAAA)	Personnel record reflects completion of orientation and signed job description. Contract providers will provide documentation of receiving such training.
Staff participating in the direct provision of services to patients must satisfactorily complete all appropriate CEUs based on individual licensure	Documentation on file.

requirements at a minimum, as per the license requirement for each licensed mental health practitioner.	
Each mental health service provider must have and implement a written plan for regular supervision of all licensed staff. Notes of weekly supervisory conferences shall be maintained for such staff. Staff subject to formal supervision must be evaluated at least annually by their supervisor according to written provider policy on performance appraisals.	Agency has written plan of supervision. Supervisors' files reflect notes of weekly supervisory conferences. Personnel files contain annual performance evaluations.

QUALITY MANAGEMENT:

Program outcome: 75% of clients with mental health concerns will show maintenance in mental health functioning from baseline assessment at care entry.

Indicators:

- Number of clients attending Mental Health Services who are engaged in treatment.*
- Number of clients who have addressed at least 2 treatment goals.

**Engaged =individual invested in treatment and attends a minimum of 50% of mental health appointments.*

Service Unit(s): Face to face individual level Mental Health visit and/or face to face group level Mental Health visit in ARIES

Standard of Care	***Outcome Measure***	***Numerator***	***Denominator***	***Data Source***	***Goal/Benchmark***
I. Process					
An appointment will be scheduled within three (3) working days of a client's request for mental health services. In emergency circumstances, an appointment will be scheduled within twenty-four (24) hours. If service cannot be provided within these time frames, the Agency will offer to refer the client to another organization that can provide the requested services in a timelier manner.	Documentation in patient's file.	Number of days documented between client request and appt.	Number of clients	Client Files ARIES	75% of clients will have an appointment scheduled within three working days of request for mental health services.

A comprehensive assessment including the following will be completed within 10 days of intake or no later than and prior to the third counseling session: • Presenting Problem • Developmental/Social history • Social support and family relationships • Medical history • Substance abuse history • Psychiatric history • Complete mental status evaluation (including appearance and behavior, talk, mood, self attitude, suicidal tendencies, perceptual disturbances, obsessions/compulsions, phobias, panic attacks) • Cognitive assessment (level of consciousness, orientation, memory and language) • Psychosocial history (Education and training, employment, Military service, Legal history, Family history and constellation, Physical, emotional and/or sexual abuse history, Sexual and relationship history and status, Leisure and recreational activities, General psychological functioning). • Estimated end date or rationale for continuation with note of frequency of intervention plan.	Documentation in client record, which must include DSM-IV diagnosis or diagnoses, utilizing at least Axis I.	Number of new client charts with assessment completed within 10 days of intake	Number of new clients	Client Files ARIES	75% of new client charts have documented comprehensive assessments completed within 10 days of intake.
A treatment plan shall be completed within 30 days that is specific to individual client needs. The treatment plan shall be prepared and documented for each	Documentation in client's file.	Number of client charts with treatment plans within 30 days of first visit	Number of clients	Client Files ARIES	75% of client charts will have documentation of a treatment plan within 30 days of first visit.

client. Individual, and family case records will include documentation of the following: • Eligibility • Psychosocial assessment • Goals and objectives • Progress notes • Referrals • Discharge summary • Suggested number of sessions • Anticipated start and end date					
Progress notes are completed for every professional counseling session and must include: • Client name • Session date • Observations • Focus of session • Interventions • Assessment • Duration of session • Counselor authentication, in accordance with current Joint Commission on Accreditation of Healthcare Organization (JCAHO) standards (www.jcaho.org).	Legible, signed and dated documentation in client record.	Number of client charts with progress notes	Number of clients	Client Files ARIES	75% of client charts will have documented legible, signed and dated progress notes.
Discharge planning is done with each client after 30 days without client contact or when treatment goals are met: • Circumstances of discharge • Summary of needs at admission • Summary of services provided • Goals completed during counseling • Discharge plan • Counselor authentication, in accordance with current JCAHO standards	Documentation in client's record.	Number of discharged clients	Number of clients	Client Files ARIES	75% of client charts have documentation of discharge planning within 30 days of treatment goals being met or no client contact.
Clients accessing Psychiatric care	Clients are assessed for	Number of psychiatric	Number of	Client Files	75% of clients accessing psychiatric care

are medically adherent and are engaged in their psychiatric treatment plans.	psychiatric care and when engaged in psychiatric care, are medically adherent.	clients	clients	ARIES Agency Policy and Procedure Manual	are medically adherent and are engaged in their psychiatric treatment plans.
II. Outcomes					
Access to and maintenance in Medical Care: RW clients' ongoing participation in primary HIV medical care	Each client is assessed and verified for engagement in HIV medical care and assisted with establishing linkages to care if not currently receiving care. Assessed initially, then re-assessed and documented every 3 months.	Number of clients assessed/verified for medical care initially and every 3 months	Number of clients	Client Files ARIES	75% of clients are assessed and verified for engagement in medical care. This is assessed initially, then re-assessed and documented every 3 months.

NON-MEDICAL CASE MANAGEMENT

DEFINITION:

Non-Medical Case Management includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services.

Non-medical case management does **not** involve coordination and follow-up of medical treatments, as medical case management does.

SERVICES:

Non-Medical Case Management is a collaborative process that assesses, educates, plans, implements, coordinates, monitors, evaluates and documents the options and services required to meet the client's health and human service needs. Case Management is seen as an encounter that involves assessment and care planning with the goal of independence for the client.

Due to the episodic nature of HIV, it is expected that clients will have varying levels of need throughout their enrollment in services. Some clients may demonstrate a low level of need and would therefore benefit from *non-Medical Case Management*. Distinct case management categories are described in detail under separate sections (See description for Medical Case Management Services).

Enrollment in either medical case management services (active) or non-medical case management (direct services only) is not permanent; a client may move from one type of case management to the other depending on current circumstances. On-going and frequent assessment by a non-medical case manager and a medical case management supervisor should occur to ensure that clients receive the level of care that is appropriate. Routine screening tools and acuity scales should be used consistently by all case management providers, as mandated by the Bexar County Department of Community Resources and proven to incorporate standardized components.

Key activities of non-medical case management include, but are not limited to:

a. Providing information and assistance with linkage to medical case management and psycho-social services as needed
b. Advocating on behalf of clients to decrease service gaps and remove barriers to services
c. Helping and empowering clients to develop and utilize independent living skills and strategies
d. Providing unbiased and ethical services
e. Benefits and entitlements counseling, with respect to the Affordable Care Act
f. Helping clients with applications for all other resources available for their service needs
g. Transitional case management for incarcerated persons as they prepare to exit the correctional system.

Case management services are home and community-based. Case managers will encounter clients in their environment, which may include a residence, a public facility, in the streets, or in the facilities of the Case Management service provider agency. Case management shall provide for a face-to-face or phone contact, and a home visit, as determined by client need.

Clients with a lower level of need, requiring only the direct services offered or referred by the agency (e.g., rental assistance and monthly medication refills) would benefit from *Non-medical Case Management.*

Case Management (Non-Medical) Objectives

To accomplish the goal of case management services, each agency will:

a. Ensure agency staff who provide direct services to clients are properly trained in case management;
b. Hire case managers who meet the qualifications described in the agency case management job description;
c. Ensure the availability of the case manager(s) to attend required meetings;
d. Provide opportunities for required training and ongoing education;
e. Maintain agency policies and procedures regarding confidentiality, client consent, grievance procedures and client rights;
f. Assure that services are delivered in a culturally competent manner with special attention given to ensure accommodation of individuals with special needs;
g. Ensure that services are rendered in a timely and appropriate manner;
h. Ensure that the Standards of Care (SOC) are upheld; and
i. Provide ongoing supervision and support to each case manager.

PERSONNEL:

Staff Qualification	Expected Practice
Minimum qualifications for Part A and Part B Providers: All case managers will meet the qualifications for the position as outlined in the Agency's job description. The minimum requirements are: a. A minimum of an Associate's Degree from an accredited college or university or equivalent (in education or experience); **and** b. A minimum of one year paid work experience with persons with HIV/AIDS or other catastrophic illness **preferred**; **and/or** c. State or National certification from a recognized state/national certification organization and/or licensing organization **preferred** (i.e. LBSW, LMSW, LCSW, LPC, LMFT, LCDC, etc,); **or** d. Case managers employed prior to March 1, 2009 and who did not meet the minimum qualifications listed above may be granted a waiver from these qualifications by the Administrative Agency; **and** e. Knowledge and training in assessment of needs, formulation of care plans, monitoring of care plans and evaluation of case pro files; **and**	Personnel files/resumes/applications for employment reflect requisite experience and education.

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

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

QUALITY MANAGEMENT:

Program outcome:

- The provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed supportive services.

Indicators: Number of self-sufficient clients

Service Unit(s): Face to face visit or phone conversation with client(s) documented in ARIES

Standard of Care	*Outcome Measure*	*Numerator*	*Denominator*	*Data Source*	*Goal/Benchmark*
I. Structure					
The objectives of the enrollment process are: ➢ Inform the client of: • all services available AND • all Ryan White funded case management agencies in the area • what client can expect if s/he	Documentation in client's chart and in ARIES.	Number of clients with acuity score	Number of clients	ARIES Client charts	75% of all clients will have a signed acknowledgement form of services available and have acuity score in ARIES.

enrolls in case management services; ➢ Establish client eligibility for services; ➢ Establish acuity score using scale to determine needs of client; ➢ Collect required state/federal client data for reporting purposes; ➢ Completion of a complete AIDS Regional Information Evaluation System (ARIES) Intake.					
Funded Non-Medical Case Management agencies must be able to: ➢ Make initial contact with client and/or referring agent within five (5) working days of receiving request for services. ➢ Provide enrollment within ten (10) working days of initial contact; ➢ Schedule an appointment at the client's convenience; ➢ Refer the client to another agency in the event of a waiting list or any capacity constraints prohibiting an agency from serving a client immediately.	Agency policy and procedures reflect the availability of walk-in services. Documented referral kept on file at the agency.	Number of client contacts	Number of clients	ARIES Client charts	75% of all agencies funded for Non-Medical Case Management will show a 10 working day enrollment process period.
II. Process					
Within ten (10) working days of enrollment, an **intake** shall be completed to evaluate the client's needs and will be reassessed annually.	Documentation of intake will include: • Medical history and current health/primary care status • Available financial resources (including insurance status) with emphasis on Medicaid, THMP, SSI and other resources. • Availability of food, shelter, and transportation • Available support system • Need for legal assistance • Substance abuse history and status • Emotional/mental health history and status	Number of clients enrolled	Number of clients	ARIES and/or client charts	75% of all clients enrolled in non-medical case management will have a completed intake within 10 working days of enrollment and will be reassessed annually.

After completion of intake, results shall be reviewed and analyzed by a case management supervisor and/or multi-disciplinary team to determine appropriate level of case management services.	Client chart contains documentation of review and case assignment by supervisor or multi-disciplinary team.	Number of clients enrolled	Number of clients	Client charts	75% of all clients enrolled with complete intake shall have documentation of a supervisor review for appropriateness.
A client should be discharged from case management services through a systematic process that includes a discharge or case closure note in the client's record. The discharge/case closure note will include a reason for the discharge/closure and a transition plan to other services or other provider agencies, if applicable. If client does not agree with the reason for discharge, s/he should be informed again of the provider agency's grievance procedure. A client may be discharged from HIV case management services for the following reasons: a. death; b. at the request of the client (client no longer needs or desires services); c. if a client's actions put the agency, case manager, or other clients at risk of harm or danger; d. if client moves out of the service area; an attempt should be made to connect client to services in the new service area; or; e. if after repeated and documented attempts, a case manager is unable to reach a client for a period of six (6) months. This criterion recognizes that some clients require only minimal services, such as information and referral; thus, may be having only periodic contact with the case manager. Ideally case managers should check in with their clients monthly as determined by client need, but at a minimum of every three (3) months.	Documentation of discharge in client chart.	Number of clients discharged.	Number of clients	ARIES and/or client chart	75% of all clients discharged from non-medical case management will have documentation in chart with reasons for discharge.
In all cases, case managers shall ensure that,	Documentation in client's	Number of clients	Number of	Client chart	75% of all clients transitioning from

to the greatest extent possible, clients who leave care are linked with appropriate services to meet their needs. For example, if a client were moving to another area, the case manager would ideally refer the client to an appropriate provider in that area; or if the client has to be discharged from services, the case manager may, as is appropriate to the circumstance, provide the client with a list of alternative resources.	record indicating referrals or transition plan to other providers/agencies.	transitioning.	clients	and/or ARIES	case management care are linked with appropriate services to meet their needs.

ORAL HEALTH CARE

DEFINITION:

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

SERVICES:

- Services will include routine dental examinations, prophylaxis, x-rays, fillings, endodontistry, prosthodontics, and basic oral surgery (simple extractions) and will be capped at $3000.00 per unduplicated client per calendar year.
- Emergency procedures will be treated on a walk-in basis as availability and provisions allow. All emergency costs will be added to the client's maximum allowable benefit. Funded Oral Health Care providers are permitted to provide necessary emergency care regardless of a client's annual benefit balance. Further non-emergency procedures will not be allowed once the cap has been reached. If provider cannot provide adequate services for emergency care, the patient will be referred to a hospital emergency room.
- Cosmetic dentistry for cosmetic purposes only is prohibited.

PERSONNEL:

Staff Qualification	Expected Practice
Dentists must be licensed and accredited as specified by the Texas State Board of Dental Examiners (TSBDE).	Personnel files/resumes/applications for employment reflect requisite licensing and accreditation.
Dental hygienists must be licensed and accredited as specified by the TSBDE.	Personnel files/resumes/applications for employment reflect requisite licensing and accreditation.
Dental assistants must register with the TSBDE within one year if they administer x-rays.	Personnel files/resumes/applications for employment reflect requisite SBDE registration.
Staff Vaccinations: a. Hepatitis B required as defined by the Texas State Department of Health Services (DSHS) b. Tuberculosis tests at least every 12 months for all staff is strongly recommended c. OSHA guidelines must be met to ensure staff and patient safety	Staff health records will be maintained at each agency to ensure that all vaccinations are obtained and precautions are met.
Service providers shall employ staff (i.e., receptionists, schedulers, file clerks, etc.) who are knowledgeable and experienced regarding their area of practice as	Agency will maintain documentation of unconditional staff certification and licensure in their particular area of practice, and will monitor the activities of

well as in the area of HIV/AIDS. All staff without direct experience with HIV/AIDS shall be supervised by one who has such experience.	staff to ensure that only qualified employees administer services.
Dental hygienists and assistants must perform all services to patients under supervision of a licensed dentist.	Copy of supervising dentist license on file.
Provider/Agency shall be accredited and/or licensed to deliver dental services.	Documentation of current unconditional license and/or certification is on file for each provider and for organization as a whole, where applicable.

QUALITY MANAGEMENT:

Program outcome:

- 75% of clients in Oral Health Care will show decrease in the number of caries
- 50% of clients with Phase 1[5] treatment plans completed within first 12 months of initial exam

Indicators:

- Number of clients enrolled in Oral Health Care
- Number of clients with completed Phase 1 of treatment plan

Service Unit(s): Face to face clinic visit in ARIES

Standard of Care	***Outcome Measure***	***Numerator***	***Denominator***	***Data Source***	***Goal/Benchmark***
I. Process					
Provider obtains and documents HIV primary care provider contact information for each patient.	Documentation of HIV primary care provider information in the patient's chart/file. At minimum, provider should obtain the clinic and/or physician's name and telephone number.	Number of clients with documented primary care provider in chart	Number of clients	Client Files ARIES	75% of client charts have documentation of HIV primary care provider contact information.
Provider collects and documents health history information for each patient once per measurement year with updates as medically appropriate prior to providing care. This information	Documentation of health history information in patient's chart/file. Reasons for missing health history information are documented.	Number of clients with health history	Number of clients	Client Files ARIES	75% of client charts have documentation of health history information once per measurement year, with updates as medically appropriate.

[5] Phase I treatment plans: prevention, maintenance and/or elimination of oral pathology that results from dental caries or periodontal disease. This includes: restorative treatment; basic periodontal therapy (non-surgical); basic oral surgery that includes simple extractions and biopsy; non-surgical endodontic therapy; and space maintenance and tooth eruption guidance for transitional dentition.

should include, but not be limited to, the following: • A baseline current (within the last 6 months) CBC laboratory test results for all new patients and an annual update thereafter; • Current (within the last 6 months) Viral Load and CD4 laboratory test results, when medically necessary; • Patient's chief complaint, when necessary; • Current Medications; • Sexually transmitted diseases; • HIV-associated illnesses; • Allergies and drug-sensitivities; • Alcohol use; • Recreational drug use; • Tobacco use; • Neurological diseases; • Hepatitis; • Usual oral hygiene; • Date of last dental examination; • Involuntary weight loss					
Patient must have an Initial comprehensive oral exam (ADA code D0150) and then periodic recall (ADA code D0120) oral evaluation at least twice each year to check any oral manifestations: linear gingival erythema (LGE) and necrotizing ulcerative periodontitis (NUP).	Documentation in patient chart/file of rate of oral manifestations: LGE and NUP.	Number of clients with initial comprehensive oral exam and periodic recall oral examinations	Number of clients	Client Files ARIES	75% of client charts have documentation of initial comprehensive oral exam and then periodic recall oral evaluations at least twice each year.
A comprehensive, multi-disciplinary Oral Health treatment plan will be developed in conjunction with the patient within 12 months of initial intake. This information should	Treatment plan dated and signed by both provider and patient in patient chart/file. Updated treatment plan dated and signed by both provider	Number of clients with treatment plans signed and dated Number of clients with updated treatment plans	Number of clients Number of clients	Client Files ARIES	75% of client charts have documentation of treatment plans signed and dated. 75% of client charts have documentation of updated treatment plans signed and

include, but not limited to: • Patient's primary reason for dental visit; • Patient strengths and limitations will be considered in development of treatment plan; • Treatment priority should be given to pain management, infection, traumatic injury or other emergency conditions. Treatment plan will be updated every six (6) months.	and patient in patient's chart/file.	signed and dated every six (6) months			dated every six (6) months.
The following elements are part of each patient's initial comprehensive oral and semi-annual exam hard/soft tissue examination: • Charting of caries; • X-rays; • Periodontal screening; • Written diagnoses, where applicable; • Treatment plan.	Documentation in patient's file/chart. Review of Agency's Policy and Procedures.	Number of clients with comprehensive oral and semi-annual exam hard/soft tissue	Number of clients	Client Files ARIES	75% of client charts have documentation of initial comprehensive oral and semi-annual exam hard/soft tissue examination as indicated.
Provider must provide patient oral health education once each year which includes the following: Caries prevention: • Fluoride (ADA code D1310) • Nutritional (ADA code D1310 • Smoking/tobacco cessation counseling (ADA code D1320), as indicated. Oral hygiene instructions (OHI) should be provided to each patient (ADA code 1330).	Documentation in patient's chart/file of rate of dental disease and oral pathology. Documentation in patient's chart/file of rate of smoking/tobacco cessation. Documentation of content of oral hygiene instructions in patient's chart/file.	Number of clients with documented general oral health education Number of clients with documented education on smoking/tobacco cessation Number of clients with documented education of oral hygiene instructions	Number of clients Number of clients Number of clients	Client Files ARIES	75% of client charts have documented general oral health education provided. 75% of client charts, when applicable, have documentation of smoking/tobacco cessation education provided. 75% of client charts have documented education provided on oral hygiene instructions.
II. Outcomes					
Clients with HIV infection will	Documentation of oral exam by	Number of clients with	Number of	Client Files	50% of clients with HIV infection receive

receive an oral exam by a dentist at least once during the grant year.	dentist in client file.	oral exams	clients	ARIES	an oral exam by a dentist at least once during the grant year.
HIV-infected oral health patients[6] who had a periodontal screen or examination[7] at least once in the grant year.	Documentation of periodontal screen or examination in client file	Number of clients with periodontal screen or examination	Number of clients	Client Files ARIES	50% of HIV-infected oral health patients have a periodontal screen or examination at least once in the grant year.
HIV-infected oral health patients with a Phase 1 treatment plan that is completed within 12 months.	Documentation of Phase 1 treatment plan in client file.	Number of clients that completed Phase 1 treatment within 12 months of establishing a treatment plan	Number of clients with a Phase 1 treatment plan established in the year prior to the grant year.	Client Files ARIES	50% of HIV-infected oral health patients have documentation of Phase 1 treatment plan completed within 12 months of establishing treatment plan.

[6] "Patient" includes all patients aged 13 year or older.

[7] A periodontal screen should 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 "the evaluation of periodontal conditions, probing and charting, evaluation and recording of the patient's dental caries, missing or unerupted teeth, restorations, occlusal relationships and oral cancer evaluation" (Source: American Dental Association. Current Dental Terminology: CDT 2009-2010.) The screening or examination may be performed and documented by either a licensed dentist or, where state regulations allow, by a dental hygienist, but the interpretation of data and diagnosis must be made by a licensed dentist.

OUTPATIENT/AMBULATORY HEALTH SERVICES

DEFINITION:

Outpatient/Ambulatory Health Service is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight.

LIMITATIONS:

Services provided in emergency rooms, hospitals, urgent care/minor emergency clinics, or any other types of inpatient settings are not allowable.

SERVICES:

Services includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, treatment adherence, and referral to and provision of specialty care (includes all medical subspecialties).

Diagnostic Laboratory Testing includes all laboratory tests integral to the treatment of HIV infection and related complications.

Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.

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

Office-based or clinic-based medical care given to HIV+ individuals in an outpatient setting by or under the direction of a licensed physician, physician assistant, nurse practitioner or registered nurse. Services focus on appropriate medical intervention, continuous health care and/or chronic disease care over time as the patient's condition progresses.

PERSONNEL:

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

QUALITY MANAGEMENT:

Program outcome:

- 75% of clients will show reduced rate of progression of AIDS at 6 and 12 months.
- Services address client goals (self-managed protocol)

Indicators:

- The number of clients with CD4 counts <200 on ARVs.
- The number of clients with viral load (HIV RNA) <5000 copies/ml if eligible for antiretroviral therapy according to current national treatment guidelines.
- The number of clients with no additional new AIDS-defining condition (OI or CD4<200).
- The number of clients that achieve viral suppression, i.e. <200 copies/ml.
- The number of clients in the Ryan White delivery system with an AIDS diagnosis at entry.

Service Unit(s): Face to Face Clinic Visit in ARIES

AOMC Standard of Care	*Outcome Measure*	*Numerator*	*Denominator*	*Data Source*	*Goal/Benchmark*
Service providers shall have an established quality assurance/performance improvement plan.	Quality Assurance/Performance Improvement Plan on record with met or exceeding performance goals on at least 2 “process of care” measures annually.	Number of care process measures in which goal is met or exceeded.	Number of process measures tracked under quality improvement activities during	Chart audit report (can be all HIV clients, not just Part A	2 or more measures where performance meets or exceeds service provider(s) set targets.

			the year.	funded)	
All HIV infected patients receiving medical care shall have an initial comprehensive medical evaluation/assessment and physical examination. The comprehensive assessment/evaluation will be completed by the MD, NP or PA in accordance with professional and established HIV practice guidelines (https://aidsinfo.nih.gov/guidelines) within 4 weeks of initial contact with the patient. Treatment shall be offered and delivered according to most recent United States Public Health Service (USPHS) guidelines for the treatment of people with HIV/AIDS.	Clients have CD4 counts and HIV viral loads monitored every 3-6 months. Clients will receive a health assessment and comprehensive physical exam including a mental health assessment that includes screening for clinical depression and a substance use/abuse history. All newly diagnosed clients will receive an HIV drug resistance test. Clients who meet current guidelines for ART are offered and/or prescribed ART. Clients will have at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between the first medical visit in the prior 6-month period and the last medical visit in the subsequent 6-month period. Clients with a CD4 count below 200 who are recommended and/or prescribed PCP prophylaxis.	Number of clients with CD4 counts and viral loads every 3-6 months. Number of clients with assessment and physical exam. Number of clients offered and/or prescribed ART. Number of clients with medical visits every 3-6 months. Number of clients with CD4 counts <200 who are recommended and/or prescribed PCP prophylaxis.	Number of clients. Number of clients. Number of clients who meet guidelines. Number of clients. Number of clients with CD4 counts <200.	ARIES or chart audits.	75% of clients have 2 or more CD4 counts and HIV viral loads annually. 75% of clients will receive a health assessment and comprehensive physical exam including a mental health assessment that includes screening for clinical depression and a substance use/abuse history. 75% of newly diagnosed clients will receive an HIV drug resistance test. 100% of clients who meet current guidelines for ART are offered and/or prescribed ART. 75% of clients will have at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between the first medical visit in the prior 6-month period and the last medical visit in the subsequent 6-month period. 100% of clients with a CD4 count below 200 who are recommended and/or prescribed PCP prophylaxis.
Basic laboratory tests are ordered per USPHS guidelines. http://www.cdc.gov/hiv/pdf/hivtestingalgorithmrecommendation-final.pdf	Clients' medical record document the following screenings: Clients on ART receive lipid screens annually;	Number of clients on ART with annual	Number of clients on ART; Number of clients;	ARIES or chart audits.	75% of clients on ART receive lipid screens

		lipid screen;			annually.
	Clients receive syphilis screens annually;	Number of clients with annual syphilis screen;	Number of clients;		75% of clients receive syphilis screens annually.
	Clients receive Chlamydia screening annually;	Number of clients with annual Chlamydia screening;	Number of clients;		75% of clients receive Chlamydia screens annually.
	Clients receive gonorrhea screening annually;	Number of clients with annual gonorrhea screening;	Number of clients needing hepatitis screens as indicated;		75% of clients receive gonorrhea screens annually.
	Clients receive hepatitis A, B & C screens if not immune and then annually for high-risk individuals;	Number of clients with hepatitis screens as indicated;	Number of clients;		75% of clients receive hepatitis A, B & C screens if not immune and then annually for high-risk individuals.
	Clients receive a TB screen at initial HIV diagnosis, then annually for high-risk individuals, as determined by their medical provider.	Number of clients with annual TB screen;	Number of female clients.		75% of clients receive TB screens at least once since diagnosis.
	Female clients receive pap smears annually.	Number of female clients with annual pap.			60% of female clients receive pap smears annually.
A hepatitis C (HCV) protocol is in place for clients testing positive for hepatitis C.	All clients with hepatitis C will be evaluated or referred for evaluation of treatment suitability.	Number of hepatitis C clients evaluated for treatment.	Number of clients with hepatitis C.	Client charts.	75% of clients will have a document evaluation or referral for treatment suitability.
Clients are offered immunizations or have documentation of decline of immunizations.	Documentation that clients receive vaccinations according to current standards (or document decline): • Influenza • Pneumococcal as appropriate	Number of clients with influenza vaccine. Number of clients	Number of clients. Number of clients needing pnemo.	ARIES or client charts.	75% of clients receive vaccinations according to current standards (or document decline): • Influenza

	• Completion of hepatitis A vaccines series, unless otherwise documented as immune. • Completion of hepatitis B vaccines series, unless otherwise documented as immune. • Tetanus • HPV as appropriate	with pneumococcal vaccine. Number of clients with hepatitis A vaccine series completed. Number of clients with hepatitis B vaccine series completed. Number of clients with tetanus vaccine. Number of clients with HPV vaccine.	vaccine. Number of clients. Number of clients. Number of clients. Number of clients needing HPV vaccine.		• Pneumococcal as appropriate • Completion of hepatitis A vaccine series, unless otherwise documented as immune. • Completion of hepatitis B vaccines series, unless otherwise documented as immune. • Tetanus • HPV as appropriate
Assessment of treatment adherence and counseling, which adhere to current USPHS guidelines.	Documentation that clients' are assessed for treatment adherence and counseling at a minimum of twice a year. If adherence issue is identified, follow-up action is documented. Documentation of missed clients appointments and efforts to bring the client into care.	Number of clients on ART with treatment assessment minimum of twice a year. Number of clients with adherence issues have follow-up. Number of charts with documented missed appts and efforts to bring clients into care.	Number of clients on ART. Number of clients with adherence issues. Number of clients with missed appts.	Client charts	75% of charts with assessment of treatment adherence documented at a minimum of twice a year. 75% of charts document follow-up action if adherence issue is identified. 75% of charts document missed client appointments and efforts to bring the client into care.
Clients are assessed for risk behaviors and receive risk reduction counseling to reduce secondary transmission of HIV.	Charts document a risk behavior assessment and clients receive risk reduction counseling.	Number of clients with risk reduction counseling.	Number of clients.	Client charts	75% of charts document a risk behavior assessment and clients receive risk reduction counseling.
Clients are screened and receive tobacco	Charts document screening for	Number of clients	Number of clients.	Client charts	75% of clients are screened

cessation counseling annually (or document decline of tobacco use).	tobacco use and cessation counseling (or document decline).	with tobacco cessation counseling.			and receive tobacco cessation counseling annually (or document decline of tobacco use).
Clients receive referrals for Oral Health Care annually.	Client charts document referrals for a dental oral exam annually.	Number of clients with dental referral.	Number of clients.	Client charts and/or ARIES	75% of client charts document referrals for a dental oral exam annually.

OUTREACH SERVICES

DEFINITION:

Outreach Services are programs that have as their principal purpose identification of people with unknown HIV disease or those who know their status so that they may become aware of, and may be enrolled in care and treatment services (i.e., case finding), not HIV counseling and testing nor HIV prevention education. These services may target high-risk communities or individuals. Outreach programs must be planned and delivered in coordination with local HIV prevention outreach programs to avoid duplication of effort; Be targeted to populations known through local epidemiologic data to be at disproportionate risk for HIV infection; Be conducted at times and in places where there is a high probability that individuals with HIV infection will be reached; And be designed with quantified program reporting that will accommodate local effectiveness evaluation.

SERVICES:

Outreach services are intended to identify individuals who know their status or those of unknown status so that they may become aware of the availability of Part A services and access care and treatment.

Activities must be planned and delivered in coordination with State and local HIV prevention outreach activities to avoid duplication of effort and to address a specific service need category identified through State and local needs assessment processes.

Individual outreach is defined as activities aimed at locating individuals who are aware of their HIV status so that they may be successfully linked into Primary Medical Care. Individuals who are not aware of their HIV status should be linked to Early Intervention Services (EIS) or a collaborative prevention program. Activities should be conducted in such a manner as to reach those known to have delayed seeking care.

Outreach services may include both case finding and consumer recruitment through street outreach. Street outreach activities should be designed to find individuals who are at high risk of HIV and to refer those individuals into care and treatment services (such as Early Intervention Services (EIS), Primary Medical Care (PMC) and Medical Case Management (MCM). Case finding activities should also be targeted to reach populations known to be at disproportionate risk for HIV infection, as demonstrated through local epidemiologic data.

Outreach services should be continually reviewed and evaluated in order to maximize the probability of reaching individuals who know their HIV status but are not actively in treatment. Quantified program reporting is required to assist local planning and evaluation efforts. Broad activities that market the availability of health-care services for People Living with HIV (PLWH) are not considered appropriate Part A outreach services. HIV prevention education, counseling and testing are not allowable activities under this service category. Outreach providers are required to collaborate with State and local prevention programs.

PERSONNEL:

Staff Qualification	Expected Practice
Service providers will employ staff that are knowledgeable and experienced regarding HIV outreach and the HIV continuum of care (i.e. care and clinical resources). Staff and volunteers who provide outreach services shall possess the following: • Knowledge about and experience working with underserved populations; • Knowledge of and ability to effectively utilize interviewing, assessment and presentation skills and techniques in working with a wide variety of people; • Knowledge of community resources available to eligible persons so that appropriate effective referrals can be made; and • The skills and experience necessary to work with a variety of HIV/AIDS service providers, including other outreach workers, case managers and interdisciplinary personnel and consumers who are culturally and linguistically diverse.	Documentation of experience in HIV outreach and knowledge of continuum of care in employee's file.
Training in HIV outreach and counseling is required for all staff funded under this initiative. Service providers shall provide its staff and volunteers the following training programs or opportunities: Initial in-service training for new staff and volunteers will include the following subjects: • Standard precautions • Substance abuse and treatment • Mental health issues • Domestic violence • Clinical trials/protocols/vaccines • Tuberculosis • Sexually transmitted diseases • Partner notification • Bereavement • Nutrition • Housing Services • Suicide • Adolescent health issues • Communication • Opportunistic infections	Documentation of completion of in-service trainings on all subjects in personnel file or training log. Documentation of continuum of care and referral training in personnel file or training log. Documentation of safety protocol training in personnel file or training log.

• Commercial sex workers • Incarcerated/recently released • Gay/lesbian/bisexual/transgender concerns • Other related topics Training regarding the continuum of care for HIV+ persons in the TGA or HSDA, including the process of referring a client to a medical intake site; Safety protocols for staff and volunteers governing the manner in which outreach services will be provided	
Ongoing training for staff must be provided to appropriate staff to maintain current knowledge about outreach, including information about advances in medical care and treatment of individuals living with HIV or AIDS.	Documentation of ongoing training in personnel file or training log.
Supervisor(s) of outreach workers shall have, at a minimum, at least two (2) years of experience conducting HIV-related outreach activities with potential clients. In the absence of a supervisor, such as may be the case with a small service provider, the service provider shall have in place a collaborative agreement with another service provider to provide access to outreach training and supervision.	Documentation of supervisory experience in personnel file, or in the alternative, documentation of collaborative agreement with another service provider to provide outreach training and supervision.
Each outreach supervisor and worker shall hold a valid Texas driver's license and proof of liability insurance, if needed, to carry out work responsibilities.	Copy of current driver's license and insurance policy in employee file.

QUALITY MANAGEMENT:

Program outcome: 75% of clients who are new and/or have fallen out of care will be successfully enrolled into Primary Medical Care reported on a semi-annual basis

Indicators:

- Number of encounters with detail if newly diagnosed or fallen out of care, duration out of care, exposure category, gender and race/ethnicity
- Number of referrals to Primary Medical Care
- Number of clients retained in Primary Medical Care that have 2 Primary Medical Care visits within first year following Outreach

Service Unit(s): Successfully completed enrollment into Primary Medical Care via encounters, contact, and referrals in ARIES

Standard of Care	*Outcome Measure*	*Numerator*	*Denominator*	*Data Source*	*Goal/Benchmark*
I. Process					
The Service Provider shall: • Operate its outreach program under a structured referral process, ensuring that contacts are referred to early intervention programs or other designated intake sites; • Be flexible regarding the hours during which outreach activities are conducted to ensure that appropriate and effective contacts are most likely to be made; and • Review the nature and purpose of each referral.	Documentation of referrals in Client's file and ARIES. Posting of hours or operation on premises. Written documentation of contacts, referrals and follow-ups in client file.	Number of referrals to providers	Number of clients	Client Files ARIES	75% of client files have documentation of written referrals to HIV service providers and primary medical care.
The Service Provider shall: • Maintain written documentation of all outreach contacts and referrals that are made and any follow-up with outreach contacts that were conducted; • Regularly follow up and collaborate with service providers to whom outreach contacts were referred to determine whether the contacts accessed medical care and/or other services to ensure that they continue receiving said services and to avoid duplication and to prevent client abuse of the care system; • Maintain written documentation of each follow up and the results thereof; and • Plan and deliver outreach	Documentation of coordinated outreach activities in client's file.	Number of coordinated outreach activities	Number of clients	Client Files ARIES	75% of client files reflect documentation of coordinated outreach activities as indicated.

services in coordination with state and local HIV prevention outreach activities.					
II. Outcomes					
Re-engage those who have fallen out of care or erratically in care into primary care Enroll PLWHA in support services.	Primary Care appointments are made within 24 hours of outreach engagement. Case Management appointment made if client does not have a CM or has not seen one in 6 months. Appt made w/in 24 hrs. Mental Health appointment made within 24 hours of outreach engagement. Substance Abuse treatment arrangements made within 24 hours of outreach engagement if client desires	Number of Primary Care appointments made w/in 24 hours. Number of Case Management appointments made w/in 24 hours. Number of Mental Health appointments made w/in 24 hours. Number of Substance Abuse treatment arrangements made w/in 24 hours	Number of clients needing PC appts Number of clients needing CM Number of clients needing MH care Number of clients wanting Substance Abuse treatment	Client Files ARIES	75% of Primary Care appointments are made within 24 hours1. 75% of Case Management appointments are made within 24 hours. 75% of Mental Health appointments are made within 24 hours. 75% of Substance Abuse treatment arrangements are made within 24 hours.

SUBSTANCE ABUSE OUTPTIENT CARE

DEFINITION:

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

SERVICES:

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

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

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

PERSONNEL:

Staff Qualification	Expected Practice
All staff providing direct substance abuse counseling or treatment services to clients will meet the qualifications for the position as outlined in the agency's job description and shall include the following: • Licensed by the State of Texas to provide substance abuse counseling (e.g., LPC, LCSW, LMSW, LMFT, LCDC, CDAC, licensed clinical psychologist), or a Counselor in Training (CIT) supervised by an appropriate licensed/certified professional, *AND*	Personnel files/resumes/applications for employment reflect requisite licenses, certifications, experience and training. Documentation of supervision during client interaction with Counselors In Training (CIT) or Interns as required by the Texas Department of State Health Services (DSHS).

• Two years of experience in HIV or other catastrophic illness and continuing education in HIV, *AND* • One year experience in family counseling as pertaining to substance abuse, *AND* • Non-violent crisis intervention training, *AND* • Professional liability coverage for individuals and for the agency, *AND* • At least three (3) hours annually of cultural competency training as required in the Universal Standards of Care regarding populations who have an incidence of HIV infection in the TGA (e.g., ethnic, gay/lesbian/bisexual/transgender, women, homeless, adolescents, sex trade workers, deaf/hard of hearing, drug cultures, *AND* • Training in mental health issues and knowing when to refer a client to a mental health program/counselor, *AND* • Supervision as required by licensure.	
A substance abuse treatment supervisor shall, at a minimum, be a Master's level professional (e.g., LPC, LMSW, or Licensed Clinical Psychologist) licensed by the State of Texas and qualified to provide supervision per applicable licensing rules.	Proof of licenses and certifications indicated in personnel file.
Orientation shall be provided to all staff within ten (10) working days of employment, including at a minimum: • Crisis intervention procedures • DSHS Administrative Code for Substance Abuse • Standards of Care • Confidentiality • Documentation in case records (ARIES training) • Consumer Rights and Responsibilities • Consumer abuse and neglect reporting policies and procedures • Professional Ethics • Emergency and safety procedures • Data Management and record keeping • Infection Control and universal precautions • Review of job description • Occupational Safety and Health Administration (OSHA) regulations pertaining to substance abuse in the workplace, and • The Americans With Disabilities Act as Amended (ADAAA)	Orientation program educates staff on required subject matters. Personnel file reflects completion of orientation and signed job description.
Continuing education/in-service training. In accordance with DSHS and state licensing and credentialing boards, all direct care staff must satisfactorily complete the required hours in continuing education training.	Documentation to include in the employee file that reflects date of training, contents, name of trainer, topic, length of training and signature of employee.

Each substance abuse treatment provider must have and implement a written plan for regular supervision of all staff by a licensed supervisor/Qualified Credentialed Counselor (QCC) in accordance with all applicable laws and regulations.	Agency has written plan for supervision of all staff on site.
Notes of weekly supervisory conferences shall be maintained for such staff.	Supervisor's files reflect notes of weekly supervisory conferences.
Staff must be evaluated at least annually by their supervisor according to written provider policy on performance appraisals.	Personnel files contain annual performance evaluations.
The provider agency must be a licensed hospital or a licensed facility with outpatient treatment designation and must comply with the rules and standards established by DSHS' Substance Abuse Facility Licensing Group.	Documentation of current facility licensing on site.
Provider agency must be in compliance with the Americans with Disabilities Act as Amended (ADAAA) to indicate full accessibility by all clients. If not in compliance at the time of funding, agency must demonstrate a plan, including timeline, to become compliant within the funding period.	Evidence of ADAAA compliance or plan and timeline for compliance on file at provider agency.
Provider agency must have at least one person on staff with current certification in CPR and first aid on the premises at all times services are rendered (RN and MD can be substituted for first aid).	Documentation of CPR-certified staff and evidence of first aid capability at site.
Provider agency must develop and implement policies and procedures for handling crisis situations and psychiatric emergencies, which include, but are not limited to, the following: • Verbal Intervention • Non-violent physical intervention • Emergency medical contact information • Incident reporting • Voluntary and involuntary patient admission • Follow-up contacts • Continuity of services in the event of a facility emergency	Documentation of client and staff safety policies and procedures on site.

QUALITY MANAGEMENT:

Program outcome: 75% of clients enrolled in Substance Abuse Services-Outpatient who decrease substance use or maintain sobriety under treatment after accessing Substance Abuse Services-Outpatient

Indicators:

- Number of clients attending Substance Abuse services who are engaged in treatment.*
- Number of clients who have addressed at least 2 treatment goals.

**Engaged=individual invested in treatment and attends a minimum of 50% of substance abuse services appointments*

Service Unit(s):

- Treatment Visit (A visit that is not a counseling session or a dosing visit. Ex: visit for random drug screen)
- Individual Level Treatment Session (An individual visit where the Treatment Plan is discussed)
- Group Level Treatment Session (A group counseling session)
- Medication Assisted Treatment Visit (A visit where medication for substance abuse treatment is dispensed)

Standard of Care	***Outcome Measure***	***Numerator***	***Denominator***	***Data Source***	***Goal/Benchmark***
I. Structure					
Case conferences with members of the client's multi-disciplinary team shall be held as appropriate.	Client records include documentation of multi-disciplinary case conferences, as appropriate.	Number of client records with case conference documentation	Number of clients	Client Files ARIES	75% of client records have documentation of case conferences with members of the client's multi-disciplinary team.
II. Process					
An appointment will be scheduled within three (3) working days of a client requesting substance abuse treatment services. In emergency circumstances, appointments will be scheduled within one (1) working day. If services cannot be provided within these time frames, the agency will offer to refer the clients to another organization to provide the requested services in a timelier manner.	Client chart contains documentation of each item listed above.	Number of clients with appointments scheduled	Number of clients	Client Files ARIES	75% of client charts will have documentation of an appointment scheduled within three (3) working days of request for substance abuse treatment services.
The intake process will include:	Documentation of intake information in client's file	Number of clients with intakes	Number of clients	Client Files	75% of client charts will have documentation of intake process as

• Screening for substance abuse and/or dependency for alcohol and other drugs using SAMISS • Verification of Medicaid/Medicare eligibility • Client's demographic information • Client's address • Client's phone number(s)/e-mail address • Client's housing status • Client's employment and income status • Client's alcohol and drug history and current usage • Client's physical health • List of current medications • Presenting problems • Suicide and homicide assessment	and in ARIES.			ARIES	indicated.
Initial assessment protocols shall provide for screening individuals to determine level of need and appropriate service plan. The initial assessment shall include, but not be limited to, the following: • The presenting problem • Substance abuse history • Medical and psychiatric history • Treatment history • Psychological history and current status	Client's chart contains documentation of each assessment item listed and documentation that a copy was given to the client.	Number of clients with initial assessments	Number of clients	Client Files ARIES	75% of client charts will have documentation of initial assessments as indicated.

• Complete mental status evaluation (including appearance and behavior, talk, mood, self-attitude, suicidal tendencies, perceptual disturbances, obsessions/compulsions, phobias, panic attacks) • Cognitive assessment (level of consciousness, orientation, memory and language) • Social support and family relationships • Strengths and Weaknesses Specific assessment tools such as the Addiction Severity Index (ASI) could be used for substance abuse and sexual history, the Substance Abuse and Mental Illness Symptoms Screener (SAMISS) for substance abuse and mental illness symptoms and the Mini Mental State Examination (MMSE) for cognitive assessment. A copy of the assessment(s) will be provided to the client.					
A psychosocial history will be completed and must include: • Education and Training • Employment • Military Service • Legal History • Family history and	Client's chart contains documentation.	Number of clients with psychosocial histories completed	Number of clients	Client Files ARIES	75% of client charts have documentation of completed psychosocial history as indicated.

constellation • Physical, emotional and/or sexual abuse history • Sexual and relationship history and status • Leisure and recreational activities • General psychological functioning					
Treatment plans are developed jointly with the counselor and client and must contain all the elements set forth in DSHS' Administrative Code for Substance Abuse, including: • Statement of the goal(s) of counseling • The plan of approach • Mechanism for review The plan must also address the full range of substances the client is abusing. Treatment plans must be completed no later than five (5) working days of admission and the client must be provided a copy of the plan. Individual or group therapy should be based on professional guidelines. Supportive and educational counseling should include prevention of HIV-related risk behaviors including substance abuse as clinically indicated.	Client chart contains documentation of client's treatment plan and that client was given a copy of the plan. For methadone treatment, client charts will document contact with the client's medical provider within 72 hours of initiation of methadone to inform the provider of the new prescription OR client refusal to authorize this communication.	Number of clients with treatment plans completed no later than 5 working days after admission Number of client charts with methadone treatment documentation of contact with medical provider within 72 hours of treatment initiation	Number of clients Number of clients on methadone	Client Files ARIES	75% of client charts have documentation of treatment plans completed no later than 5 working days after admission. 75% of client charts, for client on methadone, will have documentation of contact with client's medical provider within 72 hours of treatment initiation or the client's refusal to authorize this communication.

In accordance with DSHS's Administrative Code on Substance Abuse, the treatment plan shall be reviewed at a minimum midway through treatment or at least every 12 sessions and must reflect ongoing reassessment of client's problems, needs and response to therapy. The treatment plan duration, review interval and process must be stated in the agency policies and procedures and must follow criteria outlined in the Administrative Code.	Documentation of treatment plan review in client's file and agency treatment review policies and procedures on file at site.	Number of clients with updated/reviewed treatment plans	Number of clients	Client Files ARIES	75% of client charts will have documentation of updated treatment plans midway through treatment or at least every 12 sessions.
Client and family participation in service planning should be maximized.	Documentation on site.	Number of clients with documentation of family participation	Number of clients	Client Files ARIES	75% of client charts with documented family participation have documentation of their participation in service planning for the client's needs.
A client may be discharged from substance abuse services through a systematic process that includes a discharge or case closure summary in the client's record. The discharge/case closure summary will include: • Circumstances of discharge • Summary of needs at admission • Summary of services provided • Goals completed during counseling • Counselor signature and credentials and date.	Documentation of case closure in client's record. Documentation of reason for discharge/case closure (e.g., case closure summary).	Number of discharged clients	Number of clients	Client Files ARIES	75% of discharged client charts have documentation of case closure or reason for discharge.

• A transition plan to other services or provider agencies, if applicable • Consent for discharge follow-up					
In all cases, providers/case managers shall ensure that, to the greatest extent possible, clients who leave care are linked with appropriate services to meet their needs. For example, if a client were moving to another area, the provider/case manager would ideally refer the client to an appropriate provider in that area; or if the client has to be discharged from services, the provider/case manager may, as is appropriate to the circumstance, provide the client with a list of alternative resources.	Documentation in client's record indicating referrals or transition plan to other providers/agencies.	Number of clients needing referrals to other agencies	Number of clients	Client Files ARIES	75% of discharged client charts will have documentation of referrals or transition plans to other providers/agencies.
II. Outcomes					
Clients demonstrate decreased drug use frequency or maintenance of decreased drug use in a 6 month time frame through urine or blood drug screens or self report.	Decreased use of drugs and alcohol frequency or maintenance of decreased drug use.	Number of clients show decreased drug use frequency or maintenance of decreased drug use in a 6 month time	Number of clients	Client Files ARIES	70% of clients show decreased drug use frequency or maintenance of decreased drug use in a 6 month time frame demonstrated through urine or blood drug screens or through self report.

SUBSTANCE ABUSE SERVICES (RESIDENTIAL)

DEFINITION:

Substance Abuse Services (Residential) include the provision of medical or other treatment and/or counseling to address substance abuse problems (i.e. alcohol and/or legal and illegal drugs) in a 24-hour residential health service setting, rendered by a physician or under the supervision of a physician.

SERVICES:

Provision of treatment and/or counseling addresses substance abuse and addiction/dependency for alcohol and other drugs. Services consist of 24 hour, residential non-medical services to individuals recovering from problems related to alcohol and/or other drug abuse and who need alcohol and/or other drug abuse treatment and detoxification services. Services include treatment, counseling, social detoxification and/or referral to medical detoxification (including methadone treatment) when necessary as appropriate to the client. A goal of the continuum of substance abuse treatment is to encourage individuals to access primary medical care and adhere to HAART as well as other treatments indicated. All treatment providers will have specific knowledge, experience, and services regarding the needs of persons with HIV/AIDS.

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

Services will emphasize the intersection between HIV/AIDS and substance abuse, with special focus given to psychosocial aspects of living with HIV/AIDS and HIV prevention. Whenever possible, clients should be provided gender and/or sexual identity-specific services or be referred to appropriate providers who provide such services.

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

PERSONNEL:

Staff Qualification	Expected Practice
All staff providing direct substance abuse counseling or treatment services to clients will meet the qualifications for the position as outlined in the agency's job description and shall include the following: ▪ Licensed by the State of Texas to provide substance abuse counseling (e.g., LPC, LCSW, LMSW, LMFT, LCDC, CDAC, licensed clinical psychologist), or a Counselor in Training (CIT) supervised by an appropriate licensed/certified professional, *AND* ▪ Two years' experience in HIV or other catastrophic illness and continuing education in HIV, *AND* ▪ One year experience in family counseling as pertaining to substance ▪ abuse, *AND* ▪ Non-violent crisis intervention training, *AND* ▪ Professional liability coverage for individuals and for the agency, *AND* ▪ At least three (3) hours annually of cultural competency training as ▪ required in the Universal Standards of Care regarding populations who have an incidence of HIV infection in the TGA (e.g., ethnic, gay/lesbian/bisexual/transgender, women, homeless, adolescents, sex trade workers, deaf/hard of hearing, drug cultures, *AND* ▪ Training in mental health issues and knowing when to refer a client to a ▪ mental health program/counselor, *AND* ▪ Supervision as required by licensure.	Personnel files/resumes/applications for employment reflect requisite licenses, certifications, experience and training. Documentation of supervision during client interaction with Counselors In Training (CIT) or Interns as required by the Texas Department of State Health Services (DSHS).
A substance abuse treatment supervisor shall, at a minimum, be a Master's level professional (e.g., LPC, LMSW, or Licensed Clinical Psychologist) licensed by the State of Texas and qualified to provide supervision per applicable licensing rules.	Proof of licenses and certifications indicated in personnel file.
Orientation shall be provided to all staff within ten (10) working days of employment, including at a minimum: ▪ Crisis intervention procedures ▪ DSHS Administrative Code for Substance Abuse ▪ Standards of Care ▪ Confidentiality ▪ Documentation in case records (ARIES training) ▪ Consumer Rights and Responsibilities ▪ Consumer abuse and neglect reporting policies and procedures ▪ Professional Ethics ▪ Emergency and safety procedures ▪ Data Management and record keeping ▪ Infection Control and universal precautions	Orientation program educates staff on required subject matters. Personnel file reflects completion of orientation and signed job description.

▪ Review of job description ▪ Occupational Safety and Health Administration (OSHA) regulations ▪ Pertaining to substance abuse in the workplace, and ▪ The Americans With Disabilities Act as Amended (ADAAA)	
Continuing education/in-service training. In accordance with DSHS and state licensing and credentialing boards, all direct care staff must satisfactorily complete the required hours in continuing education training.	Documentation to include in the employee file that reflects date of training, contents, name of trainer, topic, length of training and signature of employee.
Each substance abuse treatment provider must have and implement a written plan for regular supervision of all staff by a licensed supervisor/Qualified Credentialed Counselor (QCC) in accordance with all applicable laws and regulations.	Agency has written plan for supervision of all staff on site.
Notes of weekly supervisory conferences shall be maintained for such staff.	Supervisor's files reflect notes of weekly supervisory conferences.
Staff must be evaluated at least annually by their supervisor according to written provider policy on performance appraisals.	Personnel files contain annual performance evaluations.
The provider agency must be a licensed hospital or a licensed facility and must comply with the rules and standards established by DSHS' Substance Abuse Facility Licensing Group.	Documentation of current facility licensing on site.
Provider agency must be in compliance with the Americans with Disabilities Act as Amended (ADAAA) to indicate full accessibility by all clients. If not in compliance at the time of funding, agency must demonstrate a plan, including timeline, to become compliant within the funding period.	Evidence of ADAAA compliance or plan and timeline for compliance on file at provider agency.
All direct care staff in a residential program shall maintain current Cardio Pulmonary Resuscitation (CPR) and First Aid certification. However, licensed health professionals and personnel in licensed medical facilities are exempt if emergency resuscitation equipment and trained response teams are available 24 hours a day.	Documentation of CPR-certified staff and evidence of first aid capability at site.
Provider agency must develop and implement policies and procedures for handling crisis situations and psychiatric emergencies, which include, but are not limited to, the following: ▪ Verbal Intervention ▪ Non-violent physical intervention ▪ Emergency medical contact information ▪ Incident reporting ▪ Voluntary and involuntary patient admission ▪ Follow-up contacts ▪ Continuity of services in the event of a facility emergency	Documentation of client and staff safety policies and procedures on site.

QUALITY MANAGEMENT:

Program outcome:

75% of clients enrolled in Substance Abuse Services – Residential treatment/program who complete their recommended length of treatment stay.

75% of clients who successfully access primary medical care services.

Indicators:

- Number of units of service provided
    A. Number of units of residential treatment provided
    B. Number of units of residential detox provided

- Number of unduplicated clients receiving residential treatment services
    A. Number of new clients served
    B. Number of continuing clients served

- Number of unduplicated clients receiving residential detox services
    A. Number of new clients served
    B. Number of continuing clients served

Service Unit(s):

- Successful enrollment in a 24-hour treatment day.

Standard of Care	***Outcome Measure***	***Numerator***	***Denominator***	***Data Source***	***Goal/Benchmark***
I. Structure					
Case conferences with members of the client's multi-disciplinary team shall be held as appropriate.	Client records include documentation of multi-disciplinary case conferences, as appropriate.	Number of client records with case conference documentation	Number of clients	Client Files ARIES	75% of client records have documentation of case conferences with members of the client's multi-disciplinary team.
II. Process					
Intake will occur within three (3) working days of a client requesting substance abuse treatment services. In emergency circumstances, intake will be scheduled within one (1) working day. If services	Client chart contains documentation of each item listed above.	Number of clients with intakes scheduled	Number of clients	Client Files ARIES	75% of client charts will have documentation of an intake scheduled within three (3) working days of request for substance abuse treatment services.

cannot be provided within these time frames, the agency will offer to refer the clients to another organization to provide the requested services in a timelier manner.					
The intake process will include: • Screening for substance abuse and/or dependency for alcohol and other drugs using SAMISS • Verification of Medicaid/Medicare eligibility • Client's demographic information • Client's address • Client's phone number(s)/e-mail address • Client's housing status • Client's employment and income status • Client's alcohol and drug history and current usage • Client's physical health • List of current medications • Presenting problems • Suicide and homicide	Documentation of intake information in client's file and in ARIES.	Number of clients with intakes	Number of clients	Client Files ARIES	75% of client charts will have documentation of intake process as indicated

assessment					
Initial assessment protocols shall provide for screening individuals to determine level of need and appropriate service plan. The initial assessment shall include, but not be limited to, the following: • The presenting problem • Substance abuse history • Medical and psychiatric history • Treatment history • Psychological history and current status • Complete mental status evaluation (including appearance and behavior, talk, mood, self-attitude, suicidal tendencies, perceptual disturbances, obsessions/compulsions, phobias, panic attacks) • Cognitive assessment (level of consciousness, orientation, memory and language) • Social support and family relationships • Strengths and Weaknesses Specific assessment tools such as the Addiction Severity Index (ASI) could be used for substance abuse and sexual history, the	Client's chart contains documentation of each assessment item listed and documentation that a copy was given to the client.	Number of clients with initial assessments	Number of clients	Client Files ARIES	75% of client charts will have documentation of initial assessments as indicated.

Substance Abuse and Mental Illness Symptoms Screener (SAMISS) for substance abuse and mental illness symptoms and the Mini Mental State Examination (MMSE) for cognitive assessment. A copy of the assessment(s) will be provided to the client.					
A psychosocial history will be completed and must include: • Education and Training • Employment • Military Service • Legal History • Family history and constellation • Physical, emotional and/or sexual abuse history • Sexual and relationship history and status • Leisure and recreational activities • General psychological functioning	Client's chart contains documentation.	Number of clients with psychosocial histories completed	Number of clients	Client Files ARIES	75% of client charts have documentation of completed psychosocial history as indicated.
Treatment plans are developed jointly with the counselor and client and must contain all the elements set forth in DSHS' Administrative Code for Substance Abuse, including: • Statement of the goal(s) of counseling	Client chart will have a treatment plan initiated within five (5) working days of admission and client will be given a copy of the plan.	Number of clients with treatment plans completed no later than five (5) working days after admission	Number of clients	Client Files ARIES	75% of client charts have documentation of treatment plans completed no later than 5 working days after admission.

• The plan of approach • Mechanism for review The plan must also address the full range of substances the client is abusing. Treatment plans must be completed no later than five (5) working days of admission and the client must be provided a copy of the plan. Individual or group therapy should be based on professional guidelines. Supportive and educational counseling should include prevention of HIV-related risk behaviors including substance abuse as clinically indicated. The treatment plan shall identify discharge criteria and include initial plans for discharge. The Texas Department of Insurance criteria shall be used as a general guideline for determining when clients are appropriate for transfer or discharge, but individualized criteria shall be specifically developed for each client.					
In accordance with DSHS's Administrative Code on Substance Abuse, the	Documentation of treatment plan review in client's file and agency	Number of clients with updated/reviewed	Number of clients	Client Files ARIES	75% of client charts will have documentation of updated treatment plans midway through

treatment plan shall be evaluated on a regular basis and revised as needed to reflect the ongoing reassess-ment of the client's problems, needs, and response to treatment. The treatment plan duration, review interval and process must be stated in the agency policies and procedures and must follow criteria outlined in the Administrative Code.	treatment review policies and procedures on file at site.	treatment plans			treatment or at least every 12 sessions.
Client and family participation in service planning should be maximized.	Documentation on site.	Number of clients with documentation of family participation	Number of clients	Client Files ARIES	75% of client charts with documented family participation have documentation of their participation in service planning for the client's needs.
III. Outcomes					
A client may be discharged from substance abuse services through a systematic process that includes a discharge or case closure summary in the client's record. The discharge/case closure summary will include: • Circumstances of discharge • Summary of needs at admission • Summary of services provided • Goals completed during counseling • Counselor signature and credentials and	Documentation of case closure or discharge in client's record. Documentation of reason for discharge/case closure (e.g., case closure summary).	Number of discharged clients	Number of clients	Client Files ARIES	100% of discharged client charts have documentation of case closure or reason for discharge.

date. • A transition plan to other services or provider agencies, if applicable • Consent for discharge follow-up					
In all cases, providers/case managers shall ensure that, to the greatest extent possible, clients who leave care are linked with appropriate services to meet their needs. For example, if a client were moving to another area, the provider/case manager would ideally refer the client to an appropriate provider in that area; or if the client has to be discharged from services, the provider/case manager may, as is appropriate to the circumstance, provide the client with a list of alternative resources.	Documentation in client's record indicating referrals or transition plan to other providers/agencies.	Number of clients needing referrals to other agencies	Number of clients	Client Files ARIES	75% of discharged client charts will have documentation of referrals or transition plans to other providers/agencies.

APPENDICES

STATEMENT OF CONSUMER RESPONSIBILITIES

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

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

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

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

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

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

4. FOLLOWING THE TREATMENT PLAN – YOU HAVE THE RESPONSIBILITY

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

5. SCHEDULED APPOINTMENTS – YOU HAVE THE RESPONSIBILITY

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

6. COMMUNICATING YOUR FINANCIAL NEEDS – YOU HAVE THE RESPONSIBILITY

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

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

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

8. VOICING COMPLAINTS AND GRIEVANCES – YOU HAVE THE RESPONSIBILITY

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

9. CONTINUING CARE – YOU HAVE THE RESPONSIBILITY

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

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

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

11. ACCESS TO FINANCIAL INFORMATION – YOU HAVE THE RESPONSIBILITY

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

12. A CONSUMER GRIEVANCE PROCEDURE – YOU HAVE THE RESPONSIBILITY

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

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

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

STATEMENT OF CONSUMER RIGHTS

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

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

2. FREEDOM FROM DISCRIMINATION – YOU HAVE THE RIGHT

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

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

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

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

4. IDENTITY AND PROVIDER CREDENTIALS – YOU HAVE THE RIGHT

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

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

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

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

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

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

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

8. DECLINING SERVICE – YOU HAVE THE RIGHT

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

9. NAMING AN ADVOCATE – YOU HAVE THE RIGHT

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

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

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

11. ACCESS TO FINANCIAL INFORMATION – YOU HAVE THE RIGHT

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

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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.

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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.