PanWest-West Texas

2014-2017 Comprehensive HIV Health Services Plan

PART THREE:

APPENDICES

Revised March 2016

NEW SOLUTIONS, INC.
TRANSFORM HEALTH CARE INFORMATION TO VALUE

STARCARE
SPECIALTY HEALTH SYSTEM

APPENDIX A

THE RYAN WHITE PROGRAM - BACKGROUND

I. What are Ryan White Funds?

The Ryan White HIV/AIDS Treatment Extension Act of 2009 is federal legislation that addresses the unmet health needs of persons living with HIV and AIDS (PLWHA) by funding HIV/AIDS primary health care and support services that enhance access to and retention in care.

- First enacted by Congress in 1990, as the **Ryan White Comprehensive AIDS Resource Emergency (CARE) Act,** it was amended and reauthorized in 1996 and 2000.
  - The 2000 Reauthorization sharpened the focus on access to HIV medical care, and began targeting programs toward people living with HIV/AIDS (PLWHA) who know their status but are not receiving HIV medical care.

- Reauthorized in December 2006 as the **Ryan White HIV/AIDS Treatment Modernization Act (Modernization Act) of 2006**, Congress made significant changes to Ryan White funding. These included:
  - Changes to the funding formulas and the Title names with numbers changed to letters.
    - Part A is separated into tiers. Tier 1 is the eligible metropolitan areas (EMA) most affected by HIV/AIDS that have 2,000 or more AIDS cases reported in the last five (5) years. In Texas there are now two EMAs, Houston and Dallas. Tier 2 is the Transitional Grant Areas (TGA) – areas that had at least 1,000 but fewer than 2,000 AIDS cases reported in the last five years. Tier 2 implementation reduced funding to some former EMAs as they became categorized as TGAs. These include: Austin, Ft. Worth, and San Antonio.
    - Part B funds go to the AIDS Drug Assistance Program (ADAP) and to other HIV health care programs in the State such as those in the PanWest and West Texas.
    - Part C funds go to early intervention programs. Part D funds are for women, children and pediatric AIDS programs. Part F goes toward certain state dental programs and the AIDS Education training Centers (AETC).

- For the PanWest and West Texas Areas, one of the most visible and critical changes is the implementation of the 13 core medical services. At least 75% of Ryan White funding must be allocated to these core services. The Modernization Treatment Act lists the core medical services as:
  1. Outpatient/Ambulatory Medical Care (OAMC)
  2. AIDS Drug Assistance Program (ADAP – *administered by the TX HIV Medication Program*)
  3. HIV/AIDS Drug Reimbursement (AIDS pharmaceutical assistance – *locally administered*)

4. Oral Health Care
5. Early Intervention Services (Part B: counseling, testing and referral services)
6. Health Insurance and Premium Cost Sharing Assistance
7. Home Health Care
8. Medical Nutrition Therapy
9. Hospice Services
10. Home & Community-Based Health Services
11. Mental Health Services
12. Substance Abuse Outpatient Care
13. Medical Case Management

- A significant change for the PanWest and West Texas regions was the differentiation of Medical and Non-Medical (Social) Case Management, with the former included as a "core" service and the latter a "support" service.

- Medical Case Management continues to develop but as the name implies, its focus is on medical including educating and assisting clients to understand treatment and adhere to treatment.

- This is significant for PanWest and West Texas because, historically, case management in PanWest and West Texas was primarily social. With only 25% RWSD allowed for social services, it can be difficult to adequately allocate to social case management without too severely decreasing allocations to other social support services.
  - The Modernization Act requires states to allocate, at a minimum, 75% of Ryan White Service Delivery (RWSD) funds to the core medical categories leaving, at a maximum, 25% for ancillary services, best known as social support services.
    - Areas are not required to fund all the core medical services if not all are needed, but at least 75% of RWSD funds must be used for core medical services that are needed in the service area.
    - The Modernization Act of 2006 describes social support services as those services needed by people living with HIV/AIDS to "enhance access to and retention in care." Social support services include Non-Medical Case Management, transportation, food bank/pantry, emergency financial assistance, housing, respite, child care, health education/risk reduction and other categories.
    - At this time, the 75/25 percent requirement does not apply to State Services, just Ryan White Service Delivery.

- In late 2009, the Modernization Act was due to expire and was extended as the **Ryan White HIV/AIDS Treatment Extension Act of 2009** (Extension Act of 2009). Maintaining most components of the Modernization Act, the services authorized under the Extension Act of 2009 are intended to:
  - Reduce the use of more costly inpatient care,
  - Increase access to care for underserved populations, and
  - Improve quality of life for those affected by the HIV epidemic.

The Extension Act of 2009 works toward these goals by funding local and State programs that provide primary medical care and support services; health care provider training; and technical assistance to help funded programs address implementation and emerging HIV care issues.

II. What are Administrative Agencies (AA)?

- The Extension Act provides for significant State and local control of HIV/AIDS healthcare planning and service delivery. In Texas, Part B funds are awarded to the Texas Department of State Health Services (DSHS) who then provides them to seven regional planning areas that encompass every county in Texas. These are:
  - Area 1 West (El Paso),
  - Area 2 PanWest (Lubbock),
  - Area 3E Northeast (Dallas),
  - Area 3W Northwest (Ft. Worth),
  - Area 4 East (Houston),
  - Area 5 Central (Austin), and
  - Area 6 South (split into two major urban localities: San Antonio and Laredo).

- Each planning area is composed of smaller areas known as HIV Service Delivery Areas (HSDA) and each HSDA is composed of one or more counties.
  - The PanWest, has 58 counties in three HSDAs:
    - Amarillo HSDA for the Texas Panhandle with 26 counties
    - Lubbock HSDA for the South Plains with 15 counties
    - Permian Basin for the Midland/Odessa area with 17 counties.
  - West Texas has one HSDA, El Paso HSDA, with six counties.

- DSHS assigns each Texas planning area an administrative agency (AA) to act as a fiduciary agent and monitor the provision of HIV/AIDS services for the planning area. For both PanWest and West Texas, the AA is StarCare Specialty Health System (formerly Lubbock Regional Mental Health Mental Retardation Center - LRMHMRC). As the AA, StarCare receives Part B funds which are composed of Ryan White Service Delivery (RWSD) and State Services (general revenue as States are required to match a certain amount of RWSD).

- The AA allocates the Part B funds to three (3) subcontractors in the PanWest area and three (3) in the West Texas region to provide HIV/AIDS health care and social services. Contact information for services is listed below in Section I, Current Care System, or available by contacting the AA at 1-800-658-6198 ext. 308 or ext. 624 or by visiting the PanWest website at www.panwest.org.

- In 2013 the Extension Act of 2009 was due for reauthorization but not expiration (sunset). Since the Extension Act was not due to sunset, the legislature was not required to reauthorize it so the Extension Act of 2009 continues as originally extended in 2009.

What is HOPWA?

- The AA also administers the Housing Opportunities for Persons With AIDS (HOPWA) grant which is a federal program aimed at preventing homelessness in PLWHA. Program eligibility is based on client income, and it assists with:
  - Emergency (temporary) rent and utility assistance
  - Tenant based assistance.

- In the PanWest, HOPWA is provided in each HSDA by the same three subcontractors who provide HIV/AIDS services. In West Texas it is provided by two subcontractors, but only one is an AA contractor.

- Although the AA administers HOPWA, it does not allocate HOPWA funds. DSHS receives the HOPWA funds from the U.S. Department of Housing and Urban Development and determines the HOPWA allocations for each HSDA.

- PLWHA who need housing assistance should contact the local HIV service Subcontractor, their case manager or the AA for more information. Contact information for services is listed below in Section I, Current Care System, or available by contacting the AA at 1-800-658-6198 ext. 308 or ext. 624 or by visiting www.panwest.org.

What is Payer-of-Last Resort?

- To allow as many people as possible to receive services, Ryan White Service Delivery (RWSD), State Services, and HOPWA are designated as payers-of-last resort. This requires that all other resources, or means of paying for/accessing services, be used before these funds.

- Subcontractors are required to refer, link and access private insurance, employer-based insurance, Medicaid, Medicare, and other community resources before using Part B, State Services or HOPWA funds.

- In 2007, DSHS revised the Payer of Last Resort Policy, Policy Number HIV/STD 590.001, and it is available at www.dshs.state.tx.us/hivstd/policy/policies.shtm.

What is the statewide community planning group? What is the Texas HIV Plan? And, what is the National HIV/AIDS Strategy?

Up until 2012, Texas supported a statewide community planning group (CPG) that focused on prevention and on developing an HIV/STD Prevention Action Plan that identified which groups have the highest need for HIV prevention services and prioritize the programs and strategies for prevention. The last Texas HIV/STD Prevention Plan was presented in 2011 and in 2012 the CPG dissolved as Texas moved to collaboration with HIV/STD prevention and HIV services. Texas developed the 2012-2014 Texas HIV Plan to include both prevention and services and to work toward the goals in the 2010 National HIV/AIDS Strategy for the United States. The three

main goals of the National HIV/STD Strategy is to 1) reduce the number of people who become infected with HIV, 2) increase access to care and optimize health outcomes for people with HIV, and 3) reducing HIV-related health disparities.

What is a Comprehensive Plan for HIV Services?

- The Comprehensive Plan serves as a guide for the coordination and provision of HIV/AIDS services. It is a roadmap for achieving goals leading to the provision of quality HIV services, and is a requirement of AAs receiving Part B funding. This Comprehensive Plan incorporates the PanWest and West Texas Quality Plans. The Quality Management process and plan are described in more detail in Appendix B.

- The AA provides multiple avenues for community input for the 2014-2017 Comprehensive Plan for HIV Services including newspaper advertisements, website postings, and flyers to Subcontractors. The AA encourages feedback regarding the effectiveness of this Comprehensive Plan and invites interested persons to contact the AA. For information or to provide input, please contact:

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The AA staff are listed below:

Brandy Fernandez, Planning Coordinator
Marcella Ford, Director, Contracts Management
James Dalton Keel III, RN, MSN, Nurse Consultant
Dennis Kinman Quality/Data Manager
Jordan McCown, HIV Services Supervisor/Contract Specialist
María E. Salazar, Contract Specialist
Melissa Surita, Grant Accountant

Appendix B

PanWest and West Texas Quality Management Plan 2016

The Quality Management (QM) Program of the StarCare Specialty Health System HIV Services Administrative Agency (AA) for PanWest, Area 2, and West Texas, Area 1, consists of the following components:

I. Quality Statement

The Quality Management Committee's main function is to assure program compliance while improving the quality of Ryan White Part B HIV/AIDS services delivered in the PanWest and West Texas regions by objectively and systematically monitoring and evaluating services.

II. Quality Infrastructure: Quality Management Committee (QMC)

The Quality Management Committee (QMC) does the following in order to meet its quality statement: monitoring and assessing Subcontractor and AA activities, brainstorming methods to better implement standards of care, measuring progress by reviewing performance measures, specifically regarding medical care and case management, reviewing results of client and provider (Subcontractor) satisfaction surveys, reviewing needs assessments, discussing complaints and concerns, and sharing best practices.

Participation of Stakeholders: The AA strives to maintain a QMC that is composed of internal and external stakeholders to include a representative from each HIV service Subcontractor, a medical professional, a community/client representative from each HSDA, and Administrative Agency staff. The QMC membership is composed of the following:

- Amarillo HSDA HIV Service Subcontractor: Panhandle AIDS Support Organization (PASO) - Executive Director
- Permian Basin HSDA HIV Service Subcontractor: Permian Basin Community Centers for MHMR Basin Assistance Services (BAS) – 1) Team Lead, and 2) Quality Management Coordinator
- Lubbock HSDA HIV Service Subcontractor: South Plains Community Action Association, Inc. Project CHAMPS - Program Director
- El Paso HSDA HIV Service Subcontractor: Centro de Salud Familiar La Fe, Inc. (La Fe CARE) – Program Director and Data Manager
- El Paso HSDA HIV Service Subcontractor: South Plains Community Action Association, Inc. Project CHAMPS - Program Director and Medical Case Manager

- Medical Professional: Ogechika Alozie, MD, MPH, AAHIVS
- AA Quality Manager/Data Manager
- AA Contracts Specialists
- AA Nurse Consultant
- AA Planning Coordinator
- AA HIV Services Program Supervisor

Participant Roles: The QMC, as a whole, will 1) annually, and as needed, review and update the QM Plan, 2) quarterly, and as needed, review and update the QM Annual Quality Improvement Plan, 3) review new and existing DSHS policies to include Case Management and Clinical guidelines, 4) discuss adverse events and consumer concerns/complaints, 5) review and update consumer surveys, review consumer survey data and action plans to address survey concerns, 6) review provider (Subcontractor) surveys and action plans to address survey concerns, and 7) review performance measure percentages to assure progress is made toward meeting the goals, strategies and activities of the Comprehensive Plan for HIV Services, Quality Management Plan and Annual Quality Improvement Plan.

In addition, the QMC participants have the following responsibilities:

- The Contract Specialist reviews quarterly expenses and discusses needed reallocations.
- The Quality Manager/Data Manager conducts the following processes:
  - review service utilization data to identify patterns
  - completes bi-monthly data quality checks as described in Section IX below
  - lead the QMC, schedules QMC meetings, updates the QM Plan and Annual Quality Improvement Plan, maintains meeting minutes, and provides training.
- The Nurse Consultant monitors program adherence as described below in Section IX, Evaluation and Program Adherence.
- The Planning Coordinator works with the QM Coordinator on updating the Comprehensive Plan for HIV Services and at least quarterly monitoring and updating the goals, strategies and activities.
- The HSDA service Subcontractors conduct and present to the QMC the following processes:
  - Run 1st Tier HAB measures report in ARIES and share results; Run HAB Core Measures, will run report and present on percentages after Core Measures are uploaded in ARIES;

- Present information on objectives/activities from the Comprehensive Plan/QM Plan; and,
- Share individual agency QM activities as well as quality improvement activities implemented and piloted to improve the HAB measures and services in general (ex: new forms to streamline intakes, changes in personnel roles, policies, etc.…)

- The physician provides medical insight and educates the QMC on issues that affect HIV treatment such as co-morbidities and their effect on HIV/AIDS and other medical topics.

Meetings: The QMC meets quarterly, generally via conference call. Other meetings are scheduled as needed. The AA provides an agenda to the QMC as well as updates the QM Plan and the Annual Quality Improvement Plan. The AA keeps meeting minutes and provides them to the QMC within ten (10) workdays of the QMC meeting.

III. Annual Quality Improvement Plan

The StarCare Specialty Health System established an Annual Quality Improvement Plan (QI Plan), in conjunction with the Comprehensive Plan for HIV Services, to identify the goals and strategies of the Quality Management Program. The Annual Quality Improvement Plan addresses the strategies during the year and also identifies the target date of completion. A new Annual Quality Improvement Plan is created at the beginning of each contract year and approved by the Quality Management Committee. The plan identifies all the major activities of the committee and is the vehicle for examining how well the system is working in executing the program's priorities and strategies. The Annual Quality Improvement Plan lists the quality assurance and quality improvement activities for the contract year and is aligned with DSHS Quality Management objectives. The QI Plan is updated after each QMC meeting. Beginning April 2010, the QM Plan/QI Plan is incorporated as an attachment in the Comprehensive Plan for HIV Services.

IV. Performance Measurement

One of the key characteristics of the Quality Management Program is to use data and measurable outcomes to determine progress toward relevant, evidence-based benchmarks. The QMC will follow the HIV/AIDS Bureau's HIV Core Clinical Performance Measures for Adult/Adolescent Clients. The QMC will abide by the core performance measures listed below:

1. Viral Load Suppression (and continue to monitor CD4 cell count)
2. Prescribed Antiretroviral Therapy
3. Medical Visits Frequency
4. Gap in Medical Visits
5. PCP Prophylaxis

V. Plan to Identify, Correct, and Monitor Adverse Outcomes

I. The current system to identify potential adverse outcomes includes usage of random review of client records, data review from ARIES, media releases, complaints, subcontractor monitoring, notification from DSHS, and any other communication mechanism.

II. When a potential adverse outcome is identified, the following process is followed:

A. The staff identifying the outcome notifies all Administrative Agency staff, and the Administrative Agency staff consults to research and verify the information.
B. The Administrative Agency staff works together to develop the corrective action applicable to the issue.
C. Depending on the adverse outcome, the Contracts Specialist then notifies the Subcontractors first by phone, depending on the urgency of the outcome, and followed up in writing by e-mail and/or certified mail.
D. Subcontractors will notify clients of the adverse outcome by phone, mail, e-mail, flyers, media, website, face-to-face contacts, during visits, etc... For emergency outcomes, clients will be notified within 24 hours by phone, home visit or other face-to-face contact. Subcontractors will document their efforts and at least three attempts must be made to contact the client.
E. For emergency adverse outcomes, the Administrative Agency will assist the Subcontractors to assess immediate needs of the clients and to facilitate access to services. Depending on the adverse outcome, the attached Texas Rapid Public Health Needs Assessment Instrument (TX DSHS) and/or the attached CASPER Questionnaire will be implemented.
F. Non-emergency adverse outcomes will be addressed on a case-by-case basis with priority given according to client need.

The final results of the corrective action to the adverse outcome are reported to the Director of Contracts Management and to the Quality Management Committee.

The Administrative Agency staff works together to perform follow up monitoring and reports to the Director of Contracts Management and to the Quality Management Committee.

III. The Administrative Agency also has a Contingency Plan for Lapse of HIV Services. This plan is located in the policies and procedures under Section 14A (AA) and Section 14B (Subcontractor) – Contingency Plan for Lapse of HIV Services. This plan includes general guidance to address a significant change or situation that may occur and result in a lapse of HIV services. The primary focus of this plan is core medical services.

VI. Capacity Building

The AA informs the QMC of upcoming trainings, such as webcasts and teleconferences, conducted by the National Quality Center and the Texas Department of State Health Services (DSHS). The AA will maintain a log of QM trainings and technical assistance.

The 2015 Texas HIV Case Management Standards issued new training requirements for Medical Case Managers (MCMs) and Non-Medical Case Managements (NMCMs). All training requirements and compliance are monitored by the Nurse Consultant through desktop reviews and annual audits.

In February 2010, DSHS asked AAs to combine the QM Plan with the area comprehensive plan. Beginning April 1, 2010, the QM Plan/QI Plan is incorporated into the PanWest HIV/AIDS Service Area Comprehensive Plan for HIV Services.

VII. Expenditures

The AA monitors expenditures at least quarterly through ARIES data and Subcontractor billing data. The AA notifies DSHS of the expenditures via the Quarterly Report. The Contract Specialist discusses reallocations as needed to assure adequate funding for medical core services especially to avoid denial of services, waiting lists and delay of services for AIDS Pharmaceuticals, Health Insurance, and Ambulatory Outpatient Medical and to prevent lapse of funds. The Contract Specialist monitors the contract expenses to ensure that there is no lapse or overspending of funds at least every quarter through analyzing the expenses reported in the quarterly report by the subcontractors. If expenditures do not appear to be on target, Subcontractors are contacted and required to submit a plan to ensure funds are expended appropriately. If it is determined that the Subcontractor is unable to expend funds within the contract term, the AA initiates necessary steps following the DSHS reallocation policy (such as provide technical assistance, initiate reallocations, communicate with DSHS) if the expenses and performance objectives are not on target.

VIII. Evaluation and Program Adherence

Program Adherence: The AA Nurse Consultant is a registered nurse and performs monitoring for clinical and case management services in accordance with HIV Clinical and Case Management Services Standards to include monitoring of the care and treatment of persons with HIV according to the US Public Health Standards. The Nurse Consultant also makes site visits to the clinics of the Subcontractors in El Paso, Lubbock and Odessa to assure the medical needs of the clients are met.

In addition, the Nurse Consultant performs regular desktop monitoring of the documentation in ARIES for timeliness and content of case notes, assessing for Subcontractors adherence to payer of last resort and emergency medication policies, completion of needs assessments, implementation and updating of care plans, updating of medication and lab results specifically CD4 counts and viral loads, assessing the need for specialty referrals and assuring follow-up on referrals, assuring discharge and termination policies and procedures and all other policies and procedures related to medical and non-medical case management are followed. The Nurse Consultant communicates

regularly with Subcontractors via telephone, e-mail and on site for clarification of any identified issues. The Nurse Consultant also provides technical assistance as requested or as determined necessary to ensure clients are receiving quality services. The Nurse Consultant participates in site reviews for each Subcontractor where random samples of client charts are assessed for continuity of care and the completion and content of documentation. Beginning in 2016, the Nurse Consultant will also work in collaboration with the DSHS contracted consultant for on-site clinical reviews. The Nurse Consultant completes required reports and documentation and provides feedback to the Subcontractors related to the technical assistance and site visits.

Data Quality Check: After the data entry process is performed at the subcontractor level, the Administrative Agency Quality Manager/Data Manager performs bi-monthly data quality checks. The process includes checking for record duplication, cleaning, and generating various reports to find missing information or unknown data. After the Administrative Agency completes the process, the Subcontractors' data manager receives statistical reports containing a list of clients with missing or unknown data on a monthly basis. The missing data must be collected as soon as possible; preferably before the next data transmission begins in the following month. The Subcontractors' data managers are encouraged to share information with the case managers in order to complete this process.

As of April 1, 2010, TX DSHS implemented a new policy, Documenting Case Management Actions in ARIES, "to assist in the improvement of the quality of documentation as well make data input more uniform." The new policy requires Subcontractors to use ARIES to the maximum extent possible to include entering case notes, adherence assessments, mental health/substance abuse screenings, and risk reduction notes.

Satisfaction Surveys: The Administrative Agency (AA) implements an annual Client Satisfaction Survey and annual Provider (Subcontractor) Satisfaction Survey as a means of obtaining input and measuring satisfaction and progress.

A) Client Satisfaction Surveys, English and Spanish, are mailed directly to each client, who allows mail, along with a letter, English and Spanish, explaining the survey and a self-addressed stamped envelope to return the survey. Clients are asked to remain anonymous and not list identifying information on the survey or envelope but may list provide contact information if they want to be contacted by the AA. Clients are given the option of completing the survey by phone, in English or Spanish. A summary of the survey results are sent to the Subcontractors and reviewed by the QMC. Subcontractors are asked to review the results and respond with an action plan to adverse outcomes.

B) The Provider (Subcontractor) Satisfaction Surveys are done through Survey Monkey. A survey link is e-mailed directly to each Subcontractor staff that has regular contact with the AA and primarily includes the program director, agency director, case managers, data manager, and accountant. Subcontractors are asked to remain anonymous.

APPENDIX C

HRSA HAB PERFORMANCE MEASURES, GROUP 1 (TIER 1)

Performance Measure: Medical Visits	**Measure #1 (HAB #1)**
Percentage of clients with HIV infection who had two or more medical visits in an HIV care setting in the measurement year (Adopted HAB measure).	
Numerator	Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP, in an HIV care setting two or more times at least 3 months apart during the measurement year
Denominator	Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year

Performance Measure: CD4 Cell Count	**Measure #2 (HAB #2)**
Percentage of clients with HIV infection who had 2 or more CD4 T-cell counts performed in the measurement year (Adopted HAB measure).	
Numerator	Number of HIV-infected clients who had 2 or more CD4 T-cell counts performed at least 3 months apart during the measurement year
Denominator	Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least once in the measurement year

Performance Measure: PCP Prophylaxis	**Measure #3 (HAB #3)**
Percentage of clients with HIV infection and a CD4 T-cell count below 200 cells/mm^3 who were prescribed PCP prophylaxis.	
Numerator:	Number of HIV-infected clients with CD4 T-cell counts below 200 cells/mm^3 who were prescribed PCP prophylaxis
Denominator:	Number of HIV-infected clients who: • had a medical visit with a provider with prescribing privileges[1], i.e. MD, PA, NP at least once in the measurement year, and • had a CD4 T-cell count below 200 cells/mm^3

Performance Measure: HAART	**Measure #4 (HAB #12A)**
Percentage of clients with AIDS who are prescribed HAART (Adopted HAB measure)	
Numerator	Number of clients with AIDS who were prescribed a HAART regimen within the measurement year
Denominator	Number of active clients who have a diagnosis of AIDS (history of a CD4 T-cell count below 200 cells/mm or other AIDS-defining condition), and had at least one medical visit with a provider with prescribing privileges, i.e. MD, PA, NP in the measurement year.

Performance Measure: ARV Therapy for Pregnant Women	**Measure #5 (HAB #17)**
Percentage of pregnant women with HIV infection who are prescribed antiretroviral therapy.	
Numerator:	Number of HIV-infected pregnant women who were prescribed antiretroviral therapy during the 2nd and 3rd trimester
Denominator:	Number of HIV-infected pregnant women who had a medical visit with a provider with prescribing privileges[1], i.e. MD, PA, NP at least once in the measurement year

APPENDIX C

HIV/AIDS Bureau Performance Measures:
Core Performance Measures 1 November 2013

Performance Core Measure: HIV Viral Load Suppression	**Measure #1**
Percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year	
Numerator	Number of patients from the denominator prescribed HIV antiretroviral therapy1 during the measurement year.
Denominator	Number of patients, regardless of age, with a diagnosis of HIV with at least one medical visit in the measurement year

Performance Core Measure: Prescription of HIV Antiretroviral Therapy	**Measure #2**
Percentage of patients, regardless of age, with a diagnosis of HIV prescribed antiretroviral therapy for the treatment of HIV infection during the measurement year.	
Numerator	Number of patients from the denominator prescribed HIV antiretroviral therapy during the measurement year.
Denominator	Number of patients, regardless of age, with a diagnosis of HIV with at least one medical visit in the measurement year

Performance Core Measure: HIV Medical Visit Frequency	**Measure #3**
Percentage of patients, regardless of age, with a diagnosis of HIV who had at least one medical visit in each 6 month period of the 24 month measurement period with a minimum of 60 days between medical visits.	
Numerator	Number of patients in the denominator who had at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between first medical visit in the prior 6-month period and the last medical visit in the subsequent 6-month period.
Denominator	Number of patients, regardless of age, with a diagnosis of HIV with at least one medical visit in the first 6-months of the 24-month measurement period.

Performance Core Measure: Gap in HIV Medical Visits	**Measure #4**
Percentage of patients, regardless of age, with a diagnosis of HIV who did not have a medical visit in the last 6-months of the measurement year.	
Numerator:	Number of patients in the denominator who did not have a medical visit in the last 6 months of the measurement year.
Denominator:	Number of patients, regardless of age, with a diagnosis of HIV who had at least one medical visit in the first 6 months of the measurement year.

Performance Core Measure: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis	**Measure #5**
Percentage of patients aged 6 weeks or older with a diagnosis of HIV/AIDS, who were prescribed Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis (use the numerator and denominator that reflect patient population)	
Numerator:	Numerator 1: Patients who were prescribed Pneumocystis jiroveci pneumonia (PCP) prophylaxis within 3 months of CD4 count below 200 cells/mm3 Numerator 2: Patients who were prescribed Pneumocystis jiroveci pneumonia (PCP) prophylaxis within 3 months of CD4 count below 500 cells/mm3 or a CD4 percentage below 15% Numerator 3: Patients who were prescribed Pneumocystis jiroveci pneumonia (PCP) prophylaxis at the time of HIV diagnosis Aggregate numerator: The sum of the three numerators
Denominator:	Denominator 1. All patients aged 6 years and older with a diagnosis of HIV/AIDS and a CD4 count below 200 cells/mm3, who had at least two visits during the measurement year, with at least 90 days in between each visit; and, Denominator 2. All patients aged 1 through 5 years of age with a diagnosis of HIV/AIDS and a CD4 count below 500 cells/mm3 or a CD4 percentage below 15%, who had at least two visits during the measurement year, with at least 90 days in between each visit; and, Denominator 3. All patients aged 6 weeks through 12 months with a diagnosis of HIV, who had at least two visits during the measurement year, with at least 90 days in between each visit Total denominator: The sum of the three denominators

Performance Clinical – All Ages - Measure: CD4 Cell Count	**Measure #6**
Percentage of patients aged six months and older with a diagnosis of HIV/AIDS, with at least two CD4 cell counts or percentages performed during the in the measurement year at least 3 months apart	
Numerator	Patients with at least two CD4 cell counts or percentages performed during the measurement year at least 3 months apart
Denominator	All patients aged 6 months and older with a diagnosis of HIV/AIDS, who had at least two medical visits during the measurement year, with at least 90 days between each visit.

APPENDIX D

Medical Core and Social Support Services

Funds for the medical core categories needed in the PanWest and West Texas areas are generally allocated through Ryan White Service Delivery funds to maintain compliance with the requirement that 75% of Ryan White Part B funding be allocated to the medical core categories. These include:

1. Ambulatory Outpatient Medical Care
2. HIV/AIDS Drug Reimbursement (AIDS Pharmaceutical Assistance - local)
3. Oral Health Care
4. Early intervention Services
5. Health Insurance Premium and Cost Sharing Assistance
6. Home Health Care
7. Medical Nutrition Therapy
8. Hospice Services
9. Home & Community-Based Health Services
10. Mental Health Services
11. Substance Abuse Outpatient Care
12. Medical Case Management.

Although the AIDS Drug Assistance Program (ADAP) is a medical core category, funding is not allocated locally since the Texas HIV Medication Program administers the ADAP.

Social support services are as those services needed by people living with HIV/AIDS to "enhance access to and retention in care."[1] HRSA has identified social support services as:

1. Non-Medical Case Management,
2. Treatment adherence counseling,
3. Medical transportation,
4. Non-medical transportation,
5. Food bank,
6. Emergency financial assistance,
7. Housing,
8. Respite care,
9. Child care,
10. Health education/risk reduction
11. Outreach Services

[1] The Treatment Extension Act of 2009.

12. Psychosocial support,
13. Referral for health care/supportive services,
14. Rehabilitation,
15. Linguistic Services
16. Legal Services

APPENDIX E

Please see the Priorities and Allocations in the Download section of the website.

APPENDIX F

Healthy People 2020 Strategies Addressed With the PanWest-West Texas 2014 Comprehensive HIV Services Plan

Number	Objectives	
HIV–1	Reduce the number of new HIV diagnoses among adolescents and adults	These education, outreach and prevention strategies will be supported through Goal 4, collaborations in each of the HSDAs.
HIV–2	Reduce new (incident) HIV infections among adolescents and adults.	
HIV–3	Reduce the rate of HIV transmission among adolescents and adults.	
HIV–4	Reduce the number of new AIDS cases among adolescents and adults.	
HIV–5	Reduce the number of new AIDS cases among adolescent and adult heterosexuals.	
HIV–6	Reduce the number of new AIDS cases among adolescent and adult men who have sex with men.	Reducing AIDS cases can be accomplished with earlier diagnosis (Goal 4) and maintenance in HIV medical care (Goal 1 , 2 and 3)
HIV–7	Reduce the number of new AIDS cases among adolescents and adults who inject drugs.	
HIV–9	(Developmental) Increase the proportion of new HIV infections diagnosed before progression to AIDS.	
HIV–10	(Developmental) Increase the proportion of HIV-infected adolescents and adults who receive HIV care and treatment consistent with current standards.	Goal 1, 2 and 3
HIV–11	Increase the proportion of persons surviving more than 3 years after a diagnosis with AIDS.	
HIV–12	Reduce deaths from HIV infection.	
HIV–13	Increase the proportion of persons living with HIV who know their serostatus.	Goal 4
HIV–14	Increase the proportion of adolescents and adults who have been tested for HIV in the past 12 months.	
HIV–15	Increase the proportion of adults with tuberculosis (TB) who have been tested for HIV.	Goal 3
HIV–16	Increase the proportion of substance abuse treatment facilities that offer HIV/AIDS education, counseling, and support.	Goal 2
HIV–17	Increase the proportion of sexually active persons who use condoms.	Goal 4
HIV–18	(Developmental) Decrease the proportion of men who have sex with men who reported unprotected anal sex in the past 12 months.	