GUIDELINES FOR FY2007 STATE SERVICES RENEWAL PROCESS

(To access the forms listed below you may use the CTRL + click function to follow the link)

PERFORMANCE MEASURE GUIDELINES

WORK PLAN GUIDELINES

INSTRUCTIONS AND EXAMPLES FOR A CATEGORICAL BUDGET JUSTIFICATION

PROGRAM REQUIREMENTS for HIV ADMINISTRATIVE AGENCIES

GLOSSARY HIV-RELATED SERVICE CATEGORIES AND ADMINISTRATIVE

SERVICES

PERFORMANCE MEASURE GUIDELINES

1. Applicant shall write performance measures for project objectives and proposed target levels of performance for each measure. The proposed measures and levels of performance will be negotiated and agreed upon by applicant and DSHS if applicant is selected to negotiate a contract.

Performance measures should be SMART: specific, measurable, achievable, relevant and time-phased. Performance measures quantify program outcomes and outputs, and the number of such outputs to be performed. Performance measures also define the applicant's obligations in order to meet its contract requirements.

A well-written measure includes the following components: who will deliver the service(s) and their qualifications (as appropriate); a deliverable (a product or service and how much); a schedule/time frame; and a standard of performance. The following table provides a guide for developing the different types of performance measures:

Type	Measure	Example
Outcome	*measures the actual impact or public benefit of an entity's actions*	*One hundred percent (100%) of the SS contracts executed by the Administrative Agency are in compliance with current priorities.*
Output or Process	*counts the goods/services provided*	*At least x clients will receive at least one unit of outpatient ambulatory medical care by March 31, 2007.*

Performance measures should be reported separately for each HSDA.

Required Outcome Measures:

1. One hundred percent (100%) of the State Services (SS) contracts executed between the Administrative Agency and service providers are in compliance with current priorities.

2. (_#_) of unduplicated clients will receive at least one service during the 7 month contract period (9/1/06 - 3/31/07).

WORK PLAN GUIDELINES

Applicant shall describe its plan for service delivery to the population in the proposed service area(s) and include time lines for accomplishments. The work plan shall address any changes to the needs and the problems identified in the community assessment for improving health status. The plan shall:

1. Summarize changes to services, population to be served, location (counties to be served), etc. Also address the following two questions: a) Are you serving individuals from counties outside your stated service area? b) If your agency's budget total remains at level funding (all sources), how will this impact your overall agency program goals.

2. Describe any changes to your delivery systems, and: workforce (attach organizational chart if changed from original competitive RFP application), policies, support systems (i.e., training, research, technical assistance, and information, financial and administrative systems) and other infrastructure available to achieve service delivery and policy-making activities. "What resources do we have to perform the project, who will deliver services and how will they be delivered?"

3. Briefly describe any changes pertaining to how training and technical assistance will be given to providers on data collection activities and briefly describe your plans for quality assurance of provider data. In your response, please make specific reference to provider data submitted through the AIDS Regional Information and Evaluation System (ARIES). Please briefly describe any technical assistance on ARIES administration or quality assurance that you anticipate needing from DSHS.

4. Describe any changes to coordination with the other health and human services providers in the service area(s) and delineate how duplication of services is to be avoided. Describe how your organization ensures that the service providers you fund collaborate with the required and recommended organizations as described in Appendix A: Program Requirements.

5. Describe any changes to your ability to provide services to culturally diverse populations (e.g., use of interpreter services, language translation, compliance with Americans with Disabilities Act requirements, and other means to ensure accessibility for the defined population).

6. Summarize any changes since DSHS approval of your RWSD work plan; including changes to internal Quality Assurance/Quality Improvement (QA/QI) process utilized to monitor services as well as identify staff who use them and who is responsible for ensuring they are updated. Describe changes to the following, 1) role of the QA/QI Committee; 2) Physician's involvement in the QA/QI activities; 3) the written quality management plan (required by HRSA) that assesses the quality and appropriateness of the health and support services provided by the contractors and subcontractors and provides corrective action for identified quality issues; 4) activities utilized to identify trends of needed improvement and the frequency of those activities; 5) activities to ensure correction and follow-up to findings identified; 6) utilization and frequency of client satisfaction surveys; 7) system utilized to identify, report and monitor adverse outcomes (sentinel events); 8) process for identifying and reporting outcome measures; 9) process utilized to develop protocols and Standing Delegation Orders (SDOs); 10) process for an annual evaluation of quality management efforts and the reporting of the results of those interventions (required); and 11) internal management quality improvements. For additional information and technical assistance on Quality Management programs, please refer to Health Resources and Services Administration's (HRSA) Quality Management Manual at http://www.hab.hrsa.gov/tools/QM/ . Also, please include a copy of your agency's policies and procedures for subcontractor monitoring if they have changed.

7. Summarize changes since DSHS approval of your RWSD work plan. Describe any changes in what your organization is doing to ensure that Ryan White CARE Act and State Services funds are the payer of last resort and that funds are not used to provide items or services for which payment has already been made or reasonably can be expected to be made by third party payers (e.g. Medicare, Medicaid, private insurance, etc.). Describe changes in how this expectation is communicated to subcontractors, specific policies and procedures in place at your organization regarding third party reimbursement, how this expectation is monitored during subcontractor monitoring visits, and how clients are screened by subcontractors for eligibility for third party payers and enrolled in these resources.

8. For each county in your HSDAs describe changes to:
    - a) the process by which clients access ambulatory medical care;
    - b) how the program assures that clients have access to a physician with HIV medical experience; and
    - c) identify the specific physicians and/or ambulatory medical care clinic.

INSTRUCTIONS AND EXAMPLES FOR A CATEGORICAL BUDGET JUSTIFICATION

NOTE: All applications must include a Categorical Budget Justification. For the FY2007 budget period, the percentage administrative agencies take from home HSDAs for any non-service delivery contract cost under this RFP for the 09/1/06-3/31/07 budget period ma not exceed the amount expended by the AAs during the 9/1/05-8/31/06 budget period.

A. PERSONNEL **(Total)**

[List each position with a brief job description of 50 words or less. For each position listed, multiply the monthly salary or wages by the percentage of personnel time by the number of months which the salary is to be paid from this budget.]

Example:

Executive Director (Gonzales) **$3,200/monthly X 5% X 12 = $1920**	**1,920**
Oversees all program activities. Ensures compliance with contract requirements. Provides program/financial information to the Board of Directors. Acts as agency personnel director and public spokesperson. Supervises Program Manager.	
Bookkeeper (Jones) **$1,500/monthly X 10% X 12 = $1800**	**1,800**
Performs full charge bookkeeping duties. Inputs transaction data and produces general ledger, income/expense statements and balance sheets. Maintains and produces payroll. Checks invoices for accuracy and prepares them to be approved for payment. Prepares accounts payable.	
Clinic Nurse (Donnelly) **$3,200/monthly X 100% X 12 = $38,400**	**38,400**
Works in cooperation with CARE clinic medical personnel and UTMB staff in providing primary medical care for persons living with HIV. Provides medical case management to clients. Provides supervision for clinic aide and daily functions of the clinic.	
Program Manager (Watson) **$2,580/monthly X 40% X 12 = $12,384**	**12,384**
Supervises all HIV Services activities: Provides staff training, as needed; coordinates HIV Services programming; designs and maintains data collection system; prepares all required program reports; evaluates staff performance and conducts quality assurance.	
HIV Case Manager (McDade) **$2,375/monthly X 100% X 12 = $28,500**	**28,500**

Provides case management services to rural HIV-positive residents of Jones, Hays, Delgado counties through face-to-face client contact and phone contact. Conducts needs assessments with the clients and updates needs assessment on a regular basis. Establishes linkages with social services providers and medical providers to ensure clients have a medical home. Makes appropriate referrals for services, and collects and maintains accurate program data.

HIV Case Manager (Vacant) **28,500**
$2,375/monthly X 100% X 12 = $28,500

Provides bilingual case management services to rural HIV-positive Spanish speaking residents of Miller, Bend, Gonzales and Montemayor counties through face-to-face client contact and phone contact. Conducts needs assessments with the clients and updates needs assessment on a regular basis. Establishes linkages with social services providers and medical providers to ensure clients have a medical home. Makes appropriate referrals for services, and collects and maintains accurate program data.

Auxiliary Services Coordinator (New position) (attach Job description) **28,500**
$2,375/monthly X 100% X 12 = $28,500

Oversee all activities and day care at the ART Community Center facility, stock the food pantry, keep facility organized, maintain records of client participation and usage of the facility, serve hot lunches, order and pickup groceries for the food pantry. Assist Case Managers with reporting and filing of client information

B. FRINGE BENEFITS (Total)

[Itemize the cost of fringe benefits paid for employees, including employer contributions for Social Security, retirement, insurance and unemployment compensation. Fringe benefits requested must represent the actual benefits paid for employees.]

Example:

FICA: 0.765 x $101,604 =	**7,773**
Insurance: $2,160 x 3.55 FTEs =	**7,668**
Worker's Comp: rate x salaries = $	**$**
Unemployment: rate x salaries = $	**$**

C. STAFF TRAVEL (Total)

[Budget the projected costs of transportation, lodging, meals, and related expenses for official staff business travel conducted in carrying out the contract. Out of state travel is only allowed with pre-approval from the DSHS. NOTE: Grantees who do not have written travel reimbursement policies must use DSHS travel reimbursement rates as follows: $.405/mile, $36/day meals, $85/day lodging.]

Example:
Mileage for Case Managers in service area: **2,916**

$0.405/mile X 600 miles/mo. X 12 months - $2,916

Expenses for 3 staff members to attend Texas HIV/STD Conferences: 1,977
Airfare @ $175 X 3 staff = $525
Lodging @ $85 X 4 days X 3 staff = $1020
Meals @ $36 X 4 days X 3 staff = $432

D. EQUIPMENT (Total)

[Equipment is defined as tangible non-expendable property with an acquisition cost of over $5000, including freight, and a useful life of more than one year, with the following exceptions: costs for computers, FAX machines, stereo systems, cameras, video recorder/players, microcomputers, and printers with a unit cost of $500 or more. Prior written approval from the DSHS is required before grantee may acquire equipment. List each item, describe and explain use. Attach the Justification for Request for Equipment Purchase form for each piece of equipment requested.]

E. SUPPLIES (Total)

[This category is for the costs of materials and supplies necessary to carry out the project. It includes general office supplies, janitorial supplies, and any equipment, not on the exception list above with a purchase price, including freight, of less than $5000 or less per item.]

Example:
General office supplies - $100 mo x 12 mo 1,200

F. CONTRACTUAL (Total)

[DEFINITION: Whenever the applicant intends to delegate part of the activities identified in the scope of work to a third party, the cost of providing these activities is recorded in this category. Travel by these individuals should be included in this category if they are delivering client services. Contracts for administrative services are not included in this category; they are properly classified in the Other category.

If the applicant enters into grant contracts with sub recipients or procurement contracts with vendors, the documents will be in writing and will comply with the requirements specified in the Contracts with Sub recipients and Contracts for Procurement articles in the General Provisions for Department of State Health Services Grant Contracts available online at *www.tdh.state.tx.us/grants/forms_and_documents.htm* or by calling CSCU at 512-458-7470.

If an applicant plans to enter into a contract which delegates a substantial portion of the scope of the project, i.e., $25,000 or 25% of the applicant's funding request whichever is greater, the applicant must submit justification to DSHS and receive prior written approval from DSHS before entering into the contract.]

G. OTHER (Total)

[DEFINITION: All other allowable direct costs not listed in any of the above categories are to be included in this category. Some of the

major costs that should be budgeted in this category are:

* **contracts for administrative services;**
* **space and equipment rental;**
* **utilities and telephone expenses;**
* **data processing services;**
* **printing and reproduction expenses;**
* **postage and shipping;**
* **contract clerical or other personnel services;**
* **janitorial services;**
* **exterminating services;**
* **security services;**
* **insurance and bonds;**
* **equipment repairs or service maintenance agreements;**
* **books, periodicals, pamphlets, and memberships;**
* **advertising;**
* **registration fees;**
* **patient transportation;**
* **training costs, speaker's fees and stipends.**

H. TOTAL DIRECT COSTS **(Total)**

[Enter the total of A - G above]

I. INDIRECT COSTS **(Total)**

[A copy of the current negotiated indirect cost rate must be attached, if applicable.]

J. TOTAL BUDGET **(Total)**

PROGRAM REQUIREMENTS for HIV ADMINISTRATIVE AGENCIES

A. Description of Service Components

Ryan White CARE Act Title II funds are made available to states and territories to provide comprehensive outpatient health and support services for individuals with HIV. Eligible services to be provided or administered with state and federal resources allocated for medical and psychosocial support services are catalogued and defined in Appendix B: *Glossary of HIV-Related Service Categories and Administrative Services.*

B. Requirements for Administrative Agencies

The roles of the AA include administration, planning, evaluation, and quality management. All AAs must provide all these services. These activities are defined as follows:

1. Administrative Functions

Through a contract with DSHS, assist DSHS in providing grant administration for available federal and State HIV services and HOPWA funds, including:

a) developing funding applications and proposals
b) receipt and disbursal of program funds, including identification of providers in eachcommunity to be served who are best suited to provide the funded services through DSHS- approved procurement processes such as requests for proposals, and execute contracts for these client services.
c) developing and establishing reimbursement, accounting and financial management systems
d) preparing routine financial data and reports as required by DSHS
e) implementation of the service delivery plan for the area
f) compliance with contract conditions and audit requirements
g) subcontract monitoring and reporting, through telephone consultation, written documentation and on-site visits, for programmatic and financial contract compliance, quality and process improvement.
h) ensuring that the service needs of all clients are provided through subcontractors who are culturally, ethnically, and linguistically sensitive to these populations
i) staff training associated with administrative functions.

2. Capacity Building

a) capacity building to increase the availability of services
b) technical assistance to contractors
c) ensure that services are accessible to the populations to be served
d) assure that the care offered by providers meets current standards of care and treatment of persons with HIV.

3. Needs Assessment/Planning/Evaluation

a) collecting data on the outcomes of service delivery as specified by DSHS
b) evaluation of the cost-effectiveness of the mechanisms used in the delivery plan
c) assessing service needs, services gaps, and unmet need for HIV-related medical care within the HIV Planning Area (if AA supports planning)
d) Developing a comprehensive plan for delivery of HIV medical and psychosocial support services, including priorities and allocations
e) periodic evaluation of the success of the service delivery plan in responding to identified needs.
f) maintaining complete, accurate and timely client-level programmatic data, including adhering to the minimum requirements of maintaining the URS as required by DSHS.

4. Quality Management Functions

Quality Management is a mandated function in the RWCA. The standards apply to RWAA, RWSD, RWSS, EACPS, MAI and SNP scopes of work. Quality Management Systems require:

a) The presence of a documented, ongoing quality improvement process (program description and plan of work)
b) A quality management committee function that includes member roles and responsibilities and documented minutes of each meeting
c) Significant participation by an M.D. in quality management functions
d) Evidence of actions to improve quality of care and services, including improvements in accessibility and availability of services
e) Data analysis in order to identify quality issues
f) Satisfaction surveys follow up on all identified issues identified in the surveys and documentation of improvement of those issues
g) The identification of outcomes and efforts at improving them
h) Identification, monitoring and improvement of adverse outcomes
i) Contractor oversight, corrective action and documentation of improvements
j) Corrective action plans for identified quality issues
k) Evidence of management improvements, including revisions to program documentation, policies and procedures, committee actions and other quality initiatives
l) An annual evaluation of quality management programs

C. Use of funds

1. Allowable use of funds

Contract funds may be used for personnel, fringe benefits, equipment, supplies, staff training, travel, contractual or fee-based services, other direct costs, and indirect costs. For the purposes of insurance assistance, contract funds may be used for the payment of insurance premiums, deductibles, co-insurance payments, and related administrative costs. Equipment purchases are allowed if justified and approved in advance. All costs are subject to negotiation with the DSHS.

Contractors are required to adhere to federal principles for determining allowable costs. Such costs are determined in accordance with the cost principles applicable to the organization incurring the costs. The kinds of organizations and the applicable cost principles are set out in the DSHS contract general provisions and in the *DSHS Financial Administrative Procedures Manual.* Copies are available online at http://www.dshs.state.tx.us/grants/form doc.htm

If the contractor expends $500,000 or more in total federal financial assistance during the contractor's fiscal year, arrangements must be made for agency-wide financial and compliance audits. The audit must be conducted by an independent certified public accountant and must be in accordance with applicable Office of Management and Budget (OMB) Circulars, Government Auditing Standards, and the applicable Uniform Grant Management Standard (UGMS) State Audit Circular. Contractors shall procure audit services in compliance with state procurement procedures, as well as the provisions of UGMS. If the contractor is not required to have a Single Audit, DSHS will provide the contractor with written audit requirements if a limited scope audit will be required.

The administrative agency must:

- ensure that each subcontractor obtains a financial and compliance audit (Single Audit) if required by OMB Circular A-133 and/or UGMS,

- ensure that subcontractors who are required to obtain an audit take appropriate corrective action within six months of receiving an audit report identifying instances of non-compliance and/or internal control weaknesses, and
- determine whether a subcontractor's audit report necessitates adjustment of the administrative agency's records.

2. Disallowances

Funds provided through this RFP may not be used for the following:

Ryan White Administrative Agencies (RWAA)

- direct client services;
- to make cash payments to intended recipients of services, except for reimbursement of reasonable and allowable out-of-pocket expenses associated with consumer participation in planning activities;
- for acquisition of real property, building construction, alterations, renovations, or other capital improvements;
- to supplant other funding for services already in place.

Ryan White Service Delivery (RWSD)

- to duplicate services already available to the target group;
- to supplant other funding for services already in place;
- for charges which are billable to third party payers, e.g., private health insurance, prepaid health plans, Medicaid, and Medicare;
- mortgage payments;
- educational purposes, except health education and risk reduction education for HIV-infected individuals;
- to support employment, vocational rehabilitation, or employment-readiness services.
- funeral, burial, cremation or related expenses; and
- property taxes.

3. Program Income

All fees collected for services provided by Ryan White and SS funds are considered program income. All program income generated as a result of program funding must be proportionately integrated into the program for allowable costs and deducted from gross reimbursement expenses on the voucher before requesting additional cash payments. All program income must be reported on the quarterly financial reports. The *DSHS Financial Administrative Procedures Manual* contains additional information on program income. This document is available on the DSHS Enterprise Contract and Procurement Services Division website under "Forms and Documents" at http://www.dshs.state.tx.us/grants/form_doc.htm.

4. Payor of Last Resort

To maximize the limited program funds, Ryan White CARE Act funds must be payor of last resort. This means if there are other reasonable means of paying for an eligible service, including client payment, they should be used before Ryan White CARE Act funds. Contractors must agree to bill third party payors for applicable services provided at no cost to the client. Funds under this may not be used to provide items or services for which payment already has been made or reasonably can be expected to be made, by third party payors, including Medicaid, Medicare, and/or other state or local entitlement programs, prepaid health plans, or private insurance. Eligible individuals must be expeditiously enrolled in Medicaid and funds may not be used to pay for any Medicaid-covered services for Medicaid enrollees. Contractors who cannot become Medicaid

providers for applicable program activities may apply for a waiver. Applicants are reminded that contractors are subject to audit on this and other restrictions on use of funds.

5. Charges to Clients for Services

If an entity receiving Title II funds charges for services, it must do so on a sliding fee schedule that is available to the public. Individual, annual aggregate charges to clients receiving Title II services must conform to limitations established in the table below. The term, "aggregate charges," applies to the annual charges imposed for all such services under this Title of the CARE Act without regard to whether they are characterized as enrollment fees, premiums, deductibles, cost sharing, co-payments, coinsurance, or other charges for services. This requirement applies to all service providers from which an individual receives Title II-funded services. The State can waive this requirement for an individual service provider in those instances when the provider does not impose a charge or accept reimbursement available from any third-party payor--including reimbursement under any insurance policy or any federal or state health benefits program. The intent is to establish a ceiling on the amount of charges to recipients of services funded under Title II. Please refer to the following chart for allowable charges.

Individual/Family Annual Gross Income and Total Allowable Annual Charges

INDIVIDUAL/FAMILY ANNUAL GROSS INCOME	TOTAL ALLOWABLE ANNUAL CHARGES
Equal to or below the official poverty line	No charges permitted
101 to 200 percent of the official poverty line	5% or less of gross income
201 to 300 percent of the official poverty line	7% or less of gross income
More than 300 percent of official poverty line	10% or less of gross income

A simple application that requests information on the annual gross salary of the individual/family should suffice as the baseline by which the caps on fees will be established. The client should assure that the information provided is accurate.

D. MEDICAID PROVISION

A performing agency that contracts for funds with the DSHS is required to become a Medicaid provider for applicable program activities unless the performing agency requests and receives an annual waiver of this requirement from the HIV/STD Comprehensive Services Branch. Eligible clients must be expeditiously enrolled in Medicaid and funds may not be used to pay for any Medicaid-covered services for Medicaid enrollees. Performing Agencies must be able to demonstrate the capacity to actively promote successful client enrollment in Medicaid and other third party payor sources for which the clients may be eligible. Performing Agencies who cannot meet eligibility requirements to become Medicaid providers for applicable program activities may apply for a waiver. A waiver will be granted if the performing agency provides adequate rationale that implementing this requirement would result in a loss of critical HIV/STD services to the community, or would result in a substantial detriment to the health of a client with HIV/AIDS. "Special Care Facilities" or "Special Care Hospitals" are automatically granted unconditional waivers.

E. PROTOCOLS, STANDARDS AND TREATMENT GUIDELINES

Client services contractors are required to conduct project activities in accordance with the Quality Care: DSHS Standards for Public Health Clinic Services manual. A copy is posted on the DSHS website at http://www.dshs.state.tx.us/nursing/phnpubs.htm. Contractors are required to conduct project activities in accordance with various federal and state laws prohibiting discrimination. Guidance for adhering to non-discrimination requisites can be found on the following website: www.dshs.state.tx.us/cro.

Additionally, applicants who provide direct client services are required to adopt written protocols, standards and guidelines based on the latest medical knowledge regarding the care and treatment of persons with HIV infection. These include:

- *RECEIVING AGENCY'S HIV and STD Program Operation Procedures and Standards, 2003 and any revisions;*
- *Chapter 6A (Public Health Service) of Title 42 (The Public Health and Welfare) of the United States Code, as amended;*
- *RECEIVING AGENCY Program's HIV/STD Clinical Resources Division Standards for Clinical and Case Management Services;*
- *Public Health Service Task Force Recommendations for Use of Antiretroviral Drugs in Pregnant HIV-1-Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV-1 Transmission in the United States – February 24, 2005, or latest version;*
- *Guidelines for the Use of Antiretroviral Agents in HIV-Infected Adults and Adolescents, April 7, 2005, or latest version as developed by the Panel on Clinical Practices for Treatment of HIV Infection convened by the Department of Human Services (DHS);*
- *Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Infection; Health Resources and Services Administration (HRSA) and National Institutes of Health (NIH), March 24, 2005, or latest version;*
- *Treating Opportunistic Infections Among Infected Adults and Adolescents – Centers for Disease Control (CDC) Morbidity and Mortality Weekly Report (MMWR) 2004, Volume 53, Recommendations and Reports (RR);*
- *2001 United States Public Health Services (USPHS)/Infectious Diseases Society of America (IDSA) Guidelines for the Prevention of Opportunistic Infections in Persons Infected with HIV, November 28, 2001, or latest version;*
- *Prevention and treatment of tuberculosis among patients infected with human immunodeficiency virus: principles of therapy and revised recommendations. MMWR 1998; 47(No RR-20)*
- *Updated guidelines for the use of rifabutin or rifampin for the treatment and prevention of tuberculosis among HIV-infected patients taking protease inhibitors or nonnucleoside reverse transcriptase inhibitors. MMWR 2000; 49: 185-9.*
- *Perspectives in Disease prevention and Health Promotion Update: Universal Precautions for Prevention of Transmission of Human Immunodeficiency Virus, Hepatitis B Virus, and Other Bloodborne Pathogens Vol 37, No MM24; 377.*
- *Incorporating HIV Prevention into the Medical Care of Persons Living with HIV – CDC MMWR, Volume 52, RR 12, dated July 18, 2003;*
- *RECEIVING AGENCY Program's Universal Precautions Preventing the Spread of HIV, Tuberculosis, and Hepatitis B in Employees of HIV/STD Funded Programs, HIV/STD Policy No. 800.001;*
- *RECEIVING AGENCY'S STD Clinical Standards and Monitoring Guidelines; and*
- *Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HBV, HCV, and HIV and Recommendations for Postexposure Prophylaxis, CDC MMWR, Volume 54, RR 9, pages 1-17, dated September 30, 2005, or latest version.*

- *Revised Guidelines for HIV Counseling, Testing, Technical Expert Panel Review of CDC. HIV Counseling, Testing, and Referral Guide- Center for Disease Control (CDC) Morbidity & Mortality Weekly Report (MMWR) November 9, 2001/50 (RR19)1-58.*

Current, federally approved guidelines for clinical treatment of HIV and AIDS are available from the HIV/AIDS Treatment Information Services (ATIS) at http://www.hivatis.org; and on the HIV/STD Comprehensive Preventive Services (CPS) website at http://www.tdh.state.tx.us/hivstd/clinical/resource.htm. PERFORMING AGENCY is responsible to maintain access to current standards and guidelines.

F. ASSURANCES AND CERTIFICATIONS

- Contractors must submit with the application and maintain on file current, signed, and annually-dated assurances adhering to the following: (DSHS Assurances and Certifications,
- Nonprofit Board of Directors and Executive Officer Assurances, if the Administrative Agency is a nonprofit organization,
- HIV Contractor Assurances,
- Contractor Assurance Regarding Pharmacy Notification,
- Assurance Regarding HIV/STD Clinical Resources Standards for Clinical/Case Management Services,
- Assurance of Compliance with Requirements for Contents of AIDS-Related Written Materials. and
- Copies of each form listed above are provided in this application. Other assurances are included in the DSHS contract general provisions. All contractors must retain copies of the required assurances on file for review during program monitoring visits. Documents to support compliance with the assurances are to be kept on file with the Administrative Agency and at each respective subcontractor site, and will be reviewed by DSHS staff during site visits. Non-compliance with these *Assurances* could result in the suspension or termination of funding; therefore, it is imperative that the applicant read, understand, and comply with these *Assurances.*

G. POLICIES OF THE HIV/STD COMPREHENSIVE SERVICES BRANCH

The contractor must abide by all relevant policies of the HIV/STD Comprehensive Services Branch and the HIV/STD Epidemiology and Surveillance Branch. Contractors are required to provide pertinent policies to its subcontractors, when applicable. Policies may be found at the Branch web site: http://www.dshs.state.tx.us/hivstd/policy/default.htm. Contractors are encouraged to establish a policy manual to contain all DSHS policies.

H. FEDERAL RYAN WHITE POLICIES

Contractors and subcontractors are required to comply with HRSA's HIV/AIDS Bureau Policies for the Ryan White CARE Act. To this end, the DSHS recommends that all Administrative Agencies and their agents obtain and refer to the latest Ryan White CARE Act Title II Manual. This manual can be downloaded at http://www.hab.hrsa.gov/tools/title2/ or a hard copy can be requested by contacting the HRSA Information Center at (888) ASK HRSA.

I. PROGRAM REPORTING

1. Uniform Reporting System

Participation in the Uniform Reporting System (URS) is mandatory; currently, the URS system is the AIDS Regional Information and Evaluation System (ARIES). DSHS provides access to the URS at no cost to Administrative Agencies. Administrative Agencies are required to participate in the URS quality assurance activities. Administrative agencies must hire qualified personnel, as

defined by DSHS policy, to fulfill the required duties and standards described in the policy. This includes assisting providers in the collection and reporting of URS data and management, improvement and assistance in the application of URS data. **All Ryan White eligible services provided to Ryan White eligible clients must be reported by the DSHS.**

2. HIV Services Program Quarterly Reports

Contractors are required to collect and maintain relevant data documenting the progress toward the goals and objectives of their project as well as any other data requested by the DSHS. All program reports are due in the format found on the DSHS HIV/STD web pages listed below no later than 20 days after the end of each reporting period. The progress toward meeting the program objectives must be reported for the quarter as well as year-to-date. All other reporting information is reported by quarter. The fourth quarter report will serve as the final program report. Failure to comply with deadlines and content requirements may result in an interruption of monthly reimbursements.

RW Administrative Agency, RW Service Delivery, and State Services providers use the same quarterly report format that is located at http://www.dshs.state.tx.us/hivstd/fieldops/page9.htm.
RW Underserved and Emerging Populations format is located at
http://www.dshs.state.tx.us/hivstd/fieldops/page9.htm.
Minority AIDS Initiative and Early Access formats are located at
http://www.tdh.state.tx.us/hivstd/clinical/eip.htm#quarterly.

Email all quarterly reports to:

- hivstdreport.tech@dshs.state.tx.us
  and cc: (first name.last name@dshs.state.tx.us)
- Your Field Operations Consultant
- Your Nurse Consultant
- Public Health Regional HIV Program Manager

If electronic submission is not an option phone your Field Operations Consultant.

Due dates for the reporting periods are as follows:

1st Quarter (September 1 - November 30)	Due December 20
2nd Quarter (December 1 – February 28)	Due March 20
3rd quarter (March 1 - May 31)	Due June 20
4th quarter (June 1 - August 31)	Due September 20

3. Care Act Data Report

The CARE Act Data Report (CADR) must be submitted by February 15, 2007 for calendar year 2006. Instructions on CADR submission will be issued by DSHS. Entities that receive CARE Act funding from multiple titles are responsible for any additional registration that might be necessary to submit CADR data due to their multiple sources of funding. .

4. Documents required for reports that DSHS must compile for reports to the Health Resources and Administration (HRSA)

Report	Due Date

FY 2007 Planned Allocations: • Table 1: Services Priorities and Objectives by HSDA • Table 2: State Services Allocations	April 20, 2006 submit with State Services application
Budget Package for each RWSD subcontractor containing: • Contract/Subcontract Review and Certification (CRC) • Subcontractor Data Sheets • Categorical Budget Justification and/or a Fee-for-Service form on each subcontractor	October 1, 2006

J. FINANCIAL REPORTING

1. Quarterly Financial Status Reports

Financial status reports are required as provided in the UGMS and must be filed regardless of whether or not expenses were incurred. Quarterly Financial Status Reports (State of Texas Supplemental Form 269a/DSHS Form GC-4a), are required no later than 30 days after the end of each quarter, except the fourth quarter. Due dates are set out in the project contract.

The DSHS Enterprise Contract and Procurement Services Division will provide contractors with the required forms to use for these reports. Quarterly financial reports are to be mailed to the Department of State Health Services, Fiscal Division/Accounts Payable,1100 West 49th Street, Austin, Texas 78756-3199.

2. Final Report

A final Financial Status Report is required within 90 days following the end of the contract period. If necessary, a State of Texas Purchase Voucher is submitted by the Contractor if all costs have not been recovered or a refund will be made of excess monies if costs incurred were less than funds received.

The final financial report is to be mailed to: Department of State Health Services, Fiscal Division/Accounts Payable, 1100 West 49th Street, Austin, Texas 78756-3199.

3. Equipment Inventory

Written prior approval for equipment purchases is required. Purchased equipment must be tagged and maintained on a property inventory. All equipment purchased with DSHS funds must be inventoried each year, no later than August 31st and reported to DSHS on DSHS Form GC-11 no later than October 15th.

Equipment is defined as an item having a single unit cost of $5,000 or greater and an estimated useful life of more than one year; however, personal computers, FAX machines, stereo systems, cameras, video recorder/players, microcomputers, and printers with a unit cost of over $500 also are considered as equipment.

K. COLLABORATION WITH OTHER AGENCIES

The DSHS **requires** collaboration between administrative agencies and service providers and other HIV-related programs within the HIV Service Delivery Area (HSDA), including pediatric service demonstration projects; Ryan White Title I, II, III and IV recipients; community, migrant, and homeless health centers; providers of HIV counseling and testing and prevention programs; the Texas HIV Medication Program (THMP); mental health and mental retardation providers;

substance abuse facilities; STD clinical service providers; local and regional public health officials; community groups; and, individuals with expertise in the delivery of HIV/AIDS services and knowledge of the needs of the target population. Formal linkages with Protocol Based Counseling (PBC) and Prevention Case Management (aka Comprehensive Risk Counseling Services- CRCS) sites are also **required** to improve the integration of HIV prevention and care services. Formal linkages with hospital discharge planners are encouraged.

Also, since all newly diagnosed persons with HIV should be tested for TB and STDs, applicants must have a **formal** mechanism to refer clients for clinical services to provide TB and STD screening and diagnosis, and treatment, as appropriate, from qualified medical providers and must ensure that such care is provided to clients who receive services under this grant. Applicants must also have a formal mechanism to refer all newly diagnosed persons with HIV disease for hepatitis testing and a process to refer for services, as appropriate. Title II/State Services contractors are expected to work with one another and with other providers as cooperative partners in providing a continuum of care for clients and in making successful referrals to one another.

A lack of collaboration and cooperation with the DSHS on the part of any agency that receives DSHS funds will be considered grounds for sanctions up to and including termination of funds.

L. OUTREACH AND ACCESS TO SERVICES

Administrative Agencies must ensure that subcontractors are required to provide services that are equitably available and accessible to all HIV infected individuals needing services/care. Subcontractors must employ outreach methods to reach and provide services to eligible clients who may not otherwise be able to access the services, including difficult to reach and underserved populations. Subcontractors must provide for services so that hours of operation, availability of public transportation, and location do not create barriers to the access of services by those who need them.

M. COMPREHENSIVE SERVICES PLAN

Agencies with planning responsibilities are required to develop a Comprehensive Services Plan, which identifies needs, services, resource allocation and a plan to serve HIV infected and affected individuals within the designated planning area. A Comprehensive Services Plan includes the following components:

- An Executive Summary
- Description of how the plan was developed and how community input and comment was included in the process ;
- A Summary of HIV/AIDS epidemiology in the planning area;
    - ✓ Summary of results of comprehensive assessment of needs for HIV medical and psychosocial support services, including client and providers assessments, an inventory of available resources to meet needs, and assessment of services gaps and unmet needs for HIV-related medical
- A brief summary of the continuum of care;
- Prioritization of Service Needs and Resource Allocation; and
- A Written Plan to Meet the Prioritized Service Needs.

Needs for core medical services (medication, outpatient medical care, mental health services, substance abuse treatment, oral health care and case management) are to be considered for use of CARE Act and SS funds before other eligible categories of services. If no allocations are made to any of the above categories, the plan must specify how these services are to be delivered.

Additionally, DSHS encourages AAs to promote the use of health insurance reimbursement funds to ensure that clients with insurance retain their coverage.

N. SUBCONTRACTING

Administrative Agencies are expected to enter into contracts with service providers and must ensure that subcontracts are in writing and are subject to the requirements of the primary contract.

The Contractor must submit to DSHS all subcontractor information on the forms provided in the RWSD Application (Contract/Subcontract Review and Certification (CRC) form, Subcontractor Data Sheets and a Categorical Budget Justification or Subcontractor Fee for Service form*) 30 days from the contract begin date. **Any additional subcontractors or changes to subcontractor information must be submitted to DSHS on the proper forms within 30 days of the addition or change. Mail one original and three copies to:**

HIV/STD Report Technician
HIV Capacity Building Group
Department of State Health Services
1100 West 49th Street
Austin, Texas 78756-3199

And an additional copy mailed to the Public Health Regional HIV Program Manager.

O. QUALITY MANAGEMENT (QM)

All recipients are required to have a written quality management plan that assesses the quality and appropriateness of the health and support services provided by the contractors and subcontractors and that provides corrective action for identified quality issues.

The quality management process should include participation by representatives from agencies involved in the entire continuum of care, including: state and local governments; health, mental health, and social service providers; minority community-based agencies, community-based organizations, and persons with HIV infection. Additionally, these representatives may participate on the QM committee. The quality management plan must provide for the assessment of the extent that health services provided to patients are consistent with the most recent Public Health Service (PHS) guidelines for the treatment of HIV disease and related opportunistic infection. In addition, the plan must contain strategies for ensuring that health services are consistent with the guidelines for improvement in the access to and quality of HIV health services. An annual evaluation of quality management efforts and the results of those interventions are required. Contractors are required to implement outcomes monitoring according to the HRSA Technical Assistance Guides for Case Management and Ambulatory Care (http://hab.hrsa.gov/tools/QM/). Other services provided are also subject to the requirement for inclusion in the quality management plan, especially if they are support services for medical care. The QM program must cooperate with the DSHS quality management activities including, but not limited to, sending data, participating in studies or audits, responding to queries and complaints, completing corrective action requirements, providing access to staff and client records, documenting improvements and updating the HIV/STD Prevention Services Group on the QM program's progress in quarterly reports.

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* If a subcontractor is adopting unit cost reimbursement, then both a categorical budget justification and a subcontractor fee for service form are required to be submitted.

GLOSSARY HIV-RELATED SERVICE CATEGORIES AND ADMINISTRATIVE SERVICES

(CADR* DEFINITIONS APPLIED)

ADMINISTRATIVE SUPPORT SERVICES**

Administrative functions are activities that Administrative Agencies are asked to report on, are not service oriented and may or may not be administrative in nature, but contribute to or help to improve service delivery.

- Needs Assessment/Planning/Evaluation activities include assessment of service needs and unmet needs, assessment of area service delivery capacity and inventory of available resources, and creation of priorities and allocations to be included in the area Comprehensive Service Delivery Plan (for those AA with planning responsibility). It also includes costs associated with documenting program accomplishments and assessing the impact of programs on clients (outcome measures) s. It also includes costs of maintaining the URS.

- Capacity Building activities are related to improving core competencies that substantially contribute to an organization's ability to deliver effective RW services. Capacity development should increase access to the service system and reduce disparities in care.

- Quality Management activities are related to development of the required quality management plan that assesses the quality and appropriateness of the health and support services provided by the contractors and subcontractors and that provides corrective action for identified quality issues. They should accomplish a three-fold purpose: 1) Assist direct service medical providers in assuring that funded services adhere to established HIV clinical practice standards and Public Health Services (PHS) guidelines; 2) Ensure that strategies for improvements to quality medical care include vital health-related support services in achieving appropriate access and adherence with HIV medical care; and 3) Ensure that available demographic, clinical and primary medical care utilization information is used to monitor HIV-related illnesses and trends in the local epidemic.

- Grantee Administrative Costs activities apply to the administrative agency only. They include a) usual and recognized overhead, including established indirect cost rates, rent, utility, telephone, and other expenses related to administrative staff; expenses such as liability insurance and building-related expenses (e.g., janitorial). b) Management and over-sight of specific programs funded under Title II or State Services. This includes salaries, fringe, and travel expenses of administrative staff, including financial management staff. It does not include direct supervisors of program staff. If an administrator also directly supervises program staff, the actual portion of time devoted to that supervision is excluded. This does not include the salary or fringe of staff devoted to planning support, URS or ARIES data entry or management. c) Other types of program support such as quality assurance, quality control, and related activities. This includes expenses related to monitoring and evaluation and expenses related to hiring of consultants to perform projects related to management improvement of program quality assurance. It does not include planning activities such as needs assessments, priority setting and allocations.

TIER ONE HEALTH CARE SERVICES: Core Services

Ambulatory/outpatient medical care is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where patients generally do not stay overnight. Emergency room services are not outpatient settings. Services includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties).

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

therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.

Drug Reimbursement Program**** is an ongoing service/program to pay for approved pharmaceuticals and/or medications for person with no other payment source. Subcategories include:

- ***Local/Consortium Drug Reimbursement Program*** is a program established, operated, and funded locally by a Title I EMA or a consortium to expand the number of covered medications available to low-income patients and/or to broaden eligibility beyond that established by a State-operated Title II or other State funded drug reimbursement program.

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

Oral health care includes diagnostic, preventive, and therapeutic services provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries, and other trained primary care providers.

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

Substance abuse services–residential are the provision of treatment to address substance abuse problems (including alcohol and/or legal and illegal drugs) in a residential health service setting (short-term).

Case management services are a range of client-centered services that link clients with health care, psychosocial, and other services. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. This definition also includes inpatient case management services that prevent unnecessary hospitalization or that expedite discharge from an inpatient facility. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. Case management may include client-specific advocacy and/or review of utilization of services. This includes any type of case management (e.g., face-to-face).

TIER ONE HEALTH CARE SERVICES: Non-Core Medical Services

Treatment adherence counseling is the provision of counseling or special programs to ensure readiness for, and adherence to, complex HIV/AIDS treatments.

Health Insurance**** is a program of financial assistance for eligible individuals with HIV disease to maintain a continuity of health insurance or to receive medical benefits under a health insurance program.

Rehabilitation services include services provided by a licensed or authorized professional in accordance with an individualized plan of care intended to improve or maintain a client's quality of life and optimal capacity for self-care. Services include physical and occupational therapy, speech pathology, and low-vision training.

Home health care is the provision of therapeutic, diagnostic, supportive and/or compensatory health services as listed in the three categories below. Home health and community-based care does not include inpatient hospital services or nursing home and other long-term care facilities.

- ***Para-professional care*** is the provision of services by a homemaker, home health aide, personal caretaker, or attendant caretaker. This definition also includes non-medical, non-nursing

assistance with cooking and cleaning activities to help clients with disabilities remain in their homes.

- Professional care is the provision of services in the home by licensed health care workers such as nurses.

- Specialized care is the provision of services that include intravenous and aerosolized treatment, parenteral feeding, diagnostic testing, and other high-tech therapies.

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

TIER TWO – ACCESS SERVICES

Housing and housing-related services is the provision of short-term assistance to support temporary or transitional housing to enable an individual or family to gain or maintain medical care. Housing-related services may be housing in medical treatment programs for chronically ill clients (e.g., assisted living facilities), specialized short-term housing, transitional housing, and non-specialized housing for clients who are HIV affected.
Category includes access to short-term emergency housing for homeless people. This also includes assessment, search, placement, and the fees associated with them. NOTE: If housing services include other service categories (e.g., meals, case management, etc.), these services should also be reported in the appropriate service categories.

***Outreach* services** includes programs which 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 (i.e., case finding), not HIV counseling and testing or HIV prevention education. Outreach programs must be planned and delivered in coordination with local HIV prevention outreach programs to avoid duplication of effort; be targeted to populations known through local epidemiologic data to be at disproportionate risk for HIV infection; be conducted at times and in places where there is a high probability that individuals with HIV infection will be reached; and be designed with quantified program reporting that will accommodate local effectiveness evaluation.

Referral for health care/supportive services is the act of directing a client to a service in person or through telephone, written, or other type of communication. Referrals may be made formally from one clinical provider to another, within the case management system by professional case managers, informally through support staff, or as part of an outreach program.

Referral to clinical research is the provision of education about and linkages to clinical research services through academic research institutions or other research service providers. Clinical research are studies in which new treatments—drugs, diagnostics, procedures, vaccines, and other therapies—are tested in people to see if they are safe and effective. All institutions that conduct or support biomedical research involving people must, by Federal regulation, have an institutional review board (IRB) that initially approves and periodically reviews the research.

Transportation services include conveyance services provided, directly or through voucher, to a client so that he or she may access health care or support services.

Early intervention services for Titles I and II are counseling, testing, and referral services to PLWHA who know their status but are not in primary medical care, or who are recently diagnosed and are not in primary medical care for the purpose of facilitating access to HIV related health services.

TIER THREE – SUPPORT SERVICES

Nutritional counseling is provided by a licensed registered dietitian outside of a primary care visit. Nutritional counseling provided by other than a licensed/registered dietitian should be recorded under "Psychosocial support services."

Child care services are the provision of care for the children of clients who are HIV positive while the clients are attending medical or other appointments or attending Title –related meetings, groups, or training. NOTE: This does not include child care while a client is at work.

Child welfare services are the provision of family preservation/unification, foster care, parenting education, and other child welfare services. Services may be designed to prevent the break-up of a family and to reunite family members. Also includes foster care assistance to place children under age 21, whose parents are unable to care for them, in temporary or permanent homes and to sponsor programs for foster families. This category includes other services related to juvenile court proceedings, liaison to child protective services, involvement with child abuse and neglect investigations and proceedings, or actions to terminate parents' rights. Presentation or distribution of information to biological, foster, and adoptive parents, future parents, and/or caretakers of children who are HIV positive about risks and complications, care giving needs, and developmental and emotional needs of children is also included.

Buddy/companion service is an activity provided by volunteers/peers to assist the client with performing household or personal tasks and providing mental and social support to combat the negative effects of loneliness and isolation.

Client advocacy is the provision of advice and assistance obtaining medical, social, community, legal, financial, and other needed services. Advocacy does not involve coordination and follow -up of medical treatments, as case management does.

Psychosocial support services are 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.

Developmental assessment/early intervention services are the provision of professional early interventions by physicians, developmental psychologists, educators, and others in the psychosocial and intellectual development of infants and children. These services involve assessment of an infant's or a child's developmental status and needs in relation to the involvement with the education system, including assessment of educational early intervention services. It includes comprehensive assessment of infants and children, taking into account the effects of chronic conditions associated with HIV, drug exposure, and other factors. Provision of information about access to Head Start services, appropriate educational settings for HIV affected clients, and education/assistance to schools should also be reported in this category.

Day or respite care for adults is the provision of community or home-based, non-medical assistance designed to relieve the primary caregiver responsible for providing day-to-day care of a client.

Emergency financial assistance is the provision of short-term payments to agencies or establishment of voucher programs to assist with emergency expenses related to essential utilities, food (including groceries, food vouchers, and food stamps), and medication when other resources are not available.

Food bank/home-delivered meals are the provision of actual food, meals, or nutritional supplements, or vouchers for the provision of those items. It does not include finances to purchase food or meals. The provision of essential household supplies such as hygiene items and household cleaning supplies should be included in this item.

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

Legal services are the provision of services to individuals with respect to powers of attorney, do-not-resuscitate orders, wills, trusts, instructions for bankruptcy proceedings, and 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 CARE Act. It does not include any legal services that arrange for guardianship or adoption of children after the death of their normal caregiver.

Permanency planning is the provision of services to help clients or families make decisions about placement and care of minor children after the parents/caregivers are deceased or are no longer able to care for them.

Other Support services are direct support services not listed above, such as translation/interpretation services.

*CARE Act Data Reporting (CADR)
**Definitions not included in CADR