FY 2025 Standards of Care and Service Delivery Guidelines

Dallas Planning Area

Dallas Eligible Metropolitan Area

Dallas and Sherman-Denison HIV Services Delivery Areas

Ending the HIV Epidemic

March 1, 2025 – February 28, 2026

Prepared by the Ryan White Planning Council of the Dallas Area in Collaboration with the Ryan White Grants Management Division of Dallas County Health & Human Services

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Table of Acronyms and Abbreviations

AA	Administrative Agency
Ab	Antibody
ACA	Affordable Care Act
ACIP	Advisory Committee on Immunization Practices
ADA	American Disabilities Act
ADAP	AIDS Drug Assistance Program
AIDS	Acquired Immune Deficiency Syndrome
aPTT	Activated Partial Thromboplastin Time
TCT	Take Charge Texas Database
ART	Antiretroviral Therapy
ASAM	American Society of Addiction Medicine
ASI	Addiction Severity Index
ASL	American Sign Language
BIA	Bethesda Inhibitor Assay
BIA	Bioelectrical Impedance Analysis
BMI	Body Mass Index
BUN	Blood Urea Nitrogen
CARE/HIPP	Health Insurance Premium Payment
CBC	Complete Blood Count
CCR5	C-C chemokine receptor type 5
CD4	Cluster of Differentiation 4
CEU	Continuing Education Unit
CLAS	National Standards for Culturally and Linguistically Appropriate Services
CLIA	Clinical Laboratory Improvement Amendments
CNS	Clinical Nurse Assistant
COBRA	Consolidated Omnibus Budget Reconciliation Act
COVID-19	Coronavirus Disease 2019
CT	Chlamydia
DADS	Texas Department of Aging and Disability Services
DCHHS	Dallas County Health and Human Services
DHHS	Texas Office for Deaf and Hard of Hearing Services
DIS	Disease Intervention Specialist
DO	Doctor of Osteopathic Medicine
DPA	Dallas Planning Area
DSHS	Texas Department of State Health Services
DSW	Doctor of Social Work
EdD	Doctor of Education
EFA	Emergency Financial Assistance
eGFR	Estimated Glomerular Filtration Rate
EHE	Ending the HIV Epidemic
EIA	Enzyme Immunoassay
ePHI	Electronic Personal Health Information
EIS	Early Intervention Services

EMA	Eligible Metropolitan Area
FDA	U.S. Food and Drug Administration
FPL	Federal Poverty Level
GC	Gonorrhea
HAB	HIV/AIDS Bureau
HAV	Hepatitis A Virus
HBsAb	Hepatitis B Surface Antibody
HBV	Hepatitis B Virus
HCO_3	Bicarbonate
HCV	Hepatitis C Virus
HDL	High-density lipoprotein
HHS	U. S. Department of Health and Human Services
HIA	Health Insurance Premium and Cost-Sharing Assistance
HIV	Human Immunodeficiency Virus
HLA-B*5701	Human Leukocyte Antigen major histocompatibility complex, class I, B
HOPWA	Housing Opportunities for Persons with AIDS
HRA	High High-Resolution Anoscopy
HRSA	Health Resources and Services Administration
HSDA	HIV Service Delivery Area
IgG	Immunoglobulin G
IGRA	Interferon Gamma Release Assay
LDL	Low-density lipoprotein
LPAP	Local Pharmaceutical Assistance Program
LTBI	Latent Tuberculosis Infection
LVN	Licensed Vocational Nurse
MA	Master of Art
MA	Medical Assistant
MAC	Mycobacterium avium complex
MCM	Medical Case Manager/ Medical Case Management
MD	Doctor of Medicine
MEd	Master of Education
mL	milliliter
mm^3	cubic millimeter
MMR	Measles, Mumps, and Rubella
MMSE	Mini Mini-Mental State Examination
MNT	Medical Nutrition Therapy
MS	Master of Science
MSW	Master of Social Work
NAAT	Nucleic Acid Amplification Test
NMCM	Non-Medical Case Management
NMS	National Monitoring Standards
NP	Nurse Practitioner
nPEP	Non-occupational post-exposure prophylaxis
OAHS	Outpatient/Ambulatory Health Services
OBRA	Omnibus Budget Reconciliation Act
PA	Physician Assistant
Pap	Papanicolaou (test)

PAPS	Pharmaceutical Patient Assistance Programs
PCN	Policy Clarification Notice
PCP	Pneumocystis pneumonia
PCV13	Pneumococcal Conjugate Vaccine
PharmD	Doctor of Pharmacy
PhD	Doctor of Philosophy
PHQ-2	Patient Health Questionnaire
PLWH	People Living with HIV
PPV23	Pneumococcal Polysaccharide Vaccine
PrEP	Pre-exposure prophylaxis
PT/INR	Prothrombin and International Normalized Ratio
QTF	QuantiFERON TB Test
RD	Registered Dietician
RN	Registered Nurse
RNA	Ribonucleic Acid
RWHAP	Ryan White HIV/AIDS Program
RWPC	Ryan White Planning Council
SAMISS	Substance Abuse and Mental Illness Symptoms Screener
SDI	State Disability Insurance
SNAP	Supplemental Nutrition Assistance Program
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
STDs	Sexually Transmitted Diseases
STIs	Sexually Transmitted Infections
TAC	Texas Administrative Code
TANF	Temporary Aid to Needy Families
TB	Tuberculosis
Td	Tetanus and Diphtheria
Tdap	Tetanus, Diphtheria, and Pertussis
THMP	Texas HIV Medication Program
TMB	Texas Medical Board
TST	Tuberculin Skin Test
USPSTF	United States Preventive Services Task Force
VA	Veteran's Administration Benefits
VTCA	Vernon's Texas Code Annotated
VZV	Varicella-Zoster Virus
WIC	Special Supplemental Nutrition Program for Women, Infants, and Children
µL	microliter

INTRODUCTION

This document provides guidance for care and service delivery, billing, and documentation requirements for organizations receiving Ryan White Parts A, B, State Services, and Ending the HIV Epidemic (EHE) funding in the Dallas Eligible Metropolitan Area (EMA) and the Dallas and Sherman-Denison HIV Service Delivery Areas (HSDA). The guidelines in this document are effective March 1, 2025, through February 29, 2026, and are not to be applied retroactively. Descriptions of the core medical and support services, the *How Best to Meet the Priority* document, and the *Service Category Eligibility Based on Federal Poverty Level Guidelines* document were developed and approved by the Ryan White Planning Council of the Dallas Area (RWPC) for service delivery in the Dallas EMA and the Dallas and Sherman-Denison HSDAs, known collectively as the Dallas Planning Area (DPA).

DEFINITIONS

Activities May Include:

A list of specific activities that are reimbursable under this service category. This list **is not** comprehensive; it was developed and approved by the RWPC.

Activities Must Include:

A list of specific reimbursable activities that must be included in the delivery of this service category; developed and approved by the RWPC.

Activities May Not Include:

A list of specific activities that are not reimbursable under this service category; developed and approved by the RWPC.

Unallowable Costs Include (per the Health Resources and Services Administration (HRSA)):

- Direct payments to clients
- Clothing
- Employment and employment-readiness services, except in limited, specified instances (e.g., Non-medical case management services or rehabilitation services)
- Funeral and burial expenses
- Property taxes
- Pre-exposure prophylaxis (PrEP)
- Non-occupational post-exposure prophylaxis (nPEP)
- Materials designed to promote or encourage, directly, intravenous drug use or sexual activity, whether homosexual or heterosexual
- International travel
- The purchase or improvement of land
- The purchase, construction, or permanent improvement of any building or other facility

Unit of Service:

The increment of service delivery used for reimbursement requests, documentation, and Take Charge Texas (TCT) entry. It was developed and approved by the Ryan White Grants Management Division of Dallas County Health and Human Services (the Administrative Agency (AA)).

Billing Limitations:

Additional restrictions or limits on the type or amount of service(s) eligible for reimbursement under applicable service categories developed and approved by the RWPC and the Ryan White Grants Management Division of Dallas County Health and Human Services.

How Best to Meet the Priority:

Special instructions developed and approved by the RWPC. These recommendations are ancillary to the services described in this document. They **may not be eligible** for reimbursement through Ryan White, Housing Opportunities for Persons with AIDS (HOPWA), or State Services grants. **Note:** Backup documentation must be submitted for all service units for which reimbursement is requested.

STATE AIDS DRUG ASSISTANCE PROGRAM TREATMENTS

HRSA Description: The AIDS Drug Assistance Program (ADAP) is a state-administered program authorized under Part B of the Ryan White HIV/AIDS Program (RWHAP) to provide U.S. Food and Drug Administration (FDA)-approved medications to low-income clients living with HIV who have limited or no coverage from private insurance for eligible clients and for services that enhance access to, adherence to, and monitoring of antiretroviral therapy (ART). RWHAP ADAP recipients must conduct a cost-effectiveness analysis to ensure that purchasing health insurance is cost-effective compared to the cost of medications in the aggregate. Eligible ADAP clients must be living with HIV and meet the state's income and other eligibility criteria. Please refer to the Texas HIV Medication Program (THMP) webpage for more information.

Activities include those determined by the state. ADAP funds may not be used for Local AIDS Pharmaceutical Assistance Program (LPAP) support. LPAP funds are not emergency financial assistance for medications. Allocations for State ADAP are administered through Part B funds and cannot be allocated with Part A or Minority AIDS Initiative (MAI) funds.[1]

[1] Policy Clarification Notice #16-02: Eligible Individuals and Allowable Uses of Funds. AIDS Drug Assistance Program Treatments. Page 8

UNIVERSAL STANDARDS OF CARE

The Universal Standards listed below apply to all service categories funded under the RWHAP Part A, B, State Services, and Ending the HIV Epidemic programs for direct care service providers. These standards also apply to services funded in the Dallas EMA/HSDA. These Universal Standards are taken directly from HRSA's Ryan White HIV/AIDS Program (RWHAP) National Monitoring Standards for RWHAP Part A Recipients, which includes the Part B HIV/AIDS Bureau (HAB) National Monitoring Standards and expanded to include the Texas Department of State Health Services (DSHS) program requirements for all Ryan White Part B and State Service subrecipients. HRSA/HAB "expects recipients to monitor fiscal and programmatic compliance with all contracts and other agreements for HIV services in the [EMA and] State/Territory" and to report on "ongoing progress" of implementation of the National Monitoring Standards (NMS).

STANDARD OF CARE FOR LICENSURE OR ASSURANCES

I. All service providers that receive Dallas County Health and Human Services (DCHHS) pass-through funds from local, state, or federal sources must comply with existing local, state, or federal laws and regulations governing the need for a criminal history check of prospective staff or volunteers. If the provider employs an individual in a staff or volunteer capacity despite discovering a history of prior criminal activity, DCHHS will assume no responsibility for the service provider's decision or any adverse consequences resulting from the employment.

II. All service providers shall ensure that each staff member signs a confidentiality agreement annually, affirming individual responsibility for keeping client information and data confidential, and shall maintain original signed confidentiality and Assurances documentation in staff personnel files.

III. All service providers shall ensure that each staff member signs Assurances annually, acknowledging that they have reviewed security policies and procedures relevant to their position and shall maintain original signed confidentiality and Assurances documentation in staff personnel files.

STANDARD OF CARE FOR STAFF AND VOLUNTEER TRAINING PROGRAMS

The service provider shall provide to its staff and volunteers the following training programs or opportunities, receipt of which shall be documented in individual staff/volunteer files:

I. Initial in-service orientation and training for new staff and volunteers, including agency policies and standard precautions, and periodic development training for all staff and volunteers as required to ensure the continued, safe delivery of high-quality services;

II. Training on the laws and regulations regarding the privacy and confidentiality of client information;

III. The opportunity for licensed/credentialed staff to take relevant outside courses to both improve their skills and, if required, earn continuing education units (CEUs) sufficient to maintain licensure and certification;

IV. Annual cultural sensitivity/competency training complying with the *National Standards for Culturally and Linguistically Appropriate Services* (CLAS) to serve youth, transgender, African-American, Latinx, undocumented, and underserved populations.

V. Written procedures on reporting requirements for suspected sexual child abuse reporting, as required by the State if the agency receives funds through grants provided by DSHS.

VI. All service provider staff requiring access to local, state, or federal client information systems must complete confidentiality and security training annually before being granted access.

STANDARD OF CARE FOR KNOWLEDGE, SKILLS, AND EXPERIENCE

The staff and volunteers:

I. Shall possess knowledge of HIV/AIDS; the effects of HIV/AIDS-related illnesses and comorbidities on clients; the psychosocial effects of HIV/AIDS on clients and their families/significant others; and current strategies for management of HIV/AIDS;

II. Those who interact with clients or contacts shall possess the needed communication skills and experience in dealing with a wide variety of people and;

III. Are culturally sensitive and promote equity in working with persons affected by the HIV epidemic, such as those who are underserved or part of a disproportionately affected population.

STANDARD OF CARE FOR CLIENT RIGHTS AND CONFIDENTIALITY

The service provider:

I. Shall provide an orientation for clients, during which the clients are made aware of their rights, obligations, services available to them, and realistic expectations of service (exceptions: Health Education/Risk Reduction and Outreach Services categories);

II. Shall develop the following instruments in both English and Spanish, distributing a copy to each client and posting a copy in a conspicuous place within the facility, as indicated below (exceptions: Health

Education/Risk Reduction and Outreach Services categories):

a. A client "Bill of Rights" (distributed to each client) which takes into account state and federal laws protecting client rights (including a nondiscrimination statement covering age, gender, race, color, religion (or lack thereof), national origin, sexual orientation, gender identity or expression, disability, political affiliation, and inability to pay), and a written grievance procedure (distributed and posted in a conspicuous place), including Assurances that neither the agency nor any of its staff will retaliate against clients for filing a grievance;

b. A written policy regarding clients' entitlement to confidentiality (distributed to each client);

c. An "authorization form to disclose client information." This form must be specific to the individual(s) and service provider(s) to whom the client authorizes the disclosure of information. The form must specify what information will be disclosed, including the expiration date, and is to be signed by the client before disclosing any information. A copy of the signed authorization form shall be retained in each client's record. If a service provider's standards allow for 'verbal approval' (in urgent situations only), verbal approval will be sufficient so long as the individual obtaining the verbal approval signs the authorization form and a witness's signature to attest to the client giving verbal approval. The authorization form with both signatures should be retained in each client's record.

d. Written policies and procedures are in place to describe how the agency determines, documents, and reports suspected instances of child abuse in accordance with *Chapter 261* of the *Texas Family Code*;

e. Written policies and procedures are in place to require documented training of all staff regarding every aspect of suspected sexual child abuse screening and reporting;

f. Written emergency procedures (building evacuation map and emergency procedures to be followed by staff and clients in the event of a fire, bomb threat, severe weather, loss of power, or pandemic) must all be posted; written policy regarding chemical spills or possible biological exposure (i.e., suspected anthrax or smallpox) event need not be posted, but must be in place;

g. Application and eligibility assessment process, including written, clearly defined eligibility criteria consistent with HRSA written policy (Policy Clarification Notices (PCN) *#13-03*, *#16-02, and #21-02*), ranking criteria for eligible applicants when waiting lists exist, and a written policy regarding the transfer, discharge, or termination of services (distribute); and

h. Shall maintain client files (written or electronic) in a locked and secured area.

i. Written policies ensuring respect for client and staff gender identity and expression, which are a person's gender-related identity, appearance, or behavior, whether or not related to what is traditionally associated with the person's physical characteristics or sex assigned at birth. Gender identity may be supported by a medical history of treatment and care related to the identity, consistent

assertion, or any other affirmation that the identity is sincerely held, part of a person's core identity, and not being asserted for an improper purpose.

STANDARD FOR ACCESS, CARE, AND PROVIDER CONTINUITY

The service provider:

I. Shall, except where grant funds may be specifically restricted (e.g., MAI funds), provide its services to eligible persons regardless of age, gender, race, color, religion (or lack thereof), national origin, sexual orientation, gender identity or expression, disability, political affiliation, or inability to pay, to the extent resources allow;

II. Shall provide culturally sensitive and promote equity services for clients, and shall address linguistic barriers, either directly (by employing bilingual staff, utilizing adaptive equipment for sensory-impaired individuals, etc.) or indirectly through referral (exception: Health Education/Risk Reduction service category);

III. Shall provide access to its facility for disabled persons;

IV. Shall abide by the general principles for substance abuse/drug screening and disruptive behavior, as approved by the Ryan White Planning Council of the Dallas Area on August 11, 1999 (refer to Appendices F and G, Texas DSHS HIV/STD Policies *530.002* and *530.003*).

V. Shall provide access to its system of care for persons with HIV/AIDS twenty-four (24) hours/day (i.e., at a minimum, clients who call during non-operating hours will receive guidance via a pre-recorded message) and shall provide information regarding mechanisms to address urgent and emergency needs of the client. Shall have a process in place to respond to clients after hours where phone lines are monitored by staff trained in crisis/escalation, and the client will receive a call back the next business day with a plan to address the urgent need (only applicable to Mental Health Services and Substance Abuse Services categories).

VI. Shall develop, maintain, and enforce a security policy regarding how electronic client data are accessed, edited, and deleted, ensuring maximum client security and confidentiality.

VII. Shall maintain a safe environment within its facilities to provide services. This includes adopting a written policy to refuse services to anyone who is being verbally abusive of staff or others, is threatening physical abuse to staff or others, is in possession of illegal substances, drug paraphernalia, or weapons on agency property, or is otherwise acting in an unacceptable manner, until, in the judgment of the agency, the individual ceases such behavior. The service provider shall also explore all available alternative options for service provision to such individuals, including referral to a more appropriate service provider.

VIII. HRSA RWHAP funds are intended to support only the HIV-related needs of eligible individuals. To be an HRSA RWHAP allowable cost, HRSA RWHAP recipients and subrecipients must be able to make an explicit connection between any service supported with HRSA RWHAP funds and the HIV care and treatment of an incarcerated person and must adhere to established HIV clinical practice standards consistent with U.S.

Department of Health and Human Services Clinical Guidelines for the Treatment of HIV. See HRSA HAB Policy Clarification Notice #16-02, Ryan White HIV/AIDS Services: Eligible Individuals and Allowable Use of Funds.

IX. Shall provide gender-affirming care and treatment services as described in the HHS Guidelines for Use of Antiretroviral Agents in Adults and Adolescents Living with HIV refer across HRSA RWHAP core medical and support service categories as outlined in PCN#16-02 Ryan White HIV/AIDS Program Services: Eligible Individual and Allowable Uses of Funds

X. Where listed as an allowable activity under these standards, the option to utilize telehealth, telemedicine, or virtual visits instead of in-person services will be the client's decision, rather than the provider's requirement, unless CDC guidelines are issued that require the provider to implement social distancing due to a public health emergency.

PROVIDER RIGHTS FOR SERVICE DELIVERY IN THE DALLAS PLANNING AREA

Service providers reviewing this expectation should be able to identify unacceptable client behavior and respond accordingly with reasonable confidence that the actions taken on their behalf regarding a client were appropriate. Part of the AA's mission is to provide a wide array of services to persons living with HIV (PLWH) and other sexually transmitted diseases (STDs). That mission is achieved through contracts with various service providers who deliver those services.

The AA is responsible for ensuring each service provider understands their rights when addressing client behaviors that may be questionable or disruptive in providing Ryan White programs and services. The service provider will, therefore, be able to ensure that services are offered in a manner free from disruption. In addition, the RWPC of the Dallas Planning Area also has certain expectations of how those services are to be delivered to clients and how client rights are to be respected. On the authority vested by the *Civil Rights Code, Title 42, Chapter 21; Rehabilitation Act of 1973, Sect. 794*; *Age Discrimination Act of 1975*; *Public Law 88-352; Title VI,* and *Part 80 of 45 CFR; 25 TAC §§98.41-98.44*.

DEFINITIONS AS APPLIED TO THIS EXPECTATION

Contractor: a legal entity under contract with the Administrative Agency to provide goods or services to people living with or affected by HIV, AIDS, or STDs or to implement goals supporting the mission of the RWPC of the Dallas Planning Area.

Service Provider: a person, agency, or facility approved by the Administrative Agency that has entered into a contract with the Administrative Agency or a Texas DSHS contractor to deliver state or federal HIV programs to clients.

Service Program: Health, medical, and social services offered to PLWH by a service provider on behalf of the Administrative Agency.

PLANNING COUNCIL EXPECTATIONS FOR THE SERVICE PROVIDER/CLIENT RELATIONSHIP

The RWPC of the Dallas Planning Area expects service providers to maintain client relations of the highest possible quality by adhering to the following principles:

I. Treat each client with respect and consideration while recognizing the client's dignity and individuality.

II. Communicate the need for treatment, care, or services to promote equity in a culturally appropriate, culturally sensitive, and equitable manner.

III. Allow the client to select comprehensive outpatient health and psychosocial support services or refuse any service without fear of reprisal.

IV. Inform the client about treatment or service options, emphasize that it is the client's right to choose an option, and advise the client of several alternatives when multiple service providers are available for the same service.

V. Assure that service planning, medical treatment, and counseling plans are determined in cooperation with the client.

VI. Maintain a climate free of physical or mental abuse or exploitation in the office or other service delivery settings.

VII. Enforce local, state, or federal laws and regulations (such as no smoking or maintaining a drug-free environment) required to conduct business.

VIII. Review any decision to modify, suspend, or terminate services.

IX. Re-evaluate any modification, suspension, or termination of services to determine if the client's situation has changed (refer to Texas DSHS HIV/STD Policy *530.003*).

X. Give clients an avenue to formally complain about treatment or services and inform them of the service provider's decision to deny an application, modify, suspend, or terminate client benefits. Service providers should create a mechanism to receive an appropriate and fair review of the complaint and ensure no reprisal against the client for filing the complaint or grievance.

CONFIDENTIALITY

According to state and federal laws, the service provider must maintain confidentiality regarding all information. The right to confidentiality begins the moment the client applies for services, when the service provider first conducts an evaluation, or when counseling begins.

EQUAL ACCESS TO PROGRAMS AND SERVICES

The service provider must consider client eligibility regardless of age, gender, gender identity, gender expression, sexual orientation, marital status, ethnic origin, race, developmental and physical challenge, or religious practice. Conversely, the client has a right to refuse any recommended services.

IMPARTIAL TREATMENT

Service providers must allow clients to apply for any service or program. Clients must be given fair, impartial treatment in receiving and processing the application and receiving services.

FILING A COMPLAINT OR GRIEVANCE

Contractors must have a written client complaint procedure in place to meet the minimum requirements for managing client complaints. All clients have a right to file a complaint or grievance regarding inappropriate service provider behavior, actions, or perceptions of discrimination. The complaint may be filed per the service provider's grievance procedures. When all other sources with the service provider's grievance process have been exhausted, the client may file the complaint or grievance with the Administrative Agency representative for the DPA by calling 214-819-1849.

In the case of a complaint related to the delivery of clinical services, the client may file a complaint directly to the State of Texas licensing board without filing a complaint locally if the client so chooses.

SERVICE PROVIDER RIGHTS WHEN DEALING WITH A CLIENT

Each service provider must develop written procedures for clients who may be disruptive, uncooperative, or engaging in illegal behavior that is dangerous to themselves or others. The service provider must ensure that staff and clients are consistently informed about the procedures used in every situation. Service providers are expected to use good judgment and attempt to resolve these situations fairly without undue limitation or denial of services to the client.

MODIFYING, SUSPENDING OR TERMINATING CLIENT SERVICES

The service provider is responsible for providing a work environment free from undue disruption, turmoil, or interference. Whenever possible, the service provider should take steps to serve clients to support a healthy work environment. During service provision, clients may behave disruptively, abusively, or threateningly toward staff or other clients. When this type of behavior occurs, the service provider may take the following progressive actions:

I. Modify all or part of the services provided to the client.

II. Suspend all or part of the services provided to the client.

III. Terminate all or part of the services provided to the client.

Depending on the severity of the client's behavior, such as threatening the life of staff or other clients, the service provider may skip one or more of the above steps and take appropriate action. Refer to Texas DSHS HIV/STD Policy *530.003* for information on dealing with clients who threaten to harm themselves or others.

MODIFYING CLIENT SERVICES

The service provider may modify all or part of the services provided to the client when the client is disruptive or uncooperative. Modification may include, but is not limited to:

I. Rescheduling the client's appointment for a time later that day or in the near future,

II. arranging client services by telephone and

III. Mailing food vouchers, bus passes, etc.

SUSPENDING CLIENT SERVICES

Suspension is the temporary withdrawal of a service provided to a client by a service provider. It may be necessary for the service provider to suspend all or part of the services provided to the client for a specific period. This period should be delineated in the service provider's policy and should only be an option when alternative service delivery methods have not produced appropriate client behavior (i.e., the client is repeatedly disruptive or abusive towards staff or other clients). These cases should be directed to the Administrative Agency. Indefinite suspensions are discouraged.

TERMINATING CLIENT SERVICES

The service provider may choose to terminate all or part of the services provided to the client when alternative services delivery methods are not appropriate to the situation (i.e., the client threatens injury or homicide to a staff member or another client, etc.) or when modification or suspension of services has not produced appropriate client behavior. Clinical service providers (e.g., physicians, advanced practitioners, and registered nurses) who terminate services should follow professional practice standards concerning how client services are terminated. Professional organizations and licensing bodies can guide clinical service providers in managing these situations.

DENYING, SUSPENDING, OR TERMINATING A CLIENT'S SERVICE DUE TO SUBSTANCE MISUSE

The service provider may not deny, suspend, or terminate any service funded through HRSA/DSHS if the client is suspected of substance misuse or refuses to accept treatment for substance misuse. Exceptions to this may occur in the course of delivering medical care when a client's active substance misuse contraindicates the prescription of certain medications and treatments. The treating clinician must evaluate these professional decisions on a case-by-case basis.

NOTIFICATION OF THE DECISION TO MODIFY, SUSPEND, OR TERMINATE CLIENT SERVICES

The decision to modify, suspend, or terminate services must promptly and appropriately be communicated to the client. Notice of service termination may be done by any verifiable method, such as in person or by certified letter. When services are to be modified or suspended, staff should establish and communicate the duration of the suspension and inform the client that the resumption of services will depend on the client's willingness and ability to meet certain behavioral expectations. The behavioral expectations should be clearly defined and communicated to the client. The client should also be provided information about alternative methods by which services will be delivered or where such assistance may be obtained. Finally, the service provider should ensure that all actions regarding the modification, suspension, or termination of services are clearly documented in the client's record.

TECHNICAL ASSISTANCE

When desired, the service provider may contact the Administrative Agency to discuss specific situations or to obtain technical assistance. Decisions regarding modifying, suspending, or terminating client services remain with the service provider.

ADMINISTRATIVE AGENCY REVIEW OF DECISIONS TO MODIFY, SUSPEND, OR TERMINATE CLIENT SERVICES

As part of a routine review of the quality of client services or a complaint investigation, AA staff may review the events that led to a modification, suspension, or termination of client services. AA staff will evaluate, at minimum, whether the service provider:

I. Followed their internal policies and those of the AA in taking action to resolve the situation;

II. respected client rights, and

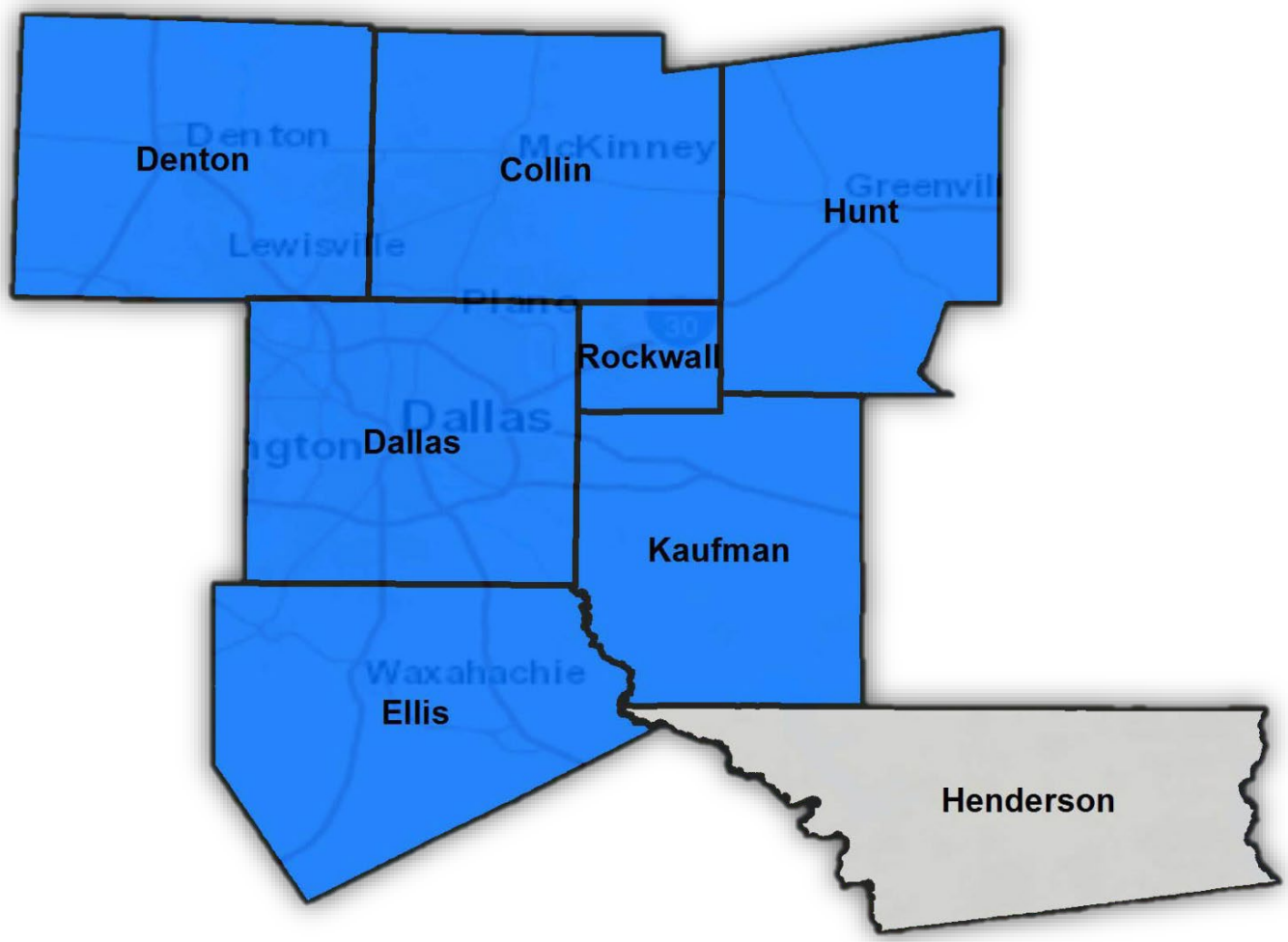
III. Applied the least restrictive limitation on client services necessary to maintain a service delivery setting free of physical and mental abuse or exploitation.

SELF-REFERRALS

Clients can self-refer to core medical and support services and may seek assistance from staff (e.g., a care/case manager) at any time. All agencies are expected to have an intake process and should enroll clients based on service eligibility.

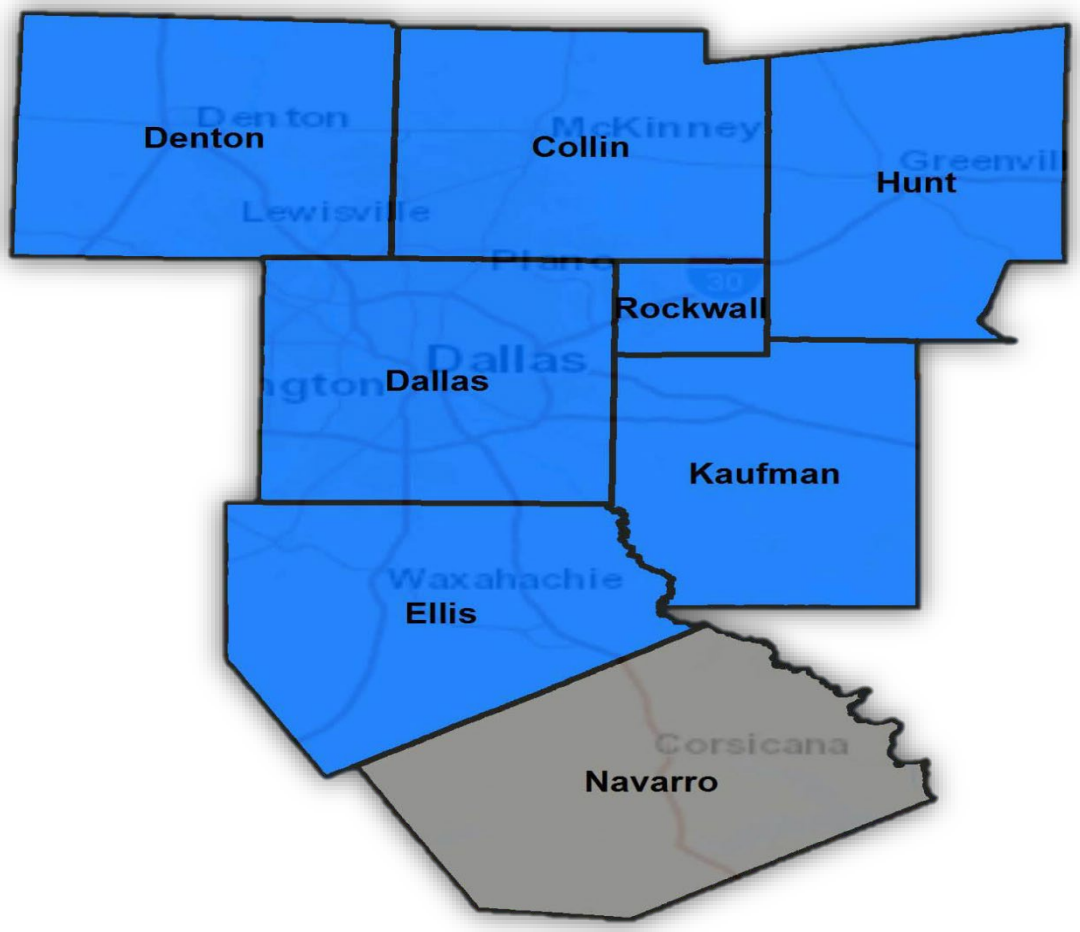
DALLAS ELIGIBLE METROPOLITAN AREA MAP

The Dallas EMA covers eight counties: Collin, Dallas, Denton, Ellis, Henderson, Hunt, Kaufman, and Rockwall.



DALLAS HIV SERVICE DELIVERY AREA MAP

The Dallas HSDA covers eight counties: Collin, Dallas, Denton, Ellis, Hunt, Kaufman, Navarro, and Rockwall.



SHERMAN-DENISON HIV SERVICE DELIVERY AREA MAP

The Sherman-Denison HSDA covers three counties: Cooke, Fannin, and Grayson.

CORE MEDICAL SERVICES

AIDS PHARMACEUTICAL ASSISTANCE

HRSA Description: Local Pharmaceutical Assistance Program (LPAP) is operated by an RWHAP Part A or B recipient or subrecipient as a supplemental means of providing medication assistance when an ADAP has a restricted formulary, waiting list, and/or restricted financial eligibility criteria.[2]

SERVICES

RWHAP Part A or B recipients using the LPAP service category must establish the following:

- Uniform benefits for all enrolled clients throughout the service area
- Adhere to the DSHS Part B Monitoring Standards
- A recordkeeping system for distributed medications
- Adhere to LPAP advisory board guidance
- Adhere to the drug formulary approved by the LPAP advisory board
- Adhere to the 340B drug distribution system
- Client enrollment and eligibility determination process, including screening for ADAP and LPAP eligibility with rescreening at least every six months.
- Coordination with the state's RWHAP Part B ADAP
    - A statement of need should specify the state ADAP restrictions and the need for LPAP.
- Implementation per requirements of the 340B Drug Pricing Program and the Prime Vendor Program

Activities must include:

Payments to agencies made on behalf of an eligible client for prescribed medications within the locally approved drug formulary to prolong life, improve health, or prevent the deterioration of health. The provider wishing to prescribe medication (including over-the-counter medicines) not on the formulary shall make a request to the LPAP Board for approval.

Activities may not include:

- The LPAP may not duplicate services available through the Texas ADAP program.
- Payment for medications not included in the LPAP formulary.
- Payment for medications dispensed as part of an Emergency Financial Assistance Program (less than 60 days);
- Payment for medications during the application period in the state AIDS Drug Assistance Program;
- Payment for medications that are dispensed or administered during a regular medical visit or are considered part of the services provided during that visit;

[2] Policy Clarification Notice #16-02: Eligible Individuals and Allowable Uses of Funds. AIDS Pharmaceutical Assistance. Page 8

- Payment for more than one month of medication at a time and payments for name-brand prescriptions when generic scripts are available.

STANDARD OF CARE 1.0: LICENSURE OR ASSURANCES

The service provider:

1.1 Shall ensure that medication costs are based on section 340B drug pricing or lower price if available;
1.2 Shall develop a memorandum of understanding with one or more pharmacies to ensure continuous availability and best price of medications.
1.3 Shall ensure the provision of medication to patients as prescribed by the patient's medical care provider;
1.4 Shall maintain appropriate, locked storage of medications and supplies when needed (including refrigeration);
1.5 Shall provide and maintain accurate program record keeping, including medication inventory control.

EARLY INTERVENTION SERVICES

HRSA Description: RWHAP Parts A and B Early Intervention Services (EIS) must include the following four components:[3]

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

Early Intervention Services are limited to:

- EIS services are limited to counseling and HIV testing, referral to appropriate services based on HIV status, linkage to care, and education and health literacy training for clients to help them navigate the HIV care system. EIS services require coordination with prevention services providers and should be provided at specific entry points.
- Counseling, testing, and referral activities are designed to bring individuals with HIV into Outpatient/Ambulatory Health Services (OAHS). The goal of EIS is to decrease the number of underserved individuals with HIV by increasing access to care. EIS also provides the added benefit of educating and motivating clients on the importance and benefits of getting into care. Individuals found not to have HIV should be referred to appropriate prevention services.

[3] Policy Clarification Notice #16-02: Eligible Individuals and Allowable Uses of Funds. Early Intervention Services. Page 10

- Telehealth and telemedicine are alternative modalities to provide most Ryan White Part B and State Services-funded services. For the Ryan White Part B/SS-funded providers and Administrative Agencies, telehealth & telemedicine services are to be delivered in real-time via audio and video communication technology and may include videoconferencing software.
- DSHS HIV Care Services requires that for Ryan White Part B or SS-funded services, providers must use features to protect electronic protected health information (ePHI) transmission between clients and providers. RW providers must use a telehealth vendor that provides assurances to safeguard ePHI, including the vendor signing a business associate agreement (BAA). Ryan White Providers using telehealth must also follow DSHS HIV Care Services guidelines for telehealth and telemedicine outlined in DSHS Telemedicine Guidance.

Activities must include:

- Targeted HIV testing to help the unaware learn of their HIV status and receive a referral to HIV care and treatment services if found to be living with HIV;
- Referral services to improve HIV care and treatment services at key points of entry;
- Access and linkage to HIV care and treatment services such as HIV OAHS, Medical Case Management, and Substance Use Care; and
- Outreach Services and Health Education/Risk Reduction related to HIV diagnosis.
- Counseling (pre-test and post-test); and HIV testing to confirm the presence of the disease or diagnose the extent of the deficiency of the immune system;
- Periodic examination and testing to monitor the extent of the deficiency of the immune system until the client can access primary medical care;
- Referrals to primary medical care or biomedical research facilities;
- Providing therapeutic measures for preventing and treating the deterioration of the immune system until the client can access primary medical care;
- Providing continuous follow-up care until there is confirmation the patient has accessed medical services;
- Providing information about other HIV service providers for support services that will increase access to primary care;
- Educating the client on the importance of remaining in primary medical care, including education and counseling in health maintenance and maintenance of the immune system.

STANDARD OF CARE 1.0: LICENSURE OR ASSURANCES

The service provider shall ensure that:

1.1 All facilities are appropriately licensed or certified as required by Dallas County for providing early intervention services for HIV, including phlebotomy services.

1.2 All staff who provide care and counseling services to clients shall be specifically trained to provide those services for recently diagnosed HIV-positive clients and shall be competently supervised by, at a minimum, a licensed mid-level medical provider.

HEALTH INSURANCE PREMIUM & COST-SHARING ASSISTANCE

HRSA Description: Health Insurance Premium & Cost-Sharing Assistance 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 coverage program. Health care coverage costs that are allowable uses of RWHAP ADAP funds include premiums and medication cost-sharing regardless of the kind of health care coverage (public or private). To use RWHAP funds for health insurance premiums and cost-sharing assistance, a RWHAP Part recipient must implement a methodology that incorporates the following requirements:[4]

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

The service provision consists of either or both of the following:

- Paying health insurance premiums to provide comprehensive HIV Outpatient/Ambulatory Health Services and pharmacy benefits that offer a full range of HIV medications for eligible clients.
- Paying cost sharing on behalf of the client.

Activities must include:

- Payment of insurance premiums (premiums will be paid directly to the insurance carrier or its designated agent);
- Payment of related copays and deductibles;
- Copayments for prescriptions included on the formulary approved by the Local Pharmaceutical Assistance Program Board with the exclusions listed in the Local Drug Reimbursement category;
- Payment of three-month prescription copays from mail-order pharmacies where cost-effective or plan-required, with pro-rated monthly costs towards service cap.

Activities may include:

- Copayments, premiums, coinsurance, or deductible costs for individuals enrolled in high-risk pools;
- Supplemental healthcare coverage insurance.

Activities may not include:

- Direct payments to clients;

[4] Policy Clarification Notice #18-01: Clarifications Regarding the Use of Ryan White HIV/AIDS Program Funds for Health Care Coverage Premium and Cost Sharing Assistance. Page 2

- Use of RWHAP funds to pay for administrative costs outside the premium payment of health plans or high-risk pool (private health insurance coverage).
- Use of RWHAP funds to pay for premiums or cost-sharing assistance for private health plans that are paid for or reasonably expected to be paid for by Medicaid.

ADDITIONAL PROVISIONS FOR RYAN WHITE PART B

Activities must include:

- Financial assistance, according to the Texas Department of State Health Services policies

Activities may include:

- Copayments, coinsurance, or deductible costs for individuals enrolled in the Texas Risk Pool

Activities may not include:

- Copayments, coinsurance, or deductible costs associated with hospitalization and emergency room care;
- Premium assistance for individuals enrolled in the Texas Risk Pool;
- A limit on the assistance an individual may receive under the Texas Department of State Health Services policies for costs associated with copayments, coinsurance, or deductible payments.

STANDARD OF CARE 1.0: LICENSURE OR ASSURANCES

The service provider shall ensure the following:

1.1. That insurance assistance staff who provide direct services to clients have continuing access to the most up-to-date information available about effective medical care of those with HIV/AIDS and about applicable insurance programs and options;

1.2. that it maintains detailed records in legible form, documenting client eligibility, along with premiums, deductibles, and copays that are paid on behalf of the clients; and

1.3. that client eligibility is re-examined at the birth month and half-birth month intervals to align with eligibility requirements as established by HRSA/DSHS national standards of client eligibility.

RWHAP Parts A, B, C, and D may not pay premiums for Medicare Part D alone; however, RWHAP ADAP funds may be used to pay Medicare Part D premiums and cost-sharing assistance alone when it is cost-effective to do so versus paying for the total cost of medications. RWHAP funds must not be used to pay for premiums or cost-sharing assistance for Medicare Part A, as inpatient care is not a RWHAP allowable cost (see Table 1). Ryan White grant subrecipients must vigorously pursue these other sources of premium and cost-sharing assistance to ensure the RWHAP remains the payer of last resort.

Table 1. Medicare Costs Allowable in the Ryan White HIV/AIDS Program[5]	
Medicare Part	**RWHAP Funds**
Medicare Part A	• Must not be used by any RWHAP recipient to pay premiums or cost sharing.
Medicare Part B	• May be used by all RWHAP recipients to pay premiums or cost-sharing in conjunction with paying for Medicare Part D premiums or cost-sharing.
Medicare Part C	• May be used by all RWHAP recipients to pay premiums or cost-sharing when the Medicare Part C plan includes prescription drug coverage; or • in conjunction with paying for Medicare Part D premiums and cost-sharing for plans that do not include prescription drug coverage.
Medicare Part D	• May be used by RWHAP Part A, B, C, and D recipients to pay premiums or cost-sharing in conjunction with paying Medicare Part B or Medicare Part C premiums or cost-sharing. • May be used by RWHAP ADAP recipients to pay Medicare Part D premiums and cost-sharing when cost-effective versus paying for the total cost of medications.

HOME AND COMMUNITY-BASED HEALTH SERVICES

HRSA Description: Home and Community-based Health Services are provided to a client living with HIV in an integrated setting appropriate to a client's needs, based on a written plan of care established by a medical care team under the direction of a licensed clinical provider. Includes skilled health services furnished to the individual in the individual's home based on a written plan of care established by a medical case management team that includes appropriate health care professionals.

Services include:

- Durable medical equipment;
- home health aide services and personal care services in the home;
- day treatment or other partial hospitalization services;
- home intravenous and aerosolized drug therapy (including prescription drugs administered as part of such therapy);
- routine diagnostic testing administered in the home;

[5] Policy Clarification Notice #18-01: Clarifications Regarding the Use of Ryan White HIV/AIDS Program Funds for Health Care Coverage Premium and Cost Sharing Assistance. Page 5

- assistance with housing-based testing, treatment, and therapies;
- and appropriate mental health, developmental, and rehabilitation services.

This definition also includes non-medical, non-nursing assistance with cooking and cleaning activities to help clients with disabilities remain in their homes.

Activities may not include:

- Inpatient hospital services;
- Nursing home or other long-term care facility services.

STANDARD OF CARE 1.0: LICENSURE OR ASSURANCES

The service provider shall ensure the following:

1.1 They are licensed and certified by the State of Texas to provide home health services.
1.2 All provider staff, contractors, and consultants who provide direct-care services and require licensure shall be appropriately licensed by the State of Texas.

HOME HEALTH CARE

HRSA Description: Home Health Care is the provision of services in the home that are appropriate to a client's needs and are performed by licensed professionals. Services must relate to the client's HIV disease and may include the following:[6]

- Administration of prescribed therapeutics (e.g., intravenous and aerosolized treatment and parenteral feeding)
- Preventive and specialty care
- Wound care
- Routine diagnostics testing administered in the home
- Other medical therapies, including physical and rehabilitative treatment

The provision of Home Health Care is limited to clients who are homebound. Home settings do not include nursing facilities or inpatient mental health/ residential substance abuse treatment facilities.

Activities may not include:

- Inpatient hospital services;
- Nursing home or other long-term care facility services.

STANDARD OF CARE 1.0: LICENSURE OR ASSURANCES

The service provider shall:

[6] Policy Clarification Notice #16-02: Eligible Individuals and Allowable Uses of Funds. Home Health Care. Page 12

1.1 Be licensed and certified by the State of Texas to provide home health care services.
1.2 Ensure all provider staff, contractors, and consultants who provide direct-care services and require licensure are appropriately licensed by the State of Texas.
1.3 Be available to all individuals eligible to receive Ryan White services, regardless of their religious denominational affiliation.

HOSPICE SERVICES

HRSA Description: Hospice services are end-of-life care services provided to clients in the terminal stage of an HIV-related illness.[7]

Allowable services are:

- Mental health counseling
- Nursing care
- Palliative therapeutics
- Physician services
- Room and board
- Social support;
- Spiritual guidance.

Activities must include:

- Medically ordered care.

Activities may not include:

- Service provision in skilled nursing facilities or nursing homes.
- Provision of nutritional services, durable medical equipment, and medical supplies or case management services.

STANDARD OF CARE 1.0: LICENSURE OR ASSURANCES

The service provider shall:

1.1 Be licensed and certified by the State of Texas to provide hospice services.
1.2 Ensure all provider staff, contractors, and consultants who provide direct-care services and require licensure are appropriately licensed by the State of Texas.
1.3 Ensure that physician certification of life expectancy is specified, as established by terminal illness, and does not exceed six months.
1.4 Be available to all individuals eligible to receive Ryan White services, regardless of their religious denominational affiliation.

[7] Policy Clarification Notice #16-02: Eligible Individuals and Allowable Uses of Funds. Hospice Services. Page 13

MEDICAL CASE MANAGEMENT

HRSA Description: Medical Case Management (MCM) is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum. Activities may be prescribed by an interdisciplinary team that includes other specialty care providers. Medical Case Management consists of several types of case management encounters (e.g., face-to-face, phone contact, and other communication forms).[8,9]

Key activities include:

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

Activities must include:

- Assessment of client's medical needs and overall acuity;
- Developing and reviewing a care plan (according to the Standards of Care) based on the client's needs and choices, with goals and strategies for completion;
- Medically focused form of case management;
- Linking and coordinating client care to ensure that quality medical care is received, including medical, mental health, vision, and dental care;
- Implementing the care plan through time-lined strategies;
- Coordination with client's medical providers;
- Providing information, referrals, and assistance with linkages to needed medical services;
- Monitoring and following up on the goals of the care plan and revising as necessary;
- Providing education about medical therapies, including the benefits and side effects of medications;
- Providing interventions; treatment adherence counseling to improve adherence to medical therapies; compliance with medical appointments;
- In-patient case management to prevent unnecessary re-hospitalization or to expedite discharge;
- Assessment of the client's need for medical nutrition therapy.

Activities may include:

- Screening for practice that may make an individual susceptible to HIV followed by reduction interventions for persons living with HIV susceptible of transmitting HIV;

[8] Policy Clarification Notice #16-02: Eligible Individuals and Allowable Uses of Funds. Medical Case Management. Page 13
[9] Texas Department of State Health Services: Medical Case Management (including Treatment Adherence Services) Service Standard

- Implementing interventions or strategies promoting adherence to antiretroviral medications for HIV+ persons with all types of case management, including face-to-face, phone contact, and other forms of communication;
- Benefits Counseling, Enrollment & Outreach Education (e.g., Medicaid, Medicare, Market Place/Exchange, other private insurance, etc.);
- Allow Medical Case Managers to complete intakes, screening for client eligibility, and determine the need for all services;
- Take Charge Texas (TCT) and other types of data entry or documentation directly related to case management performed for/on behalf of a client.
- Virtual Visits
- Telehealth/Telemedicine – addresses virtual visits (per local policy)

Activities may not include:

- Mental health or substance abuse counseling;
- Diagnostic or preventive care;
- Nutrition counseling;
- Complementary or alternative treatments, including chiropractic care, massage therapy, hypnotherapy, herbal therapy other than those prescribed by a physician, and acupuncture;
- Compilation of outcome measures reports;
- Development, distribution, or analysis of client satisfaction surveys;
- Recreational activities

STANDARD OF CARE 1.0: LICENSURE OR ASSURANCES

The service provider must ensure that:

1.1. Each staff person who provides medical case management services to patients shall have, at a minimum, a bachelor's degree in social science or behavioral science, nursing, or a related field from an accredited domestic or international college or university. Alternatively, a minimum of one (1) year of employment experience performing medical case management, case management, or client advocacy may substitute for each year of college education.

1.2. Each medical case management supervisor shall, at a minimum, be a registered nurse licensed by the State of Texas or a professional with a Master's degree in social science or behavioral science or a related field from an accredited domestic or international college or university.

STANDARD OF CARE 2.0: MEDICAL CASE MANAGEMENT SERVICES CORE COMPONENTS

2.1 Coordinating medical care includes scheduling appointments for various treatments and referrals, including lab screenings and medical specialist appointments, as well as mental health, oral health care, and substance abuse treatment.

2.2 Follow-up of medical treatments includes accompanying clients to medical appointments, calling, emailing, texting, or writing letters concerning various treatments to ensure appointments are kept or rescheduled as needed. Additionally, follow-up includes ensuring clients have the appropriate documentation, transportation, and understanding of procedures. MCM staff must also encourage and enable open dialogue with medical healthcare professionals.

2.3 Treatment adherence includes the provision of counseling or special programs to ensure readiness for and adherence to HIV/AIDS treatments.

The HRSA/HAB performance measures for Medical Case Management Services are on the HRSA website at the following link: *Medical Case Management HRSA/HAB Performance Measures.*

MEDICAL NUTRITION THERAPY

HRSA Description: Medical nutrition therapy must include the following:[10]

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

These services can be provided in individual or group settings, aside from HIV Outpatient/Ambulatory Health Services. All services provided under this category must be according to a medical provider referral and based on a nutritional plan developed by the registered dietician or other licensed nutrition professional.

Activities may include:

- Referral for BMI (Body Mass Index), Bioelectrical Impedance Analysis (BIA), or other appropriate measures of nutritional status;
- Review of lab results to gauge nutritional/supplement needs;
- Provide counseling in health promotion, disease progression, and disease prevention;
- Food provisions based on the medical care provider's recommendation:
- Provision of nutritional supplements:
    - Nutritional supplements include medical, nutritional formulas, vitamins, and herbs;
    - The provision of food consists of recommending a significant change in daily food intake based on a deficiency, which may directly affect HIV/comorbidities.

Activities may NOT include:

- Provision of food or meals.

[10] Policy Clarification Notice #16-02: Eligible Individuals and Allowable Uses of Funds. Medical Nutrition Therapy. Page 14

STANDARD OF CARE 1.0: LICENSURE OR ASSURANCES

1.1 Services must be provided by a licensed, registered dietician (RD) or other licensed nutrition professional pursuant to a medical provider's written referral.

1.2 This level of specialized instruction is above basic nutrition counseling and includes an individualized dietary assessment performed by an RD.

MENTAL HEALTH SERVICES

HRSA Description: Mental health services are the provision of outpatient psychological and psychiatric screening, assessment, diagnosis, treatment, and counseling services offered to clients living with HIV. Services are based on a treatment plan, conducted in an outpatient group or individual session, and provided by a mental health professional licensed or authorized within the state to render such services. Such professionals typically include psychiatrists, psychologists, and licensed clinical social workers.[11]

Activities must include:

- Outpatient mental health therapy and counseling services provided solely by Mental Health Practitioners licensed in the State of Texas.
- Mental Health Assessment
- Treatment Planning
- Treatment Provision
- Individual psychotherapy
- Conjoint psychotherapy
- Group psychotherapy
- Psychiatric medication assessment, prescription, and monitoring
- Psychotropic medication management
- Drop-In Psychotherapy Groups
- Emergency/Crisis Intervention
- Mental health services can be delivered via telehealth, subject to federal guidelines, Texas State law, and DSHS policy.

Activities may include

- Virtual Visits
- Telehealth/Telemedicine Visit (Address virtual telehealth/telephone visit/consultation)

[11] Policy Clarification Notice #16-02: Eligible Individuals and Allowable Uses of Funds. Mental Health Services. Page 15

STANDARD OF CARE 1.0: LICENSURE OR ASSURANCES

Licensure must meet the following criteria:

1.1 Level I psychiatric services include individual psychiatric and medication treatment and monitoring of psychiatric disorders provided by a board-certified or board-eligible psychiatrist (D.O. or M.D.) or board-certified mid-level provider licensed and specializing in psychiatry (w/supervision as required by law). Services must be provided in an outpatient clinic setting, OR,

1.2 Level II counseling services include intensive mental health therapy and counseling (individual, family, and group) provided solely by a state-licensed mental health professional. Direct service providers must possess postgraduate degrees in psychology, psychiatry, or counseling (Ph.D., Ed.D., DSW, D.O., M.D., M.S., M.A., MSW, M.Ed., or equivalent) and must be licensed by the State of Texas to provide such services; OR,

1.3 Level III counseling services include general mental health therapy and counseling (individual, family, and group). Direct service providers must possess a postgraduate degree in the appropriately related field, be in the process of obtaining Level II licensure with the State of Texas, and be properly supervised by a licensed clinical supervisor approved by the state licensing board.

STANDARD OF CARE 2.0

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

2.2 Confidentiality must be maintained, is critically important, and cannot be overstated unless otherwise indicated based on federal, state, and local laws and guidelines (i.e., abuse, self, or other harm).

SERVICE STANDARDS AND PERFORMANCE MEASURES

The following standards and performance measures are guides to improving healthcare outcomes for PLWH throughout the State of Texas within the Ryan White Part A, Part B, and State Services Program.

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

• The client's responsibilities for receiving program services and the agency's responsibilities for delivering them • Patient rights, including the grievance process	
Mental Health Assessment All clients referred to the program will receive a Mental Health Assessment by licensed mental health professionals. A mental health assessment should be completed no later than the third counseling session and should include, at a minimum, the following as guided by licensure requirements: • Presenting problems • Completed mental status evaluation (including appearance and behavior, self-attitude, speech, psychomotor activity, mood, insight, judgment, suicidal ideation, homicidal ideation, perceptual disturbances, obsessions/compulsions, phobias, panic attacks) • Cognitive assessment (level of consciousness, orientation, memory, and language) • Current risk of danger to self and others • Living Situation • Social support and family relationships, including client strengths/weaknesses, coping mechanisms, and self-help strategies • Medical history • Current Medications • Substance use history • Psychosocial history to include: o Education and employment history, including military service o Sexual and relationship history and status o Physical, emotional, and sexual abuse history o Domestic violence assessment o Trauma assessment o Legal history o Leisure and recreational activities Clients are assessed for care coordination needs, and referrals are made to case management programs as appropriate. If pressing mental health	• Percentage of clients with documented mental health assessment completed by the third (3rd) counseling session, unless otherwise noted, in the client's primary record.

needs emerge during the mental health assessment requiring immediate attention that results in the assessment not being finalized by the third session, this must be documented in the client's primary record.	
Treatment Plan All eligible client files should have documented evidence of a detailed treatment plan and documentation of services provided within the client's primary record. A treatment plan shall be completed within 30 days of the Mental Health Assessment. The treatment plan should include: • Diagnosed mental health issue • Goals and objectives • Treatment type (individual, group) • Start date for mental health services • Recommended number of sessions • Date for reassessment • Projected treatment end date (estimated) • Any recommendations for follow up Treatment, as clinically appropriate, should include counseling regarding: • Risk reduction and health promotion • Substance use disorder • Treatment adherence • Development of social support systems • Community resources • Maximizing social and adaptive functioning • The role of spirituality and religion in a client's life, disability, death and dying, and exploration of future goals The treatment plan must be signed by the mental health professional rendering service and developed in conjunction with the client. Treatment plans are reviewed and modified at a minimum, midway through the number of determined sessions agreed upon for frequency of modality or more frequently as clinically indicated.	• Percentage of clients with documented detailed treatment plan and documentation of services provided within the client's primary record. • Percentage of clients with treatment plans completed and signed by the licensed mental health professional rendering services in the client's primary record. • Percentage of clients with documented evidence of treatment plans reviewed/modified at a minimum midway through the number of determined sessions agreed upon for frequency of modality in the client's primary record.
Psychiatric Referral Clients are evaluated for psychiatric intervention, and appropriate referrals are initiated as documented in the client's primary record.	• Percentage of clients with a documented need for psychiatric intervention are referred to services as evidenced in the client's primary record.
Psychotropic Medication Management	• Percentage of clients accessing medication management services with documented evidence in the client's

Psychotropic medication management services are available for all clients directly or through referrals. PharmDs can provide psychotropic medication management services. The mental health professional will discuss with the client concerns about prescribed medications (side effects, dosage, interactions with HIV medications, etc.). The mental health professional will encourage the client to discuss concerns about prescribed medications with their HIV-prescribing clinician (if the mental health professional is not the prescribing clinician) to manage medications effectively. Prescribing providers will follow all regulations required for prescribing psychoactive medications as outlined by the *Texas Administrative Code, Title 25, Part 1, Chapter 415, Subchapter A, Rule 415.10*.	primary record of education regarding medications. • Percentage of clients with changes to psychotropic/psychoactive medications with documented evidence of this change shared with the HIV-prescribing provider, as permitted by the client's signed consent to share information, in the client's primary record.
Provision of Services Services will be provided according to the individual's treatment plan and documented in the client's primary record. Progress notes are completed according to the service provider's standardized format for each session and will include the following: • Client name • Session date • Focus of session • Interventions • Progress on treatment goals • Newly identified issues/goals • Counselor signature and authentication (credentials). In urgent, non-life-threatening circumstances, an appointment will be made within one (1) business day. If an agency cannot provide the needed services, the agency will offer to refer the client to another organization that can provide the services. The referral must be made within one (1) business day for urgent, non-life-threatening situation(s).	• Percentage of clients with documented evidence of progress notes completed and signed in accordance with the individual's treatment plan in the client's primary record.
Coordination of Care Care will be coordinated across the mental health care coordination team members. The client is involved in the decision to initiate or defer treatments. The mental health professional will involve the entire care team in educating the	• Percentage of agencies who have documented evidence in the client's primary record or care coordination, as permissible, of shared mental health treatment adherence with the client's prescribing provider.

client, providing support, and monitoring mental health treatment adherence. Problem-solving strategies or referrals are in place for clients who need to improve adherence (e.g., behavioral contracts). There is evidence of consultation with medical care/psychiatric/pharmacist as appropriate regarding medication management, interactions, and treatment adherence.	
Referrals As needed, mental health providers will refer clients to a full range of medical/mental health services, including: • Psychiatric evaluation • Pharmacist for psychotropic medication management • Neuropsychological testing • Day treatment programs • In-patient hospitalization • Family/Couples therapy for relationship issues unrelated to the client's HIV diagnosis	• Percentage of clients with documented referrals, as applicable, for other medical/mental health services in the client's primary record.
Discharge Planning Discharge planning will be done with each client when treatment goals are met or when a client has discontinued therapy, as evidenced by non-attendance of scheduled appointments, as applicable. Documentation for discharge planning will include, as applicable: • Circumstances of discharge • Summary of needs at admission • Summary of services provided • Goals and objectives completed during counseling • Discharge plan • Counselor authentication, in accordance with current licensure requirements	• Percentage of clients with documentation of discharge planning when treatment goals are being met as evidenced in the client's primary record. • Percentage of clients with documentation of case closure per agency non-attendance policy as evidenced in the client's primary record.

ORAL HEALTH CARE

HRSA Definition: Oral health care services provide outpatient diagnostic, preventive, and therapeutic services by dental health care professionals, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants.[12]

Activities must include:

- Diagnosis and treatment of existing dental disorders and services aimed at preventing similar disorders in the future. [13]

Activities may include:

- Preventive Services: dental cleanings, examinations, x-rays, adjustments to removable appliances, and one surface restorations;
- Routine Services: initial examinations, emergency appointments, deep cleanings with anesthesia, simple extractions, multiple surface restorations, biopsies, and localized chemotherapy;
- Specialty Service: surgical extractions, extensive restorations, periodontal surgeries, restorations requiring sedation, root canals, occlusal guards, and prosthodontics (partials and dentures).
- Oral health services visits may be delivered via telehealth and are subject to federal guidelines, the Texas Dental Board, DSHS policy, and guidelines established by the Administrative Agency.
- Virtual Visits
- Telehealth/Medicine Visit (Addresses virtual telehealth/telephone visit/consultation)

Activities may not include:

- Cosmetic dentistry for cosmetic purposes only is prohibited.

STANDARD OF CARE 1.0: LICENSURE OR ASSURANCES

1.1. All service provider staff, contractors, and consultants who provide direct-care services and require licensure shall be appropriately licensed by the Texas State Board of Dental Examiners.

1.2. Dental students and dental hygiene students who provide direct-care services may only do so under the direction and supervision of a licensed dentist.

SERVICE STANDARDS AND PERFORMANCE MEASURES

The following standards and performance measures are guides to improving healthcare outcomes for PLWH throughout the State of Texas within the Ryan White Part A, Part B, and State Services Program.

[12] Policy Clarification Notice #16-02: Eligible Individuals and Allowable Uses of Funds. Oral Health Care Program. Page 15

[13] American Dental Association Parameters. https://ebd.ada.org/en/evidence/guidelines

Service Standard	Performance Measure
Dental and Medical History To develop an appropriate treatment plan, the oral health care provider shall obtain complete information about the patient's health and medication status. This information shall include, but not be limited to, the following: • The client's HIV-prescribing primary medical care provider's name and phone number; • Pregnancy status as applicable; • A baseline current CBC laboratory test; • Current CD4 and Viral Load laboratory test results; • Coagulants (PT/INR, aPTT, and if hemophiliac baseline deficient factor level [e.g., Factor VIII activity]) and inhibitor titer (e.g., BIA); • Tuberculosis screening result; • Patient's chief complaint; • Current Medications, including any osteoporotic medications; • Sexually transmitted infections; • HIV-associated illnesses; • Allergies and drug sensitivities; • Alcohol use; • Recreational drug use; • Tobacco use; • Neurological diseases; • Hepatitis A, B, C status; • Usual oral hygiene; • Date of last dental examination; and • Any predisposing conditions that may affect the prognosis, progression, and management of oral health conditions. All lab results documented in the medical and dental history must align with current treatment guidelines.	• Percentage of oral health patients who had a dental and medical health history (initial or updated) at least once in the measurement year **(HRSA/HAB Performance Measure).**
Limited Physical Examination The oral health provider is responsible for completing an initial limited physical examination in accordance with the Texas Board of Dental Examiners that shall include, but not be limited to: • Blood Pressure; • Pulse/Heart Rate; and	• Percentage of oral health patients with a documented limited physical examination completed in the primary client oral health record.

• Basic vital signs. The dental practitioner shall also record blood pressure and pulse heart rate as indicated for invasive procedures involving sedation and anesthesia. If the dental practitioner is unable to obtain a patient's vital signs, the dental practitioner must document in the patient's oral health care record why the attempt to obtain vital signs was unsuccessful.	
Oral Examination Clinical oral evaluations include evaluation, diagnosis, and treatment planning. A patient must have either an initial comprehensive oral exam or a periodic recall oral evaluation once per year, such as: • Comprehensive oral evaluation, to include bitewing x-rays, new or established patients; • Periodic Oral Evaluation to include bitewing x-rays established patient; • Detailed and Extensive Oral Evaluation, problem-focused by report; • Re-evaluation, limited, problem-focused (established patient; not post-operative visit), or • Comprehensive Periodontal Evaluation, new or established patient.	• Percentage of oral health patients with a documented oral examination completed within the measurement year in the client's primary oral health record.
Periodontal Screening or Examination A periodontal screen shall include the assessment of medical and dental histories, the quantity and quality of attached gingival, bleeding, tooth mobility, and a radiological review of the status of the periodontium and dental implants. A comprehensive periodontal examination includes: • Evaluation of periodontal conditions; • Evaluation and recording of dental caries; • Evaluation and recording of missing or unerupted teeth; • Evaluation and recording of restorations; • Evaluation and recording of occlusal relationships; • Evaluation of oral cancer; • Probing and charting;	• Percentage of oral health patients who had a periodontal screen or examination at least once in the measurement year **(HRSA/HAB Performance Measure).**

• Evaluation and recording of the patient's dental and medical history; and • General health assessment. Some forms of periodontal disease may be more severe in individuals with immune system disorders. Patients with HIV may have especially severe forms of periodontal disease. The incidence of necrotizing periodontal diseases may increase in patients with acquired immune deficiency syndrome (AIDS).	
Dental Treatment Plan A dental treatment plan that includes preventive care, maintenance, and elimination of oral pathology shall be developed and discussed with the patient. Various treatment options shall be discussed and developed in collaboration with the patient. A treatment plan appropriate for the patient's health status, financial status, and individual preference must include as clinically indicated: • Provision for the relief of pain; • Elimination of infection; • Preventive plan component; • Periodontal treatment plan if necessary; • Elimination of caries; • Replacement or maintenance of tooth space or function; • Consultation or referral for conditions where treatment is beyond the scope of services offered; • Determination of adequate recall interval; • Invasive Procedure Risk Assessment (before oral surgery, extraction, or other invasive procedure); • The dental treatment plan will be signed by the oral care health professional providing the services. (Electronic signatures are acceptable)	• Percentage of oral health patients who had a dental treatment plan developed or updated at least once in the measurement year **(HRSA/HAB Performance Measure).**
Phase 1 Treatment Plan Phase 1 treatment includes prevention, maintenance, and elimination of oral pathology that results from dental caries or periodontal disease. This includes: • Restorative treatment; • Basic periodontal therapy (nonsurgical);	• Percentage of oral health patients with a Phase 1 treatment plan completed within 12 months **(HRSA/HAB Performance Measure).**

• Basic oral surgery that includes extractions and biopsy; • Non-surgical endodontic therapy and • Space maintenance and tooth eruption guidance for transitional dentition. A Phase 1 treatment plan will be established and updated annually to include diagnostic, preventive, and therapeutic services that will be provided. The Phase 1 treatment plan, if the care was completed on schedule, is completed within 12 months of initiating treatment.	
Oral Health Education Oral health education must be provided and can be documented by either a licensed dentist, dental hygienist, dental assistant, or dental case manager and shall include: • Oral hygiene instruction • Daily brushing and flossing (or other interproximal cleanings) and prosthetic care to remove plaque; • Daily use of over-the-counter fluorides to prevent or reduce cavities when appropriate and applicable to the patient. If deemed appropriate, the reason is stated in the patient's oral health record; and • Smoking/tobacco cessation counseling as indicated. Additional areas for instruction may include Nutrition. For pediatric patients, oral health education shall be provided to parents and caregivers and be age-appropriate.	• Percentage of oral health patients who received oral health education at least once in the measurement year **(HRSA/HAB Performance Measure)**.
Referrals Referrals for other services must be documented in the patient's oral health care chart. Any referrals provided by the oral health provider must have documented evidence of outcomes of the referral and/or follow-up documentation regarding the referral.	• Percentage of oral health patients with documented referrals provided have outcomes and/or follow-up documentation in the primary oral health care record.

OUTPATIENT/AMBULATORY HEALTH SERVICES

HRSA Definition: Outpatient/Ambulatory Health Services (OAHS) are diagnostic and therapeutic services provided directly to a client by a licensed healthcare provider in an outpatient medical setting. Outpatient medical settings include clinics, medical offices, and mobile vans where clients do not stay overnight. Emergency room or urgent care services are not considered outpatient settings.[14]

Allowable activities include:

- Medical history taking
- Physical examination
- Diagnostic testing, including laboratory testing
- Treatment and management of physical and behavioral health conditions, including minor surgeries, care of minor injuries, and continuing care and management of chronic conditions.
- Behavioral risk assessment, subsequent counseling, and referral, including early intervention and risk assessment;
- Preventive care and screening
- Pediatric developmental assessment
- Prescription and management of medication therapy, including antiretroviral medications and prophylaxis and treatment of opportunistic infections;
- Treatment adherence
- Education and counseling on health, prevention, and nutritional issues
- Referral to and provision of specialty care related to HIV diagnosis
- Vision Screening/Eye exam as primary medical care visit
- Telemedicine is an acceptable means of providing OAHS but must conform to the Texas Medical Board (TMB) guidelines for providing telemedicine, *Texas Administrative Code, Texas Medical Board, Rules, Title 22, Part 9, Chapter 174, RULE §174.1 to §174.12* and the *February 2020 Texas Medicaid Provider Telecommunication Services Handbook, Volume 2*.

Activities must include:

- Provision of care that is consistent with Public Health Service guidelines.

Activities may not include:

- Complementary or alternative treatments, including chiropractic care, massage therapy, hypnotherapy, and acupuncture;
- Inpatient medical services;
- Emergency room, urgent care, hospital, or any inpatient treatment center services;
- Pharmacist consultations.

[14] Policy Clarification Notice #16-02: Eligible Individuals and Allowable Uses of Funds. Outpatient/Ambulatory Health Services. Page 15

STANDARD OF CARE 1.0: LICENSURE OR ASSURANCES

1.1. the service provider's facilities shall be appropriately licensed, as required by the State of Texas, for the provision of medical care services.

1.2. All service provider staff, contractors, and consultants who provide direct-care services and who require licensure shall be properly licensed by the State of Texas or documented to be pursuing Texas licensure while performing tasks that are legal within the provisions of the Texas Medical Practice Act (or in the case of a nurse, the Nursing Practice Act), including satisfactory arrangements for malpractice insurance.

STANDARD OF CARE 2.0: DIAGNOSTIC LABORATORY TESTING

2.1. Diagnostic Laboratory Testing includes all indicated medical diagnostic testing, including all tests considered integral to treating HIV and related complications (e.g., viral load, CD4 (cluster of differentiation 4) counts, and genotype assays). Funded tests must meet the following conditions:

a. Tests must be consistent with medical and laboratory standards as established by scientific evidence and supported by professional panels, associations, or organizations;

b. Tests must be (1) approved by the FDA when required under the FDA Medical Devices Act; and (2) performed in an approved Clinical Laboratory Improvement Amendments of 1988 (CLIA)-certified laboratory or State-exempt laboratory; and

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

SERVICE STANDARDS AND PERFORMANCE MEASURES

The following standards and performance measures are guides to improving clinical care throughout the State of Texas within the Ryan White Program. The most current *Guide for HIV/AIDS Clinical Care* is cited throughout the standards for additional reference materials for direct care service providers.

Service Standard	Performance Measure
Medical Evaluation/Assessment • All HIV patients receiving medical care shall have a completed initial comprehensive medical evaluation/assessment and physical examination that adheres to the current U. S. Department of Health and Human Services (HHS) guidelines within one (1) month of HIV diagnosis[15] or within 15	• Percentage of patients who attended a routine HIV medical care visit within one (1) month of HIV diagnosis **(HRSA/HAB Measure – Linkage to Care).** • Percentage of existing patients (returning to care and those in current medical care for more than one year) with a documented comprehensive assessment/evaluation completed by a doctor of medicine (MD), nurse

[15] U.S. Department of Health and Human Services, Health Resources and Services Administration, Guide for HIV/AIDS Clinical Care – 2014 Edition. Page 61

business days of initial contact with a patient who has been in care. • Primary medical care for the treatment of HIV includes the provision of care that is consistent with the most current HHS treatment guidelines.	practitioner (NP), clinical nurse specialist (CNS), or physician assistant (PA) within 15 business days of initial contact with a patient in accordance with professional and established HIV practice guidelines.
Comprehensive HIV-related History Primary medical care for the treatment of HIV includes the provision of care that is consistent with the most current HHS treatment guidelines. History shall consist of, at a minimum, general medical history, comprehensive HIV-related history, and psychosocial history to include: • Documented past medical and surgical history with regard to chronic diseases such as diabetes, high blood pressure, heart disease, cholesterol, asthma or emphysema, sickle cell disease, etc., per HHS guidelines. • Psychosocial history includes socio-cultural assessment, occupational history, hobbies (as applicable), travel history, mental health, and housing status. • Lifestyle includes tobacco use, alcohol use, illicit substance use, exercise, and travel history. • Sexual Health includes partners, practices, past sexually transmitted infections (STIs), and contraception use (past and present). • HIV-related health history, including most recent CD4 and Viral Load results, current antiretroviral therapy (if applicable), previous adverse ART drug reactions, history of HIV-related illness and infections, HIV treatment history, and staging. The physical examination will include documentation from the complete review of systems, as indicated in the comprehensive medical history.[16] This can be completed during the initial visit or divided over the course of two or three early visits.	• Percentage of new patients with a documented comprehensive HIV-related history that is inclusive of all components listed in the OAHS Standard as referenced in the HHS guidelines. • Percentage of existing patients with a documented comprehensive HIV-related history that is inclusive of all components listed in the OAHS Standard as referenced in the HHS guidelines.
Physical Examination	• Percentage of new patients with a documented annual physical examination.

[16] U.S. Department of Health and Human Services, Health Resources and Services Administration, Guide for HIV/AIDS Clinical Care – 2014 Edition. Pages 61-70

Primary medical care for the treatment of HIV includes the provision of care that is consistent with the most current HHS treatment guidelines.[17] Providers should perform a baseline and annual comprehensive physical examination, with particular attention to areas potentially affected by HIV. Examination of the oral cavity should be included in the initial and interim physical examinations of all HIV patients.	• Percentage of new patients living with HIV who received an oral cavity exam during the physical exam as documented in the patient's primary record. • Percentage of existing patients with a documented annual physical examination. • Percentage of existing persons living with HIV who received an oral cavity exam during the physical exam as documented in the patient's primary record
Initial laboratory tests, as clinically indicated by licensed provider:[18] **Tests will include as clinically indicated:** • HIV Antibody, if not documented previously; • CD4 Count and/or CD4 Percentage • Quantitative Plasma HIV RNA (HIV Viral Load) • Standard genotypic drug-resistance testing (refer to *Table 3* in the *"Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents Living with HIV"* for guidance on other scenarios where genotype testing is recommended) • Co-receptor Tropism Test (if considering the use of a CCR5 co-receptor antagonist or for patients who exhibit virologic failure on a CCR5 antagonist) • HLA-B*5701 testing (only before initiating abacavir-containing regimen per guidelines) • Complete Blood Count (CBC) with Differential and Platelets • Chemistry Profile: Electrolytes, Creatinine, Blood Urea Nitrogen (BUN) • Liver Transaminases, Bilirubin (Total and Direct) • Urinalysis with Urine Protein and Creatinine • Quantitative HCV RNA viral load testing (for Hepatitis C (HCV)- positive patients who are candidates for treatment)	• Percentage of new patients with documented initial laboratory tests completed according to the OAHS Standard and HHS treatment guidelines. • Percentage of new patients with documented CD4 count (absolute). • Percentage of new patients with documented HIV-RNA viral load **(HRSA/ HAB Measure)**. • Percentage of new patients with documented drug resistance testing, as applicable. • Percentage of new patients living with HIV susceptible to STIs who had a test for chlamydia within the measurement year **(HRSA/HAB Measure)**. • Percentage of new patients living with HIV susceptible to STIs who had a test for gonorrhea within the measurement year **(HRSA/HAB Performance Measure)**. • Percentage of new adult patients who had a test for syphilis performed within the measurement year **(HRSA/HAB Performance Measure)**. • Hepatitis B screening was performed at least once since the diagnosis of HIV or for whom there is documented infection or immunity **(HRSA/HAB Performance Measure)**. • Percentage of new patients for whom HCV screening was performed at least once since the diagnosis of HIV **(HRSA/HAB Performance Measure).**

[17] U.S. Department of Health and Human Services, Health Resources and Services Administration, Guide for HIV/AIDS Clinical Care – 2014 Edition. Pages 73-77

[18] Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV. Department of Health and Human Services. Initial Laboratory Tests. Page C-1.

• Hepatitis A (HAV) antibody, Hepatitis B (HBV) surface antigen, core Ab (core antibody), and surface antibody & Hepatitis C antibody screens at initial intake (providers should screen all patients diagnosed for anti-HCV antibodies at baseline) • Lipid Profile (Total Cholesterol, low-density lipoprotein (LDL), high-density lipoprotein (HDL), Triglycerides); fasting • Glucose (preferably fasting) or hemoglobin A1C • Pregnancy Test (for clients with cervix of childbearing potential) • RPR or treponemal antibody (Syphilis Screening) • Extra-genital gonorrhea (GC) and Chlamydia (CT) Testing • *Toxoplasma gondii* immunoglobulin G (IgG) • Trichomoniasis testing Primary medical care for the treatment of HIV includes the provision of care that is consistent with the most current HHS treatment guidelines.[19]	
Other Diagnostic Testing Primary medical care for the treatment of HIV includes the provision of care that is consistent with the most current HHS treatment guidelines. A chest x-ray will be completed if pulmonary symptoms are present; if positive latent tuberculosis infection (LTBI) test (either tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA)); or if prior evidence of LTBI or pulmonary tuberculosis (TB) (perform annually).[20]	• Percentage of new or existing patients with documented chest x-rays completed if pulmonary symptoms were present, after an initial positive QuantiFERON TB Test (QTF), after initial positive TST, or annually if prior evidence of LTBI or pulmonary TB.
Initial Screenings/Assessments Primary medical care for the treatment of HIV includes the provision of care that is consistent with the most current HHS treatment guidelines. Patients should receive screening for opportunistic infections and assessment of	• Percentage of new patients with documented initial medical screenings and assessments as indicated in the OAHS Standard and in accordance with HHS guidelines. • Percentage of new clients with a cervix living with HIV who were screened for

[19] U.S. Department of Health and Human Services, Health Resources and Services Administration, Guide for HIV/AIDS Clinical Care – 2014 Edition. Pages 79-89

[20] U.S. Department of Health and Human Services, Health Resources and Services Administration, Guide for HIV/AIDS Clinical Care – 2014 Edition. Page 85

psychosocial needs initially and annually according to the most current HHS guidelines. **Screening should include, at a minimum:** • Mental health assessment that includes screening for clinical depression patient health questionnaire (PHQ-2) at a minimum) • Psychosocial assessment, including domestic violence and housing status[21] • Substance use and abuse screening • Tobacco use screening • Pediatric patients (14 years and younger) will be screened for child abuse as defined in *Chapter 261 of the Texas Family Code* and DSHS policy. Consider screening youth 14-17 for child abuse. • Oral health exam and assessment • TB Screening • Cervical Cancer Screen (following the most current clinical recommendations)[22] • **Women Aged <30 Years with HIV:** o If younger than age 21, known to have HIV or newly diagnosed with HIV, and sexually active, a Pap test should be performed within one (1) year of onset of sexual activity regardless of the mode of HIV transmission. • **Women Aged >30 Years with HIV** o Papanicolaou (Pap) Testing Only: • Pap test should be done at baseline and every 12 months • If the results of three (3) consecutive Pap tests are normal, follow-up Pap tests can be performed every three (3) years **Additional screenings as medically indicated include:**	cervical cancer in the last three years **(HRSA/HAB Performance Measure).** • Percentage of new patients aged 12 years and older screened for clinical depression on the date of the encounter using an age-appropriate standardized depression screening tool, AND if positive, a follow-up plan is documented on the date of the positive screen **(HRSA/HAB Performance Measure).** • Percentage of new patients with documented initial psychosocial assessment to include domestic violence and housing status. • Percentage of new patients living with HIV who have been screened for substance use (alcohol & drugs) in the measurement year **(HRSA/HAB Performance Measure)**. • Percentage of new patients aged 18 years and older screened for tobacco use one or more times within 24 months AND received cessation-counseling intervention if identified as a tobacco user **(HRSA/HAB Performance Measure).** • Percentage of new patients, if applicable, with completed child abuse assessment (completed if patient aged 14 years and younger). • Percentage of new patients aged three months and older living with HIV for whom there was documentation that a TB screening test was performed and results interpreted (for TB skin tests) at least once since the diagnosis of HIV **(HRSA/HAB Performance Measure)**.

[21] U.S. Department of Health and Human Services, Health Resources and Services Administration, Guide for HIV/AIDS Clinical Care – 2014 Edition. Page 65

[22]Panel on Opportunistic Infections in Adults and Adolescents with HIV. Guidelines for the prevention and treatment of opportunistic infections in adults and adolescents with HIV: recommendations from the Centers for Disease Control and Prevention, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. Cervical Cancer Screen Guidelines for <30 and over 3 years of age

• Dilated eye exam every 6 to 12 months if the CD4<50 by an ophthalmologist **Anal Cancer (Dysplasia) Screening** The Anal Cancer (Dysplasia) Screening Guidelines recommend, at a minimum, an annual digital examination to detect masses on palpation that could be anal cancer. However, performing the digital exam alone as a screening procedure for anal dysplasia or cancer will miss many lesions. Anal cancer screening using a Pap test can improve sensitivity for detecting anal dysplasia or cancer.[23] Cytology combined with high-resolution anoscopy (HRA) is considered the best strategy for the screening of precancerous lesions. If anal pap is performed, clinicians should refer patients with abnormal anal cytology for HRA. In communities where HRA is unavailable, clinicians should consider referring patients with abnormal anal cytology to a surgeon for evaluation.	
Immunizations Primary medical care for the treatment of HIV includes the provision of care that is consistent with the most current HHS treatment guidelines. Immunizations/vaccinations will be given according to the most current HHS guidelines and the Centers for Disease Control and Prevention's (CDC) "*2019 Recommended Adult Vaccination Schedule.*" Providers will initiate prophylaxis for specific opportunistic infections. **Patients will be offered vaccinations for the following:** • Tetanus, Diphtheria, and Pertussis (Tdap) per recommended treatment guidelines for immunizations[24] • Measles, Mumps, Rubella (MMR) per recommended treatment guidelines for immunizations.[25] Adults and adolescents	• Percentage of patients with Tetanus, Diphtheria, and Pertussis current within ten (10) years, tetanus and diphtheria (TD) booster doses every ten (10) years thereafter, or documentation of refusal. • Percentage of patients aged six months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization **(HRSA/HAB Performance Measure)**. • Percentage of patients living with HIV who completed the vaccination series for Hepatitis B **(HRSA/HAB Performance Measure)**. • Percentage of patients living with HIV who ever received a pneumococcal

[23] U.S. Department of Health and Human Services, Health Resources and Services Administration, Guide for HIV/AIDS Clinical Care – 2014 Edition. pages 83-89

[24] Panel on Opportunistic Infections in Adults and Adolescents with HIV. Guidelines for the prevention and treatment of opportunistic infections in adults and adolescents with HIV: recommendations from the Centers for Disease Control and Prevention, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. TDAP Vaccination Guidelines

[25] Panel on Opportunistic Infections in Adults and Adolescents with HIV. Guidelines for the

	with a CD4 cell count <200 cells/μL should not receive MMR. • Influenza (inactivated vaccine)- annually during flu season, October 1st - March 31st • Pneumococcal is recommended for all patients; two separate vaccines are recommended; • Receive a dose of pneumococcal conjugate vaccine (PCV13 (Prevnar 13)), followed by a dose of pneumococcal polysaccharide vaccine (PPV23 (Pneumovax)) at least eight (8) weeks later.[26] • Completion of Hepatitis B (HBV) vaccines series, unless otherwise documented as immune, vaccinated patients should be tested for a hepatitis B surface antibody (HBsAb) response 1–2 months or at the subsequent scheduled clinic visits after the third dose.[27] • Completion of Hepatitis A vaccine series, unless otherwise documented as immune. • Varicella-Zoster virus (VZV): Please reference current treatment guidelines for VZV.[28] **This vaccination is contraindicated in persons with HIV and a CD4 count <200.** • The Advisory Committee on Immunization Practices (ACIP) recommends, and HHS states: "because of the potential benefit in preventing HPV-associated disease and cancer in this population, HPV vaccination	vaccine **(HRSA/HAB Performance Measure)**. • Percentage of patients living with HIV who completed the vaccination series for Hepatitis A.

prevention and treatment of opportunistic infections in adults and adolescents with HIV: recommendations from the Centers for Disease Control and Prevention, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. MMR Vaccination Guidelines

[26] Panel on Opportunistic Infections in Adults and Adolescents with HIV. Guidelines for the prevention and treatment of opportunistic infections in adults and adolescents with HIV: recommendations from the Centers for Disease Control and Prevention, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. Pneumococcal Vaccination Guidelines

[27]Panel on Opportunistic Infections in Adults and Adolescents with HIV. Guidelines for the prevention and treatment of opportunistic infections in adults and adolescents with HIV: recommendations from the Centers for Disease Control and Prevention, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. Hepatitis B Vaccination Guidelines

[28] Panel on Opportunistic Infections in Adults and Adolescents with HIV. Guidelines for the prevention and treatment of opportunistic infections in adults and adolescents with HIV: recommendations from the Centers for Disease Control and Prevention, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. Varicella Vaccination Guidelines

is recommended for HIV-positive males and females aged 13 through 26". • For providers who need a vaccine to provide their patients at no cost to the provider, please reference the *Adult Safety Net Program*. For providers who want to refer their patients for vaccines offered at no cost or reduced cost, please review the *Eligibility and Benefits for the Adult Safety Net Program*.	
Antibiotic Treatment (Recommend Prophylactic Antibiotic Treatment) **Antibiotic prophylaxis for opportunistic infections will be initiated if an active infection has been ruled out and the following conditions are met:** • *Mycobacterium avium* complex (MAC): if CD4 <50 • Toxoplasmosis: if CD4 <100 and toxoplasma IgG is positive • Pneumocystis pneumonia (PCP) prophylaxis will be completed adhering to the current HHS Guidelines. ○ **Preventing 1st Episode of PCP (Primary Prophylaxis) Indications for Initiating Primary Prophylaxis:** • CD4 count <200 cells/mm^3 or • CD4% <14% of total lymphocyte count or CD4 count >200 but <250 cells/mm^3 if ART cannot be initiated and if CD4 cell count monitoring (e.g., every three (3) months) is not possible[29]	• Percentage of patients, regardless of age, offered MAC Prophylaxis as medically indicated. • Patients aged six weeks or older diagnosed with HIV, with CD4 counts of less than 200 cells/μL or a CD4 percentage below 15%, will be prescribed PCP prophylaxis **(HRSA/HAB Performance Measure)**.
Antiretroviral Therapy Primary medical care for the treatment of HIV includes the provision of care that is consistent with the most current HHS treatment guidelines. ART will be prescribed in accordance with the HHS-established guidelines.	• Percentage of patients, regardless of age, living with HIV, are prescribed ART for the treatment of HIV during the measurement year **(HRSA/HAB Performance Measure)**.

[29] Panel on Opportunistic Infections in Adults and Adolescents with HIV. Guidelines for the prevention and treatment of opportunistic infections in adults and adolescents with HIV: recommendations from the Centers for Disease Control and Prevention, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America.

Patients who meet current guidelines for ART are offered and/or prescribed ART.[30]	
Drug Resistance Testing Primary medical care for the treatment of HIV includes the provision of care that is consistent with the most current HHS treatment guidelines. "HIV drug-resistance testing is recommended for persons diagnosed with HIV at entry into care. Genotypic testing is recommended as the preferred resistance testing to guide therapy in ARV-naïve patients."[31,32] Drug resistance testing must follow the most recent, established guidelines on resistance testing, including genotypic testing on all ARV-naïve patients. The patient's medical practitioner, a registered nurse, or other appropriately licensed healthcare providers (if designated by the practitioner) must provide counseling and education about drug resistance testing.[33] **Drug Resistance Assay Not Usually Recommended** **After therapy is discontinued:** Drug-resistance testing is not usually recommended more than four (4) weeks after ARV drugs are discontinued. **In patients with low HIV RNA levels,** Drug-resistance testing is not usually recommended in patients with a plasma viral load of <500 copies/mL.	• Percentage of patients, regardless of age, living with HIV who had an HIV drug resistance test performed before initiation of HIV ART if therapy started during the measurement year **(HRSA/HAB Performance Measure)**.
Health Education/Risk Reduction Health education will adhere to the most current HHS guidelines.	• Percentage of patients living with HIV who received HIV counseling in the measurement year **(HRSA/HAB Performance Measure)**. • Percentage of patients aged 18 years and older screened for tobacco use one or

[30] U.S. Department of Health and Human Services, Health Resources and Services Administration, Guide for HIV/AIDS Clinical Care – 2014 Edition. Antiretroviral Therapy. Pages 207-220

[31] Panel on Opportunistic Infections in Adults and Adolescents with HIV. Guidelines for the prevention and treatment of opportunistic infections in adults and adolescents with HIV: recommendations from the Centers for Disease Control and Prevention, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America.

[32] Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV. Page C-12

[33] U.S. Department of Health and Human Services, Health Resources and Services Administration, Guide for HIV/AIDS Clinical Care – 2014 Edition. Drug Resistance Testing. Page 81

	Providers will provide routine HIV-reduction counseling and behavioral health counseling for HIV-infected patients. Since patients' behaviors change over time as the course of disease changes and their social situations vary, health education providers will tailor routine risk-reduction counseling and behavioral health counseling not only to the individual patient but also to the particular point in time in the patient's life. **The following will be conducted initially and as needed:** • Providers should discuss safer sexual practices to decrease the probability of transmitting HIV. • Providers should counsel persons living with HIV about the possibility of acquiring syphilis and other STIs from unprotected sexual contact, including all sites of possible transmission, such as the anus, cervix, vagina, urethra, and oropharynx.[34] • Providers should discuss family planning with patients • Contraception counseling/hormonal contraception • Drug interaction counseling Providers should counsel patients on tobacco cessation annually for those patients that were screened and positive for smoking (or documented decline of tobacco use)[35] • When current alcohol or other substance use is identified, providers should discuss the possible effects of such use on the patient's general health and HIV medications, as well as options for treatment if indicated. • Providers should routinely discuss with patients the importance of disclosure to partners. Patients should be educated about the options for voluntary partner notification. • When HIV patients are diagnosed with early syphilis (primary, secondary, or early	more times within 24 months AND received cessation-counseling intervention if identified as a tobacco user **(HRSA/HAB Performance Measure)**. • Percentage of patients with documented counseling about family planning method appropriate to patient's status, as applicable. • Percentage of patients with documented instruction regarding new medications, as appropriate. • Percentage of patients with documented counseling regarding the importance of disclosure to partners.

[34] U.S. Department of Health and Human Services, Health Resources and Services Administration, Guide for HIV/AIDS Clinical Care – 2014 Edition. Patient Education. Pages 57-59

[35] U.S. Department of Health and Human Services, Health Resources and Services Administration, Guide for HIV/AIDS Clinical Care – 2014 Edition. Smoking Cessation. Pages 189 -196

latent), providers should intensify reduction counseling, including discussing the importance of condom use.
• **Nutritional Counseling regarding:**[36]
  ○ Quality and quantity of daily food and liquid intake
  ○ Exercise (as medically indicated)	

Treatment Adherence Assessment of treatment adherence and counseling will be provided that adheres to current HHS guidelines.[37] Patients are assessed for treatment adherence and counseling at a minimum of twice a year. Those prescribed ongoing ART regimen must receive adherence assessment and counseling on every HIV-related clinical encounter. If an adherence issue is identified by another member of the healthcare team (Medical Case Manager (MCM), medical assistant (MA), licensed vocational nurse (LVN), or registered nurse (RN)), there should be documented evidence of adherence counseling and follow-up action. This adherence counseling documentation must be evident in the patient's medical record and indicate that the prescribing provider was aware of the adherence issue.	• Percentage of patients with documented assessment for treatment adherence two or more times within the measurement year if the patient is on ART. • Percentage of patients with documented adherence issues who received counseling for treatment adherence two or more times within the measurement year.
Referrals Providers will refer to specialty care or other systems as appropriate in accordance with current HHS guidelines. At a minimum, patients should receive referrals to specialized health care/providers/services **as needed or medically indicated** to augment medical care:[38] • If the CD4 count is below 50, the patient should be referred for examination by an ophthalmologist. • AIDS Drug Assistance Program (ADAP) • Medication Assistance Programs	Percentage of patients, as medically indicated, who had documentation of referrals for: • Mental Health and/or Substance Use • Oral Health • Ophthalmological services • Child abuse (if abuse is suspected) • Disease intervention specialist • Other specialty services. • Percentage of patients with a documented referral in the measurement year has a progress note in the patient's chart regarding attendance and outcomes of the referral.

[36] U.S. Department of Health and Human Services, Health Resources and Services Administration, Guide for HIV/AIDS Clinical Care – 2014 Edition. Nutrition. Pages 197-202

[37] U.S. Department of Health and Human Services, Health Resources and Services Administration, Guide for HIV/AIDS Clinical Care – 2014 Edition. Adherence. Page 273

[38] U.S. Department of Health and Human Services, Health Resources and Services Administration, Guide for HIV/AIDS Clinical Care – 2014 Edition. Initial Physical Examination. Page 73

• Medical care coordination
• Medical Specialties
• Mental health and substance use services
• Treatment education services
• Partner counseling and referral
• Annual oral hygiene and intraoral examinations, including dental caries and soft-tissue examinations.
• Medical Nutrition Therapy (MNT)
• Health maintenance, as medically indicated, such as:
  ○ Cervical Cancer Screening
  ○ Family Planning
  ○ Colorectal cancer screening
  ○ Breast cancer screening
• Specialty medical care for any preexisting chronic diseases
• Case Management Services or a Disease Intervention Specialist (DIS) for follow-up if a client misses appointments.
Service providers/staff are expected to follow up on each referral to assess attendance and outcomes.
Refer to the *United States Preventive Services Task Force* (USPSTF) for details on specific screening modalities and timeframes.	

Follow-up Visits Outpatient Medical Care will adhere to the current HHS guidelines for ongoing health care. Reassessment/reevaluation of health history, comprehensive physical examination, and annual laboratory testing should be documented in the patient's medical record. All HIV patients should have the following lab tests documented annually: urinalysis, with urine protein and creatinine; fasting lipid profile; syphilis screening; and gonorrhea and chlamydia testing (screen all sites of possible exposure). These tests may need to be performed more frequently if clinically indicated. **Every 3-6 months:**[39]	• Percentage of existing patients with documented initial medical screenings and assessments as indicated in the OAHS Standard and in accordance with HHS guidelines. • Percentage of patients, regardless of age, living with HIV who had at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits **(HRSA/HAB Performance Measure)**. • Percentage of patients, regardless of age, living with HIV who did not have a medical visit in the last six (6) months of the measurement year **(HRSA/HAB Performance Measure)**. • Percentage of patients, regardless of age, living with HIV with an HIV viral load less

[39] Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV. Department of Health and Human Services. Table 3

	• HIV-RNA viral load; CBC with differential; chemistry profile (to include electrolytes, BUN, creatinine, bicarbonate (HCO_3), estimated glomerular filtration rate (eGFR)); • liver function tests (to include transaminases, total and direct bilirubin); • and glucose[40] (preferably fasting) or hemoglobin A1c. These tests may need to be performed more frequently if clinically indicated. Providers will continually evaluate patients for adverse outcomes and document the actions taken, outcomes, and follow-up.[41]	than 200 copies/mL at the last HIV viral load test during the measurement year **(HRSA/HAB Performance Measure)**. • Percentage of existing clients with cervix living with HIV who were screened for cervical cancer in the last three years **(HRSA/HAB Performance Measure)**. • Percentage of existing patients living with HIV susceptible to STIs who had a test for chlamydia within the measurement year **(HRSA/HAB Performance Measure)**. • Percentage of existing patients living with HIV susceptible to STIs who had a test for gonorrhea within the measurement year **(HRSA/HAB Performance Measure)**. • Percentage of existing adult patients living with HIV who had a test for syphilis performed within the measurement year **(HRSA/HAB Performance Measure)**. • Percentage of existing patients aged 12 years and older screened for clinical depression (annually) on the date of the encounter using an age-appropriate standardized depression screening tool, AND if positive, a follow-up plan is documented on the date of the positive screen **(HRSA/HAB Performance Measure)**. • Percentage of existing patients with documented annual psychosocial assessment to include domestic violence and housing status. • Percentage of existing patients living with HIV who have been screened for substance use (alcohol & drugs) in the measurement year **(HRSA/HAB Performance Measure)**. • Percentage of existing patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user **(HRSA/HAB Performance Measure)**.

[40] Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV. Department of Health and Human Services. Table 3

[41] U.S. Department of Health and Human Services, Health Resources and Services Administration, Guide for HIV/AIDS Clinical Care – 2014 Edition. Adverse Reactions to HIV Medications. Page 527

	• Percentage of existing patients, if applicable, with completed child abuse assessment (completed if patient aged 14 years and younger). • Percentage of existing patients aged three (3) months and older living with HIV for whom there was documentation that a TB screening test was performed and results interpreted (for TB skin tests) at least once since the diagnosis of HIV **(HRSA/HAB Performance Measure)**. • Percentage of existing patients, regardless of age, for whom Hepatitis B screening was performed at least once since the diagnosis of HIV or for whom there is documented infection or immunity **(HRSA/HAB Performance Measure)**. • Percentage of existing patients for whom HCV screening was performed at least once since the diagnosis of HIV **(HRSA/HAB Performance Measure)**. • Percentage of patients, regardless of age, living with HIV who were prescribed HIV ART and who had a fasting lipid panel during the measurement year **(HRSA/HAB Performance Measure)**.
Documentation in Patient's Medical Chart Primary medical care for the treatment of HIV includes the provision of care that is consistent with the most current HHS treatment guidelines. Clinicians will develop/update the plan of care at each visit. If a patient refuses a treatment, such as vaccinations, documentation of denial will be written in the patient's medical chart. The provider developing the plan will sign each entry.	• Percentage of patient medical records with signed clinician entries. • Percentage of flow sheets present and updated in the patient medical records. • Percentage of problem lists present and updated in the patient medical records. • Percentage of medication lists present and updated in the patient medical records.
Documentation of Missed Patient Appointments and Efforts to Bring the Patient into Care.	• Percentage of patient medical records with documentation of specific barriers and efforts to address missed appointments.

The service provider or staff will conduct the following:[42] • Contact patients who have missed three (3) consecutive appointments, using at least three (3) different forms of contact (email, phone, mail, emergency contact, phone call, referral to a DIS for home visit) prior to determining they are lost to follow-up; • Address any specific barriers to accessing services; Document the number of missed patient appointments and efforts to bring the patient into care	

SUBSTANCE ABUSE OUTPATIENT CARE

HRSA Description: Substance abuse outpatient care is the provision of outpatient services for treating drug or alcohol use disorders.[43]

Services include:

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

Services are limited to the services below, as stated in the HRSA National Monitoring Standards. RWHAP funds shall not be used to establish or operate any programs for distributing sterile needles or syringes for the hypodermic injection of any illegal drugs. Please reference the *Texas Health and Safety Code, Title 6, Subtitle C, Chapter 481, Subchapter A. General Provisions*.

[42] U.S. Department of Health and Human Services, Health Resources and Services Administration, Guide for HIV/AIDS Clinical Care – 2014 Edition. Supporting Patients in Care. Page 1

[43] Policy Clarification Notice #16-02: Eligible Individuals and Allowable Uses of Funds. Substance Abuse Outpatient Care. Page 16

Activities may include:

- Individual and group therapy;
- Skills training;
- Discharge planning;
- Aftercare and follow-up;
- Harm reduction counseling.
- Virtual Visits
- Telehealth/Medicine Visit
- (Address virtual telehealth/telephone visit/consultation

Activities may not include:

- Residential health services.

STANDARD OF CARE 1.0: LICENSURE OR ASSURANCES

The service provider shall:

1.1 Be appropriately licensed by DSHS Substance Abuse Outpatient Services.

1.2 Satisfy all requirements, as outlined in DSHS Substance Abuse Services Licensure Rules and Counselor Licensure Rules. All service provider staff and contractors who deliver direct client care shall be properly licensed/credentialed.

1.3 Provide access to its system of substance abuse treatment for those with HIV/AIDS twenty-four (24) hours/day, and must provide mechanisms for urgent and emergency care; and

1.4 provide a means for clients who have discontinued service due to discharge, discontinuation, relapse, etc., to return to services with the service provider or be referred to a more appropriate service provider.

1.5 Work with the client to develop and implement goals, objectives, and strategies within an individualized, written treatment plan, which the client shall sign. The plan shall identify services and support needed to address problems and needs identified during a comprehensive psychosocial assessment consistent with DSHS Substance Abuse Services rules and regulations. The agency shall review the plan at least every six months, revise it as necessary,

1.6 identify discharge criteria, and include an initial discharge plan. The discharge plan shall address the continuity of services and ongoing needs of the client. The service provider shall document follow-up no sooner than 60 days and no later than 90 days after discharge.

SERVICE STANDARDS AND PERFORMANCE MEASURES

The following standards and performance measures are guides to improving healthcare outcomes for PLWH throughout the State of Texas within the Ryan White Part A, Part B, and State Services Program.

Service Standard	Performance Measure
Initial Appointment/Screening	• Percentage of client charts with documentation of an appointment

Face-to-face client orientation is provided to all new clients to introduce them to program services, ensure their understanding of the need for continuous care, and empower them to access services. In accordance with the Texas Administrative Code (TAC), clients will be informed of opportunities for the family to be involved in the client's treatment. An appointment will be scheduled within a reasonable amount of time, not more than ten (10) business days, from a client's request for substance use services. The agency may provide written orientation materials to the client that support the above information, are culturally sensitive, promote equity, and are linguistically appropriate. In urgent, non-life-threatening emergency circumstances, an appointment will be made as soon as possible but no later than within one (1) business day, subject to licensure requirements. If an agency cannot provide the needed services, the agency will offer to refer the client to another organization that can provide the services. The referral must be made within one (1) business day for urgent, non-life-threatening situation(s). Each client must complete a documented screening based on best practice standards of care using the Texas Department of Insurance criteria per TAC standards. The screening process shall collect the necessary information to determine the services required to meet the client's needs.[44]	scheduled after request (referral) for substance use outpatient services. • Percentage of client charts with documentation of completed screening as indicated.
Comprehensive Psychosocial Assessment All clients referred to the program will receive a Comprehensive Psychosocial Assessment (in accordance with TAC Standards) by a licensed substance use counselor. Initial comprehensive psychosocial assessment protocols shall provide for screening individuals to determine the level of need and appropriate treatment plan development. A comprehensive psychosocial assessment will be completed before the third counseling session* and will include the following: • Presenting problems resulting in need;	

[44] Texas Administrative Code, Title 25, Part 1, Chapter 448, Subchapter H, Rule §448.801, Screening

• Alcohol and other drug use; • Psychiatric and chemical dependency treatment; • Medical history and current health status, to include an assessment of Tuberculosis (TB), HIV, and other sexually transmitted infections (STI) as permitted by law; • Relationships with family, including domestic/intimate partner violence; • History of trauma/related events; • Stigma; • Housing Stability, expelled from home; • Treatment adherence (e.g., HIV meds); • Social and leisure activities; • Education and vocation training; • Employment history; • Legal issues; • Mental/emotional functioning; and • Strengths and weaknesses.[45] The assessment shall result in a diagnosed substance use issue, as allowed by the counselor's license and scope of practice. *Note: Clients are assessed for care coordination needs, and referrals are made to other case management programs as appropriate. If pressing needs emerge during the assessment requiring immediate attention that results in the assessment not being finalized by the third session, this must be documented in the client's primary record. Specific assessment tools such as the Substance Abuse and Mental Illness Symptoms Screener (SAMISS) and Addiction Severity Index (ASI) may be used for substance use and sexual history, and the Mini-Mental State Examination (MMSE) may be used for cognitive assessment.	
Treatment Modalities Providers must discuss treatment options with substance-using clients and ask which treatment options they prefer. Providers should inquire about the use of multiple substances and consider the full spectrum of the client's drug use when discussing treatment options.	• Percentage of client charts with documentation of discussion of treatment modalities with the client. • Percentage of client charts for clients on medication-assisted therapies, with documentation of contact with the client's medical provider within **72 hours** of treatment initiation or the client's refusal to authorize the communication.

[45] Texas Administrative Code, Title 25, Part 1, Chapter 448, Subchapter H, Rule §448.801, Screening

Providers must discuss alternative treatment modalities with the client(s) targeted toward the substance(s) that the client is still using. Providers must rely on the *ASAM Criteria* (formerly known as the ASAM Patient Placement Criteria) of the American Society of Addiction Medicine (ASAM) for guidance on selecting the best treatment alternatives for specific clients. Medical treatment for substance use must adhere to current HIV Clinical Guidelines.	• Percentage of clients with acupuncture services rendered with documented evidence of a physician's order.
Treatment Plan A treatment plan shall be completed within 30 calendar days of completing a comprehensive psychosocial assessment specific to individual client needs. The treatment plan shall be prepared and documented for each client. Treatment planning will be a collaborative process through which the provider and client develop desired treatment outcomes and identify the strategies for achieving them. Individual and family case records will include documentation of the following: • Identification of the substance use disorder • Goals and objectives • Treatment modality (group or individual) • Start date for substance use counseling • Recommended number of sessions • Date for reassessment • Projected treatment end date • Any recommendations for follow up Treatment, as appropriate, will include counseling about (at minimum): • Prevention and transmission, including root causes and underlying issues related to increased HIV transmission. • Treatment adherence • Development of social support systems • Community resources • Maximizing social and adaptive functioning • The role of spirituality and religion in a client's life, disability, death and dying, and exploration of future goals The substance use counselor rendering service will sign the treatment plan. In accordance with TAC	• Percentage of client charts that have documentation of treatment plans completed within 30 calendar days of the completed comprehensive assessment. • Percentage of client charts with documented evidence of treatment plans reviewed/modified at a minimum midway through the number of determined sessions agreed upon for frequency of modality in the client's primary record.

on Substance Abuse, the treatment plan shall be reviewed at a minimum midway through the number of determined sessions agreed upon for frequency of modality and must reflect an ongoing reassessment of the client's problems, needs, and response to therapy.	
Progress Notes Services will be provided according to the individual's treatment plan and documented in the client's record. **Progress notes are completed for every professional counseling session and include the following:** • Client name • Session date • Clinical observations • Focus of session • Interventions • Assessment • Duration of session • Newly identified issues/goals • Client's responses to interventions and referrals • HIV medication adherence • Substance use treatment adherence • Counselor authentication per current TAC Standards of Care for Substance Abuse Services.	• Percentage of client charts with documented progress notes for each counseling session as indicated.
Referrals The service provider will make appropriate referrals when necessary.	• Percentage of client charts, as applicable, with documented referrals made based on need demonstrated in the assessment and progress notes.
Discharge Planning **Discharge planning will be done with each client when treatment goals are met and include:** • Circumstances of discharge • Summary of needs at admission • Summary of services provided • Goals and objectives completed during counseling • Referral after completing substance use treatment to the case manager and primary care provider, as appropriate • Discharge plan	• Percentage of client charts with documentation, as applicable, of discharge planning with the client prior to case closure.

• Counselor authentication, in accordance with TAC Standards and the counselor licensure requirements. In all cases, providers/case managers shall ensure that, to the greatest extent possible, clients who leave care are linked with appropriate services to meet their needs.	
Discharge **Services may be discontinued when the client has:** • Reached goals and objectives in their treatment plan • Missed three (3) consecutive appointments in six (6) months. • Continued non-adherence to a treatment plan • Chooses to terminate services • Unacceptable client behavior • Deceased Completed discharge summary in accordance with *TAC Standards (§448.805)4*, as applicable.	• Percentage of client charts with documentation of case closure (discharge), the reason for discharge, or discharge summary if applicable. • **Proposed System Level Outcome Measure:** Percentage of clients who demonstrate improved viral suppression after completing Substance Use Outpatient Treatment Plan objectives.

SUPPORT SERVICES

CHILD CARE SERVICES

HRSA Description: The RWHAP supports intermittent childcare services for the children living in the household of HIV clients to enable clients to attend medical visits, related appointments, and RWHAP-related meetings, groups, or training sessions.[46]

Allowable uses of funds include:

- A licensed or registered childcare provider to deliver intermittent care
- Informal childcare provided by a neighbor, family member, or another person (with the understanding that existing federal restrictions prohibit giving cash to clients or primary caregivers to pay for these services)

Activities must include:

- Continuing or intermittent provision of basic childcare, including child development activities that promote cognitive learning and social skills development;

Activities may not include:

[46] Policy Clarification Notice #16-02: Eligible Individuals and Allowable Uses of Funds. Child Care Services. Page 17

- Off-site recreational or social activities or to pay for a gym membership.
- Daycare while the HIV+ parent, guardian, or caretaker is at work or school.

STANDARD OF CARE 1.0: LICENSURE OR ASSURANCES

The service provider shall:

1.1 Ensure that its child care facility is licensed by either the Texas Department of State Health Services as a Special Care Facility, the Texas Department of Family and Protective Services as a Day Care Facility, or the Texas Department of Aging and Disability Services as a Pediatric Extended Care Facility and that its license(s) are current and available;

1.2 ensure that staff and volunteers who require licensure or certification are appropriately licensed/certified and consistent with their professional categories;

1.3 ensure that its child/adolescent care facility meets health, fire, and safety standards, including adequate ventilation, clean water, and heating and cooling units, as evidenced by passing the most recent inspections by appropriate regulatory bodies;

1.4 obtain an initial test for tuberculosis for prospective staff and volunteers, and a repeat test at least annually to protect clients; and

1.5 ensure the availability of age-appropriate services.

1.6 Except where grant funds may be specifically restricted (e.g., Minority AIDS Initiative funds), provide its services to eligible children and adolescents (birth through age 18) living with or affected by HIV/AIDS, regardless of gender, race, color, religion (or lack thereof), national origin, disability, or inability to pay, to the extent resources allow.

EMERGENCY FINANCIAL ASSISTANCE

HRSA Description: Emergency financial assistance (EFA) provides limited one-time or short-term payments to assist the RWHAP client with an emergent need for paying for essential utilities, housing, food (including groceries and food vouchers), transportation, and medication. **NOTE:** Part A and Part B programs require Emergency funds to be allocated, tracked, and reported by type of assistance.[47] Emergency financial assistance can be directly paid to an agency or through a voucher program.[48]

Activities may include:

- Payment of short-term payments for antiretroviral medication.
- Dispensing fee for ADAP medications during the ADAP eligibility determination period.
- Provision of short-term payments/vouchers for housing, transportation (bus/gas voucher), food, and medication assistance.

[47] HIV/AIDS Bureau, Division of Metropolitan HIV/AIDS Programs National Monitoring Standards for Ryan White Part A Grantees: Program – Part A

[48] Policy Clarification Notice #16-02: Eligible Individuals and Allowable Uses of Funds. Emergency Financial Assistance. Page 17

- Provision of short-term payments for essential utilities, including water, gas, and electric bills, paid directly to the utility provider.

Activities may not include:

- Provision of short-term payments made directly to clients.

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

- The agency must set priorities and delineate and monitor what part of the overall allocation for emergency assistance is obligated for each subcategory. Careful monitoring of expenditures within a subcategory of "emergency assistance" is necessary to ensure that planned amounts for specific services are implemented and determine when reallocations may be required. Policies and procedures should be implemented to avoid duplication of services.
- Limitations on providing emergency assistance to eligible individuals/households should be delineated and consistently applied to all clients. It is expected that all other sources of funding in the community for emergency assistance will be effectively used and that any allocation of EFA funding for these purposes will be the payer-of-last-resort and for limited amounts, limited use, and limited periods.[49]

Initial medications purchased and reimbursed dispensing fees associated with purchased medication are not subject to the $800/client/fiscal year cap. EFA to individual clients is provided with limited frequency and for a limited period, with specified frequency and duration of assistance. Emergent needs must be documented each time funds are used.

Assistance is provided only for the following essential services/subcategories:

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

SERVICE STANDARDS AND PERFORMANCE MEASURES

The following standards and performance measures are guides to improving healthcare outcomes for PLWH throughout the State of Texas within the Ryan White Part A, Part B, and State Services Program.

Service Standard	Performance Measure
Assisting Clients during the ADAP Eligibility Determination Period	• Percentage of clients that have documented evidence in the client primary record of short-term HIV

[49] Texas Department of State Health Services HIV/STD Program Policies: DSHS Funds as Payment of Last Resort (Policy 590.001).

HIV+ clients with documented evidence of the emergency need for HIV medications can receive short-term medication assistance (30-day supply) with limited use of EFA for no more than 60 days (2 months or less). **Assisting Clients with Short-Term Medications** HIV+ clients with documented evidence of pending health insurance medication plan approval can receive short-term HIV medication assistance no more than 60 days through EFA.	medication assistance provided during the ADAP application period. • Percentage of clients that have documented evidence in the client primary record of short-term HIV medication copay assistance provided during the health insurance application period.
Client Determination for Emergency Financial Assistance **Applicants must demonstrate an emergent need resulting in their inability to pay their utility bills or prescriptions without assistance and risk disconnection of service due to one or more of the following:** • A significant increase in bills • A recent decrease in income • High unexpected expenses on essential items • They are unable to provide for basic needs and shelter • A failure to provide EFA will result in danger to the physical health of the client or dependent children • Other emergency needs as deemed appropriate by the agency Agency staff will conduct an assessment of the presenting problems/needs of the client with emergency financial issues. A service plan will be developed documenting the client's emergent need resulting in their inability to pay bills/prescriptions without assistance, and other resources pursued noted before using EFA funding for assistance. The client will be assessed for the ongoing status and outcome of the emergency assistance. Referrals for services, as applicable, will be documented in the client file. The resolution of the emergency status will be documented in the client record.	• Percentage of clients with documented evidence of determination of EFA needs noted in the client's primary record. • Percentage of clients with documented service plan for EFA in the client's primary record that indicates an emergent need, other resources pursued, and outcome of EFA provided. • Percentage of clients with documented evidence of resolution of the emergency status and referrals made (as applicable) with outcome results in the client's primary record.

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

FOOD BANK/HOME-DELIVERED MEALS

HRSA Description: Food Bank/Home Delivered Meals refers to the provision of actual food items, hot meals, or a voucher program to purchase food. This also includes the provision of essential non-food items that are limited to the following:[50]

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

This category includes providing actual food, prepared meals, or food vouchers to purchase prepared meals. Food bank services are the provision of actual food and personal care items in a food bank setting.

Activities may include:

- Providing food including fresh fruit, vegetables, meats, dairy products, staples, etc.;
- Providing personal hygiene products, including toothpaste, feminine hygiene, bathing soap, shampoo, and deodorant;
- Providing cleaning and paper goods such as toilet paper;
- Delivery of food, personal hygiene items, and cleaning goods to a client's home (rural areas only);
- Provision of nutritional supplements for meal replacement;
- Provision of education for safe food preparation practices;

[50] Policy Clarification Notice #16-02: Eligible Individuals and Allowable Uses of Funds. Food Bank/ Home Delivered Meals. Page 17

- Provision of nutritionally balanced meals, on-site in a congregate housing setting or home-delivered meals to non-ambulatory individuals with a documented medical need for meal assistance.

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

Activities may not include:

- The provision of prepared meals if receiving funding for food pantry services*;
- The provision of food pantry services if receiving funding for home-delivered meals*;
- The provision of pet food or products, household appliances;
- Nutrition counseling;
- Cash to purchase food.

* Approval from the AA is required

STANDARD OF CARE 1.0: LICENSURE OR ASSURANCES

The food bank shall:

1.1 ensure that its food pantry program meets all requirements of the local health department for food handling and storage;
1.2 maintain and show evidence that all required inspections are current and resulted in acceptable findings;
1.3 provide adequate space and equipment to store food in a sanitary manner;
1.4 if bulk foods are repackaged, all handlers should be licensed food handlers and
1.5 have a Food Product Establishment Permit, if required by the local municipality.
1.6 Ensure that if they operate within the City of Dallas, at least one person on staff with direct responsibility for the provision of food is certified by the City of Dallas as a Food Service Manager or is certified by the Texas Department of State Health Services Retail Foods Division as having satisfactorily completed a state-accredited food protection management program.

SERVICE STANDARDS AND PERFORMANCE MEASURES

The following standards and performance measures are guides to improving healthcare outcomes for PLWH throughout the State of Texas within the Ryan White Part A, Part B, and State Services Program.

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

Nutrition Assistance Program (SNAP), as evidenced in their primary record. Clients accessing food banks have documentation in the client's primary record of the reason/need assessed. Assessment of the client's immediate or ongoing need for food bank services is documented in the client's primary record.	• Percentage of clients with documentation in the client's primary record of the assessment of the need for food resources.
Dietary Guidance A registered dietician must be consulted to develop a dietary/nutritional policy that lists specific food items offered in the food bank/pantry or prepared for home-delivered meals. There is a plan to address the needs of clients' special diets. As applicable, clients are referred to an RD for specific dietary issues. Clients are offered counseling, if requested, to help with meal planning and food appropriateness. The program must ensure that available foods are selected, considering special nutritional needs (incorporating generally accepted nutritional standards), religious requirements, and ethnic food preferences, as appropriate. Attempts must be made on a regular basis to provide choices on food items that meet the individual dietary needs of clients, including the foods that fall into the recognized food categories for a healthy diet identified in the dietary guidelines issued by the U.S. Department of Agriculture and U.S. Department of Health and Human Services.	• Percentage of clients accessing food banks are referred, as applicable, to an RD for specific dietary issues as documentation in the client's primary record. • Percentage of clients accessing food banks offered counseling for meal planning and food appropriateness.
Home-Cooked/Hot Meals Clients assessed for food security and offered home-cooked meals/hot meal programs have evidence of the need documented in the client's primary record. Clients provided vouchers for hot meal programs have an increase in food security**.**	• Percentage of clients accessing hot meal programs have documented evidence of assessment of need in the client's primary record. • **PILOT:** Percentage of clients accessing hot meal programs have increased food security as documented in the client's primary record.
Discharge/Termination The service provider will develop discharge/termination for cause criteria and procedures.	• Percentage of clients discharged from food bank/home delivered meals have documentation of reason of discharge in the client's primary record.

HEALTH EDUCATION/RISK REDUCTION

HRSA Description: Health Education/Risk Reduction is the provision of education to clients living with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes sharing information about medical and psychosocial support services and counseling clients to improve their health status. This service may not be funded using Ryan White Part B funds. DSHS must approve the provision of services not found in other service categories. Topics covered may include:[51]

- Education on risk reduction strategies to reduce transmission, such as pre-exposure prophylaxis (PrEP) for clients' partners and undetectable equals untransmittable (U=U)
- Education on health care coverage options (e.g., qualified health plans through the Marketplace, Medicaid coverage, Medicare coverage)
- Health literacy
- Treatment adherence education

Activities must include:

- Preparation and dissemination of the informational handbook, including the following information;
- Chart to track labs and medications;
- Efficient and useful comprehensive service agency listings;
- HIV-reduction messages;
- Reasons to enter and remain in primary medical care;
- Information on Ryan White services;
- Information on eligibility for Ryan White services;
- A method to track referrals;
- General information for newly diagnosed;
- Space to write in provider information (physician, case manager, pharmacy, etc.);
- General health information, including space to document and track body weight, blood pressure, nutrition questions, and questions about medications;
- Explanation of HOPWA;
- Phone numbers of other EMAs;
- Comprehensive Care Coordination section;
- Maintaining a distribution list that includes, at a minimum, key points of entry, Part A, MAI, Part B, State Services, and State HOPWA-funded providers.

Activities may not include:

- Provision of professional and volunteer training and education;
- Provision of verbal information and education about reduction and available HIV-related services.
- Services delivered anonymously.

[51] Policy Clarification Notice #16-02: Eligible Individuals and Allowable Uses of Funds. Health Education/ Risk Reduction. Page 18

HOUSING

HRSA Description: Housing provides transitional, short-term, or emergency housing assistance to enable a client or family to gain or maintain outpatient/ambulatory health services and treatment, including temporary assistance necessary to prevent homelessness and to gain or maintain access to medical care. Housing may provide some core medical or support service and be essential for a client or family to gain or maintain access to and compliance with HIV-related outpatient/ambulatory health services and treatment.[52]

HRSA/RWHAP recipients and subrecipients that use funds to provide Housing must have mechanisms to assess and document new clients' housing status and housing service needs, at least annually for existing clients. HRSA/RWHAP recipients, subrecipients, and local decision-making planning bodies are strongly encouraged to institute duration limits to housing activities.

HRSA/HAB recommends recipients and subrecipients align duration limits with those definitions used by other housing programs, such as those administered by the Department of Housing and Urban Development, which currently uses 24 months for transitional housing. Housing provides transitional, short-term, or emergency housing assistance to enable a client or family to gain or maintain outpatient/ambulatory health services and treatment, including temporary assistance necessary to prevent homelessness and to gain or maintain access to medical care. Housing services include housing referral services and transitional, short-term, or emergency housing assistance.

Activities must include:

- The development of an individualized housing plan, updated quarterly, to guide the client's linkage to permanent housing.
- Documentation of the necessity of housing services for the purposes of medical care.

Activities may include:

- Housing referral services, assessment, search, placement, and housing advocacy services are provided on behalf of the eligible client and fees associated with these activities.
- Housing referral services provided by a housing case manager or other professionals to include assessment, search, placement, and advocacy services, which possess a comprehensive knowledge of local, state, and federal housing programs and how these programs can be accessed.

Activities may not include:

- Direct payments to eligible clients cannot be used for mortgage payments.

STANDARD OF CARE 1.0: LICENSURE OR ASSURANCES

The service provider shall:

[52] Policy Clarification Notice #16-02: Eligible Individuals and Allowable Uses of Funds. Housing. Page 18

1.1 ensure that each of its housing facilities is licensed by DSHS as an assisted living facility or as a special care facility, as appropriate;

1.2 keep its license current and available;

1.3 Ensure that housing facilities meet health, fire, and safety standards, including adequate ventilation, clean water, and heating and cooling units, as evidenced by passing the most recent inspections by appropriate regulatory bodies, and comply with applicable local government zoning and occupancy codes in its housing facilities.

Service Standard	Performance Measure
Emergency Housing Assistance Agency staff will initiate an intake within three (3) business days' onset of the emergency housing need. Assessment of client housing status and housing service needs must be documented. Reason(s) for emergency assistance may include but are not limited to: • The client is unable to pay rent due to a recent job loss, unpaid medical leave of absence, exhausted all leave balances • The client is unable to work due to recent hospitalization • The client had to recently purchase unexpected costly HIV medications or pay for unexpected HIV-related medical expenses out of pocket. **Assessment that the household need is:** • Actual costs to avoid eviction • Other resources are not reasonably available to address the unmet housing need. • The client will maintain or have stable housing as a result of housing assistance. Staff will contact the client at the end of the month to determine if the housing emergency has been resolved. If not resolved and the client needs additional assistance, the client may be assessed for short-term housing assistance.	Percentage of client charts with documented evidence of emergency housing needs assessed. Percentage of client charts that have a documented assessment of other resources reviewed and determined not available to assist the client in a housing emergency. Percentage of client charts with documented evidence of follow-up to housing need with a resolution of housing emergency. Percentage of patients with an HIV diagnosis who were homeless or unstably housed in the 12-month measurement period **(HRSA/HAB Performance Measure)**. Percentage of client charts accessing housing assistance, with stabilized housing documented as a result of the assistance provided.
Housing Plan for Transitional (temporary) and Short-Term Housing **All clients receiving assistance for transitional or short-term housing must have a Housing**	Percentage of client charts with a documented housing plan developed.

Plan documented within the client files that includes: • Housing status; • Reason for housing assistance need; • Other resources screened for housing assistance. Plans must detail the ongoing housing stability goal, focusing on access to medical treatment and supportive services. **The plan must include:** • Sustainable short-term and long-term goals for alleviating susceptibility to homelessness, establishing affordable permanent housing stability, and improving access to health care and supportive services. • Identification of barriers to sustainable housing; • Steps to address housing needs; • Referral(s) to available housing support services; and • Budget and money management skills building, if indicated. Documentation in the client's primary record/progress notes that the housing plan is reviewed monthly.	Percentage of client charts with documented evidence of monthly updated housing plans with progress toward goals identified.
Housing Referral Services Housing-related referrals provided by housing assistance/referral providers include housing assessment, search, placement, and advocacy services to seek housing (application to funding sources, visits to court systems). Staff will document all activities in the client's primary record to assist the client in securing housing and the outcome of the assistance.	Percentage of client charts with documented evidence of housing referral services provided, as applicable, including all elements as indicated. Percentage of clients who received housing referral services that obtained secure, stable housing as a result of the assistance

LINGUISTIC SERVICES

HRSA Description: Linguistic services provide interpretation and translation services, both oral and written, to eligible clients. Qualified linguistic services providers must provide these services as a component of HIV service

delivery between the healthcare provider and the client. These services are to be provided when necessary to facilitate communication between the provider and client or support the delivery of RWHAP-eligible services.[53]

Activities may include:

- Verbal interpretation between a client or caregiver and other service providers to facilitate the delivery of services;
- Written translation of documents into another language, or Braille, for other Dallas County pass-through grant-funded agencies to facilitate the delivery of services to a client or clients;
- Sign language interpretation between a client or caregiver and other service providers to facilitate the delivery of services.

STANDARD OF CARE 1.0: LICENSURE OR ASSURANCES

The service provider shall ensure the following:

1.1 That services be provided by a qualified linguist service, both oral and written, including a language line.

1.2 The services must comply with the *National Standards for Culturally and Linguistically Appropriate Services*.

1.3 That its interpretation/translation/sign language program staff who provide direct services to clients shall have had at least one year of college and a minimum of six (6) months of experience providing services in this or a related field. One year of stable and relevant employment in the areas of outreach work, community service, supportive work with families and individuals, supportive work with youth, corrections, public relations, or customer service can substitute for the education requirement;

1.4 that, if its contract with Dallas County Health and Human Services allows for services for the visually impaired, it makes written materials available in large print;

1.5 that staff and volunteers who provide sign language services hold at least Level I American Sign Language (ASL) certification from the Texas Office for Deaf and Hard of Hearing Services (DHHS);

1.6 that it does not utilize Ryan White Part A or Part B funds to provide interpretation/translation services for ineligible individuals or agencies; and

1.7 that it maintains detailed records in legible form, documenting all clients, the number of interpretation/translation/sign language units, phone contacts with clients, contacts with service providers on behalf of clients, and contacts with service providers requesting interpretation/translation/sign language services.

MEDICAL TRANSPORTATION

HRSA Description: Medical transportation provides non-emergency transportation services that enable an eligible client to access or be retained in core medical and support services.[54]

[53] Policy Clarification Notice #16-02: Eligible Individuals and Allowable Uses of Funds. Linguistic Services. Page 19
[54] Policy Clarification Notice #16-02: Eligible Individuals and Allowable Uses of Funds. Medical Transportation. Page 19

Activities must include:

- Transporting an eligible client to an HIV-related medical or support service appointment, HRSA RWHAP-related local planning council/committee meetings, or training sessions.
- Delivering HIV-related medications to an eligible client or in bulk quantity to community-based agencies;
- Distributing bus passes, taxi/ride-sharing vouchers, or gas vouchers to provide access to HIV-related appointments.

Activities may not include:

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

STANDARD OF CARE 1.0: LICENSURE OR ASSURANCES

The service provider shall ensure the following:[55]

1.1 through a contractual arrangement, lease agreement, or ownership, that its vehicle service fleet is operated, maintained, and insured exclusively by the service provider;

1.2 that it maintains vehicle liability insurance coverage on each vehicle, or as a fleet, with a minimum acceptable limit of $300,000 combined single limit coverage per vehicle, and that each vehicle used by the provider maintains a current Texas State Inspection, registration, and license plates;

1.3 that each driver maintains a current, valid Texas Driver's License, and it shall keep a copy on file;

1.4 that it maintains detailed records in legible form of mileage driven, name of individuals provided with transportation, and origin and destination for all trips;

1.5 that it has in place a means to communicate with the transport vehicle (a radio, cell phone, or other devices, preferably hands-free);

1.6 that it does not utilize Ryan White Part A or Part B funds to transport clients to off-premise social or recreational activities and

1.7 It has a written policy defining an "acceptable driving record" and that each driver meets the policy's requirements.

NON-MEDICAL CASE MANAGEMENT SERVICES

HRSA Description: Non-Medical Case Management Services (NMCM) provide guidance and assistance in accessing medical, social, community, legal, financial, and other needed services. Non-medical case management services may also include assisting eligible clients in obtaining access to other public and private programs for which they may be eligible, such as Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical

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

Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, or health insurance Marketplace plans.[56]

This service category includes several methods of communication, including face-to-face, phone contact, and any other forms deemed appropriate by the RWHAP recipient.

Key activities include:

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

Activities must include:

- Completing intakes, screening for client eligibility, and determining the need for all services;
- Assessing and reassessing (according to current Standards of Care) a client's bio-psychosocial history, including the needs of the client and support system;
- Developing and reviewing a care plan based on the client's needs and choices with goals and strategies for completion every six (6) months;
- Implementing the care plan through time-lined strategies;
- Providing information, referrals, and assistance with linkages to needed services;
- Monitoring and following up on the goals of the care plan;
- Advocating on behalf of a client to remove barriers to service;
- Collaborating with other service providers to coordinate client care;
- Providing appropriate crisis intervention as needed.

Activities may include:

- Case management to prevent unnecessary hospitalization or to expedite discharge;
- Screening followed by reduction interventions for HIV-positive persons susceptible of transmitting HIV;
- Benefits Counseling, Enrollment & Outreach Education (e.g., Medicaid, Medicare, Market Place/Exchange, other private insurance, etc.).
- Take-Charge-Texas (TCT) and other types of data entry or documentation directly related to case management performed for/on behalf of a client.

Activities may not include:

- Coordination and follow-up of medical treatments;
- Compilation of outcome measures reports;
- Development, distribution, or analysis of client satisfaction surveys;

[56] Policy Clarification Notice #16-02: Eligible Individuals and Allowable Uses of Funds. Non-Medical Case Management Services. Page 20

- Recreational activities.

STANDARD OF CARE 1.0: LICENSURE OR ASSURANCES

The service provider shall ensure that:

1.1 Each staff person who provides case management services to clients shall have, at a minimum, a bachelor's degree in social science or behavioral science, nursing, or a related field from an accredited domestic or international college or university. As an alternative, a minimum of one (1) year of employment experience performing medical case management, case management, or client advocacy may substitute for each year of college education;

1.2 each case management supervisor shall have, at a minimum, a bachelor's degree in social science or behavioral science, nursing, or a related field from an accredited domestic or international college or university. As an alternative, a minimum of one (1) year of employment experience performing medical case management, case management, or client advocacy may substitute for each year of college education.

1.3 Its case management staff, who provide direct services to clients, have continuing access to the most up-to-date information available about effective medical care for those with HIV/AIDS and

1.4 case management supervisors and case managers shall each hold a valid driver's license in accordance with Texas law if needed to carry out work responsibilities.

1.5 Case managers complete the HIV Case Management training series for case management annually.

NON-MEDICAL CASE MANAGEMENT SERVICES - HOUSING-BASED CASE MANAGEMENT

Housing-based case management is non-medical case management in a congregate housing setting. This category is a local exception for the Dallas EMA/HSDA but must comply with the requirements outlined in Non-Medical Case Management.

OTHER PROFESSIONAL SERVICES (LEGAL SERVICES)

HRSA Description: Other Professional Services allow for the provision of professional and consultant services rendered by members of particular professions licensed or qualified to offer such services by local governing authorities.[57]

Such services may include:

[57] Policy Clarification Notice #16-02: Eligible Individuals and Allowable Uses of Funds. Other Professional Services. Page 21

- Legal services provided to or on behalf of the individual living with HIV and involving legal matters related to or arising from their HIV disease, including:
- Assistance with public benefits such as Social Security Disability Insurance (SSDI)
- Interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the RWHAP

Preparation of:

- A healthcare power of attorney
- Durable powers of attorney
- Living wills
- Permanency planning to help clients/families make decisions about the placement and care of minor children after their parents/caregivers are deceased or are no longer able to care for them, including:
    - Social service counseling or legal counsel regarding the drafting of wills or delegating powers of attorney
    - Preparation for custody options for legal dependents, including standby guardianship, joint custody, or adoption

Activities may include:

- The preparation of powers of attorney, do not resuscitate orders;
- Interventions necessary to ensure access to eligible services, including discrimination or breach of confidentiality litigation related to services eligible for funding under the Ryan White HIV/AIDS Treatment Modernization Act.

Activities may not include:

- Legal services related to criminal defense, class action suits, or any legal matters unrelated to CARE Act service access;
- Legal services that arrange for guardianship or adoption of children after the death of their normal caregiver;
- Wills, trusts, and bankruptcy proceedings.

STANDARD OF CARE 1.0: LICENSURE OR ASSURANCES

The service provider shall ensure that:

1.1 All attorneys, both staff and volunteer, meet the requirements for licensure and are in good standing with the State Bar of Texas; law students, law school graduates, and other legal professionals will be supervised by a qualified licensed attorney.

1.2 all staff and volunteer paraprofessionals and notaries possess and maintain proper licenses and certifications as required in the State of Texas;

1.3 legal services provided are related to clients' HIV status.

1.4 Staff will attend and have continued access to training activities:

- Agency-paid legal staff and contractors must complete two (2) hours of HIV-specific training annually.

- The new agency-paid legal staff and contractors must complete two (2) hours of HIV-specific training within 90 days of the start date.
- Volunteer legal staff are encouraged to complete HIV-specific legal training.
- Documentation of training on current applicable laws related to HIV is located in the personnel file.
- The agency maintains a system for disseminating HIV/AIDS information relevant to the legal assistance needs of PLWH to staff and volunteers.
- The agency will document the provision of in-service education to staff regarding current treatment methodologies and promising practices.

OUTREACH SERVICES

HRSA Description: Outreach services include the provision of the following three activities:[58]

- Identification of people who do not know their HIV status and linkage to Outpatient/Ambulatory Health Services
- Provision of additional information and education on healthcare coverage options
- Reengagement of people who know their status in Outpatient/Ambulatory Health Services

Activities must include:

- Identifying HIV-positive individuals who know their HIV status and are not receiving care;
- Providing targeted verbal and written information with explicit and clear links to health care services; Directing individuals to early intervention services (EIS) or primary care (HIV counseling and testing, diagnostic, and clinical ongoing prevention counseling services with appropriate providers of health and support services);
- Educating the client on the importance of remaining in primary medical care;
- Completing follow-up by tracking linkages to primary medical care and services that will retain them in primary medical care and treatment;
- Outreach services conducted in conjunction with a primary medical care program.

Activities may include:

- Providing referrals to case management;
- Condom distribution;
- Individual prevention education, which includes screening of practices that may make an individual susceptible to acquiring HIV, followed by reduction interventions for persons living with HIV who may be susceptible to transmission.

Activities may not include:

[58] Policy Clarification Notice #16-02: Eligible Individuals and Allowable Uses of Funds. Outreach Services. Page 22

- HIV counseling/testing;
- Needle distribution;
- Broad scope awareness activities that address the general public;
- Marketing efforts for specific agencies that do not include information about services available in the continuum;
- Outreach conducted in group settings.

OUTREACH (STREET)

HRSA Description: Outreach services are programs that have as their principal purpose the 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 or 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; be conducted at times and in places where there is a high probability that individuals with HIV will be reached, and be designed with quantified program reporting that will accommodate local effectiveness evaluation.[59]

Activities must include:

- Providing referrals to case management;
- Providing targeted verbal and written information;
- Directing individuals to early intervention services (EIS) or primary care (HIV counseling and testing, diagnostic, and clinical ongoing prevention counseling services with appropriate providers of health and support services;
- Educating the client on the importance of remaining in primary medical care;
- Completing follow-up by tracking linkages to early intervention services, primary medical care, and services that will retain them in primary medical care and treatment;
- Targeting populations identified in local needs assessment, epidemiological data, and service utilization data as being susceptible to HIV disease.

Activities may include:

- Condom distribution;
- Prevention education, which includes screening of practice followed by reduction interventions to reduce acquisition/transmission of HIV; HIV counseling/testing.

Activities may not include:

- HIV counseling/testing;
- Needle distribution;
- Marketing efforts for specific agencies that do not include information about services available in the continuum;

[59] Policy Clarification Notice #16-02: Eligible Individuals and Allowable Uses of Funds. Outreach Services. Page 22

- Outreach conducted in group settings of more than ten (10) individuals.

STANDARD OF CARE 1.0: LICENSURE OR ASSURANCES

The service provider shall ensure the following:

1.1 That its outreach workers know about and have experience working with underserved populations;
1.2 That its supervisor(s) of outreach workers has, at a minimum, at least two years of experience conducting HIV-related outreach activities with potential clients. In the absence of a supervisor, such as may be the case in a small agency, the agency shall have in place a collaborative agreement with another agency to provide access/outreach training and supervision;
1.3 that each outreach supervisor and worker holds a valid driver's license in accordance with Texas law if needed to carry out work responsibilities and
1.4 that it has ongoing access to names and last-known locating information for individuals known to be HIV+ and to have become lost to follow-up.

STANDARD OF CARE 2.0: CLIENT RIGHTS AND CONFIDENTIALITY

The service provider shall:

2.1 Provide information to potential clients regarding how to access services that may be available to them and their rights and obligations should they become agency clients.

STANDARD OF CARE 3.0: ACCESS, CARE, AND PROVIDER CONTINUITY

The service provider shall:

3.1 Provide access for staff, outreach contacts, and clients to current resource information relevant to the population of the EMA/HSDA;
3.2 address an outreach contact's specific barriers to accessing services to be able to make appropriate referrals and
3.3 establish and maintain an association with prisons, homeless shelters, substance abuse treatment centers, and other entities that have ongoing contact with persons known to be disproportionately impacted by HIV and subject to access barriers.

REFERRAL FOR HEALTHCARE AND SUPPORT SERVICES

HRSA Description: Referral for Health Care and Support Services directs a client to needed core medical or support services in person or through telephone, written, or other types of communication. Activities provided under this

service category may include referrals to assist HRSA/RWHAP-eligible clients in obtaining access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, and other state or local health care and supportive services, or health insurance Marketplace plans).[60]

ADAP Eligibility Worker

The ADAP eligibility worker assists with an ADAP application, including documentation and follow-up needed to ensure the ADAP eligibility process is accomplished per DSHS Standards of Care.

Program Guidance

Referrals for Health Care and Support Services provided by outpatient/ambulatory healthcare providers should be reported under the Outpatient/Ambulatory Health Services category.

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

Activities must include:

- Referral Worker: A documented encounter wherein the Referral Worker directs a client to a service in person or through telephone, written, or other types of communication, including management of such services where they are not provided as part of Outpatient Ambulatory Health or Case Management Services.
- ADAP Eligibility Worker: A completed ADAP application **accepted by** the Texas HIV Medication Program (THMP).

Activities may include:

- Efforts related to ensuring clients can access other public and private programs for which they are eligible.

Activities may not include:

Case Management services.

SERVICE STANDARDS AND PERFORMANCE MEASURES [61]

The following standards and performance measures are guides to improving healthcare outcomes for PLWH throughout the State of Texas within the Ryan White Part B and State Services Program.

Service Standard	Performance Measures
Benefits Counseling	• Percentage of clients with documented evidence of education provided on other public and

[60] Policy Clarification Notice #16-02: Eligible Individuals and Allowable Uses of Funds. Referral Services. Page 24
[61] Referral for Health Care and Support Services: Service Standard

Activities should be client-centered, facilitating access to and maintaining health and disability benefits and services. It is the primary responsibility of staff to ensure clients are receiving all needed public and private benefits and resources for which they are eligible. Staff will educate clients about available benefit programs, assess eligibility, assist with applications, provide advocacy with appeals and denials, assist with re-certifications, and advocate for other areas relevant to maintaining benefits/resources. **Staff will explore the following as possible options for clients, as appropriate:** • AIDS Drug Assistance Program (ADAP) • Health Insurance Plans/Payment Options (CARE/HIPP (Health Insurance Premium Payment), Consolidated Omnibus Budget Reconciliation Act (COBRA), Omnibus Budget Reconciliation Act (OBRA), Health Insurance Assistance (HIA), Medicaid, Medicare, Private, Affordable Care Act (ACA)/Marketplace) • SNAP • Pharmaceutical Patient Assistance Programs (PAPS) • Social Security Programs (Supplemental Security Income (SSI), SSDI, State Disability Insurance (SDI)) • Temporary Aid to Needy Families (TANF) • Veteran's Administration Benefits (VA) • Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) • Other public/private benefits programs • Other professional services Staff will assist eligible clients with completing benefits application(s) as appropriate within 14 business days of the eligibility determination date. Conduct a follow-up within 90 days of the completed application to determine if additional and ongoing needs are present.	private benefits programs in the primary client record. • Percentage of clients with documented evidence of other public and private benefit applications completed as appropriate within 14 business days of the eligibility determination date in the primary client record. • Percentage of eligible clients with documented evidence of the follow-up and result(s) to a completed benefit application in the primary client record.
Health Care Services Clients should be assisted in accessing health insurance, or Marketplace plans to assist with	• Percentage of clients with documented evidence of assistance to access health insurance or Marketplace plans in the primary client record.

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

RESPITE CARE FOR ADULTS

HRSA Description: Respite care is the provision of community or home-based, non-medical assistance designed to relieve the primary caregiver responsible for providing day-to-day care of a client with HIV/AIDS.[62]

Activities must include:

- Structured home or center-based activities that promote skills-building and social interaction that contribute to the maintenance and improvement of the client's support system;
- Periodic and time-limited respite for the caregiver(s) of the infected individual.

Activities may not include:

- Care of a child/youth.

STANDARD OF CARE 1.0: LICENSURE OR ASSURANCES

The service provider shall:

1.1 Ensure that center-based facilities meet health, fire, and safety standards and,
1.2 Make available daily, structured program activities in each client's care, for clients, and promote the importance of client socialization; and
1.3 provide required, non-medical support services to all clients as needed.
1.4 Obtain an initial test for tuberculosis for prospective staff and volunteers and a repeat test at least annually to protect clients; and
1.5 ensure the availability of age-appropriate services.

SERVICE STANDARDS AND PERFORMANCE MEASURES

The following standards and performance measures are guides to improving healthcare outcomes for PLWH throughout the State of Texas within the Ryan White Part A, Part B, and State Services Program.

Service Standard	Performance Measure
Initial Brief Assessment **Service provider staff will initiate an intake within five (5) business days of the referral to include:** • Client's support system • Needs of the client	• Percentage of clients with documented evidence of a brief initial assessment completed within five (5) business days of the referral in the client's primary record.

[62] Policy Clarification Notice #16-02: Eligible Individuals and Allowable Uses of Funds. Respite Care. Page 24

Supporting documentation of the need for respite care will be included in the assessment. If informal respite care is to be used, the assessment must include the qualifications of the client's personal support network provider.	
Plan of Care In collaboration with the client and the client's family, a plan of care will be developed within ten (10) business days of the brief initial assessment. The plan of care should be signed and dated by both the client and the client's family or legal guardian and located in the client's primary record. A copy of the plan will be offered and documented in the client's record. **The plan of care should include:** • the objective of respite care • estimate of the number of respite care visits anticipated and services to be provided • type of setting in which respite services will be provided for the client **Documentation that the plan of care is being followed may include, at a minimum:** • Sign-in sheet documenting attendance in a facility or documentation of informal personal support network provider attendance in the home. • The objective should be listed at the top of the sign-in sheet or documentation for reimbursement by the informal personal support network provider. The plan of care should be reviewed at least every six (6) months to see if progress is being made towards meeting the objective of the respite care with documentation present in the client's primary record.	• Percentage of clients with a documented plan of care developed within ten (10) business days of the initial assessment in the client's primary record. • Percentage of clients with updated and reviewed plans of care every six (6) months documented in the client's primary record.
Referrals If the client's needs are beyond the scope of the services provided by the service provider or the	• Percentage of clients with documented referrals for services beyond the scope of respite care provider in the client's primary client record.

client's informal support network, an appropriate referral to another level of care is made. Documentation of referral and outcome of the referral is present in the client's primary record.	• Percentage of clients referred to another level of care have documentation of referral outcome in the client's primary record.
Discharge Once objectives have been met, the agency and client will collaborate on a discharge plan. **Reasons for discharge may include:** • Services are no longer needed. • Services needed are outside the scope of respite care • Client is deceased • The client has moved out of the area • Unacceptable client behaviors • The client has not attended or received respite care per agency policy and procedure.	• Percentage of clients with documented evidence of the reason for discharge in the client's primary record.

RESPITE CARE FOR CHILDREN/YOUTH/ADOLESCENTS

HRSA Description: Respite care is the provision of community or home-based, non-medical assistance designed to relieve the primary caregiver responsible for providing day-to-day care of a client with HIV/AIDS.

Activities may include:

- Provision of basic childcare, including child development activities that promote cognitive learning and social skills development for a child/youth with HIV;
- Periodic and time-limited respite for the caregiver of a child/youth with HIV.

Activities may not include:

- Off-site recreational or social activities
- Care of an adult.

APPENDICES

APPENDIX A: HOW BEST TO MEET THE PRIORITY

Fiscal Year 2023 Ranking	Service Category	Special Instructions
2	**AIDS Pharmaceutical Assistance**	• Provide information on drug reimbursement programs to formerly incarcerated individuals who are recently released. • Provide information to populations in the Stemmons Corridor area (see the zip code table attached). • Provide information to consumers on copayment assistance available through Ryan White and alternative insurance funding.
7	**Health Insurance Premium & Cost Sharing Assistance**	• Educate consumers about the various types of insurance, program requirements, and necessary documentation in medical clinics.
3	**Medical Case Management**	• Educate consumers about the differences between medical and social case management and the appropriate usage of each. • Provide information about the importance of remaining in primary care and maintaining dental hygiene.

		• Collaborate with and refer clients to prevention case managers or reduction specialists to encourage the reduction of practices that may make an individual susceptible to HIV. • Inform newly diagnosed individuals about the importance of entering and remaining in primary medical care. • Provide information in English and Spanish about the availability of local drug reimbursement programs. • Increase the number of bilingual medical case managers as funding allows. • Provide information and referrals to gender-segregated programs (if any) appropriate to the client's self-affirmed gender identity and sense of safety. • Educate and collaborate with alternatively funded substance abuse programs on the treatment of PLWH.
5	**Mental Health Services**	• Provide information about the importance of remaining in primary care while retaining mental health counseling and information on available primary medical care services. • Collaborate with Early Intervention Services to support newly diagnosed clients and consumers reentering HIV medical care.

		• Educate and collaborate with alternatively funded substance abuse programs on the treatment of PLWH.
6	**Oral Health Care**	• Inform medical and non-medical case managers about dental care options and providers to make appropriate referrals. • Stagger appointments, so the waiting room is not full (no more than two (2) people in the waiting room). • Longer wait times could be due to the provider relocating to a new site • Sites providing services adhere to safety recommendations from the CDC.
1	**Outpatient Ambulatory/Health Services**	• When and where applicable, provide for the rapid start of medication for newly diagnosed within 48-72 hours; 2 weeks for those returning to care; 6 months for viral suppression once the medication is accessed. • Provide information about Ryan White programs to reduce financial concerns about seeking care. • Ensure providers are knowledgeable regarding managing patients co-infected with HIV and HCV. • Provide information about the importance of remaining in primary care and maintaining dental hygiene. • Provide information in English and Spanish about the availability of local drug reimbursement programs. • Incorporate prevention messages into the medical care of PLWH.

		• Educate and collaborate with alternatively funded substance abuse programs on treatment for PLWH. • Educate and collaborate with alternatively funded mental health programs on treatment for PLWH. • Telehealth and telemedicine should be allowed wherever and whenever possible, i.e., case management, eligibility, • Provider feedback - good responses to telehealth • Receiving services by telephone/ virtual • Meal programs are to-go, and bus passes are distributed using minimal contact. • Business agreements with virtual platforms • Flexibility needs to be maintained when accessing this service • In-person eligibility screening is not required federally • Patient-centered care should be considered • Personal protective equipment (PPE) should be available to clients
9	**Substance Abuse Services**	• Educate and collaborate with alternatively funded substance abuse programs on treatment for PLWH. • Educate and collaborate with alternatively funded mental health programs on treatment for PLWH. • Placement in/or assignment to gender-segregated programs (if any)

		shall be based on the client's self-affirmed gender identity. A client's sense of where they will be safest and receive the most benefit should be considered. • Personal protective equipment (PPE) should be made available for clients • Virtual group activity to educate and support clients with substance misuse. • COVID-19 education should be provided.
Fiscal Year 2023 Ranking	**Service Category**	**Special Instructions**
3	**Non-Medical Case Management**	• Collaborate with non-Ryan White key points of entry anywhere a client may present for HIV care to provide information on Ryan White Case Management services. • Provide educational materials and activities to promote self-empowerment and reduce fear and denial to facilitate entry into primary medical care. • Provide information about the benefits and security of the Take Charge Texas (TCT) system to promote client sharing. • Collaborate with and refer clients to prevention case managers or reduction specialists to encourage a reduction in practices that may make an individual susceptible to HIV. • Educate clients on the importance of remaining in primary medical care.

		• Provide information in English and Spanish about the availability of local drug reimbursement programs. • Target outreach to African American, Hispanic, and other vulnerable populations to increase utilization of insurance assistance programs. • Increase the number of bilingual non-medical case managers as funding allows. • Educate consumers on their role in the case management process to encourage self-efficacy. • Provide information and referrals to gender-segregated programs (if any) appropriate to the client's self-affirmed gender identity and sense of safety. • Ensure that intake data for transgender clients is sufficient to fully use the transgender-related categories available in Take Charge Texas (TCT). • Incorporate prevention messages into the medical care of PLWH. • PPE should be available for all clients visiting the facility • Ensure there is a workforce that is sensitive to transgender clients • Education about COVID-19 • Offer telehealth and telemedicine whenever possible.
11	**Child Care Services**	• Evaluate options for providing childcare at medical clinics or other appointments, not including work, to

		encourage clients (especially women) to attend medical appointments. • Offer telehealth and telemedicine whenever possible. • COVID-19 education should be provided. • Personal protective equipment (PPE) should be made available for clients.
2	**Housing (Congregate)**	• Provide information about the importance of remaining in primary care while addressing housing needs and provide information on available primary medical care services. • Placement in/or assignment to gender-segregated programs (if any) shall be based on the client's self-affirmed gender identity and consider a client's sense of where they will be safest and benefit most. • Care plans and advocacy to remove barriers to service should consider a client's self-affirmed gender identity and sense of safety where appropriate. • COVID-19 education should be provided. • Personal protective equipment (PPE) should be made available for clients • Offer telehealth and telemedicine whenever possible. • Adhere to CDC social distancing guidelines. • Protocol for screening, testing, and quarantining individuals who test positive for COVID-19 and any other

		airborne pathogens as identified by CDC. • Create a wellness station near entrances and lobbies with masks and hand sanitizer.
1	**Food Bank**	• Provide quality and comprehensive food pantry services in both rural and urban areas. • Provide information about available primary care services. • Provide special non-perishable food items to be taken with medication specifically for the chronically homeless population. • If possible, provide food delivery services. • Create a plan or system to ensure clients at home receive food. • Meet with food banks and service providers and establish an MOU. • Maintain CDC guidelines for social distancing.
3	**Case Management (Housing-based)**	• Collaborate with non-Ryan White key points of entry anywhere a client may present for HIV care to provide information on Ryan White Case Management services. • Provide referrals to non-Ryan White community resources when appropriate. • Provide educational materials and activities to promote self-empowerment and reduce fear and denial to facilitate entry into primary medical care.

		• Provide information about the benefits and security of the Take Charge Texas (TCT) system to promote client sharing. • Collaborate with and refer clients to prevention case managers or reduction specialists to encourage a reduction in practices that may make an individual susceptible to HIV. • Collaborate with homeless shelters to link out-of-care PLWH to housing services. • Placement in/or assignment to gender-segregated programs (if any) shall be based on the client's self-affirmed gender identity and consider a client's sense of where they will be safest and benefit most. • Care plans and advocacy to remove barriers to service should consider a client's self-affirmed gender identity and sense of safety where appropriate. • COVID-19 education should be provided. • Personal protective equipment (PPE) should be made available for clients • Maintain CDC guidelines for social distancing • Protocol for screening, testing, and quarantining individuals who test positive for COVID-19 and any other airborne pathogens as identified by CDC.

		• Create a wellness station near entrances and lobbies with masks and hand sanitizer.
4	**Medical Transportation**	• Identify additional options for those living in suburban and rural areas with limited public transportation. • Identify and exhaust all other transportation options, including paratransit. • Personal protective equipment (PPE) should be made available for clients • Maintain CDC guidelines for social distancing
6	**Outreach Services**	• Track the barriers to care that caused clients to cease accessing medical care and provide an annual report to the Ryan White Planning Council. Each client contacted must be asked why they dropped out of care and whether they reconnected to care. Each answer should be recorded.

No special instructions exist for the following service categories:

- **Core Medical Services**
  - Early Intervention Services
  - Home and Community-based Health Services
  - Home Health Care
  - Hospice Services
  - Medical Nutrition Therapy
  - State AIDS Drug Assistance Program

- **Support Services**
  - Health Education/Risk Reduction

- Home Delivered Meals
- Linguistic Service
- Other Professional Services (Legal Services)
- Outreach – Street
- Referral for Health Care and Support Services
- Respite Care for Adults
- Respite Care for Children/Youth/Adolescents

ZIP CODES WITH HIGH RATES OF INCIDENCE

Zone 1: East Dallas, Mesquite/Garland, Vickery	
Geographic Location	**Zip Code**
East Dallas	75204
East Dallas	75206
East Dallas	75214
East Dallas	75218
East Dallas	75223
East Dallas	75226
East Dallas	75228
East Dallas	75246
Mesquite/Garland	75040
Mesquite/Garland	75041
Mesquite/Garland	75042
Mesquite/Garland	75043
Mesquite/Garland	75044
Mesquite/Garland	75048
Mesquite/Garland	75088
Mesquite/Garland	75150
Mesquite/Garland	75182
Vickery	75231
Vickery	75238
Vickery	75243

Zone 2: Grand Prairie, Irving, West Dallas, Northern Corridor	
Geographic Location	**Zip Code**
Grand Prairie	75050
Grand Prairie	75051
Grand Prairie	75052
Grand Prairie	75053
Grand Prairie	75102
Irving	75001
Irving	75006
Irving	75015
Irving	75019
Irving	75038
Irving	75039
Irving	75060
Irving	75061
Irving	75062
Irving	75063
Irving	75234
Irving	75261
West Dallas	75212
Northern Corridor	75080
Northern Corridor	75081
Northern Corridor	75205
Northern Corridor	75225
Northern Corridor	75230
Northern Corridor	75240
Northern Corridor	75244
Northern Corridor	75248
Northern Corridor	75251

Zone 4: South East Dallas, South Dallas	
Geographic Location	**Zip Code**
Southeast Dallas	75141
Southeast Dallas	75149
Southeast Dallas	75159
Southeast Dallas	75172
Southeast Dallas	75180
Southeast Dallas	75181
Southeast Dallas	75217
Southeast Dallas	75227
Southeast Dallas	75253
South Dallas	75210
South Dallas	75215

Zone 5: Stemmons Corridor	
Geographic Location	**Zip Code**
Stemmons Corridor	75201
Stemmons Corridor	75202
Stemmons Corridor	75207
Stemmons Corridor	75209
Stemmons Corridor	75219
Stemmons Corridor	75220
Stemmons Corridor	75229
Stemmons Corridor	75235
Stemmons Corridor	75247

APPENDIX B: UNITS OF SERVICE AND BILLING LIMITATIONS

Service Category	Units of Service	Billing Limitation
AIDS Pharmaceutical Assistance	• One (1) prescription	• Generic medications should be used when available; • Prescriptions issued for cosmetic purposes, non-medically necessary purposes, and over-the-counter medications are not reimbursable; • Only one month of medications may be filled at a time; • Erectile dysfunction and human growth hormone prescriptions are not reimbursable, and • Medications must be on the approved Local Pharmaceutical Assistance Program (LPAP) formulary to be eligible for reimbursement.
Case Management (Non-Medical)	• One (1) fifteen (15) minute face-to-face/other encounter • One (1) virtual visit • One (1) telehealth/telemedicine visit/consultation	• Units billed must be based on documented time spent delivering the service; • Generic newsletters, invitations, etc., sent to clients may not be billed, and • Messages left for clients or on behalf of a client may not be billed.
Case Management (Non-Medical – Housing)	• One (1) fifteen (15) minute face-to-face/other encounter • One (1) virtual visit • One (1) telehealth/telemedicine visit/consultation	• Units billed must be based on documented time spent delivering the service; • Administrative activities may not be billed as units of service;

		• Generic newsletters, invitations, etc., sent to clients may not be billed, and • Messages left for clients or on behalf of a client may not be billed.
Child Care Services	• One (1) hour of childcare	None
Early Intervention Services	• One (1) medical visit • One (1) fifteen (15) minute counseling and referral contact	None
Emergency Financial Assistance	• One (1) payment or voucher	$800/year/client cap
Food Bank	• One (1) visit for up to a seven (7) day supply of food	None
Health Education/ Risk Reduction	• One (1) fifteen (15) minute individual intervention • One (1) fifteen (15) minute group- level intervention	None
Health Insurance Premium and Cost Sharing Assistance	• One (1) monthly payment	• Payment(s) for monthly premiums, related copays, and deductibles shall not exceed nine hundred dollars ($900.00) as established by the Ryan White Planning Council and AA.
Home and Community-based Health Services	• One (1) visit by non-licensed healthcare workers • Durable medical equipment	• Any service provided to an individual eligible for home health coverage under another third-party reimbursement plan may not be billed to DCHHS unless the client has exhausted the benefits available under the plan and, • No units of service will be reimbursed without a physician's order.
Home Health Care	• One (1) visit by licensed healthcare workers	• Any service provided to an individual eligible for home health coverage under another third-party reimbursement plan may not be billed to DCHHS unless the client has exhausted the benefits available

		under the plan and, • No units of service will be reimbursed without a physician's order.
Home Delivered Meals	• One (1) on-site meal or nutritional supplement	None
Hospice Services	• One (1) day of hospice care	None
Housing	• One (1) day of housing, not to exceed the monthly lease rate	• Effective March 27, 2008, there is a 24-month cumulative period of eligibility per household for housing services *(HRSA HAB Policy 99-02)*. • Transitional housing assistance is based on need and available resources and is limited to no more than (6) continuous months of funding within a contract year. Emergency housing assistance is limited to one (1) month of rental/utility assistance within a contract year.
Other Professional Services (Legal Services)	• One (1) fifteen (15) minute period of consultation or legal advocacy by an attorney or a paraprofessional	None
Linguistic Services	• One (1) fifteen (15) minute increment of interpretation or sign language • One (1) document	• Units billed must be based on documented time spent delivering the service and, • Interpretation or translation provided for another agency or a group will be reimbursed for the time spent interpreting or translating, not the number of clients receiving the interpretation.
Medical Case Management	• One (1) fifteen (15) minute face-to-face/other encounter • One (1) virtual visit • One (1) telehealth/telemedicine visit/consultation	• Units billed must be based on documented time spent delivering the service;

		• Generic newsletters, invitations, etc., sent to clients may not be billed, and • Messages left for clients or on behalf of a client may not be billed.
Medical Nutrition Therapy	• One (1) visit	• No more than one (1) visit per client per day may be reimbursed; • Any service provided to an individual eligible for medical care coverage under another third-party reimbursement plan may not be billed to DCHHS unless the client has exhausted the benefits available under the plan.
Medical Transportation Services	• One (1) van trip per one-way • One (1) bus pass/token • One (1) taxi/ride-share voucher • One (1) gas voucher • One (1) delivery of medications (regardless of the number of medications to be delivered in a single delivery) per one-way	• Pick-up and return van trips during which clients or medications are not being transported may not be billed as units of service, and • Only one (1) unit of medication delivery may be billed regardless of the number of medications to be delivered in a single one-way delivery per client.
Mental Health Services	• One (1) individual Level I psychiatric evaluation visit • One (1) individual Level I medication management visit • One (1) Level II individual forty-five (45) minute session • One (1) Level III individual fort-five (45) minute session • One (1) patient participating in a sixty (60) minute Level II group session • One (1) patient participating in a sixty-(60) minute Level III group session • One (1) virtual visit	• Mental health therapy groups may have no more than twelve (12) participants per group; • Individual sessions should be at least 45 minutes in length and will be reimbursed by the session; • Group sessions should be at least 60 minutes in length and will be reimbursed by the session; • No more than four (4) psychiatric evaluation visits per year per client may be reimbursed; • Fractions of a unit may not be billed;

	• One (1) telehealth/telemedicine visit/consultation	• Any service provided to an individual eligible for mental health services covered under another third-party reimbursement plan may not be billed to DCHHS unless the client has exhausted the benefits available under the plan and, • Inpatient psychiatric or psychological services may not be reimbursed.
Oral Health Care	• One (1) dental prophylaxis • One (1) dental routine visit • One (1) dental specialty visit • One (1) prosthetic device • One (1) virtual visit • One (1) telehealth/telemedicine visit/consultation	• $3,000 per year cap unless a waiver is approved • A maximum of two (2) visits per day per client may be reimbursed. A single visit may include multiple services or procedures, and • Any service provided to an individual eligible for dental health services coverage under another third-party reimbursement plan may not be billed to DCHHS unless the client has exhausted the benefits available under the plan.
Outpatient Ambulatory/Health Services	• One (1) visit • One (1) virtual visit • One (1) telehealth/telemedicine visit • One (1) laboratory service • One (1) diagnostic service	• No more than two (2) visits per client per day may be reimbursed; • Outpatient medical services provided over the phone are reimbursable as units of service • Any service provided to an individual eligible for medical care coverage under another third-party reimbursement plan may not be billed to DCHHS unless the client has exhausted the benefits available under the plan.

Outreach Services	• One (1) documented encounter	None
Outreach - Street	• One (1) documented encounter	None
Referral for Health Care and Supportive Services	• One (1) Referral • One (1) fifteen (15) minute, face-to-face/other encounters with a referral worker to assist a client with access to other services the client may be eligible for • One (1) virtual visit • One (1) telehealth/telemedicine visit/ • (Address virtual telehealth/telephone visit/consultation)	None
Respite Care for Adults	• One (1) hour of respite care to an HIV+ adult (aged 25+ years)	• Units billed must be based on documented time spent delivering the service.
State AIDS Drug Assistance Program	• **Not Applicable—Not for bid**	
Substance Abuse Services	• One (1) individual forty-five (45) minute counseling session • One (1) patient participating in a sixty (60) minute group session (not to exceed ten (10) grant-funded patients per group) • One (1) virtual visit • One (1) telehealth/telemedicine visit • (address virtual telehealth/telephone visit/consultation)	• Any service billed to DCHHS must be provided at the facility location licensed by the Department of State Health Services to provide that level of treatment; • Individual sessions should be at least 45 minutes in length and will be reimbursed by the session; • Group sessions should be at least 60 minutes in length and will be reimbursed by the session; • Fractions of a unit may not be billed, and • Any service provided to an individual eligible for substance abuse services coverage under another third-party reimbursement plan may not be billed to DCHHS unless the client has

		exhausted the benefits available under the plan.

Unit(s) of Service vs. Time Billing Table				
Unit(s) of Service	1	2	3	4
Time	1-29 minutes	30-44 minutes	45-59 minutes	60 minutes

APPENDIX C: CLIENT ELIGIBILITY REQUIREMENTS

Services must be available to all eligible clients seeking care in the Dallas EMA/HSDA. All clients will be served regardless of age, sex, race, color, religion, national origin, or sexual orientation, in accordance with the American Disabilities Act (ADA). No eligible client will be refused services.

All clients, both new and already enrolled in care, shall be screened in accordance with *TDSHS Client Eligibility Policy 220.001*. Clients may self-refer to all services supported by funds awarded through the request for proposal (RFP) for Part A, Part B, State Services, and State Rebate of the RWHAP. To the extent feasible, subrecipients will implement consistent, standardized intake and documentation processes that will utilize common forms, minimize the burden on clients, and reduce duplication of data-gathering and reporting on service providers. At a minimum, all subrecipients must comply with the eligibility criteria listed below.

Initial Eligibility and Annual 12-Month Recertification of HIV Status, Texas Residency, and Income

Upon initiation of services, as well as every 12 months, providers must determine whether a respondent meets the following RWHAP Part B/State Services eligibility criteria:

- have a diagnosis of HIV;
- provide documentation of Texas residency and
- provide complete and accurate income documentation.

Recertification of HIV status after initial eligibility determination is not required.

Clients must be screened for program eligibility every six months (no later than the last day of the clients' birth month for the annual 12-month recertification and no later than the last day of the clients' half-birth month for the 6-month self-attestation).

Initial Eligibility Determination Period

A 30-day determination period for all funded services can be accessed by clients who are:

- Newly diagnosed within the previous six months;
- New to the State of Texas/local EMA/HSDA and in need of medical services;
- Engaging in care for the first time after being diagnosed for longer than six months;
- Returning to medical care after an absence of six months or longer and/or;
- In need of early intervention services.

As applicants are being linked to services, providers should work to complete the eligibility process and collect the required documents. An eligibility determination must be completed within 30 days of program application initiation.

Providers must have an established alternative source of funding should a client be found to be ineligible for Ryan White Part B or state-funded services. This must be documented in agency policy and tracked in

the client file if applicable. The policy must delineate the process for any necessary administrative adjustments if a cost is determined to be unallowable.

Documentation of HIV Status

To be eligible for services paid for by RWHAP and State Services, an individual must have an HIV-positive diagnosis. Affected individuals (people not living with HIV) may be eligible for RWHAP services in limited situations; services for affected individuals must always benefit PLWH. For further clarification on providing services to affected individuals, please refer to *HRSA Policy Clarification Notice (PCN) #16-02, Eligible Individuals and Allowable Uses of Funds*. **For EHE services, the only client eligibility requirement is an HIV diagnosis. Services presently funded through EHE include the following:**

- Health Education/ Risk Reduction
- Non-Medical Case Management
- Oral Health
- Outpatient/Ambulatory Health Services
- Outreach Services
- Referral for Healthcare and Support Services

There are many different ways to document HIV infection. Some examples of acceptable forms of documentation are provided below; however, this should not be viewed as a complete list.

Laboratory Documentation

Proof of HIV diagnosis may be found in laboratory test results that bear the client's name. Some examples include:

- A positive result from HIV screening test (HIV 1/2 Combo Ab/Ag enzyme immunoassay [EIA]);
- A positive result from an HIV 1 RNA qualitative virologic test such as an HIV 1 Nucleic Acid Amplification Test (NAAT) or
- Detectable quantity from an HIV 1 RNA quantitative virologic test (e.g., viral load test)

NOTE: HIV testing technology changes rapidly, and standards of HIV confirmation continue to evolve. Providers must stay informed of advances in testing technology as newer tests may also provide proof of HIV diagnosis.

Other Forms of Documentation

Some examples include:

- A signed statement from an entity with prescriptive authority attesting to the HIV-positive status of the person or,
- A complete THMP Medical Certification Form signed by a physician (required by THMP) or,
- A hospital discharge summary documenting the individual is HIV-positive.

NOTE: Exposed infants born to people living with HIV can be served with documentation of the mother's HIV-positive status up to 12 months of age. Children older than 12 months must meet the same criteria for proof of HIV as listed above to continue services.

Facilitating Linkage with an HIV Preliminary Positive Result

A preliminary positive is a positive result from an HIV screening test. Although a preliminary positive is not considered proof of HIV status (because it is not a supplemental test in the current HIV testing algorithm), individuals with such a result are very likely to have HIV infection and would benefit from quick linkage to ongoing medical care. Having only a preliminary positive result from one HIV test should not be a barrier in linkage to medical care.

The ability to rely upon a preliminary positive test result to facilitate linkage to care does not negate the responsibility of the HIV testing site to conduct supplemental testing. The receiving medical provider must be informed of the individual's unconfirmed preliminary positive HIV test result. Once the supplemental results are received from the lab, HIV testing staff must provide these results to the individual and, if a Release of Information is signed, to the HIV care provider. Clinics receiving such individuals may choose to arrange an abbreviated first appointment, during which the individual could receive counseling on HIV infection, orientation to medical care, conduct eligibility screening, and/or begin laboratory work.

NOTE: HIV medical providers may elect to conduct the HIV supplemental test if a memorandum of understanding (MOU) is signed with the HIV testing agency.

Documentation of Texas Residency

To be eligible for services paid for by RWHAP Part B/State Services/THMP, an applicant must reside within the geographic boundaries of Texas and express intent to remain within the state and not claim residency in any other state or country. Texas residency is not a requirement for services exclusively funded by RWHAP Part A. Consult with the DCHHS Ryan White Grants Management Division for more information.

Individuals do not lose their Texas residency status because of a temporary absence from the state. For example, a migrant or seasonal worker may leave the state during certain periods of the year but maintain a home in Texas and return to that home after this temporary absence. This individual will not lose their Texas residency status.

Students

Students from another state living in Texas who are going to attend school may claim Texas residency based on their student status while residing in Texas.

Acceptable proof of residency documents must include the applicant's full legal name and residential address and be unexpired or from the last 30 days.

Documentation of proof of Texas residency can be determined using one of the following:

- valid (unexpired) Texas Driver's License;
- Texas State identification card (including identification from criminal justice systems);

- recent Social Security, Medicaid/Medicare, or Food Stamp/TANF benefit award letters;
- IRS Tax Return Transcript, Verification of Non-Filing, W2, or 1099;
- current employment records (pay stub);
- post office records;
- official state mail;
- current voter registration;
- rent or utility receipts for one month before the month of application in the client's name;
- a mortgage or official rental lease agreement in the client's name;
- valid (unexpired) motor vehicle registration;
- proof of current college enrollment or financial aid;
- property tax receipt;
- a letter of identification and verification of residency from a verifiable homeless shelter or community center serving homeless individuals or,
- a statement/attestation (does not require notarization) with the client's signature declaring that the client has no resources for housing or shelter. For THMP, a letter from an agency worker attesting that the individual has no resources for housing or shelter will be accepted.

If none of the items listed above are available, Texas residency may be verified through:

- Credit card, phone, or cable bill with the client's address clearly indicated on the document; or
- Bank brokerage statement with address clearly indicated on the document; or
- statement from landlord/neighbor/another reliable source; or
- submission of the DSHS-THMP Supporter Statement. This is only accepted when no other proof of residency is available and must be accompanied by a signed statement on agency letterhead from the agency enrollment worker detailing steps that were taken to obtain proof of residency and why they were not successful; or
- observance of personal effects and living arrangement (e.g., visit to the residence). For THMP, a signed statement on agency letterhead detailing this observance and why other forms of proof of residency were not available will be accepted.

There are no further proof of residency requirements (e.g., the requirement for a photo ID or documentation of immigration status) other than those listed above. Subrecipients and providers may not impose more stringent proof of residency requirements regarding eligibility for RWHAP and State HIV-funded services than those listed. Subrecipients must document that all eligibility staff have been made aware of this policy no less frequently than annually. Subrecipients should contact the DCHHS Ryan White Grants Management Division for questions about acceptable documentation of Texas residency.

Documentation of Income

To be eligible for services paid for by RWHAP Part A, MAI, Part B, and State Services, including State Rebate, an applicant must submit proof of income and FPL. Subrecipients must use the DSHS-provided Income Calculation Worksheet to calculate an applicant's income. Consult the DSHS policy for detailed instructions.

Local Criteria for Eligibility Determination

Dallas RWPC determines the financial eligibility for each prioritized service category. This limit may not exceed 500% of the FPL. Periodically, the Dallas RWPC may alter financial eligibility limits. The financial eligibility for FY 2025-2026 services is listed in Appendix E. Subrecipients should contact the DCHHS Ryan White Grants Management Division for questions regarding financial eligibility limits.

APPENDIX D: DOCUMENTATION REQUIREMENTS

For agencies receiving funding awards, documentation requirements for all service categories must be completed before submission for a reimbursement request. Documentation should occur after each contact, resulting in a reimbursable unit of service. Documentation should include the following elements for all service categories unless noted below:

I. **WHO RECEIVED:** Who received the service? The client's name or identifying number should be on all backup documentation. Not required for Outreach-Street.

II. **WHO PROVIDED:** Who provided the service? For every unit of service for which reimbursement is requested, someone at the agency level had to interface with the client – the backup documentation for every encounter should include their name, signature, and credentials, if appropriate. Not required for Insurance Assistance and Drug Reimbursement.

III. **WHAT:** What service was provided? All documentation should indicate the service provided: medical case management, transportation, food pantry, etc.

IV. **WHEN:** Date and time of service provided; the duration of time on that date or start and stop times.

V. **HOW MUCH:** How many units of the service were provided? Each unit of service billed to DCHHS should match the number of units documented. This documentation of units should follow the guidelines in the Dallas Planning Area Standards of Care and Service Delivery Guidelines for each service category.

VI. **WHERE:** Where was the service provided? Specify the location: clinic, street corner, client's home, van, health fair, etc. This is not required for Health Insurance and Premium Cost Sharing Assistance and Drug Reimbursement.

VII. **WHY:** What was the purpose or intent of the service encounter? Documentation should always reflect the client's needs and address the goals or objectives identified in the care plan. This is not required for Outreach-Street.

VIII. **STATUS:** Progress or lack of progress in achieving goals outlined in the care plan. This is not required for Health Insurance and Premium Cost Sharing Assistance, Drug Reimbursement, Outreach-Street, and Interpretation/ Translation.

To be an allowable cost under the HRSA RWHAP and DSHS, all services must:

- Relate to HIV diagnosis, care, and support,
- Adhere to established HIV clinical practice standards consistent with the U.S. Department of Health and Human Services Clinical Guidelines for the Treatment of HIV and other related or pertinent clinical guidelines, and
- Comply with state and local regulations provided by licensed or authorized providers, as applicable.

Agencies may develop documentation formats to meet their needs while incorporating these required elements. Sample documentation forms for each service category may be obtained from a DCHHS program monitor.

APPENDIX E: FINANCIAL ELIGIBILITY FOR THE DALLAS PLANNING AREA BASED ON FEDERAL POVERTY GUIDELINES

Background: Planning Councils can identify categorically specific activities that address "how best to meet the need." Specific components or interventions can be modified for and within categories, populations, and geographic focus areas to enhance HIV programming and service delivery within the Dallas EMA.

Rationale: Increase financial eligibility percentages for the FY 2020 Dallas EMA/HSDA for the Outpatient Ambulatory/Health Services, Medical Case Management, AIDS Pharmaceutical Assistance, Health Insurance Premium and Cost Sharing Assistance, and Non-Medical Case Management service categories for Ryan White Part A, B, and State Services based on federal poverty guidelines.

Justification: Due to the increased cost of insurance plans, HIV medications, and outpatient medical care visits, the Planning and Priorities Committee proposes an increase in financial eligibility percentages in core medical & support service categories based on federal poverty guidelines to assess the impact on service utilization, linkage to care, treatment retention, and viral suppression. Additional provisions include an analysis to track/document the number of individuals who qualified or were denied services at 300-400% & 400-500% intervals.

Recommendation: The Planning and Priorities Committee recommends increasing the financial eligibility percentages for FY 2020 Dallas EMA/HSDA for the Outpatient Ambulatory/Health Services, Medical Case Management, AIDS Pharmaceutical Assistance, Health Insurance Premium and Cost Sharing Assistance, and Non-Medical Case Management service categories based on the federal poverty guidelines (subject to HRSA guidance).

Statement of Conflict: All RWPC members employed by RWHAP-funded service providers are conflicted.

Financial Eligibility for the Dallas Planning Area Based on Federal Poverty Guidelines						
Service Category	**Funding Source**	**Percentages for FY 2018**	**Percentages Proposed for FY 2019**	**Percentages Approved for FY 2019**	**Percentages Proposed for FY 2020**	**Percentages Approved for FY 2023**
CORE MEDICAL SERVICES						
Outpatient Ambulatory/Health Services	Part A, B, State Services	300%	400%	400%	500%	500%
Oral Health Care	Part A, B	300%		300%	300%	400%
Mental Health Services	Part A, State Services	300%		300%	400%	500%
Medical Case Management	Part A, B, State Services	300%	400%	400%	500%	500%
AIDS Pharmaceutical Assistance	Part A, B, State Services	300%	500%	500%	500%	500%
Substance Abuse Services	Part A	300%		300%	300%	500%
Health Insurance Premium and Cost-sharing Assistance	Part A, B	300% ACA Plans: must have a subsidy	400%	400%	400%	400%
Early Intervention Services	Part A	300%	Not Funded	Not Funded		Not Funded
Home and Community-based Health Services		Not Funded		Not Funded		Not Funded
Home Health Care		Not Funded		Not Funded		Not Funded
Medical Nutrition Therapy		Not Funded		Not Funded		400%
Hospice Services		Not Funded		Not Funded		Not Funded

Financial Eligibility for the Dallas Planning Area Based on Federal Poverty Guidelines						
Service Category	**Funding Source**	**Percentages for FY 2018**	**Percentages Proposed for FY 2019**	**Percentages Approved for FY 2019**	**Percentages Proposed for FY 2020**	**Percentages Approved for FY 2023**
SUPPORT SERVICES						
Food Bank	Part A, B, State Services	300%		300%	300%	400%
Case Management (Non-Medical)	Part A, B, State Services	300%		300%	500%	500%
Medical Transportation	Part A, B, State Services	300%		300%	300%	400%
Case Management (Non-Medical - Housing-Based)	Part A, B, State Services	300%		300%	300%	400%
Emergency Financial Assistance	Part A, B, State Services	300%		300%	400%	400%
Outreach Services	Part A, B	300%		300%	300%	400%
Housing	State Services	10% of Gross Income; 30% of Adjusted Income				400%
Other Professional Services (Legal Services)	Part A, B, State Services	300%		300%	300%	400%
Home Delivered Meals	Part A, B, State Services	300%		300%	300%	400%
Health Education/ Risk Reduction	State Services	300%		300%	300%	400%
Respite Care for Adults/ Youth/ Children/Adolescents	Part A, B, State Services	300%		300%	300%	400%
Child Care Services	Part A, State Services	300%		300%	300%	Not funded
Linguistic Services	Part A	300%		300%	300%	400%
Referral for Health Care and Support Services	Part B, State Services				500%	500%

The Ryan White Legislation prohibits imposing the first-party charge on individuals whose income is at or below 100% of the Federal Poverty Level (FPL). Costs to clients with incomes higher than 100% of the FPL are based on a discounted fee schedule and sliding fee scale. **For services rendered using Ending the HIV Epidemic (EHE) funding, the FPL is non-applicable.**

Individual Income	Maximum Charge
At or below 100% of FPL	$0
101% to 200% of FPL	No more than 5% of gross annual income
201% to 300% of FPL	No more than 7% of gross annual income
Over 300% of FPL	No more than 10% of gross annual income

Ryan White Services should not be denied due to a client's inability to pay.

APPENDIX F: HIV/STD PROGRAM POLICY 530.002: SECTION EXPECTATIONS AND PROVIDER RIGHTS REGARDING THE DELIVERY OF CLIENT SERVICE

1.0 Purpose

This policy clarifies the rights of a Contractor/Subcontractor (Provider) in responding to unacceptable client behavior while providing HIV/STD prevention, treatment, and social services under a contract with the Texas Department of State Health Services (DSHS), TB/HIV/STD Section (Section). Providers reviewing this policy should be able to identify unacceptable client behavior and respond accordingly with reasonable confidence that the actions taken on behalf of the provider agency regarding a client were appropriate. The policy will also outline what the Section expects from the Provider in delivering client services.

2.0 Background

One part of the Section's mission is to provide a wide array of services to persons with HIV. That mission is achieved through contracts with various Providers who deliver those services. The Section is responsible for ensuring that Providers understand their rights when addressing client behaviors that may be questionable or disruptive. The Provider will, therefore, be able to ensure that services are offered in a manner free from disruption. In addition, the Section also has certain expectations of how those services are to be delivered to clients and how client rights are to be respected.

3.0 Authority

Civil Rights Code, Title 42, Chapter 21; Rehabilitation Act of 1973, Sect. 794; Age Discrimination Act of 1974; Public Law 88-352; Title VI, and Part 80 of 45 CFR; 25 TAC §§98.41-98.44.

4.0 Definitions as Applied to this Policy

Contractor - a legal entity under contract with DSHS to provide goods or services to people infected or affected by HIV, AIDS, or STDs or to implement goals supporting the Section's mission.

Provider - a person, agency, or facility approved by the DSHS that has entered into a contract with DSHS or with a DSHS contractor to deliver state or federal HIV/STD programs to clients.

Services - program activities offered by a Provider on behalf of the Section for prevention, health, medical, and social services.

5.0 Section Expectations Regarding the Provider/Client Relationship

The Section expects the Provider to maintain client relations of the highest possible quality.

5.1 General Section Expectations

1. Treat each client with respect, consideration, and recognition of the client's dignity and individuality.
2. Communicate the need for treatment, care, or services in a culturally sensitive and equitable manner.
3. Allow the client to select comprehensive outpatient health and psychosocial support services or to refuse any service without fear of reprisal.
4. Inform the client about treatment or service options, emphasize that it is the client's right to choose, and advise them of alternatives when multiple providers are available for the same service.
5. Assure that service planning, medical treatment, and counseling plans are determined in cooperation with the client.
6. Maintain a climate in the office or other service delivery setting free of physical or mental abuse or exploitation.
7. Enforce local, state, or federal laws or regulations (such as no smoking or maintaining a drug-free environment) required to conduct business.
8. Review any decision to modify, suspend, or terminate services.
9. Re-evaluate any modification, suspension, or termination to determine if the client's situation has changed.
10. Give clients an avenue to formally complain about treatment or services and the Provider's decision to deny an application, modify, suspend, or terminate client benefits, a mechanism to receive an appropriate and fair review of the complaint, and ensure that there is no reprisal of any type against the client for filing the complaint or grievance.

5.2 Confidentiality

The Provider is required to maintain the confidentiality of all information according to state and federal laws. The right to confidentiality begins when the client applies for services, when the Provider first conducts an evaluation, or when counseling begins.

5.3 Equal Access to Programs and Services

The Provider is required to consider client eligibility regardless of age, gender, sexual orientation, gender expression/identity, marital status, ethnic origin, physical challenge, or religious practice. Conversely, the client has a right to refuse any recommended services.

5.4 Impartial Treatment

Providers must allow the client to apply for any service or program. The client must be given fair, impartial treatment in receiving and processing the application and receiving services.

5.5 Filing a Complaint or Grievance

Contractors are required to have a written client complaint procedure in place to meet the minimum requirements for client complaints.

All clients have a right to file a complaint or grievance regarding inappropriate Provider behavior, actions, or perceptions of discrimination. The complaint may be filed in accordance with the grievance procedures of the Provider or with the local organization responsible for monitoring the Provider. When all other sources have been exhausted, the client may file the complaint or grievance with the Section by calling 1-512-533-3000.

In the case of a complaint related to the delivery of clinical services, the client may file a complaint directly to the Section without filing a complaint locally if the client chooses. The Section will investigate all complaints in accordance with HIV/STD Policy 020.050, "Public Complaints and Allegations Related to the Delivery of HIV or STD Programs."

6.0 General Provider Rights When Dealing with a Client

Each Provider should develop written procedures to deal with clients who may be disruptive or uncooperative. The Provider's responsibility is to ensure that staff is well informed about the procedures and use them consistently in every situation. Providers are expected to use good judgment and attempt to resolve these situations fairly without undue limitation or denial of client services.

7.0 Modifying, Suspending, or Terminating Client Services

The Provider is responsible for providing a work environment free from undue disruption, turmoil, or interference. Whenever possible, the Provider should take steps to serve clients and support a healthy work environment.

During the course of serving clients, clients may behave in a disruptive, abusive, or threatening manner toward staff or other clients. When this type of behavior occurs, the Provider may take the following progressive action:

1. Modify all or part of the services provided to the client
2. Suspend all or part of the services provided to the client
3. Terminate all or a portion of the services provided to the client

Depending on the severity of the client's behavior, such as threatening the life of staff or other clients, the Provider may skip one or more of the above steps and take appropriate action. Refer to *HIV/STD Policy No. 530.003* for information on dealing with clients who threaten to harm themselves or others.

7.1 Modifying Client Services

The Provider may modify all or part of the services provided to the client when the client is disruptive or uncooperative. Modification may include, but is not limited to:

1. rescheduling the client's appointment for a time later that day or in the near future,

2. arranging client services by telephone and

3. mailing food vouchers, bus passes, etc.

7.2 Suspending Client Services

Suspension is the temporary withdrawal of a service or services provided to a client by a Provider. It may be necessary for the Provider to suspend all or part of the services provided to the client for a specific period when alternative service delivery methods have not produced appropriate client behavior (i.e., the client is repeatedly disruptive or abusive towards staff or other clients).

7.3 Terminating Client Services

The Provider may choose to terminate all or part of the services provided to the client when alternative services delivery methods are not appropriate to the situation (i.e., the client threatens injury or homicide to a staff member or another client, etc.) or when modification or suspension of services has not produced appropriate client behavior.

Clinical service providers (e.g., physicians, advanced practitioners, and registered nurses) who terminate services should follow professional practice standards concerning how client services are terminated. Professional organizations and licensing bodies can guide clinical service providers in managing these situations.

7.4 Denying, Suspending, or Terminating a Client's Service on the Basis of Substance Abuse

The Provider may not deny, suspend, or terminate any service funded through DSHS because the client is **suspected** of substance abuse or refuses to accept treatment for substance abuse.

Exceptions to this may occur in the course of delivering medical care when a client's active substance abuse contraindicates the prescription of certain medications or treatments.

The treating clinician must evaluate these professional decisions on a case-by-case basis.

7.5 Notification of the Decision to Modify, Suspend, or Terminate Client Services

The decision to modify, suspend, or terminate services must be communicated to the client promptly and appropriately. This may be done by any verifiable method, such as in person or certified letter. When services are to be modified or suspended, staff should establish and communicate a specific period for the suspension and inform the client that the resumption of services will depend on the client's willingness and ability to meet certain behavior expectations. The behavior expectations should be clearly outlined and communicated to the client. The client should be given information about alternative methods by which services will be delivered or where such assistance may be obtained.

7.6 Documentation

The Provider should ensure that all modification, suspension, and termination actions are clearly documented in the client's record.

7.7 Technical Assistance

When desired, the Provider may contact the Section to discuss specific situations or to obtain technical assistance. **Decisions regarding modifying, suspending, or terminating client services remain with the Provider.**

7.8 Section Review of Decisions to Modify, Suspend, or Terminate Client Services

As part of a routine review of the quality of client services or a complaint investigation, Section staff may review the events that led to a modification, suspension, or termination of client services. Section staff will evaluate, at minimum, whether the Provider:

1. followed their internal policies and those of the Section in taking action to resolve the situation;
2. respected client rights, and
3. applied the least restrictive limitation on client services necessary to maintain a service delivery setting free of physical and mental abuse or exploitation.

APPENDIX G: HIV/STD PROGRAM POLICY 530.003: HOW TO DEAL WITH CLIENTS WHO THREATEN TO HARM THEMSELVES OR OTHERS

1.0 Purpose

To provide guidance to Contractors/Subcontractors (Providers) in responding to a client's violent or threatening behavior or when a client threatens suicide or exhibits suicidal behavior while providing HIV/STD prevention, clinical treatment, and social services under a contract with the Texas Department of State Health Services (DSHS), TB/HIV/STD Section (Section).

2.0 Authority

Vernon's Texas Code Annotated (VTCA) Health and Safety Code 611.002, Confidentiality of Information and Prohibition Against Disclosure; Health and Safety Code 611.004, Authorized Disclosure of Confidential Information Other than in Judicial or Administrative Proceeding; Health and Safety Code 81.046, Confidentiality; Health and Safety Code 81.103, Confidentiality, Criminal Penalty; Texas Administrative Code, Title 25, 98.44, Denial of Application; Modification, Suspension, or Termination of Client Benefits; Criteria; HIV/STD Policy No. 530.002, Section Expectations and Provider Rights Regarding the Delivery of Client Services.

3.0 Definition as Used in this Policy

Professional - a person licensed or certified by the state or an employee of a facility licensed, certified, or operated by the state.

Provider - a person, agency, or facility approved by the DSHS that has entered into a contract with DSHS or with a DSHS contractor to deliver state or federal HIV/STD programs to clients.

4.0 Provider Rights When Dealing With a Client

Providers should develop written procedures to deal with clients who are violent or exhibit threatening behavior. Providers are expected to use good judgment and attempt to resolve these situations fairly without denying services whenever possible as long as the work environment can remain free from violence or threats (See *HIV/STD Policy No. 530.002*, Section Expectations and Provider Rights Regarding the Delivery of Client Service).

4.1 Responding to Clients Who Display Violent or Threatening Behavior

When responding to clients who display violent or threatening behavior, staff should take the following actions as appropriate to the situation:

1. Remain calm and speak in a calming voice.

2. If possible, summon a qualified mental health professional for assistance or make a referral.
3. Reschedule the client's appointment for a time later that day or in the near future.
4. When warranted, use alternative service delivery methods, such as telephone for case management, mailing food vouchers, or bus passes.
5. Notify the director of the contracting agency regarding serious client behavior problems for additional appropriate action.
6. Take whatever action is legally available to ensure the work environment is free from violence or threats.
7. Call the proper authorities when a client threatens staff or other clients with a weapon or creates a situation in which other clients and staff fear their safety.
8. Follow-up on any referrals or other actions taken to manage the client.
9. Document any action(s) taken in the client's case file.

4.2 Responding To Clients Who Make Homicidal Threats or Exhibit Homicidal Behavior

A client who makes homicidal threats or exhibits homicidal behavior should be taken seriously. Staff should attempt to take the following actions as appropriate to the situation:

1. Remain calm and leave the area, if possible.
2. Alert another staff member, preferably a supervisor, to the situation (this person should call the police immediately).
3. Try to calm the threatening individual (do not argue or talk back).
4. If possible, summon a qualified mental health professional for assistance or make a referral.
5. Notify the director of the contracting agency regarding serious client behavior problems for additional appropriate action.
6. Call the proper authorities when a client threatens staff or other clients with a weapon or creates a situation in which other clients and staff fear their safety.
7. Follow-up on any referrals or other actions taken to manage the client.
8. Document any action(s) taken in the client's file.

4.3 Responding to Clients Who Threaten Suicide or Exhibit Suicidal Behavior

A client who threatens suicide or exhibits suicidal behavior shall be taken seriously. Staff should carefully question clients to determine the seriousness of the threat before taking any action. Unqualified staff should

not attempt to diagnose clients' mental health status beyond identifying a potential suicidal situation. The following questions may be used to obtain more information from the client:

1. Ask the client what is meant by the threat.
2. Ask the client if they have ever attempted suicide before.
3. Ask the client if there is a history of suicide in the client's family or if someone close to the client has ever committed suicide.
4. Try to find out if the client has a plan and a means to commit suicide.

Any staff member confronted with a suicidal threat should take the following actions as appropriate to the situation:

1. Attempt to detain the client until the extent of the client's need for further help can be determined and the appropriate referral made or action taken.
2. Attempt to persuade the client to talk with a mental health professional or, if they already have one, assist the client in contacting their mental health professional.
3. Contact a family member or friend of the client, if the client is willing, and discuss a protection/safety plan.
4. Complete a "No Harm Agreement" (see attached example) that will cover the period from the current occurrence until the client's next contact with a case manager or mental health provider (the client should keep a copy, and a copy should be placed in the client's chart)
5. If none of the above, the staff member should contact the appropriate mental health center and refer the client (the most likely contact will be the Mental Health and Mental Retardation provider in the local county).
6. Give the client written instructions on contacting their local crisis hotline and hospital emergency room.
7. If unsuccessful with the above, call 911 and request a mental health officer.
8. Notify the director of the contracting agency regarding serious client behavior problems for additional appropriate action.
9. Follow-up on any referrals or other actions taken to manage the client.
10. Document any action taken on behalf of the client in the client's case file.

5.0 Obligation to Report

Communications between a patient and a professional and records of a patient's identity, diagnosis, evaluation, or treatment created or maintained by a professional are confidential (Health and Safety Code §611.002). However, a professional **may** disclose confidential information to medical or law enforcement

personnel if the professional determines that imminent physical injury is probable by the patient, to the patient, or others, or immediate mental or emotional harm is possible to the patient (Health and Safety Code §611.004).

6.0 Where to Go for Help

When desired, the Provider may contact the TB/HIV/STD Section to discuss specific situations or to obtain technical assistance. Decisions regarding whether to continue, modify, suspend, or terminate client services remain with the Provider. (See *" HIV/STD Policy No. 530.002, Section Expectations and Provider Rights Regarding the Delivery of Client Service"* for more information.)

For an online directory of suicide hotlines, go to www.suicide.org/hotlines/texas-suicide-hotlines.html or call the National Hope Line Network at **1-800-SUICIDE (1-800-784-2433)**.

INNOVATIVE STRATEGIES