# How Best to Meet the Need

# Group 3

- Outreach
- Health Education Risk Reduction (HERR)
- Early Intervention Services (EIS)
- Home Health
- Psychosocial Support
- Other Professional Services

## Needs Assessment Data General Information:

- 506 people completed the needs assessment survey
    - 64 of the 506 were classified as "out-of-care;" for the purposes of the Needs Assessment. This was defined as an individual that was out-of-care for at least six months, and had returned to care for 90 days or less, from the time that the assessment was administered
    - Surveys were available in English and Spanish
    - Demographic information such as age, gender, race/ethnicity, and geographic location based on zip code data closely matched the demographics of the Ryan White care system
- The Needs Assessment focused mainly on funded services, and there is no relevant data for Respite Care or Rehabilitative Services
- The Needs Assessment did not differentiate between Medical Case Management and Non-Medical Case Management
- An open-ended question was asked: As a person living with HIV, what service do you wish you could get that is not available today? 78 respondents answered the question with the following responses, with the highlighted answers being the most frequent responses:
    - Housing/rent assistance
    - Case management
    - Support groups/counseling
    - Dental care
    - Eye glasses
    - Child care
    - Case management
    - Financial assistance
    - Disability/social security benefits
    - Food pantry
    - Virtual doctor visits
    - Exercise/gym
    - Find a cure
- When reviewing the needs assessment data, the Comprehensive Planning Committee noted that mental health services data and substance abuse services data may not be truly reflective of the needs of the population
    - Mental Health Services data shows a marked increase in mental health diagnoses when compared to the national average, most notably, when examining statistics around a bipolar disorder diagnosis

  - Substance Abuse data can be tricky for many reasons – respondents may feel that identifying themselves as a substance user may have a negative impact on their ability to receive services; others may use substances that are not prescribed to them, but not identify as having a misuse disorder, and yet others may simply not wish to share their experiences due to perceived stigma
- Please feel free to ask clarifying questions about all needs assessment data, as needed

**North Central Texas HIV Planning Council Needs Assessment Recommendations:**

- Create a comprehensive resource guide with listings by location and service type, with a separate section for referral-only services.

- Conduct further study related to mental health and substance abuse, medications, housing, food, and barriers for Spanish-speaking clients.

- For rural and working populations, explore alternative methods of service delivery (e.g., hours of operation, transportation, telemedicine).

- Suggest funded agency representatives review agency-specific paperwork with the goal or reducing redundant client forms.

- Consider revising service standards to provide medical transportation services to core and support services.

- Utilize the current U=U campaign for clients, healthcare workforce, and community.

# Federal Poverty Level (FPL) Limits by Service Category

Current Service FPL Limits (Can Not Exceed 500%)

| Core Service Categories | % of FPL |
|---|---|
| Case Management - Medical | 500% |
| Counseling & Testing | 500% |
| Early Intervention Services | 500% |
| Health Insurance Premium & Cost Sharing Assist | 500% |
| Home & Community Based Health Services | 275% |
| Housing Services | 350% |
| Local AIDS Pharmaceutical Assistance | 400% |
| Medical Nutrition Therapy | 400% |
| Mental Health Services | 400% |
| Oral Health Services | 400% |
| Outpatient/Ambulatory Health Services | 400% |
| Substance Abuse Outpatient Care | 400% |

| Support Service Categories | % of FPL |
|---|---|
| Case Management - Non-Medical | 500% |
| Emergency Financial Assistance - Other | 275% |
| Emergency Financial Assistance - Prescriptions | 400% |
| Food Bank/Home-Delivered Meals (Congregate) | 275% |
| Food Bank/Home-Delivered Meals (Food Pantry) | 100% |
| Health Education / Risk Reduction | 500% |
| Outreach Services | 500% |
| Psychosocial Support Services - Counseling | 400% |
| Referral for Health Care/Support Services (Pat. Nav | 500% |
| Transportation | 275% |

**Tarrant County FPL client breakdown**

| | 0-100% | 101-200% | 201-300% | 301-400% | 401-500% |
|---|---|---|---|---|---|
| **Ryan White Clients Part A, B, and State Services** | **1717** | **804** | **420** | **163** | **75** |

# Demographic Report

## GRAND TOTALS

| CLIENTS | Total | New | Ongoing |
|---|---|---|---|
| | 3,210 | 1,723 | 2,455 |

| UNITS | 103,915.00 |
|---|---|
| SERVICES | 78,173 |

Example: A client came in for a service and received 4 units of service. This is counted as one service and four units.

| GENDER | Male | Female | Trans. Female to Male | Trans. Male to Female | Other Gender |
|---|---|---|---|---|---|
| | 2,361 | 817 | 1 | 31 | 0 |

| RACE | American Indian or Alaskan Native | Asian | Black | Native Hawaiian or Other Pacific Islander | More than one race | White | Other Race |
|---|---|---|---|---|---|---|---|
| | 43 | 60 | 1,581 | 3 | 0 | 1,494 | 0 |

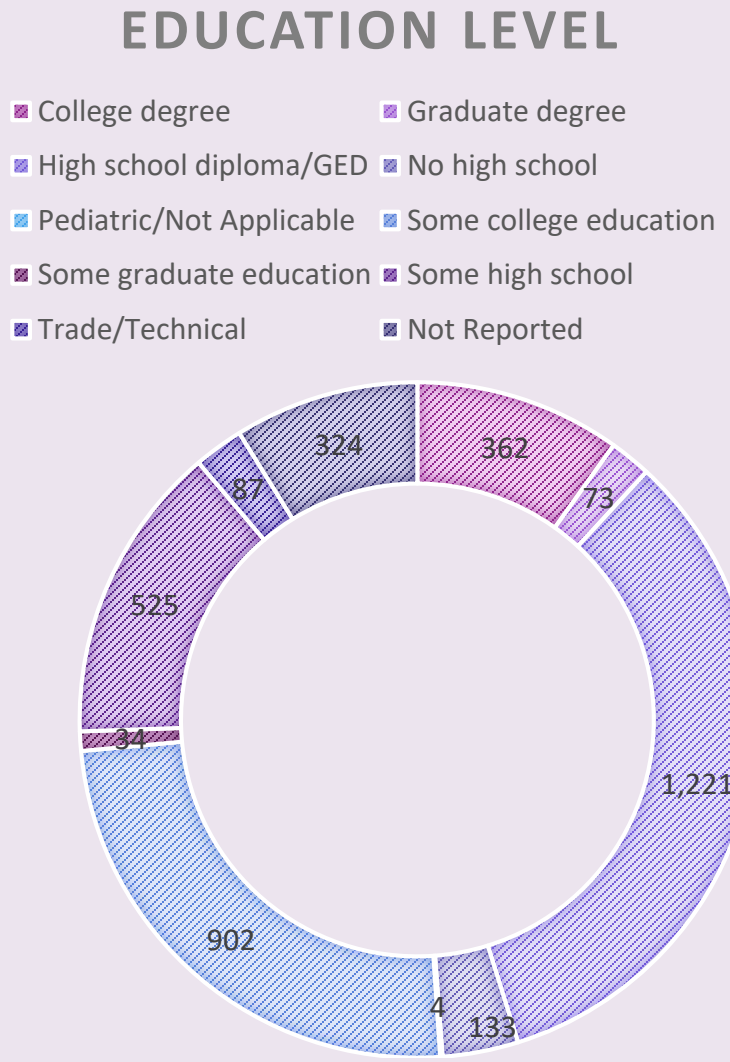
| ETHNICITY | Haitian | Hispanic | Non-Hispanic | Unknown |
|---|---|---|---|---|
| | 0 | 742 | 2,464 | 0 |

| FPL | 0 - 49 | 50-100 | 101 - 150 | 151-200 | 201 - 250 | 251 - 285 | 286-299 | 300 - 349 | 350 - 399 | 400-449 | 450 - 499 | 500+ |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 1,023 | 694 | 445 | 359 | 253 | 123 | 44 | 106 | 57 | 48 | 27 | 24 |

| AGE | 0 - 18 | 18-29 | 30-39 | 40-49 | 50 + |
|---|---|---|---|---|---|
| | 2 | 501 | 829 | 702 | 1,176 |

# Demographic Report

| Education Level | |
|---|---|
| College degree | 362 |
| Graduate degree | 73 |
| High school diploma/GED | 1,221 |
| No high school | 133 |
| Pediatric/Not Applicable | 4 |
| Some college education | 902 |
| Some graduate education | 34 |
| Some high school | 525 |
| Trade/Technical | 87 |
| Not Reported | 324 |

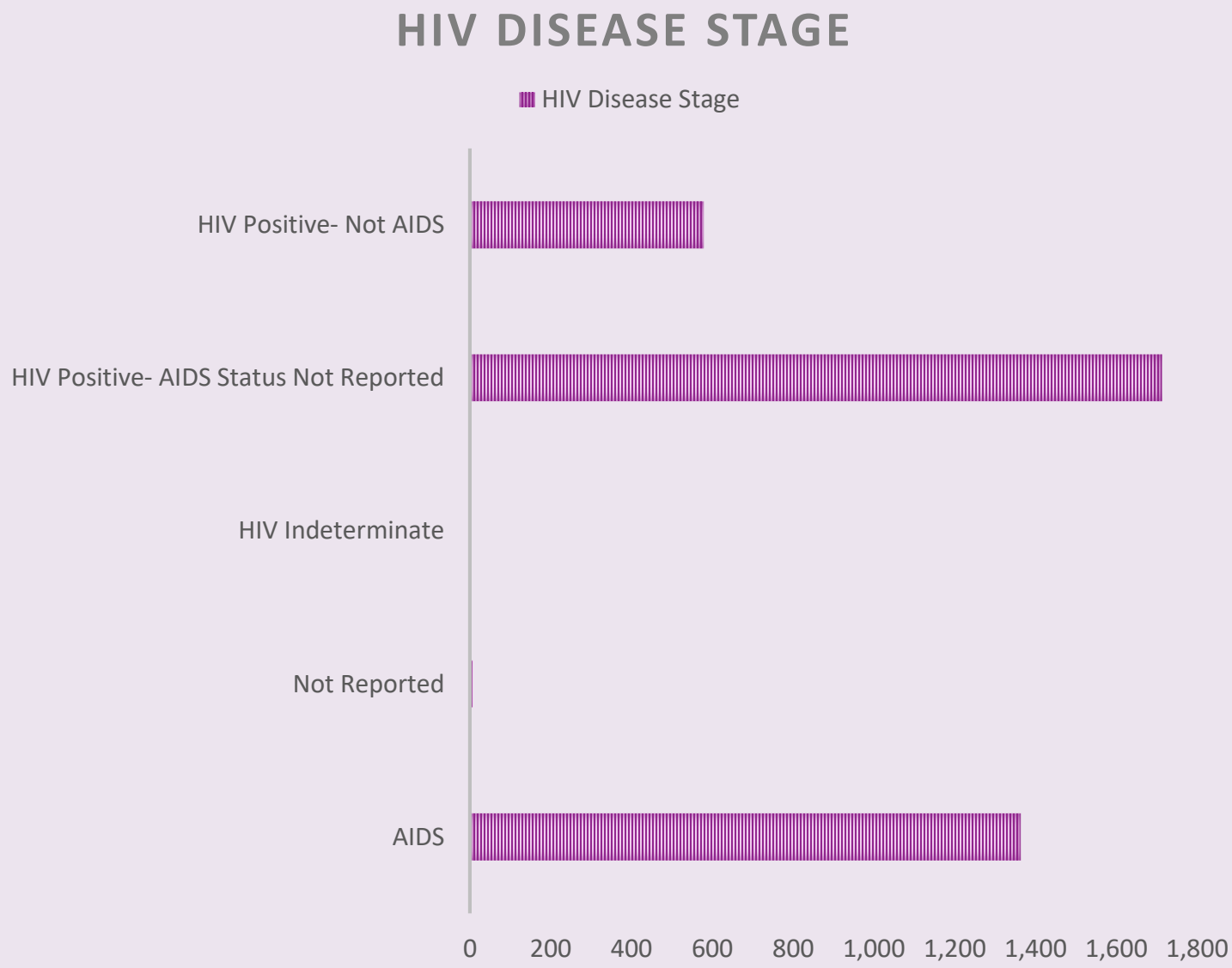


# Demographic Report

| Veteran Status | |
|---|---|
| Not Reported | 10 |
| Yes | 106 |
| No | 3,549 |

# Demographic Report

| HIV Disease Stage | |
|---|---|
| AIDS | 1,363 |
| Not Reported | 8 |
| HIV Indeterminate | 2 |
| HIV Positive- AIDS Status Not Reported | 1,713 |
| HIV Positive- Not AIDS | 579 |



# Group 3

| Funded Service Categories | Unfunded Service Categories |
| --- | --- |
| Outreach | Health Education Risk Reduction (HERR) |
| Early Intervention Services (EIS) | Home Health |
| Psychosocial Support | Other Professional Services |

# Outreach Services Definition

The Outreach Services category has as its principal purpose identifying PLWH who either do not know their HIV status, or who know their status but are not currently in care.

Outreach Services provide the following activities:
1) identification of people who do not know their HIV status and/or
2) linkage or re-engagement of PLWH who know their status into services, including provision of information about health care coverage options.

Because Outreach Services are often provided to people who do not know their HIV status, some activities within this service category will likely reach people who are HIV negative. When these activities identify someone living with HIV, eligible clients should be linked to Ryan White services.

# Outreach Services Definition

Outreach Services must:

1) Use data to target populations and places that have a high probability of reaching PLWH who

    a. have never been tested and are undiagnosed,

    b. have been tested, diagnosed as HIV positive, but have not received their test results, c. have been tested, know their HIV positive status, but are not in medical care;

2) Be conducted at times and in places where there is a high probability that PLWH will be identified

3) be delivered in coordination with local and state HIV prevention outreach programs to avoid duplication of effort.

# Outreach Services Definition

Outreach Services may be provided through community and public awareness activities (e.g., posters, flyers, billboards, social media, TV or radio announcements) that meet the requirements above and include explicit and clear links to and information about available Ryan White services.

Program Guidance:

- Outreach Services provided to an individual or in small group settings cannot be delivered anonymously, as some information is needed to facilitate any necessary follow-up and care.
- Outreach Services must not include outreach activities that exclusively promote HIV prevention education. Recipients and subrecipients may use Outreach Services funds for HIV testing when Ryan White resources are available and where the testing would not supplant other existing funding.

# Demographic Report- Outreach

***Service Category: Outreach Services***

| CLIENTS | Total | New | Ongoing |
|---|---|---|---|
| | 306 | 194 | 112 |

| | |
|---|---|
| UNITS | 858.00 |
| SERVICES | 1,377 |

Due to the nature of outreach, data is maintained outside of Provide Enterprise, the AA's client level data system.

| GENDER | Male | Female | Trans. Female to Male | Trans. Male to Female | Other Gender |
|---|---|---|---|---|---|
| | 266 | 29 | 1 | 10 | 0 |

| RACE | American Indian or Alaskan Native | Asian | Black | Native Hawaiian or Other Pacific Islander | More than one race | White | Other Race |
|---|---|---|---|---|---|---|---|
| | 1 | 0 | 231 | 0 | 0 | 73 | 0 |

| ETHNICITY | Haitian | Hispanic | Non-Hispanic | Unknown |
|---|---|---|---|---|
| | 0 | 39 | 267 | 0 |

| FPL | 0 - 49 | 50-100 | 101 - 150 | 151-200 | 201 - 250 | 251 - 285 | 286-299 | 300 - 349 | 350 - 399 | 400-449 | 450 - 499 | 500+ |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 133 | 65 | 29 | 29 | 19 | 12 | 5 | 8 | 2 | 2 | 0 | 2 |

| AGE | 0 - 18 | 18-29 | 30-39 | 40-49 | 50 + |
|---|---|---|---|---|---|
| | 0 | 78 | 104 | 51 | 73 |

# Additional Outreach Data

MAI EIS - 320 total clients with six new diagnoses (1.9% positivity rate)

- 319 men, one trans woman
- Race / Ethnicity
  - 117 Black, non-Hispanic
  - 3 Black, Hispanic
  - 200 White, Hispanic
- Age Range
  - 15 – 25: 112
  - 26 – 30: 102
  - 31 – 40: 68
  - 41 – 50: 25
  - 51 – 60: 10
  - 61+: 2
  - Age missing: 1

Outreach – 586 total clients

- 484 men, 91 women, 10 trans women, 1 trans man
- Race / Ethnicity
  - 313 Black
  - 166 White
  - 98 Hispanic
  - 2 Asian
  - 4 Native American
  - 3 Multi-racial or other
- Age Range
  - 15 – 25: 53
  - 26 – 30: 114
  - 31 – 40: 186
  - 41 – 50: 104
  - 51 – 60: 101
  - 61+: 28

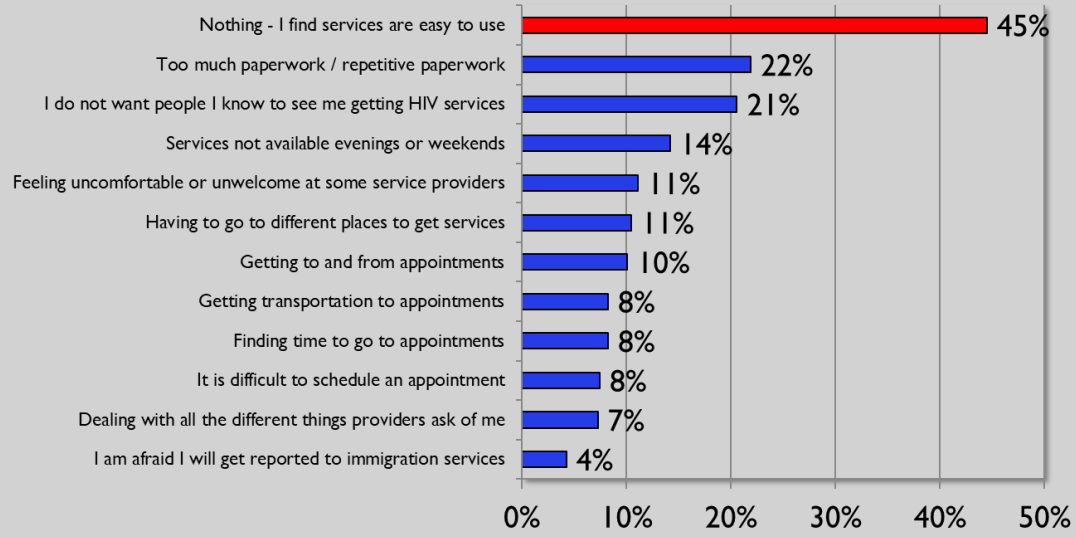
- Other – approximately 50 needed translation services in Spanish. Eight needed translation in a language other than Spanish. Five of those clients required French translation which was provided by the outreach worker. The remaining three used the language line.

# Needs Assessment Results
## Outreach Services

- Q. Which of the following are the MOST IMPORTANT to you when getting HIV medical care and support services? N=506
  - The top four most important characteristics to respondents when getting HIV medical care and support services are: the staff understands the needs of people living with HIV, I can get multiple services at the same location, no waiting lists to get into care, and services are free or low cost.

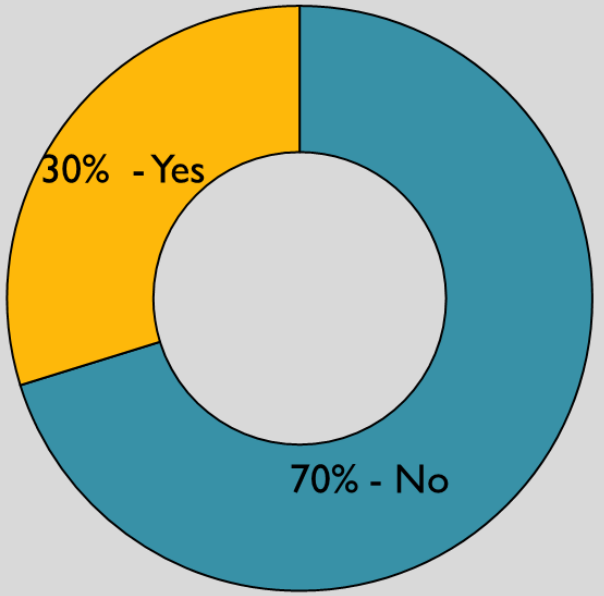
# Needs Assessment Results
## Outreach Services

- Q. What is the hardest thing about using HIV medical care and support services? N=506
  - The top three hardest things about using HIV services are: too much paperwork or repetitive paperwork, not wanting others to know they are getting HIV services, and services not available on evenings or weekends.
  - Almost half (45%) said they find nothing difficult about getting services.



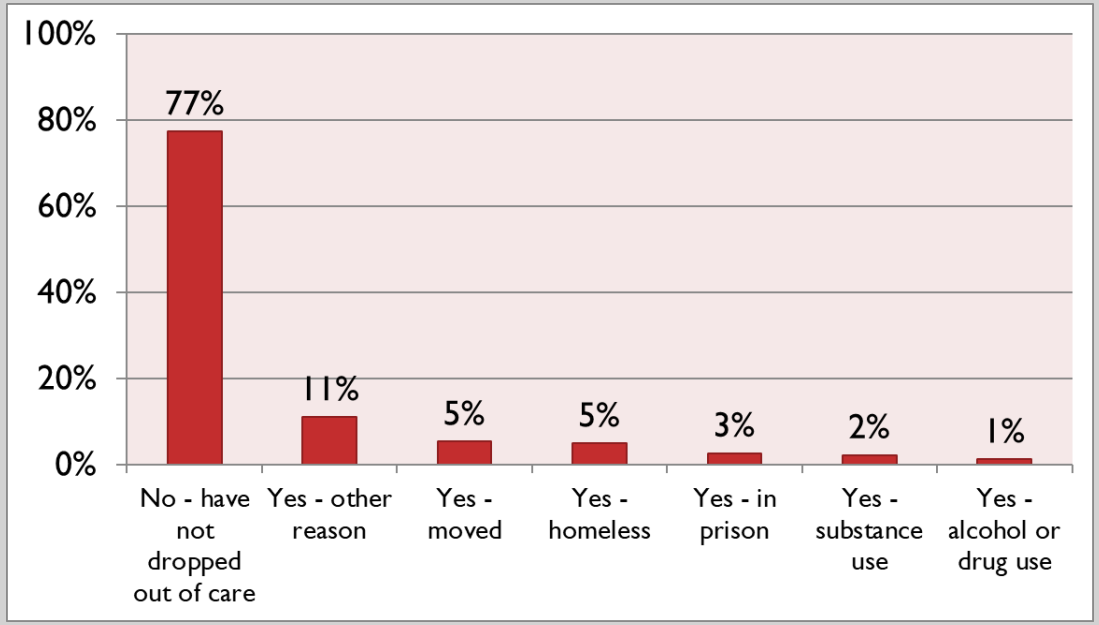
# Needs Assessment Results
## Outreach Services

- Q. Have you missed any medical appointments in the PAST YEAR? N=506
  - 30% of respondents (45% of Asian, 31% of Black, 30% of Hispanic, and 25% of White) reported they have missed a medical appointment within the past year.
  - 30% of Tarrant County and 23% of non-Tarrant County respondents reported they have missed a medical appointment within the past year.
  - Primary reasons for missing the appointment: lack of transportation, forgot, in prison, and work.
  - Things that would help respondents make it to appointments were: help with transportation, evening/weekend appointments, and reminders.



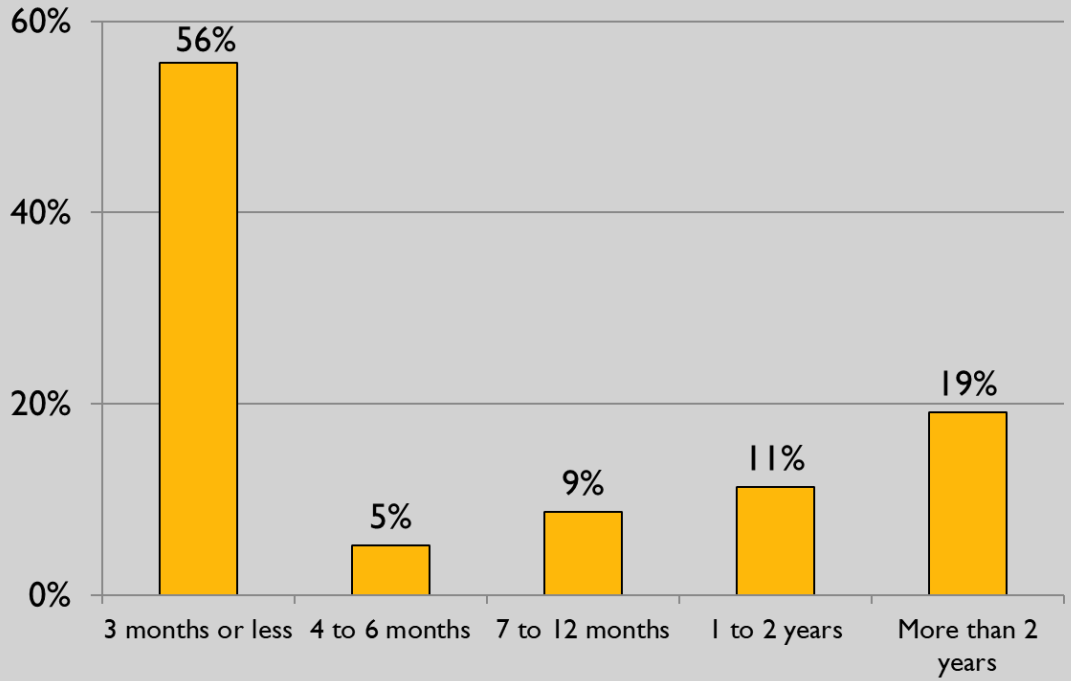
# Needs Assessment Results
## Outreach Services

- Q. Have you ever stopped getting HIV medical care, getting lab work, or taking your HIV medications for more than 6 months/ N=506
  - 77% of respondents (64% of Asian, 80% of Black, 77% of Hispanic, and 74% of White) have NOT dropped out of care. 76% of Tarrant County and 94% of non-Tarrant County respondents have not dropped out of medical care.
  - Reasons for dropping out of care were: moved, homeless, in prison, substance use, drug or alcohol use. Other reasons: no job, no transportation, depression, no insurance, and just started in treatment.



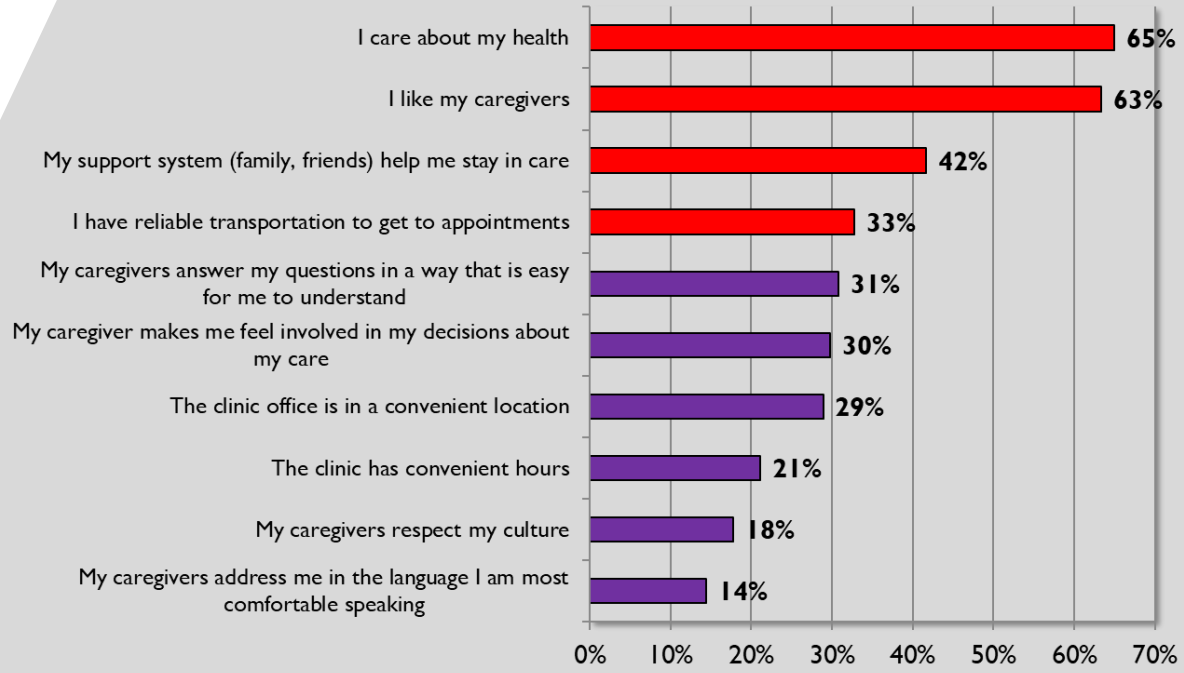
# Needs Assessment Results
## Outreach Services

- Q. How long have you been back in medical care? N= Respondents who dropped out of care 115
  - 56% of respondents who dropped out of care have been back in care for 3 months or less.



# Needs Assessment Results
## Outreach Services

- Q. Some people do not stay in medical care and drop out. We want to learn from you what keeps you in medical care. Check the TOP REASONS why you stay in medical care. N= 506
  - The top reasons respondents stay in care are: I care about my health, I like my caregivers, my support system (family/friends) help me stay in care, and I have reliable transportation to get to appointments.



# GROUP THREE STANDARDS OF CARE

## Local Standards of Care – Outreach Services

**DEFINITION**

Programs that have as their principal purpose identification of people with HIV disease so that they may become aware of, and may be enrolled in, care and treatment services, not HIV counseling and testing nor HIV prevention education. Outreach programs must be planned and delivered in coordination with State and local HIV prevention outreach programs to avoid duplication of effort; be targeted to populations known through local epidemiologic data to be at disproportionate risk for HIV infection; be conducted at times and in places where there is a high probability that individuals with HIV infection will be reached; and be designed with qualified program reporting that will accommodate local effectiveness evaluation.

**STANDARD OF CARE**

HIRING STANDARDS

- All paid Outreach program staff must possess, at minimum, a high school diploma or equivalent.
- Outreach should reflect the community that the program proposes to serve.

TRAINING STANDARDS

- As addressed in the Universal Agency Standards of Care, all Outreach staff must complete HIV/AIDS training and cultural competency.
- Within three (3) months of hire, Outreach staff must become acquainted with all of their program's collaborating agencies (including local correctional facilities).
- Within the first (3) months of hire, Outreach staff must complete training that includes, at minimum, the following criteria:
    - HIV / AIDS Training
        - HIV Basics (i.e., getting tested, transmission, disease stages)
        - Understanding Labs (i.e., reading lab results, understanding lab values)
        - Medication and Side Effects (i.e., understanding drug resistance, side effects and the goals of medications)
        - Adherence (i.e., adherence strategies)
    - Communication Skills
        - Active Listening
        - Asking Tough Questions
        - Non-Verbal Communication
        - Responding to Conflict
        - Culture and Cultural Competency
    - Substance Use and Mental Health Recognition and Referral
    - Personal Safety on the Job

**Note that training may be provided by the agency, an outside agency, or online. However, funded agencies must provide documentation that Outreach staff completed the training in the prescribed time period. A list of online training resources is available from the Planning Council.*

JOB PERFORMANCE STANDARDS

- Outreach staff must attend the monthly interagency outreach meetings with collaborating agencies.
- Outreach staff must refer clients to Patient Navigators / Case Managers for addressing Barriers to Care.
- Outreach staff must attempt to return clients to care after an agency / medical provider referral has been given.
- Outreach staff must follow Memorandum of Understanding with collaborating agencies for proper feedback.

REPORTING STANDARDS

- All Outreach staff should abide by local requirements for reporting, including the documentation of notes in ARIES when applicable.
- When not applicable, Outreach staff must maintain individual client records within the agency.

**SPECIAL INSTRUCTIONS**

1. Providers must develop a Memorandums of Understanding with collaborating agencies detailing a system for proper referrals.

# HRSA Definition:

The principal purpose of the Outreach Services category is to identify people living with HIV (PLWH) who either do not know their HIV status, or who know their status but are not currently in care. Outreach Services provide the following activities:

- Identification of people who do not know their HIV status;
- Linkage or re-engagement of PLWH who know their status into RWHAP services; and/or
- Provision of additional information and education on health care coverage options.

# Limitations:

Recipients and subrecipients may use Outreach Services funds for HIV testing when RWHAP resources are available, however testing must not supplant other existing funding.

# Services:

Outreach Services must:

1. Use local epidemiological data to focus outreach efforts on populations and places that have a high probability of reaching PLWH who
    1. have never been tested and are undiagnosed;
    2. have been tested, diagnosed as HIV positive, but have not received their test results, or
    3. have been tested, know their HIV positive status, but are not in medical care;
2. be conducted at times and in places where there is a high probability that PLWH will be identified;
3. be delivered in coordination with local and state HIV prevention outreach programs to avoid duplication of effort; and
4. designed with quantified program reporting that will accommodate local effectiveness evaluation.

Outreach Services are often provided to people who do not know their HIV status therefore activities within this service category will likely reach people who are HIV negative. When these activities identify someone living with HIV, eligible clients should be linked to HRSA RWHAP services. HIV-negative people may receive Outreach Services and should be referred to risk reduction activities.

Outreach Services may be provided through community and public awareness activities (e.g., posters, flyers, billboards, social media, TV or radio announcements) that meet the requirements above and include explicit and clear links to and information about available RWHAP services. Outreach Services may include both case findings and client recruitment through street outreach.

# Program Guidance:

Outreach Services provided to an individual or in small group settings cannot be delivered anonymously, as some information is needed to facilitate any necessary follow-up and care.

Outreach Services must not include outreach activities that exclusively promote HIV prevention education.

Outreach services data are reported in the RSR in aggregate.

Outreach models may vary by provider, but outreach services should increase available access points to care.

# Service Standard and Performance Measure

The following Standards and Performance Measures are guides to improving health outcomes for PLWH throughout the State of Texas within the Ryan White Part B and State Services Program.

| Standard | Measure |
|---|---|
| **Linkage:** Identified PLWH who do not know their status will be linked to a RWHAP or non-RWHAP service provider to facilitate the transition to medical services. Outreach models vary by provider, but outreach services should increase available access points to care. Identified PLWH who do not know their status may be linked to the following services:<br><br>• Early Intervention Services<br>• Medical Case Management Services<br>• Non-Medical Case Management<br>• Outpatient Ambulatory Health Services | Percentage of identified PLWH who did not know their status that have documented evidence of linkage to a service provider.<br><br>Percentage of individuals with documented evidence of follow-up to determine PLWH linkage to RWHAP services in the Outreach provider primary record. |

| Standard | Measure |
| --- | --- |
| • Referral for Health Care<br><br>Outreach Services include linkage follow-up to ensure and confirm the identified PLWH scheduled or attended a medical appointment. | |
| **Re-engagement:** Identified PLWH who know their status but not currently in care will be re-engaged into RWHAP or non- RWHAP services to facilitate access to appropriate medical care and obtain needed support services. Outreach models vary by provider, but outreach services should increase available access points to care. Identified PLWH who know their status but not in care may be re-linked to a previous medical provider or case manager.<br><br>Outreach Services include follow-up to ensure the identified PLWH scheduled or attended a medical appointment. | Percentage of identified PLWH who know their status but not in care that have documented evidence of re-linkage to a service provider.<br><br>Percentage of individuals with documented evidence of follow-up to determine PLWH linkage to RWHAP services in the Outreach provider primary record. |

# Early Intervention (EIS) Services Definition

The elements of EIS often overlap with other service category descriptions; however, *EIS is the combination of such services rather than a stand-alone service*.
HRSA RWHAP Parts A and B EIS services must include the following four components:

- **Targeted HIV testing** to help the unaware learn of their HIV status and receive referral to HIV care and treatment services if found to be 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 Care
- **Outreach Services and Health Education/Risk Reduction** related to HIV diagnosis

# Demographic Report- Early Intervention Services

***Service Category: Early Intervention Services (EIS)***

| CLIENTS | Total | New | Ongoing |
|---|---|---|---|
| | 65 | 38 | 27 |

| | |
|---|---|
| UNITS | 2,141.00 |
| SERVICES | 2,620 |

Example: A client came in for a service and received 2 units of EIS. This is counted as one service and 2 units.

| GENDER | Male | Female | Trans. Female to Male | Trans. Male to Female | Other Gender |
|---|---|---|---|---|---|
| | 54 | 10 | 0 | 1 | 0 |

| RACE | American Indian or Alaskan Native | Asian | Black | Native Hawaiian or Other Pacific Islander | More than one race | White | Other Race |
|---|---|---|---|---|---|---|---|
| | 0 | 0 | 61 | 0 | 0 | 4 | 0 |

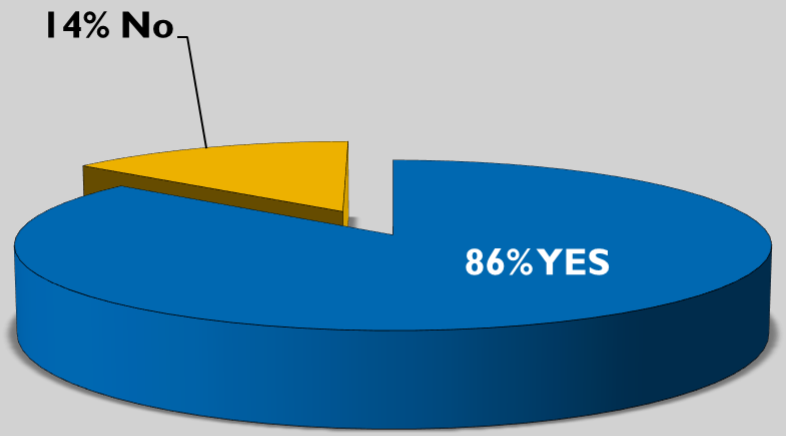
| ETHNICITY | Haitian | Hispanic | Non-Hispanic | Unknown |
|---|---|---|---|---|
| | 0 | 3 | 62 | 0 |

| FPL | 0 - 49 | 50-100 | 101 - 150 | 151-200 | 201 - 250 | 251 - 285 | 286-299 | 300 - 349 | 350 - 399 | 400-449 | 450 - 499 | 500+ |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 25 | 17 | 8 | 7 | 4 | 1 | 2 | 1 | 0 | 0 | 0 | 0 |

| AGE | 0 - 18 | 18-29 | 30-39 | 40-49 | 50 + |
|---|---|---|---|---|---|
| | 0 | 30 | 27 | 5 | 3 |

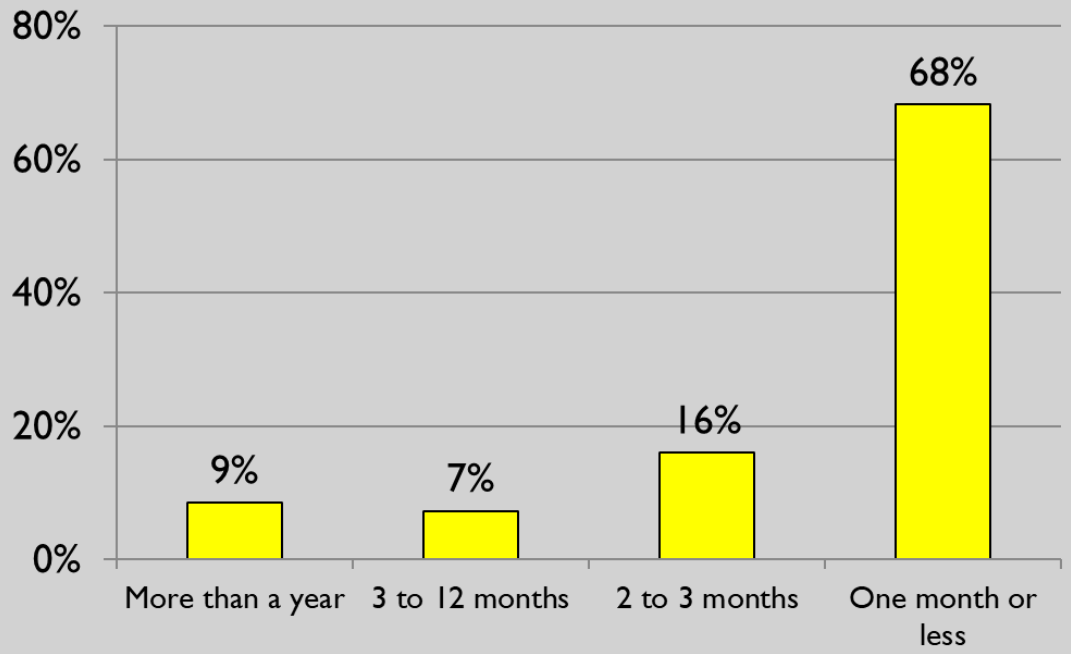
# Needs Assessment Results
## Early Intervention Services

- Q. When you received your HIV diagnosis, were you referred to medical care, support services and other resources that helped you get into treatment? N=506
  - A majority (86%) of respondents were referred to medical care, support services and other resources when they received their HIV diagnosis.
  - 77% of Whites, 88% of Blacks, and 92% of Hispanics reported they were referred to treatment services upon diagnosis. 86% of Tarrant County and 89% of non-Tarrant County respondents were referred to treatment upon HIV diagnosis.



# Needs Assessment Results
## Early Intervention Services

- Q. How long after your diagnosis with HIV did it take for you to have your FIRST medical appointment? N=506
  - 68% of all respondents had their first medical appointment within 30 days of diagnosis.
  - 76% of Hispanics, 69% of Blacks and 61% of Whites had their first medical appointment within 30 days of diagnosis. 68% of Tarrant County and 72% of non-Tarrant County respondents had their First medical appointment within 30 days of diagnosis.
  - Primary reasons for not getting into care within 30 days: in jail, in denial, scared/confused, and it took a while to get an appointment.



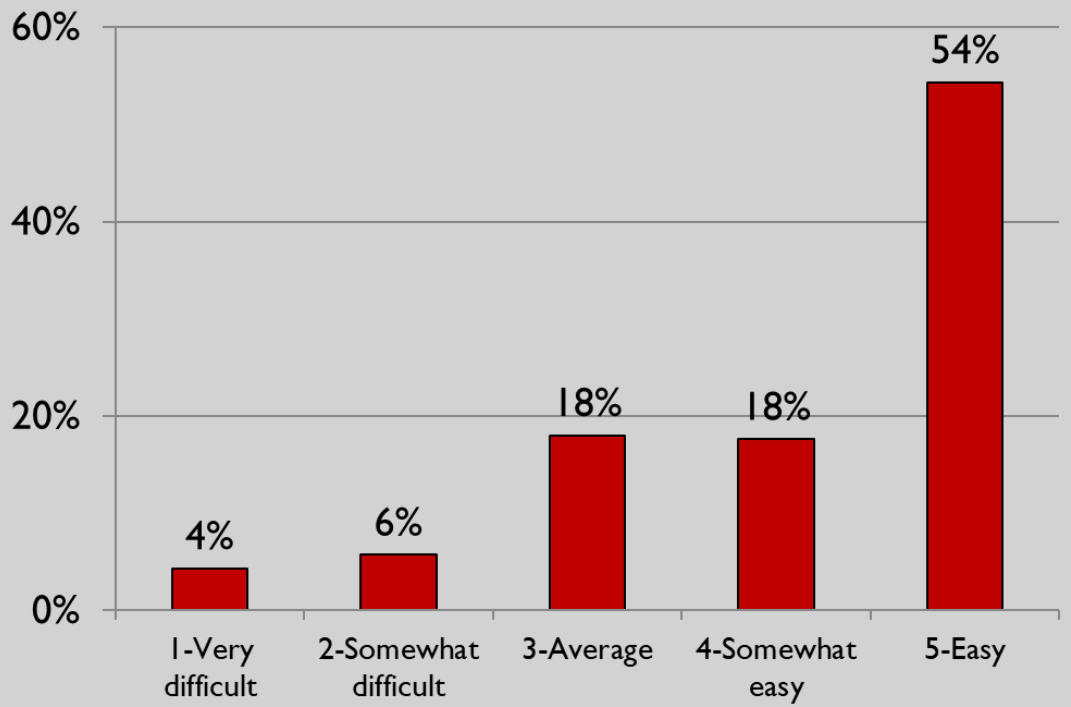
# Needs Assessment Results
## Early Intervention Services

- Q. How long after your diagnosis with HIV did it take for you to have your FIRST medical appointment? N=506 (table shows responses by age, gender, and race/ethnicity)

| Length for First Medical Appointment → | 3 to 12 months | More than a year |
|---|---|---|
| Under 25 | 11% | 6% |
| 25 to 34 | 14 | 8 |
| 35 to 44 | 4 | 10 |
| 45 to 54 | 6 | 8 |
| 55 to 64 | 7 | 11 |
| 65+ | 0 | 0 |
| | | |
| Male | 9% | 9% |
| Female | 4 | 7 |
| Transgender | 0 | 11 |
| | | |
| White | 10% | 10% |
| Black | 7 | 10 |
| Hispanic | 5 | 4 |
| Other | 9 | 9 |

# Needs Assessment Results
## Early Intervention Services

- Q. Please rate how easy or difficult it was for you to start getting medical care for your HIV. N=506
  - Just over half of respondents said it was easy for them to start getting medical care.
  - Among those who said it was somewhat or very difficult to get into care reported these primary reasons: lack of transportation, in denial, in jail, insurance difficulties, services difficult to use, and difficult to get into care.



# Needs Assessment Results
## Early Intervention Services

- Q. Please rate how easy or difficult it was for you to start getting medical care for your HIV. N=506 (table shows responses by age, gender, and race/ethnicity)

| | 5- Easy | 4- Somewhat easy | 3- Average | 2- Somewhat difficult | 1- Very difficult |
|---|---|---|---|---|---|
| Under 25 | 67% | 11% | 17% | 6% | 0% |
| 25 to 34 | 49 | 23 | 16 | 7 | 6 |
| 35 to 44 | 51 | 15 | 18 | 8 | 8 |
| 45 to 54 | 56 | 18 | 23 | 4 | 0 |
| 55 to 64 | 57 | 19 | 14 | 5 | 5 |
| 65+ | 68 | 8 | 24 | 0 | 0 |
| | | | | | |
| Male | 54% | 16% | 18% | 6% | 5% |
| Female | 53 | 19 | 20 | 5 | 3 |
| Transgender | 56 | 28 | 11 | 0 | 6 |
| | | | | | |
| White | 45% | 26% | 21% | 4% | 4% |
| Black | 57 | 17 | 14 | 7 | 5 |
| Hispanic | 59 | 13 | 20 | 5 | 3 |
| Other | 65 | 0 | 26 | 9 | 0 |

**Local Standards of Care – Early Intervention Services**

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

RWHAP Parts A and B EIS services must include the following four components:

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

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

## GOAL

The goal is to provide Early Intervention Services to link and retain clients in care (per HRSA Performance Standards) to achieve viral suppression by removing barriers to effective care for HIV clients by coordinating services, thus increasing the client's chances for a healthy, quality life. EIS is a team or program and not an individual staff person. EIS staff work for the Ryan White system and not an agency.

## STANDARD OF CARE

HIRING STANDARDS

- All agencies should abide by the Texas Department of State Health Services (DSHS) Standards of Care requirements for hiring.
- All paid EIS staff must possess, at minimum, a high school diploma or equivalent.

- EIS staff should reflect the community that the program proposes to serve.

TRAINING STANDARDS

- All EIS staff should abide by the Texas Department of State Health Services (DSHS) Standards of Care requirements for training.
- All EIS staff shall possess Texas DSHS current certification as an HIV Prevention counselor or advanced training/experience in the area of HIV infectious disease specialty.
- EIS staff should possess skills necessary to work with a variety of health care professionals, medical case managers, and interdisciplinary personnel.
- Staff should be trained in assessment of client needs in order to refer to case management, mental health services, substance abuse services, and other services.
- Within three (3) months of hire, EIS staff must visit all of their program's collaborating agencies (including those not funded through Ryan White and those not HIV-specific agencies).
- Within the first (3) months of hire, EIS staff must complete training that includes, at minimum, the following criteria:
    - HIV / AIDS Training
        - HIV Basics (i.e., getting tested, transmission, disease stages)
        - Understanding Labs (i.e., reading lab results, understanding lab values)
        - Medication and Side Effects (i.e., understanding drug resistance, side effects and the goals of medications)
        - Adherence (i.e., adherence strategies)
    - Communication Skills
        - Active Listening
        - Asking Tough Questions
        - Non-Verbal Communication
        - Responding to Conflict
        - Culture and Cultural Competency
    - Peer Role
        - Workplace Expectations (i.e., confidentiality, creating and setting boundaries, ethics, professional standards)
        - Disclosure (i.e., benefits and risks)

**Note that training may be provided by the agency, an outside agency, or online.*

JOB PERFORMANCE STANDARDS

- All EIS staff should abide by the Texas Department of State Health Services (DSHS) Standards of Care requirements for job performance.

- EIS staff should develop a plan to link and retain clients in care in order to achieve viral suppression. The plan should identify client needs, resources, goals, and a planned course of action to meet immediate needs. EIS Staff should revise the plan as necessary.
- EIS staff must attend care coordination staff meetings related to their clients.
- EIS staff must facilitate the removal of Barriers to Care for clients providing assistance with impediments that prevent client access to or retention in care, including, but not limited to:
    - Providing or arranging translation services;
    - Providing or arranging transportation to medical and social service appointments;
    - Providing or arranging assistance with obtaining medications;
    - Providing referrals and follow up for clients to necessary community resources; and
    - Providing or arranging client advocacy to assist clients with applications to third-party payer resources (e.g., Medicare/Medicaid, SSDI, insurance).
- EIS staff must attempt to return clients to care after an agency review of client attendance at medical and other appointments by contacting clients via telephone, postal mail, home visits, or any other means available which may include referral to outreach services.
- EIS staff are encouraged to work in partnership with clients to develop and track health self-management goals in such critical areas as adherence, exercise, substance abuse, sexual risk management, nutrition, and oral health.

<u>REPORTING STANDARDS</u>

- All EIS staff should abide by local requirements for reporting.

**DSHS Standards of Care – Early Intervention Services**

# HRSA Definition:

Support of Early Intervention Services (EIS) that include identification of individuals at points of entry and access to services and provision of:

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

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

# Limitations:

Ryan White HIV/AIDS Program (RWHAP) Part B funds are used for HIV testing only where existing federal, state, and local funds are not adequate *and* RWHAP funds will supplement, ***not supplant***, existing funds for testing. RWHAP Part B funds cannot be used to purchase at-home testing kits.

# Services:

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

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

# HRSA Program Guidance:

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

RWHAP EIS services must include the following four components:

- Targeted HIV testing to help the unaware learn of their HIV status and receive referral to HIV care and treatment services if found to be 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 OAHS, Medical Case Management (MCM), and Substance Use Care; and
- Outreach Services and Health Education/Risk Reduction related to HIV diagnosis.

# Service Standard and Performance Measure

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.

| Standard | Performance Measure |
|---|---|
| **HIV Testing:** Agencies providing HIV testing will ensure the following:<br><br>• Staff will be familiar with the DSHS HIV/STD Policy 2013.02;<br>• At a minimum, ensure that HIV testing is performed through the use of blood samples (either finger stick or venipuncture);<br>• Maintain records of number of HIV tests conducted in each measurement year; and | Percentage of HIV positive tests in the measurement year. *(HRSA HAB Measure)*<br><br>Percentage of individuals who test positive for HIV who are given their HIV-antibody test results in the measurement year. *(HRSA HAB Measure)*<br><br>Percentage of agencies that have documented evidence of CLIA-approved testing kits purchased and logs to track use of these testing kits. |

| Standard | Performance Measure |
|---|---|
| • Maintain records of test results with documentation that indicates whether the client was informed of their status.<br><br>State Services funds may be used to purchase CLIA-approved in-home testing kits. | |
| **Results Counseling:** Results counseling will be offered to all clients regardless of the result of the HIV test performed.<br><br>Results counseling will include discussion of risk reduction education and general health education provided to the client.<br><br>Results counseling for people living with HIV will include:<br><br>• Health education regarding HIV<br>• Risk Reduction counseling<br>• Maintenance of immune system<br>• Disclosure to partners and support systems<br>• Importance of accessing medical care and medications.<br><br>Results counseling for HIV-negative individuals will include:<br><br>• Health education<br>• Risk Reduction<br>• Referral to HIV prevention services | Percentage of clients offered results counseling as documented in the primary client record. |
| **Linkage to Care:** Clients testing positive for HIV through preliminary testing will be linked to and assisted in scheduling an appointment with a medical provider of the client's choosing.<br><br>Successful linkage to outpatient/ambulatory health services is measured as attendance to the actual medical appointment with a prescribing provider. | Percentage of clients who tested positive who were linked to outpatient/ambulatory health services in the measurement year.<br><br>Percentage of people living with HIV, regardless of age, who attended a routine HIV medical care visit within 1 month of HIV diagnosis. *(HRSA HAB Measure)*<br><br>Percentage of people living with HIV, who were homeless or unstably housed in the |

| Standard | Performance Measure |
|---|---|
| | measurement period, who attended a routine HIV medical care visit within three (3) months of HIV diagnosis. *(HRSA HAB Measure)* |
| **EIS Care Planning:** Persons living with HIV will have care plans developed during the time they are receiving services through EIS programs. Care plans will include:<br><br>• Problem Statement (Need)<br>• Goal(s) – suggest no more than 3 goals<br>• Intervention<br>  o Task(s)<br>  o Referral(s)<br>  o Service Deliveries<br>• Individuals responsible for the activity (EIS staff, client, family)<br>• Anticipated time for each task<br><br>The care plan is updated with outcomes and revised or amended in response to changes in the client's life circumstances or goals.<br><br>As EIS programs are centered to assist clients in engaging in medical care rapidly after testing positive, care plans should be updated at least monthly, or more often as goals are achieved. | Percentage of clients accessing EIS services that have a care plan developed as documented in the primary client record.<br><br>Percentage of clients accessing EIS services that have a care plan updated and/or revised as documented in the primary client record. |
| **Progress Notes:** Progress notes will be maintained in each client's primary record with documentation of the assistance the EIS staff provided to the client to help achieve the goal of a successful linkage to OAHS services. | Percentage of clients accessing EIS services that have documented progress notes showing assistance provided to the client in the primary client record. |
| **Referrals and Follow-up:** EIS staff will assist the clients with referrals to necessary services to achieve successful linkage to care.<br><br>Referrals will be documented in the client's primary record and, at a minimum, should include referrals for services such as: | Percentage of clients accessing EIS services with documented referrals in the primary client record initiated in a timely manner with client agreed participation upon identification of client needs. |

| Standard | Performance Measure |
|---|---|
| • OAHS<br>• MCM<br>• Medical transportation, as applicable<br>• Mental Health, as applicable<br>• Substance Use Treatment, as applicable<br>• Any additional services necessary to help clients engage in their medical care<br><br>All referrals made will have documentation of follow-up to the referral in the client's primary record. Follow-up documentation should include the result of the referral made (successful or otherwise) and any additional assistance the EIS staff offered to the client. | Percentage of clients with documented referrals declined by the client in the primary client record.<br><br>Percentage of clients accessing EIS services that have documentation of follow-up to the referral including appointment attended and the result of the referral in the primary client record. |
| **Transition/Case Closure:** Clients who are successfully linked to active MCM services and/or OAHS must have their cases closed with a case closure summary narrative documented on the criteria and protocol outlined below.<br><br>Common reasons for case closure, as applicable, include:<br><br>• Client is referred and successfully linked to MCM services;<br>• Client relocates outside of the service area;<br>• Client chooses to terminate services;<br>• Client is lost to care or does not engage in services;<br>• Client incarceration is greater than six (6) months in a correctional facility;<br>• Client death.<br><br>Transition criteria:<br><br>• Client has completed EIS goals and has been successfully linked to MCM services | Percentage of EIS clients with closed cases that include documentation stating the reason for closure and a closure summary (brief narrative in progress notes and formal case closure/graduation summary) in the primary client record system.<br><br>Percentage of closed cases with documentation of supervisor signature/approval on closure summary (electronic review is acceptable). |

| Standard | Performance Measure |
| --- | --- |
| • Client is no longer in need of EIS services (client declines EIS assistance).<br><br>Client is considered non-adherent with care if three (3) attempts to contact client (via phone, text, home visit, e-mail, and/or written correspondence) are unsuccessful and the client has been given 30 days from initial contact to respond.[ 1] Case closure proceedings should be initiated by the agency 30 days following the 3rd attempt. *Make sure appropriate Releases of Information and consents are signed by the client and meet requirements of Texas Medical Record Privacy Act HB 300 regarding electronic dissemination of protected health information (PHI).*<br><br>Staff should utilize multiple methods of contact (phone, text, e-mail, certified letter) when trying to re-engage a client, as appropriate. Agencies must ensure that they have releases of information and consent forms that meet the requirements of Texas Medical Record Privacy Act HB 300 regarding the electronic dissemination of PHI. | |

Notes:

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

# Psychosocial Support Services Definition

Psychosocial Support Services provide group or individual support and counseling services to assist HRSA RWHAP-eligible PLWH to address behavioral and physical health concerns. Activities provided under the Psychosocial Support Services may include:

- Bereavement counseling
- Child abuse and neglect counseling
- HIV support groups
- Nutrition counseling provided by a non-registered dietitian
- Pastoral care/counseling services

Funds under this service category **may not** be used to provide nutritional supplements. Ryan White funded pastoral counseling must be available to all eligible clients regardless of their religious denominational affiliation. *Ryan White funds may not be used for social/recreational activities or to pay for a client's gym membership*.

# Demographic Report- Psychosocial Support Services

***Service Category: Psychosocial Support Services***

| CLIENTS | Total | New | Ongoing |
|---|---|---|---|
| | 81 | 28 | 53 |

| UNITS | 3,702.00 |
|---|---|
| SERVICES | 589 |

Example: A client came in for a service and received 2 units of psychosocial support service. This is counted as one service and 2 units.

| GENDER | Male | Female | Trans. Female to Male | Trans. Male to Female | Other Gender |
|---|---|---|---|---|---|
| | 59 | 22 | 0 | 0 | 0 |

| RACE | American Indian or Alaskan Native | Asian | Black | Native Hawaiian or Other Pacific Islander | More than one race | White | Other Race |
|---|---|---|---|---|---|---|---|
| | 5 | 0 | 16 | 0 | 0 | 60 | 0 |

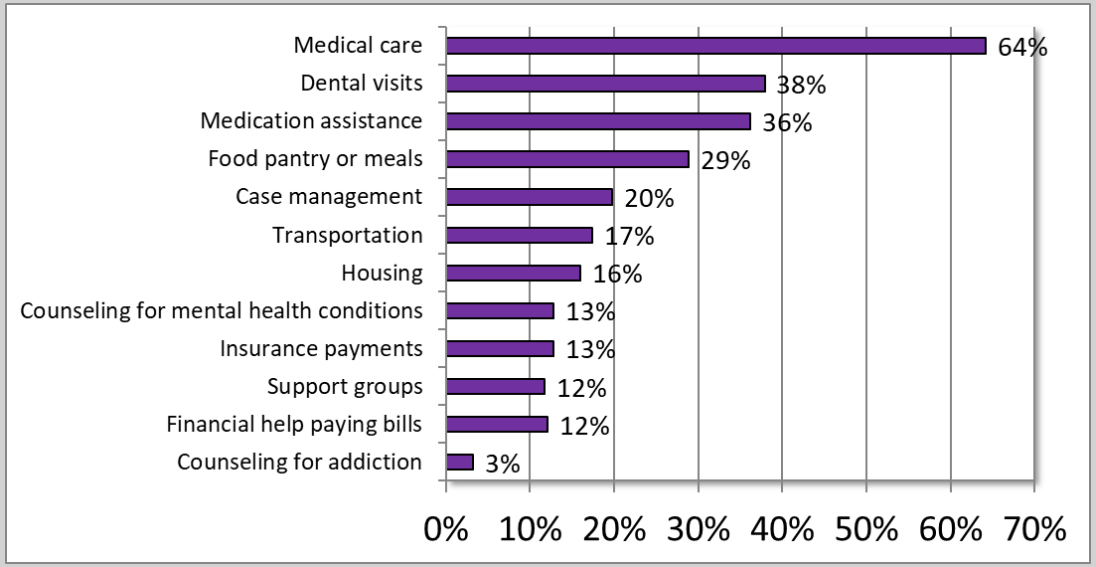
| ETHNICITY | Haitian | Hispanic | Non-Hispanic | Unknown |
|---|---|---|---|---|
| | 0 | 47 | 34 | 0 |

| FPL | 0 - 49 | 50-100 | 101 - 150 | 151-200 | 201 - 250 | 251 - 285 | 286-299 | 300 - 349 | 350 - 399 | 400-449 | 450 - 499 | 500+ |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 15 | 26 | 15 | 10 | 8 | 1 | 0 | 4 | 1 | 1 | 0 | 0 |

| AGE | 0 - 18 | 18-29 | 30-39 | 40-49 | 50 + |
|---|---|---|---|---|---|
| | 2 | 476 | 785 | 657 | 1,129 |

# Needs Assessment Results
## Psychosocial Support Services

- Q. Which three HIV-related services do you use the MOST? N=506
  - The top three HIV-related services respondents said they use the most are: medical care, dental visits, and medication assistance.



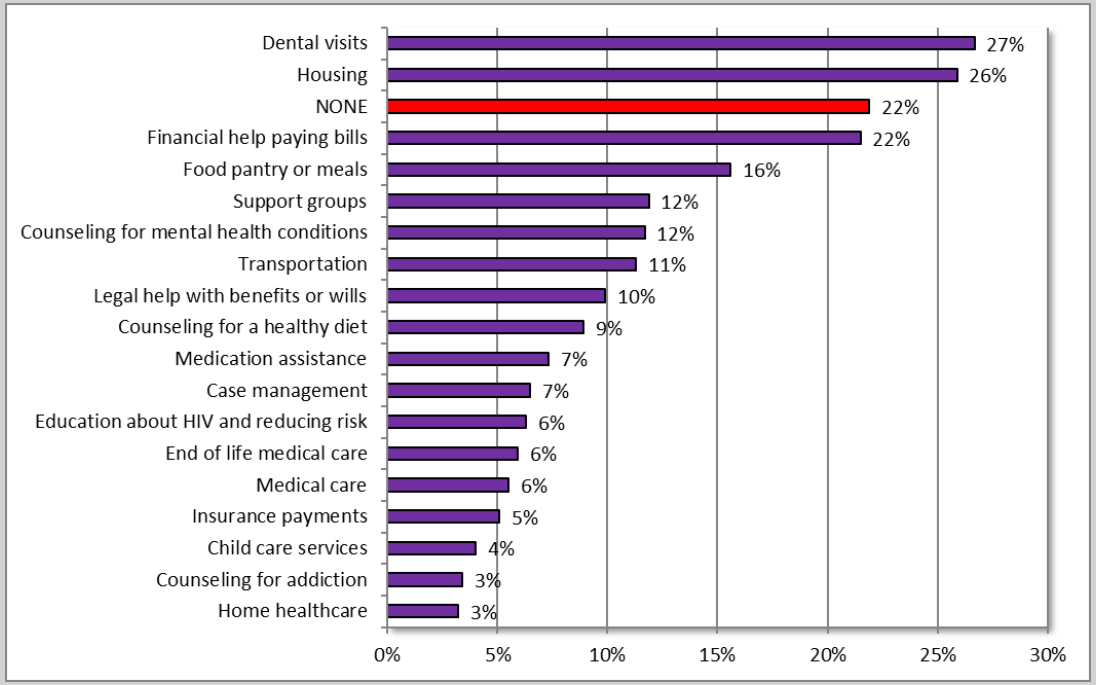
# Needs Assessment Results
## Psychosocial Support Services

- Q. Which three HIV-related services do you use the MOST? N=506 (table shows responses from both in- and out-of-care)

| HIV Services | In Care | Out of Care |
|---|---|---|
| Medical care | 65% | 59% |
| Dental visits | 40 | 31 |
| Medical assistance | 37 | 28 |
| Food pantry or meals | 30 | 23 |
| Case management | 19 | 27 |
| Transportation | 16 | 22 |
| Housing | 15 | 13 |
| Mental health counseling | 12 | 9 |
| Insurance payments | 13 | 6 |
| Support groups | 12 | 14 |
| Financial help paying bills | 11 | 17 |
| Counseling for addiction | 3 | 5 |

# Needs Assessment Results
## Psychosocial Support Services

- Q. Which services do you need but are not using right now? N=506
  - The top three HIV-related services respondents said they need the most are; dental visits, housing and financial help paying bills. One in five said they do not need additional services.



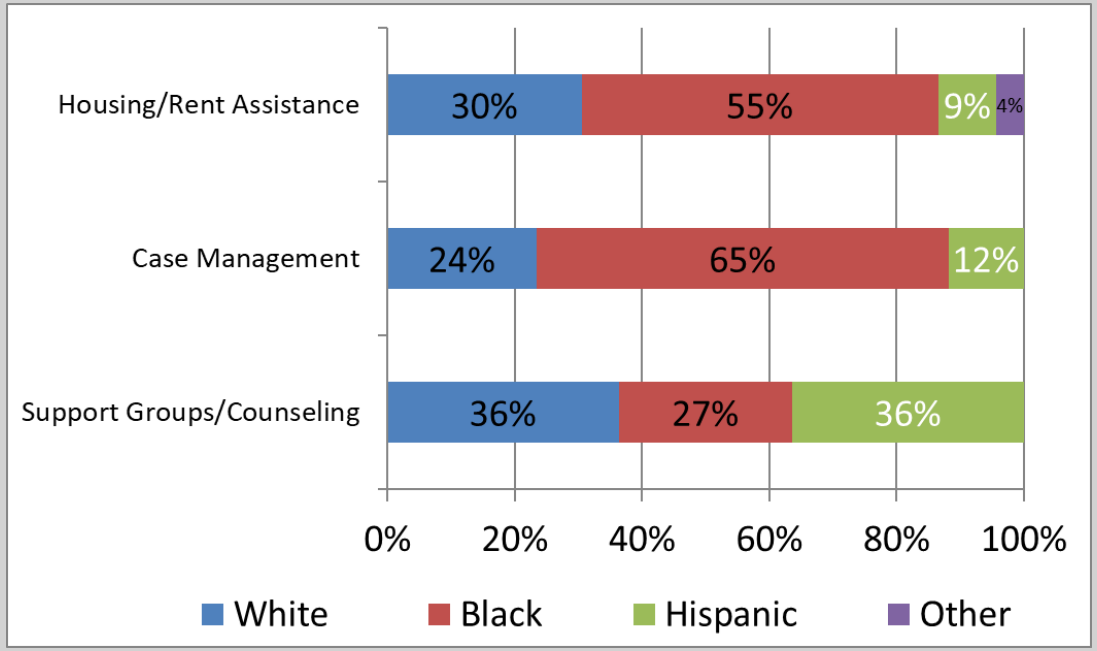
# Needs Assessment Results
## Psychosocial Support Services

- Q. Which services do you need but are not using right now? N=506 (table shows responses for both in- and out-of-care)

| HIV Services | In Care | Out of Care |
|---|---|---|
| Dental visits | 23% | 41% |
| Housing | 24 | 31 |
| NONE | 26 | 5 |
| Financial help paying bills | 19 | 27 |
| Food pantry or meals | 14 | 22 |
| Support groups | 11 | 11 |
| Mental health counseling | 10 | 22 |
| Transportation | 9 | 19 |
| Legal help with benefits or wills | 9 | 14 |
| Counseling for a healthy diet | 8 | 14 |
| Medication assistance | 6 | 17 |
| Case management | 4 | 17 |
| Education about HIV and reducing risk | 6 | 6 |
| End of life medical care | 6 | 3 |
| Medical care | 4 | 16 |
| Insurance payments | 5 | 8 |
| Child care services | 4 | 0 |
| Counseling for addiction | 2 | 5 |
| Home healthcare | 4 | 0 |

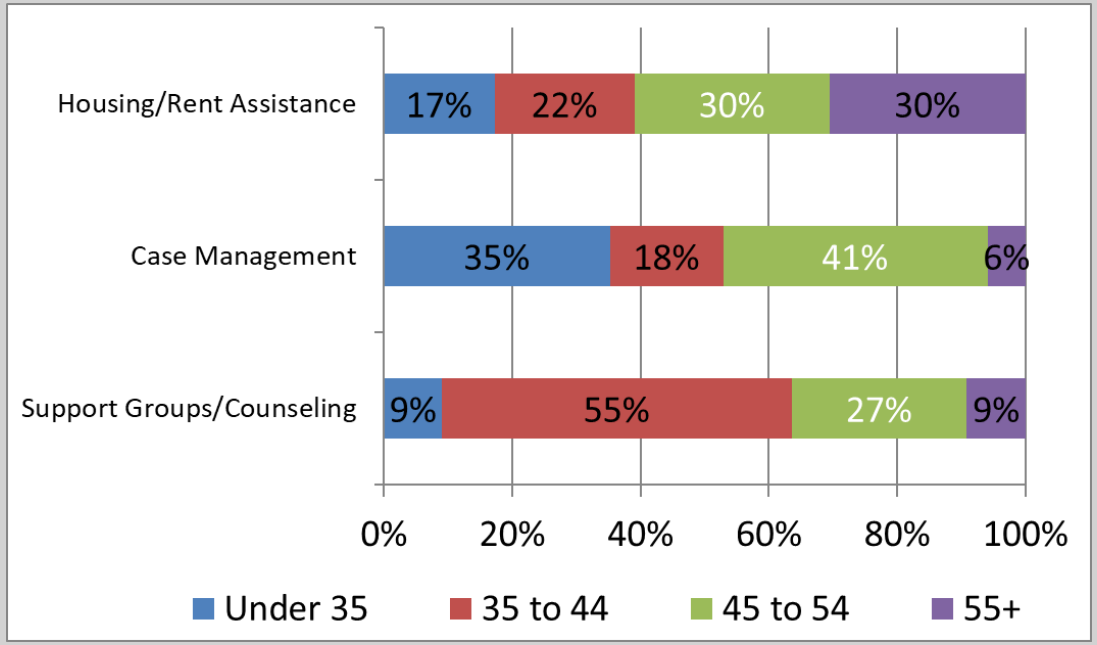
# Needs Assessment Results
## Psychosocial Support Services

- Q. As a person living with HIV, what service do you wish you could get that is not available today? N=78 (table shows top three responses by race/ethnicity)



# Needs Assessment Results
## Psychosocial Support Services

- Q. As a person living with HIV, what service do you wish you could get that is not available today? N=78 (table shows top three responses by age)



**HRSA DEFINITION**
The provision of support and counseling activities, child abuse and neglect counseling, HIV support groups, pastoral care, caregiver support, and bereavement counseling. Includes nutrition counseling provided by a non-registered dietitian but excludes the provision of nutritional supplements.

**DSHS DEFINITION**
The provision of support and counseling activities, including alternative services (e.g., visualization, massage, art, music, and play), child abuse and neglect counseling, HIV support groups, pastoral care, recreational outings, caregiver support, and bereavement counseling. Includes other services not included in mental health, substance abuse or nutritional counseling that are provided to clients, family and household members, and/or other caregivers, and focused on HIV-related problems.

LOCAL DEFINITION
The provision of support and counseling activities, including alternative services, child abuse and neglect counseling, HIV support groups, pastoral care, recreational outings, caregiver support, and bereavement counseling. Includes other services not included in mental health, substance abuse or nutritional counseling that are provided to clients, family and household members, and/or other caregivers, and focused on HIV-related problems.

Psychosocial Support Services in the north central Texas region are directed specifically to support Nutritional Assessment and/or Non-Professional Counseling.

**GOAL**
To provide peer counseling and peer support groups related to HIV health and wellness.

**STANDARD OF CARE**
- Require individuals who deliver non-professional counseling services to have a minimum of a four-year college degree or related work experience. A degree in psychiatry, psychology, family therapy, social work, counseling, or a related field is preferred.
- Require staff to complete standardized professional facilitation training.
- Require non-licensed staff or trainees who deliver non-professional counseling services be supervised by a licensed professional.

**DSHS Standards of Care**

# HRSA Definition:

Psychosocial Support Services provide group and/or individual support and counseling services to assist eligible people living with HIV to address behavioral and physical health concerns. These services may include:

- Bereavement counseling
- Child abuse and neglect counseling
- HIV support groups
- Nutrition counseling provided by a non-registered dietitian
- Pastoral Care/counseling

# Limitations:

Funds under this service category may not be used to provide nutritional supplements (nutritional supplements may be allowable under Food Bank/Home Delivered Meals and/or Medical Nutrition Therapy). RWHAP-funded pastoral counseling must be available to all eligible clients regardless of their religious denominational affiliation. Funds may not be used for social/recreational activities or to pay for a client's gym membership.

# Services:

Psychosocial services may include providing support, either individually or through group settings, for eligible clients to assist PLWH in addressing behaviors that will enhance a continuity in medical care and address physical health concerns. Psychosocial Support Services may also include individual and group counseling for child abuse and neglect, bereavement counseling, and associated HIV problems.

Pastoral care/counseling services must be:

- Provided by an institutional pastoral care program (e.g. components of AIDS interfaith networks, separately incorporated pastoral care and counseling centers, components of services provided by a licensed provider such as a home care or hospice provider)
- Provided by a licensed or accredited provider wherever such licensure or accreditation is either required or available; and
- Available to all individuals eligible for Ryan White services, regardless of their religious denominational affiliation.

Nutrition Counseling provides nutritional education, assessment, and counseling by a non-registered dietitian to persons living with HIV to assist clients in:

- Maintaining treatment regimens;
- Remaining in primary medical care; and/or
- Improving overall client wellness and quality of life.

This service is meant to help clients use food products in the best way possible to maintain or improve health and to maximize health benefits.

***Note: A nutritional plan cannot be developed by a registered dietitian under this service category.***

# Service Standard and Performance Measure

The following Standards and Performance Measures are guides to improving health outcomes for PLWH throughout the State of Texas within the Ryan White Part B and State Services Program.

| Standard | Performance Measure |
|---|---|
| **Assessment/Plan of Care for Counseling Services:** Clients are assessed within thirty (30) business days of initial session for<br><br>• Support system and psychosocial support needs<br>• History of accessing primary care and other services and barriers to access—noting psychosocial support barriers in particular.<br><br>Staff explains to the client during the first encounter what services are available at the agency based on the client's identified needs.<br><br>Within thirty (30) business days after the assessment, a service plan will be developed and agreed upon by the client and provider outlining service goals, objectives, and interventions. This should include client identified needs as well as plans for continuity of primary medical care and support services.<br><br>Client needs and service plan are reviewed and revised a minimum of every six (6) months. | Percentage of clients with documented evidence in the client's primary record of a completed assessment within 30 business days of referral for counseling.<br><br>Percentage of clients with documented evidence in the client's primary record of a service plan developed within 30 business days of the completed assessment.<br><br>Percentage of clients with documented evidence in the client's primary record of service plans reviewed and/or revised every six (6) months, at a minimum. |
| **Support Group Service Plans:** Within thirty (30) business days of first attendance, a client primary record should be established for all clients attending support groups only. | Percentage of clients attending group sessions will have documented evidence in the client's primary record of attendance and topic |

| Standard | Performance Measure |
|---|---|
| Attendance and topic discussed should be documented in the progress notes with goals for the client outlined. | discussed in progress notes with goals for the client outlined. |
| **Provision of Services - Counseling:** Staff may provide counseling related to:<br><br>• Child abuse and neglect counseling<br>• Bereavement counseling<br><br>Topics that should be covered in individual counseling sessions by non-professional staff include:<br><br>• Treatment adherence (non-clinical, supportive discussion to reiterate importance of retention in care)<br>• Access and engagement in primary care<br>• Assess and engagement in case management if appropriate<br><br>Psychosocial support staff will make appropriate referrals. | Percentage of clients with documented evidence, as applicable, in the client's primary record of counseling provided for child abuse and neglect.<br><br>Percentage of clients with documented evidence, as applicable, in the client's primary record of counseling provided for bereavement.<br><br>Percentage of clients with documented evidence in the client's primary record of discussion regarding retention in care regardless of type of counseling provided. |
| **Provision of Service - Support Groups:** HIV support groups provide discussion of topics relevant to the PLWH needs in the community through group facilitation. Staff or volunteers providing psychosocial support through group facilitation will include discussions on:<br><br>• Treatment adherence (non-clinical, supportive discussion to reiterate importance of retention in care)<br>• Access and engagement in primary care<br>• Assess and engagement in case management if appropriate<br><br>Evidence of client progress toward meeting established goals through documentation of activity including sign-in sheets, progress notes, group curricula, etc. | Percentage of clients engaged in HIV support group services with documented evidence, as applicable, in the client's primary record of client progression in meeting established goals. |

| Standard | Performance Measure |
|---|---|
| **Provision of Service - Pastoral Counseling/Care:** If pastoral counseling/care is needed, may be provided by the agency either:<br><br>• Directly if by a licensed healthcare services provider such as a home care or hospice provider;<br>• Through referral to AIDS interfaith networks, separately incorporated pastoral care and counseling center, and/or a home care or hospice licensed provider<br>  ○ If client referred to another agency, referral and follow-up regarding outcome must be documented<br><br>Must be available either directly or through referral to all individuals eligible to receive Ryan White services regardless of their religious denominational affiliation. | Percentage of clients with documented evidence, in the client's primary record, of pastoral care provided through progress notes.<br><br>Percentage of clients with documented referral, as applicable, in the client's primary record to an eligible pastoral care program (as outlined in standard).<br><br>Percentage of clients accessing pastoral care/counseling through referral with documented outcomes in client's primary record. |
| **Provision of Service – Nutrition Counseling:** Nutritional education and counseling provided under Psychosocial Support Services are by a non-registered dietitian and must be based on a client-specific nutritional assessment and plan that has been developed by a registered dietitian or other licensed nutrition professional (see Medical Nutrition Therapy Service Standard).<br><br>Progress notes will be kept in the client primary record system and will include progress toward meeting objectives outlined in the nutritional plan. | Percentage of clients with documented evidence in the client's primary record of nutritional education and counseling provided based on a client-specific nutritional assessment and plan developed by a RD or other licensed nutrition professional.<br><br>Percentage of clients with documented evidence in the client's primary record of an individualized nutritional plan based on the assessment.<br><br>Percentage of clients with documented evidence in the client's primary record of progress notes indicating client's progression toward meeting objectives outlined in the nutritional plan. |
| **Closure:** An individual is deemed no longer to be in need of psychosocial support services | Percentage of clients with documented evidence in client's primary record of case closure documented as applicable. |

| Standard | Performance Measure |
| --- | --- |
| and can be deemed inactive/case closed if one or more of these criteria is met:<br><br>• Client deceased;<br>• Client's medical condition improves and counseling/group attendance is no longer necessary;<br>• Client elects to discontinue participation and/or<br>• Client demonstrates non-attendance, as defined by agency policy and procedure | |

# Health Education Risk Reduction (HERR) Definition

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 with clients to improve their health status. Topics covered may include:

- Education on *risk reduction strategies* to reduce transmission such as preexposure prophylaxis (PrEP) for clients' partners and treatment as prevention
- Education on *health care coverage options* (e.g., qualified health plans through the Marketplace, Medicaid coverage, Medicare coverage)
- Health literacy
- Treatment adherence education

*Health Education/Risk Reduction services cannot be delivered anonymously.*

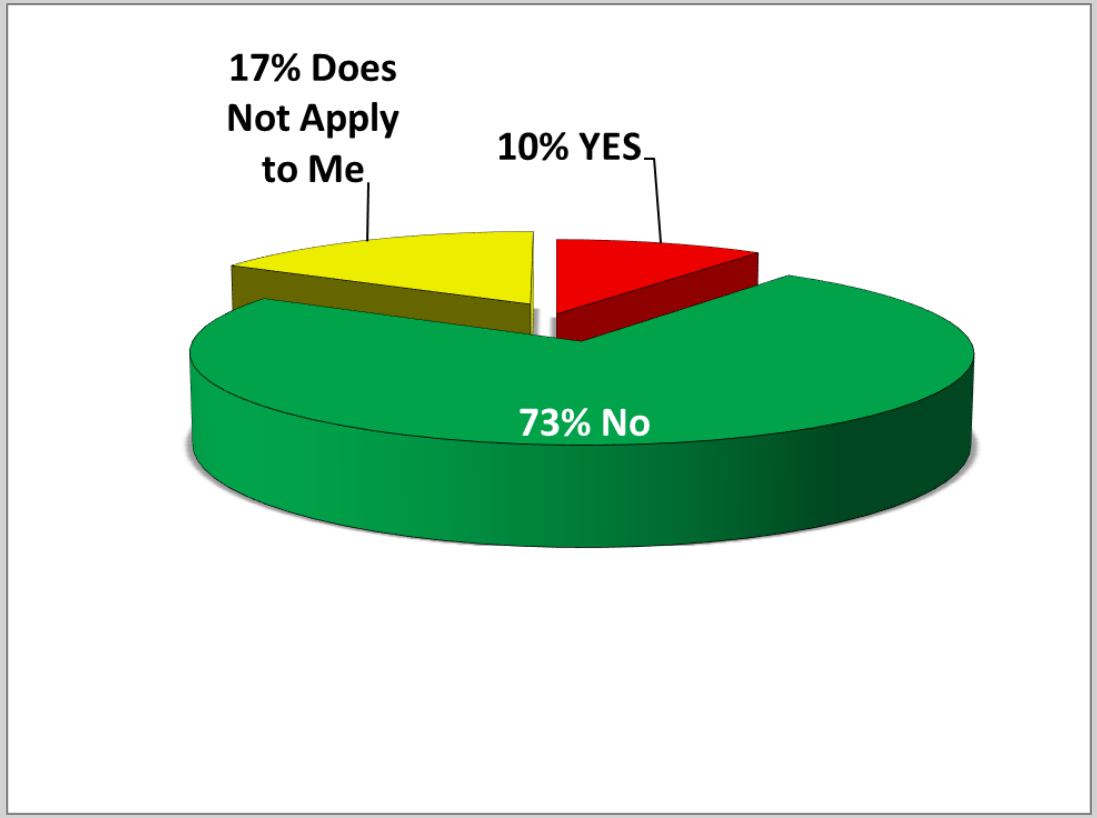
# Demographic Report-Health Education Risk Reduction (HERR)

- This service category is currently not funded.

- HERR is a component of Early Intervention Services.

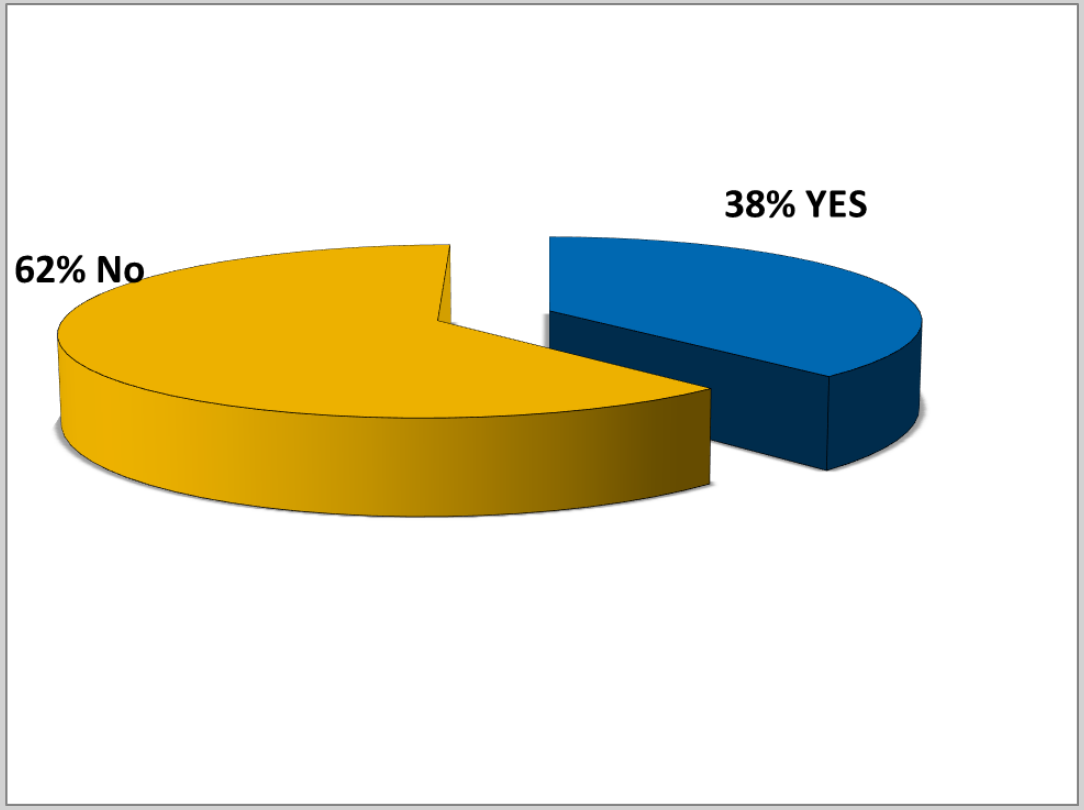
# Needs Assessment Results
## Health Education/Risk Reduction

- Q. In the past 6 months, have you needed help learning how to stay healthy while being sexually active? N=506
  - 10% of respondents said they have needed help learning how to stay healthy while being sexually active.



## Needs Assessment Results
Health Education/Risk Reduction

- Q. In the past year, have you had difficulties telling people about your HIV status? N=506
  - 38% of respondents said they have had difficulties telling people about their HIV status. This spans across all age and racial/ethnic groups.



# Needs Assessment Results
## Health Education/Risk Reduction

- Q. In the past year, have you had difficulties telling people about your HIV status? N=506 (table presents responses across age, gender, and race/ethnicity)

| | % Yes – Have difficulties |
|---|---|
| Under 25 | 50% |
| 25 to 34 | 41 |
| 35 to 44 | 43 |
| 45 to 54 | 31 |
| 55 to 64 | 37 |
| 65+ | 36 |
| | |
| Male | 36% |
| Female | 40 |
| Transgender | 56 |
| | |
| White | 29% |
| Black | 40 |
| Hispanic | 45 |
| Other | 35 |

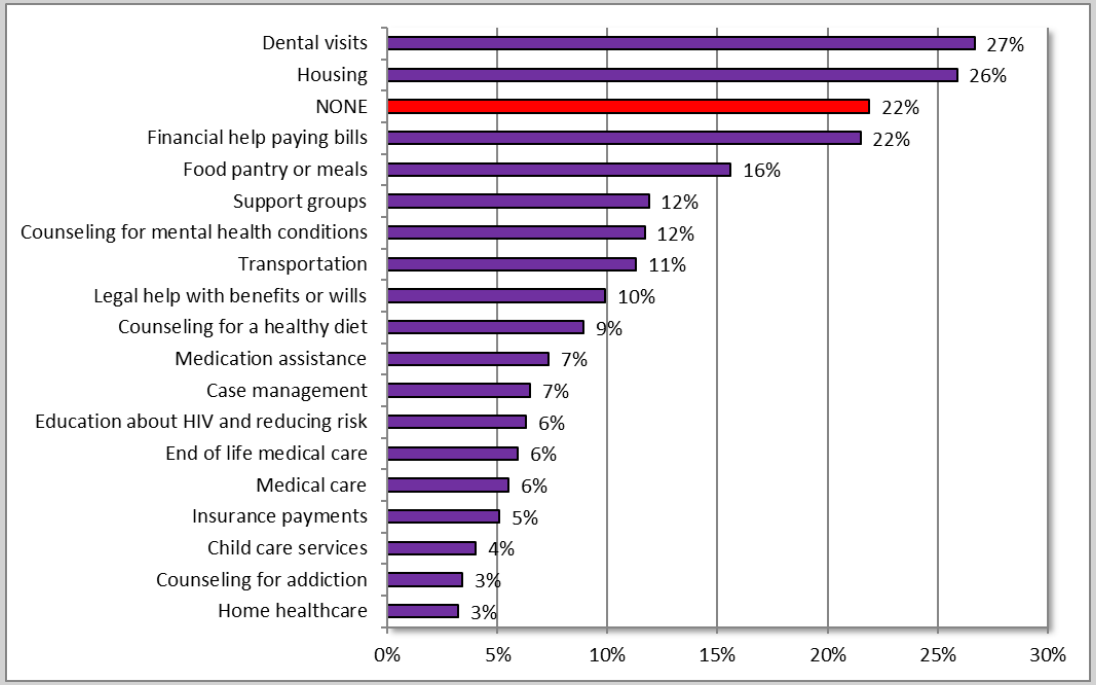
# Needs Assessment Results
## Health Education/Risk Reduction

- Q. What topics would you like to learn more about? N=506 (table presents responses based on age, gender, and race/ethnicity)

| | None | Undetectable = Untransmittable | Education about HIV | How to have difficult conversations | Viral suppression | PrEP | PEP |
|---|---|---|---|---|---|---|---|
| Under 25 | 17% | 28% | 33% | 39% | 17% | 11% | 11% |
| 25 to 34 | 19 | 39 | 34 | 26 | 22 | 20 | 13 |
| 35 to 44 | 32 | 38 | 20 | 22 | 15 | 13 | 8 |
| 45 to 54 | 28 | 31 | 29 | 20 | 13 | 7 | 6 |
| 55 to 64 | 38 | 18 | 28 | 18 | 8 | 4 | 4 |
| 65+ | 32 | 24 | 16 | 24 | 8 | 4 | 4 |
| | | | | | | | |
| Male | 28% | 31% | 30% | 21% | 15% | 10% | 7% |
| Female | 32 | 32 | 24 | 24 | 12 | 12 | 9 |
| Transgender | 39 | 17 | 11 | 22 | 6 | 6 | 0 |
| | | | | | | | |
| White | 51% | 25% | 16% | 15% | 15% | 7% | 8% |
| Black | 22 | 31 | 28 | 25 | 11 | 9 | 7 |
| Hispanic | 15 | 35 | 40 | 27 | 17 | 15 | 5 |
| Other | 39 | 39 | 17 | 13 | 22 | 17 | 13 |

# Needs Assessment Results
## Health Education/Risk Reduction

- Q. Which services do you need but are not using right now? N=506
  - The top three HIV-related services respondents said they need the most are; dental visits, housing and financial help paying bills. One in five said they do not need additional services.



# Needs Assessment Results
## Health Education/Risk Reduction

- Q. Which services do you need but are not using right now?  N=506 (table shows responses for both in- and out-of-care)

| HIV Services | In Care | Out of Care |
|---|---|---|
| Dental visits | 23% | 41% |
| Housing | 24 | 31 |
| NONE | 26 | 5 |
| Financial help paying bills | 19 | 27 |
| Food pantry or meals | 14 | 22 |
| Support groups | 11 | 11 |
| Mental health counseling | 10 | 22 |
| Transportation | 9 | 19 |
| Legal help with benefits or wills | 9 | 14 |
| Counseling for a healthy diet | 8 | 14 |
| Medication assistance | 6 | 17 |
| Case management | 4 | 17 |
| Education about HIV and reducing risk | 6 | 6 |
| End of life medical care | 6 | 3 |
| Medical care | 4 | 16 |
| Insurance payments | 5 | 8 |
| Child care services | 4 | 0 |
| Counseling for addiction | 2 | 5 |
| Home healthcare | 4 | 0 |

# Needs Assessment Results
## Health Education/Risk Reduction

- Q. Are you aware that having a low viral load can prevent transmission of HIV to others?
  - 85% of respondents (91% Asian, 87% Black, 80% Hispanic, 83% White, 86% of Tarrant County and 83% of non-Tarrant County respondents) are aware that a low viral load can prevent transmission to others.

| HIV Services | In Care | Out of Care |
|---|---|---|
| Dental visits | 23% | 41% |
| Housing | 24 | 31 |
| NONE | 26 | 5 |
| Financial help paying bills | 19 | 27 |
| Food pantry or meals | 14 | 22 |
| Support groups | 11 | 11 |
| Mental health counseling | 10 | 22 |
| Transportation | 9 | 19 |
| Legal help with benefits or wills | 9 | 14 |
| Counseling for a healthy diet | 8 | 14 |
| Medication assistance | 6 | 17 |
| Case management | 4 | 17 |
| Education about HIV and reducing risk | 6 | 6 |
| End of life medical care | 6 | 3 |
| Medical care | 4 | 16 |
| Insurance payments | 5 | 8 |
| Child care services | 4 | 0 |
| Counseling for addiction | 2 | 5 |
| Home healthcare | 4 | 0 |

# HRSA Definition:

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 with clients to improve their health status. Topics covered may include:

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

# Limitations:

Health Education/Risk Reduction services cannot be delivered anonymously.

# Services:

This service category includes the provision of information dissemination about medical and psychosocial support services and counseling to help clients with HIV improve their health status.

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

- Provision of information about available medical services, psychosocial support, and counseling services;
- Education on HIV transmission and how to reduce the risk of transmission; and
- Risk reduction counseling on how to improve their health status and reduce the risk of HIV transmission to others.

# Service Standard and Performance Measure

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.

| Standard | Performance Measure |
|---|---|
| **Health Educational Assessment and Service Plan:** HE/RR staff will complete a health/HIV educational evaluation and plan that will indicate how the client's educational needs will be met. Plan must address:<br><br>• Methods of HIV transmission<br>• How to reduce risk of HIV transmission<br>  ○ Medication adherence<br>• Available resources to meet needs for recently incarcerated<br>• Available resources to meet client needs<br>• Health literacy | Percentage of clients with documented evidence in the client's primary record of a completed health/HIV education evaluation and plan.<br><br>Percentage of clients with documented evidence in the client's primary record of a completed plan addressing methods of HIV transmission, risk reduction education, and resources available to meet client's needs. |
| **Health Education/Risk Reduction:** HE/RR staff will provide health education/risk reduction curriculum regarding:<br><br>• Methods of HIV transmission and how to reduce the risk of transmission<br><br>HE/RR staff will provide health education/risk reduction counseling regarding:<br><br>• How to improve their health status and reduce their risk of transmission to others. | Percentage of clients with documented evidence in the client's primary record of HE/RR curriculum regarding methods of HIV transmission and how to reduce risk of transmission.<br><br>Percentage of clients with documented evidence in the client's primary record of HE/RR counseling regarding how to improve health status and reduce risk of transmission. |
| **Resources:** HE/RR staff will provide information regarding available medical and psychosocial support services to reduce barriers to care. | Percentage of clients with documented evidence in the client's primary record of HE/RR education provided regarding available medical and support services in the community. |
| **Evaluation of health education/risk reduction counseling:** HE/RR staff will administer pre-post test to each client to assess | Percentage of clients with documented evidence in the client's primary record of a |

| Standard | Performance Measure |
| --- | --- |
| changes in knowledge/attitudes as a result of the health education/risk reduction counseling.<br><br>HE/RR Staff will ask each client to complete a brief program evaluation after each completion of a course/service plan to assess effectiveness of program. | pre test to assess client's understanding of disease process.<br><br>Percentage of clients with documented evidence in the client's primary record of a post-test to assess client's understanding of disease process.<br><br>Percentage of clients with documented evidence in the client's primary record of increased knowledge of disease process and risk reduction methods.<br><br>Percentage of clients with documented evidence of participation in course/service plan satisfaction survey. |

# Home Health Care- Definition

Home Health Care is the provision of services in the home that are appropriate to an eligible client's needs and are performed by licensed professionals. Activities provided under Home Health Care must relate to the client's HIV disease and may include:

- Administration of prescribed therapeutics (e.g. intravenous and aerosolized treatment, and parenteral feeding)
- Preventive and specialty care
- Wound care HIV/AIDS BUREAU POLICY 16-02 13
- Routine diagnostics testing administered in the home
- Other medical therapies

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

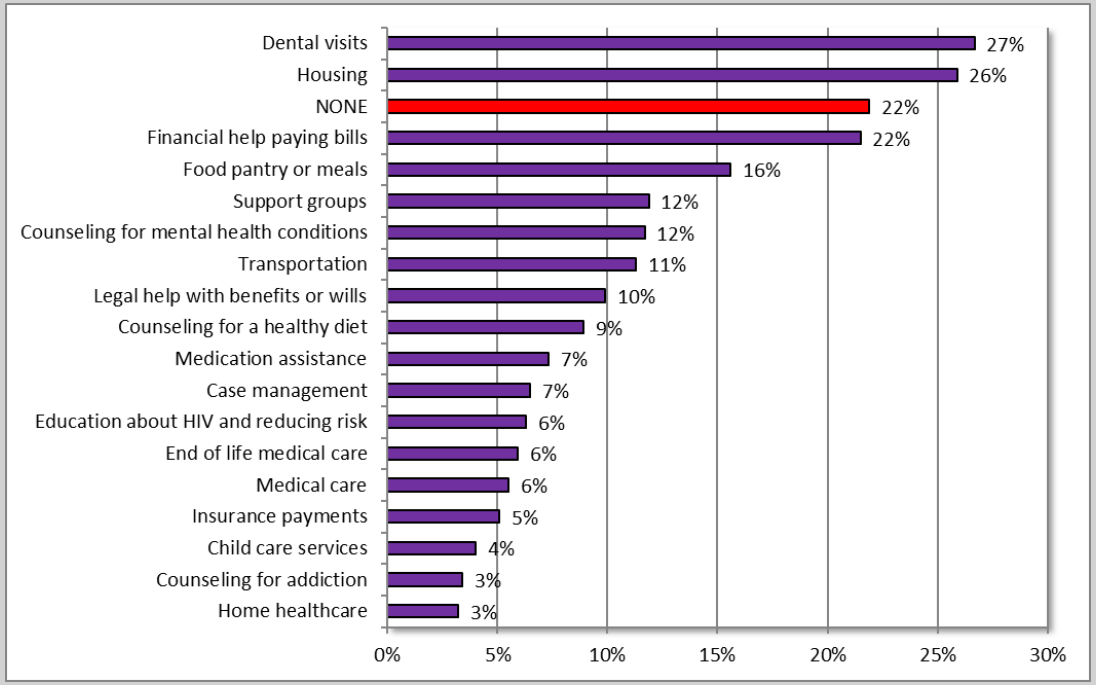
# Demographic Report- Home Health Care

This is not a funded service category.

| | |
|---|---|
| 51 to 60 years | 851 |
| 61 to 70 years | 353 |
| 71 to 80 years | 56 |
| 81 or Older | 3 |

# Needs Assessment Results
## Home Healthcare

- Q. Which services do you need but are not using right now? N=506
  - The top three HIV-related services respondents said they need the most are; dental visits, housing and financial help paying bills. One in five said they do not need additional services.



# Needs Assessment Results
## Home Healthcare

- Q. Which services do you need but are not using right now?  N=506 (table shows responses for both in- and out-of-care)

| HIV Services | In Care | Out of Care |
|---|---|---|
| Dental visits | 23% | 41% |
| Housing | 24 | 31 |
| NONE | 26 | 5 |
| Financial help paying bills | 19 | 27 |
| Food pantry or meals | 14 | 22 |
| Support groups | 11 | 11 |
| Mental health counseling | 10 | 22 |
| Transportation | 9 | 19 |
| Legal help with benefits or wills | 9 | 14 |
| Counseling for a healthy diet | 8 | 14 |
| Medication assistance | 6 | 17 |
| Case management | 4 | 17 |
| Education about HIV and reducing risk | 6 | 6 |
| End of life medical care | 6 | 3 |
| Medical care | 4 | 16 |
| Insurance payments | 5 | 8 |
| Child care services | 4 | 0 |
| Counseling for addiction | 2 | 5 |
| Home healthcare | 4 | 0 |

# HRSA Definition:

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:

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

# Limitations:

The provision of Home Health Care is limited to clients that are homebound. Home settings do NOT include nursing facilities or inpatient mental health/substance abuse treatment facilities. Excludes personal care and non-licensed in-home care providers.

# Services:

Home Health Care are services provided by a licensed/certified home health agency in a home or community-based setting in accordance with a written, individualized plan of care established by a licensed primary medical care provider. Home health care services must be prescribed by a licensed medical provider and can be performed by licensed medical professionals such as physicians, mid-level providers, nurses, and certified medical assistants.

# Service Standard and Performance Measure

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.

| Standard | Performance Measure |
| --- | --- |
| **Physician Orders:** The primary care provider has deemed home health care services necessary. The referring physician must:<br><br>• Provide signed orders in writing to the agency prior to the initiation of care<br>• Act as that client's primary care physician<br>• Maintain a consistent plan<br>• Communicate changes from the initial plan directly to the agency.<br><br>In the event that the referring provider is unable to continue the provision of primary health care services, the provider must be willing to transfer the client to the care of a willing medical care provider. | Percentage of clients with documented evidence in the client's primary record of the ordering physician's signed orders for home health care services.<br><br>Percentage of clients with documented evidence in the client's primary record of the physician's home health care plan as provided to the agency. |
| **Agency Refusal of referral:** The home health agency may refuse a referral for the following reasons only:<br><br>• Based on the agency's perception of the client's condition, the client requires a higher level of care than would be considered reasonable in a home setting.<br>  ○ The agency must document the situation in writing and immediately contact the client's primary medical care provider.<br>• The agency has attempted to complete an initial assessment and the referred client has been away from home on three occasions.<br>  ○ The agency must document the situation in writing and immediately contact the referring primary medical care provider.<br>• The client's home or current residence is determined to not be physically safe (if not residing in a community | Percentage of clients with documented evidence of agency refusal of services with detail on refusal in the client's primary record AND if applicable, documented evidence that a referral is provided for another home health agency. |

| Standard | Performance Measure |
|---|---|
| facility) before services can be offered or continued. | |
| **Initial Assessment:** A preliminary needs assessment will be conducted that includes services needed, perceived barriers to accessing services and/or medical care.<br><br>Client will be contacted within one (1) business day of the referral, and services should be initiated at the time specified by the primary medical care provider, or within two (2) business days, whichever is earlier.<br><br>A comprehensive evaluation of the client's health, psychosocial status, functional status, and home environment should be completed to include:<br><br>• Assessment of client's access to primary care<br>• Adherence to therapies<br>• Disease progression<br>• Symptom management and prevention, and<br>• Need for nursing services. | Percentage of clients with documented evidence of needs assessment completed in the client's primary record.<br><br>Percentage of clients with documented evidence of a comprehensive evaluation completed by the home health care agency provider in the client's primary record. |
| **Implementation of Care Plan**<br><br>A care plan will be completed based on primary medical care provider's order and include:<br><br>• Current assessment and needs of the client including medication, dietary, treatment, and activities orders;<br>• Need for home health services;<br>• Types, quantity, and length of time services are to be provided<br>  ○ All planned services are allowable within this service category | Percentage of clients with documented evidence of a care plan completed based on the primary medical care provider's order as indicated in the client's primary record.<br><br>Percentage of clients with documented evidence of care plans reviewed and/or updated as necessary based on changes in the client's situation at least every sixty (60) calendar days as evidenced in the client's primary record. |

| Standard | Performance Measure |
|---|---|
| ○ Care plan is signed by clinical health care professional.<br><br>Care Providers will update the plan of treatment at least every sixty (60) calendar days.<br><br>Professional staff will:<br><br>• Provide nursing and rehabilitation therapy care under the supervision and orders of the client's primary medical care provider.<br>• Monitor the progress of the care plan by reviewing it regularly with the client and revising it as necessary based on any changes in the client's situation.<br>• Advocate for the client when necessary (e.g., advocating for the client with a service agency to assist the client in receiving necessary services).<br>• Monitor changes in client's physical and mental health, and level of functionality.<br>• Work closely with client's other health care providers and to effectively communicate and address client service related needs, challenges, and barriers. | |
| **Provision of Services:** Provides assurance that the services are provided in accordance with allowable modalities and locations under the definition of home health services.<br><br>Progress notes will be kept in the primary client's record and must be written the day service rendered and incorporated into the client record within 14 working days per TAC. | Percentage of clients with documented evidence of completed progress notes within 14 working days of the service rendered in the client's primary record.<br><br>Percentage of clients with documented evidence of ongoing communication with the primary medical care provider as indicated in the client's primary record. |

| Standard | Performance Measure |
| --- | --- |
| The agency will maintain ongoing communication with the primary medical care provider in compliance with Texas Medicaid and Medicare Guidelines.<br><br>The Home Health provider will document in the client's primary record progress notes throughout the course of the treatment, the client is not in need of acute care. | |
| **Transfer/Discharge:** Transfer and discharge of clients from home health care services should result from a planned and progressive process that takes into account the needs and desires of the client and his/her caregivers, family, and support network.<br><br>A transfer plan should be developed when one or more of the following criteria are met:<br><br>• Agency no longer meets the level of care required by the client.<br>• Client transfers services to another service program.<br>• The client is not stable enough to be cared for outside of the acute care setting as determined by the agency and the client's primary medical care provider.<br>• The client no longer has a stable home environment appropriate for the provision of home health services as determined by the agency.<br>• Client is unable or unwilling to adhere to agency policies.<br>• An employee of the agency has experienced a real or perceived threat to his/her safety during a visit to a client's home, in the company of an escort or not. The agency may discontinue services or refuse the client for as long as the threat is ongoing. Any assaults, verbal or physical, must be reported to the | Percentage of clients with documented evidence, as applicable, of a transfer plan developed and documented with referral to an appropriate service provider agency as indicated in the client's primary record.<br><br>Percentage of clients with documented evidence of a discharge plan developed with client, as applicable, as indicated in the client's primary record. |

| Standard | Performance Measure |
| --- | --- |
| monitoring entity within one (1) business day and followed by a written report. A copy of the police report is sufficient, if applicable.<br><br>Per TAC, agency intending to transfer or discharge a client must:<br><br>• Provide written notification to the client or the client's parent, family, spouse, significant other or legal representative; AND<br>• Notify the client's attending physician or practitioner if he/she is involved in the agency's care of the client.<br>• Written notification must be delivered no later than five (5) days before the date on which the client will be transferred or discharged. See TAC website link for specific program policies regarding mailing versus hand-delivery.<br><br>Client may be discharged if:<br><br>• The client no longer medically requires home health care as determined by the agency or the primary medical care provider.<br>• Client moves out of the area.<br>• Client wishes to discontinue services (with or against medical advice). | |

# Other Professional Services –Definition

Other Professional Services allow for the provision of professional and consultant services rendered by members of particular professions *licensed and/or qualified* to offer such services by local governing authorities. Such services may include:

- Legal services provided to and/or on behalf of Ryan White eligible PLWH 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 Ryan White Program
  - Preparation of:
    - 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
- Income tax preparation services to assist clients in filing Federal tax returns that are required by the Affordable Care Act for all individuals receiving premium tax credits.

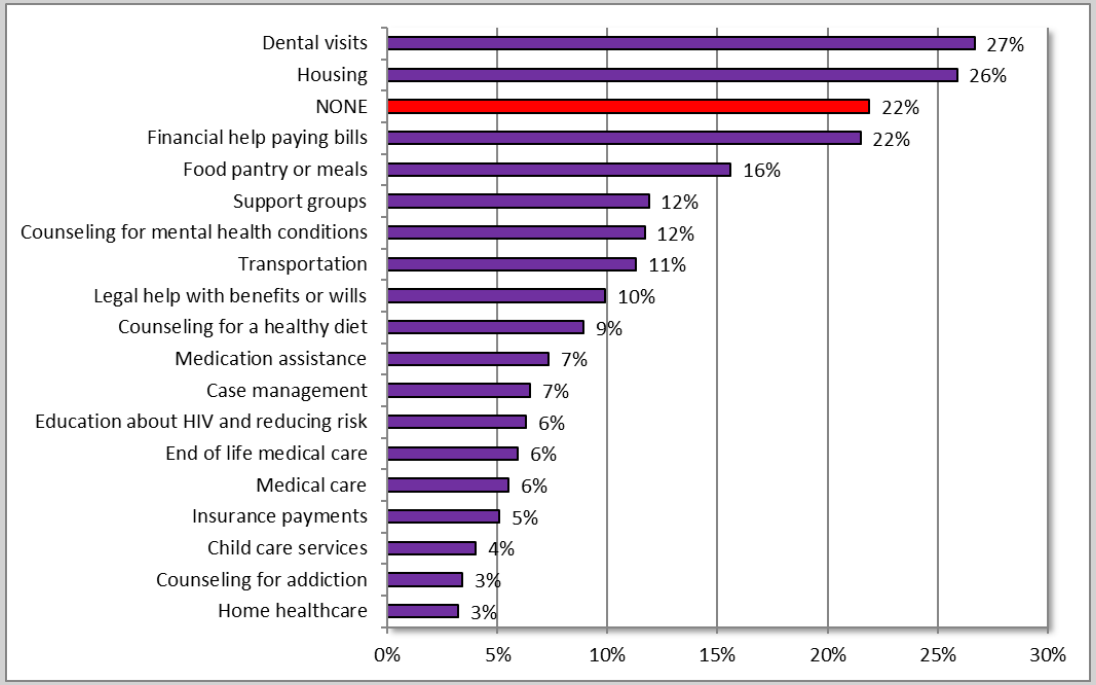
*Legal services exclude criminal defense and class-action suits unless related to access to services eligible for funding under Ryan White.*

# Demographic Report-Other Professional Services

This is not a funded service category.

# Needs Assessment Results
## Other Professional Services (Legal)

- Q. Which services do you need but are not using right now? N=506
  - The top three HIV-related services respondents said they need the most are; dental visits, housing and financial help paying bills. One in five said they do not need additional services.



# Needs Assessment Results
## Other Professional Services (Legal)

- Q. Which services do you need but are not using right now?  N=506 (table shows responses for both in- and out-of-care)

| HIV Services | In Care | Out of Care |
|---|---|---|
| Dental visits | 23% | 41% |
| Housing | 24 | 31 |
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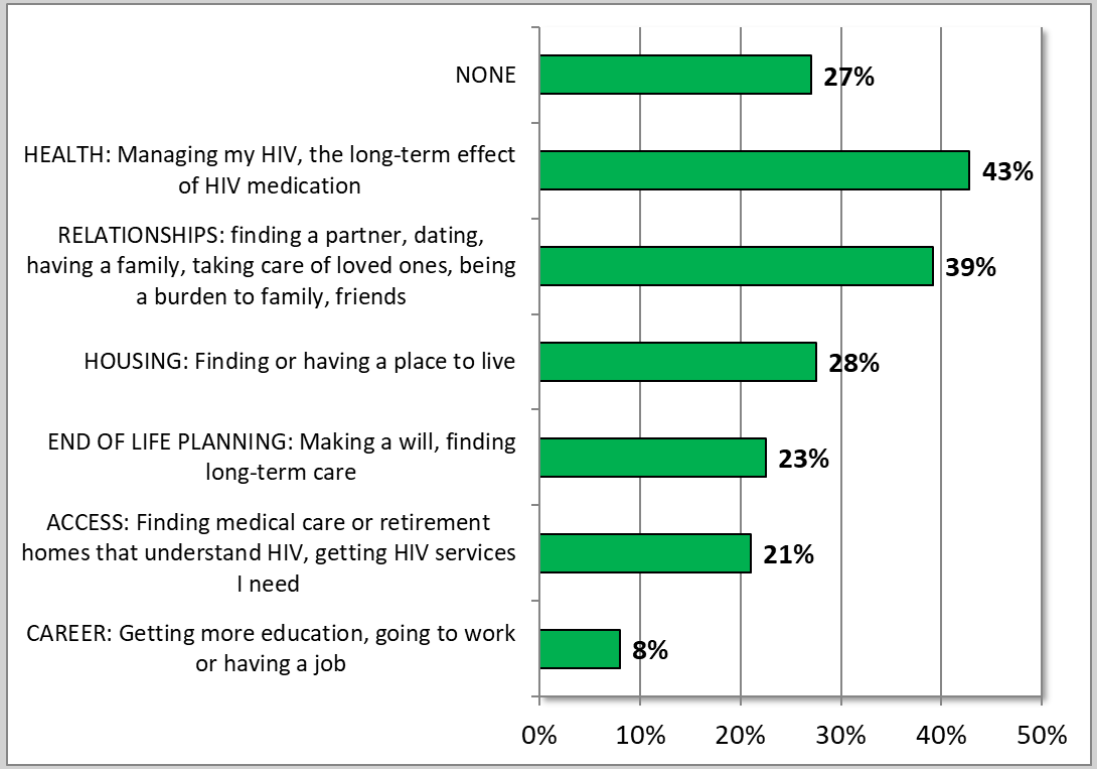
| Counseling for a healthy diet | 8 | 14 |
| Medication assistance | 6 | 17 |
| Case management | 4 | 17 |
| Education about HIV and reducing risk | 6 | 6 |
| End of life medical care | 6 | 3 |
| Medical care | 4 | 16 |
| Insurance payments | 5 | 8 |
| Child care services | 4 | 0 |
| Counseling for addiction | 2 | 5 |
| Home healthcare | 4 | 0 |

# Needs Assessment Results
## Other Professional Services (Legal)

- Q. As you grow older living with HIV, what are your concerns about services and maintaining your health?
  - Among respondents 55 or older, 27% reported they do not have these concerns. However, 43% are concerned about health issues and 39% have concerns about relationships.



# HRSA Definition:

Other Professional Services allow for the provision of professional and consultant services rendered by members of particular professions licensed and/or qualified to offer such services by local governing authorities.

# Limitations:

Legal services excludes criminal defense and class-action suits unless related to access to services eligible for funding under the Ryan White HIV/AIDS Program (RWHAP).

# Services:

Services may include:

- Legal services provided to and/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:
        - 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 deleting powers of attorney;
    - Preparation for custody options for legal dependents including standby guardianship, joint custody, or adoption.
- Income tax preparation services to assist clients in filing Federal tax returns that are required by the Affordable Care Act for all individuals receiving premium tax credits.

# Service Standard and Performance Measure

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.

| Standard | Performance Measure |
|---|---|
| **Provision of Services – Legal Services:** Legal services are provided to and/or on behalf of the individual living with HIV and involving legal matters related to or arising from their HIV disease.<br><br>Service Agreements will be developed and signed by both the attorney and the client. Clients will be kept informed and work together with legal staff to determine the objective(s) of the representation.<br><br>Agency may provide the following types of legal representation, assistance, and education:<br><br>• Assistance with public benefits such as SSDI;<br>• HIV discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the RWHAP; and/or<br>• Preparation of:<br>  ○ Healthcare power of attorney;<br>  ○ Durable powers of attorney; and/or<br>  ○ Living wills.<br><br>Attorneys will document the following in the client's record:<br><br>• A description of how the legal service is necessitated by the individual's HIV status;<br>• Types of services provided; and<br>• Hours spent in the provision of such services. | Percentage of clients accessing legal services for assistance with public benefits, as applicable, with documentation in the client's primary record of the public benefits assistance and outcomes.<br><br>Percentage of clients accessing legal services for preparation of documents allowed, as applicable, in the client's primary record with completion of healthcare POA, Durable POA, and/or living wills. |
| **Provision of Services – Permanency Planning:** Permanency planning to help | Percentage of clients accessing permanency planning services have documented evidence |

| Standard | Performance Measure |
|---|---|
| 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.<br><br>Services include:<br><br>• Social service counseling or legal counsel regarding the drafting of wills or delegating powers of attorney; and/or<br>• Preparation of custody options for legal dependents including standby guardianship, joint custody, or adoption. | in the client's primary record of services needed with outcomes. |
| **Provision of Services – Income Tax Preparation:** Income tax preparation services to assist clients in filing Federal tax returns that are required by the Affordable Care Act for individuals receiving premium tax credits.<br><br>Agencies must be licensed and/or qualified to offer income tax preparation services.Percentage of clients accessing income tax preparation services with documented evidence of assistance and outcomes in the client's primary record. | Percentage of clients accessing income tax preparation services with documented evidence of assistance and outcomes in the client's primary record. |
| **Case Closure:** Cases may be closed when:<br><br>• Legal or benefit issue has been resolved;<br>• Client has not had direct program contact for three (3) months or as locally defined, as applicable;<br>• Client is deceased;<br>• Client voluntarily discontinues the service;<br>• Client improperly uses the service;<br>• Client has not complied with the client services agreement. | Percentage of clients with documented evidence of case closure, including reasons stated, in the client's primary record. |

| Standard | Performance Measure |
| --- | --- |
| If the case is closed for a reason other than objectives met, agency will notify clients about case closure in writing. | |