PURCHASE ORDER

PO VENDOR SINGLE

PAGE NO: 1
REFERENCE NUMBER: DO 9100 16040811025
P.O DATE: 04/08/16
PRICE AGREEMENT #: MA 9100 NG120000056

VENDOR
Contact unknown
AID0089750 1
AIDS SERVICES OF AUSTIN INC
PO BOX 4874
AUSTIN TX 78765-4874

SHIP TO

BILL TO
Health & Human Services Dept
ACCOUNTING SERVICES
PO BOX 1088
Austin TX 78767

Requestor: Jackie Johnson-Garza, 972-5083
Buyer: See Solicitation, 512-974-2500

The City's standard purchase terms and conditions are hereby incorporated into this order by reference, with the same force and effect as if they were incorporated in full text. The full versions are available at https://www.austintexas.gov/financeonline/vendor_connection/index.cfm#STANDARDBIDDOCUMENTS or call the Purchasing Office at (512) 974-2500. Please include above reference number on all packages, deliveries, and invoices.

Line	Quantity	Unit	Commodity Information / Description (s)	Unit Price	Extended Amount
1			**Commodity:** 94874 HIV Services, Ryan White Part A Execute DO of Amendment 11 for HIV client direct services. FY16-17 Services include HIV Core Medical Formula, HIV Core Medical Supplemental, and HIV Core Medical MAI.	0.000000	$ 788,381.00

Order Total: $ 788,381.00

VENDOR INSTRUCTIONS:

1. SEND ORIGINAL INVOICE WITH DUPLICATE COPY TO THE CITY DEPARTMENT TO WHICH THE GOOD(S) WERE DELIVERED.
2. SHIPPING INSTRUCTIONS: F.O.B. DESTINATION UNLESS OTHERWISE SPECIFIED.
3. NO FEDERAL OR STATE SALES TAX SHALL BE INCLUDED IN PRICES BILLED. LIMITED SALES TAX #74-6000085.

Authorized Agent for City Manager
By acceptance of this purchase order, you agree to comply with the terms and conditions incorporated herein by reference and made a part of this order.

04-08-16
Date

ROUTING SLIP FOR
City of Austin Purchasing

TO: Marty James, Buyer, Purchasing Dept. **FROM:** Greg Bolds, HRAU Manager, HHSD Campus, Bldg. H

DOCUMENT: Amendment #11 for **AIDS Services of Austin, Inc.**- initial award for FY 2016-17 Ryan White **Part A** grant

Vendor Name: AIDS Services of Austin, Inc. **Vendor Code:** AID0089750

(For EXISTING Agreements Only)>> **Agreement (Master Agreement) Number:** MA 9100 **NG120000056**

Annual Agreement Term: March 1, 2016 - Feb. 28, 2017 **Total Agreement Term:** March 1, 2012 - Feb. 28, 2017

Agreement (Term/Amendment) Amount: $788,381.00 **Total Agreement Amount:** $5,888,780.00

(For NEW Agreements Only)>> **Is Agreement Subject to HB1295? (Y/N)**

Competitive Award? (Y/N) **If Yes, Number of Bids Received?**

No. of vendors solicited? **Replaces another MA? (Y/N)** **If Yes, MA Number:**

Commodity Code: **CL Description/Program Name:**

PROGRAM DESCRIPTION:

Continuation of agreement providing HIV direct client services, as funded by the FY 2016-17 initial award share under federal Ryan White Part A grant program

RQM Text: **RQS/RQM No.**

Amendment # 11 for HIV client direct services - FY16 RW Part A/MAI grant

DO Instructions:

Execute amendment and create new Delivery Order (DO) in amount(s) per Commodity Line as indicated within table below

CODE	Fund	Dept	Unit	Object	Grant Program	Program Period	Program Number	Amount
Comm. Line 01 (Part A)	6125	9100	5514	6825		D3Y17	185001	$652,678
Comm. Line 02 (MAI)	6125	9100	5514	6825		D3Y17	185020	$135,703

Encumbrance Period: March 1, 2016 - Feb. 28, 2017

Documents Attached:
- [x] Agreement/Amendment
- [x] Approved Insurance Certificates
- [x] Debarment/Suspension Forms
- [x] RCA/Council Resolution
- [x] Risk Manager approval
- [ ] Form 1295 Certificate

APPROVALS

Requestor: Greg Bolds, Manager, HIV Resources unit **DATE:** 3/17/16

Contract Manager: Hugh Beck, Grants Coordinator, HIV Resources unit **DATE:** 3/14/2016

***(For Agreement Execution Only) I acknowledge that I have sent an electronic copy of the Purchasing Routing Slip for the attached Agreement to the Contract Compliance Unit at HHSDCCU@austintexas.gov and to Glenn Selfe at glenn.selfe@austintexas.gov.**

SSP Research Analyst: **DATE:** 21 MAR 16

SSP Financial Specialist: **DATE:** 3/24/16

SSP Manager: *(Not applicable for HIV grant agreements)* **DATE:**

Deputy Director: for S. Hayden **DATE:** 3/24/16

Budget: **DATE:** 3/25/16

Asst. Director, Admin. Svcs.: **DATE:** 3/28/16

ADDITIONAL INFORMATION:

HHSD Director signature not required. Please return to Hugh Beck, HHSD Campus, Bldg. H (512-972-5079)

AUSTIN CITY COUNCIL

AGENDA

Recommendation for Council Action

Austin City Council		**Item ID**	53207	**Agenda Number**	21.
Meeting Date:	12/17/2015		**Department:**	Health and Human Services	

Subject

Authorize the negotiation and execution of Amendment No. 11 with AIDS SERVICES OF AUSTIN, INC., in an amount not to exceed $65,395 for a revised current 12-month term amount not to exceed $1,321,086 and total contract amount not to exceed $6,356,090.

Amount and Source of Funding

Funding in the amount of $65,395 is available in the Fiscal Year 2014-2015 Approved Operating Budget of the Health and Human Services Department Special Revenue Fund, Ryan White Part A HIV Emergency Relief Program. The grant period is March 1, 2015 to February 28, 2016.

Fiscal Note

A fiscal note is not required.

Purchasing Language:	
Prior Council Action:	On September 8, 2015, Council approved Ordinance No. 20150908-001 adopting the Fiscal Year 2015-2016 Operating Budget. On September 17, 2015, Council approved Part A contract increase.
For More Information:	Shannon Jones, Director, 512-972-5010; Stephanie Hayden, Deputy Director for HHSD Community Services, 972-5017, Greg Bolds, HIV Resources Administration Unit Manager, 972-5081, Elena Lloyd, Agenda Coordinator, 972-5033.
Council Committee, Boards and Commission Action:	
MBE / WBE:	
Related Items:	

Additional Backup Information

The purpose of the Ryan White Part A HIV Emergency Relief Program is to provide support to clients who have been affected by HIV/AIDS and reside in the five-county Austin Transitional Grant Area (TGA) that includes Bastrop, Caldwell, Hays, Travis, and Williamson counties. The program's goal is to assure access to primary medical care and medications, as well as provide critical support services necessary to maintain individuals in the HIV care-system. These services are provided in partnership with local AIDS- services organizations and community-based organizations.

This grant provides direct financial assistance to communities most severely affected by the HIV epidemic. AIDS SERVICES OF AUSTIN, INC. will deliver additional medical and support services to clients in the TGA. This council item is time sensitive to ensure services are continually provided to the community. A delay will negatively affect the services provided to a vulnerable population of persons affected by HIV/AIDS.

Related Department Goal:
Promotion/Prevention/Protection: Promote social services and foster increased self-sufficiency, healthy behaviors, and lifestyle among targeted population.

Performance Measures:

AUSTIN CITY COUNCIL

AGENDA

Recommendation for Council Action

Austin City Council	Item ID	13764	Agenda Number	13.
Meeting Date:	4/5/2012	**Department:**	Health and Human Services	

Subject

Approve negotiation and execution of contracts with the following seven providers of HIV-related services under the Ryan White Part A HIV Emergency Relief Project and MAI Grant Program, all for initial terms of 12 months beginning on March 1, 2012, with up to four one-year renewal options: CENTRAL TEXAS COMMUNITY HEALTH CENTERS, INC., in an amount not to exceed $1,564,716 for the initial term and each renewal term, for a total contract amount not to exceed $7,823,580; AIDS SERVICES OF AUSTIN, INC., in an amount not to exceed $1,120,954 for the initial term and each renewal term, for a total contract amount not to exceed $5,604,770; COMMUNITY ACTION OF CENTRAL TEXAS, INC., in an amount not to exceed $25,000 for the initial term and each renewal term, for a total contract amount not to exceed $125,000; AUSTIN TRAVIS COUNTY INTEGRAL CARE, via an interlocal agreement, in an amount not to exceed $435,602 for the initial term and each renewal term, for a total contract amount not to exceed $2,178,010; PROJECT TRANSITIONS, INC., in an amount not to exceed $77,673 for the initial term and each renewal term, for a total contract amount not to exceed $388,365; THE WRIGHT HOUSE WELLNESS CENTER, in an amount not to exceed $191,288 for the initial term and each renewal term, for a total contract amount not to exceed $956,440, and WATERLOO COUNSELING CENTER, INC., in an amount not to exceed $74,040 for the initial term and each renewal option, for a total contract amount not to exceed $370,200.

Amount and Source of Funding

Funding in the amount of $3,489,273 is available in the Fiscal Year 2011-2012 Operating Budget of the Health and Human Services Department (HHSD) Special Revenue Fund, Ryan White Part A HIV Emergency Relief Project and Minority AIDS Initiative. The grant and contract period is March 1, 2012 to February 28, 2013.

Fiscal Note

There is no unanticipated fiscal impact. A fiscal note is not required.

Purchasing Language:	
Prior Council Action:	Council approved the Fiscal Year 2011-2012 budget September 12, 2011.
For More Information:	Stephanie Hayden, Acting Assistant Director for HHSD Community Services, 972-5017; Greg Bolds, HIV Resources Administration Manager, 972-5081; Chris Crookham, Agenda Coordinator, 972-5010.
Boards and Commission Action:	October 4, 2011 HIV Planning Council approved FY2012 service categories allocation (see attachment A).
MBE / WBE:	
Related Items:	

Additional Backup Information

Contract No. NG 120000056

AMENDMENT NO. 11
TO
CONTRACT BETWEEN THE CITY OF AUSTIN
AND
AIDS Services of Austin, Inc.
FOR PROVISION OF SERVICES UNDER
RYAN WHITE PART A
HIV EMERGENCY RELIEF GRANT PROGRAM
CFDA No. 93.914

1.0 The City of Austin (City) has received a federal Ryan White Part A HIV Emergency Relief Grant from the U.S. Department of Health and Human Services (DHHS), which is administered by the federal Health Resources and Services Administration (HRSA).

On April 5, 2012, the City approved execution of a 12-month contract between the City and AIDS Services of Austin, Inc., a Texas non-profit corporation (Contractor), for the initial term of March 1, 2012 through February 28, 2013, with four 12-month renewal options.

2.0 The City and Contractor hereby agree to amend the above-referenced Contract by the City exercising its fourth renewal term option and increasing the amount for March 1, 2016 through February 28, 2017. There are no remaining 12-month renewal options.

3.0 The total Contract amount is increased by Seven Hundred Eighty Eight Thousand Three Hundred and Eighty One Dollars ($788,381.00) for this renewal option term, as the initial budget allocation for this 12-month term.

4.0 The total Contract authorization, term periods and amounts are summarized below:

Term	Contract Action Amount	Total Contract Amount
Initial term: (03/01/2012 – 02/28/2013)	$ 1,120,954	$ 1,120,954
Amendment No. 1: (03/01/2012 –	$ 174,848	$ 1,295,802

02/28/2013)		
Amendment No. 2: (03/01/2013 – 02/28/2014)	$ 458,500	$ 1,754,302
Amendment No. 3: (03/01/2013-02/28/2014)	$ 787,629	$ 2,541,931
Amendment No. 4: (03/01/2013-02/28/2014)	($ 12,236)	$ 2,529,695
Amendment No. 5: (03/01/2013-02/28/2014)	($ 80,500)	$ 2,449,195
Amendment No. 6: (03/01/2014 – 02/28/2015)	$ 343,625	$ 2,792,819
Amendment No. 7: Renewal Term FY 2014 (03/01/2014 – 02/28/2015)	$ 959,628	$ 3,752,447
Amendment No. 8: Increase for FY 2014 (03/01/2014 – 02/28/2015)	$ 26,866	$ 3,779,313
Amendment No. 9: FY 2015 (03/01/2015 – 02/29/2016)	$ 1,042,600	$ 4,821,913
Amendment No. 10: FY 2015 (03/01/2015 – 02/29/2016)	$ 213,091	$ 5,035,004
Amendment No. 11: FY 2016 (03/01/2016 – 02/28/2017)	$ 788,381	$ 5,823,385

5.0 The following changes have been made to the original contract ATTACHMENTS: Attachment A – Work Statement is deleted in its entirety and replaced with Attachment A – Program Work Statement. [Revised 3/2/2016]

Attachment B -- Performance Measures and Goals is deleted in its entirety and replaced with Attachment B – Program Performance Measures. [Revised 3/2/2016]

Attachment C – Budget Cost Allocation and Justification is deleted in its entirety and replaced with Attachment C – Program Budget and Narrative. [Revised 3/2/2016]

Attachment D -- Performance and Financial Report Delivery Schedule is deleted in its entirety and replaced with Attachment D – Performance and Financial Report Delivery Schedule. [Revised 3/2/2016]

6.0 As outlined in the HRSA HIV/AIDS Bureau (HAB) December 2, 2010 Program Letter (http://hab.hrsa.gov/manageyourgrants/pinspals/preexposureltr1012.pdf), Ryan White

HIV/AIDS Program (RWHAP) funds cannot pay for pre-exposure prophylaxis (PrEP) or non-occupational Post-Exposure Prophylaxis (nPEP) as the person using PrEP is not HIV infected and the person using nPEP is not diagnosed with HIV prior to the exposure and therefor are not eligible for RWHAP funded medication.

7.0 RWHAP funds cannot be used to make cash payments to intended clients of core medical or support services. This prohibition includes cash incentives and cash intended as payment for RWHAP services. Where direct provision of the service is not possible or effective, store gift cards, vouchers, coupons, or tickets that can be exchanged for a specific service or commodity (e.g., food or transportation) must be used. Store gift cards that can be redeemed at one merchant or an affiliated group of merchants for specific goods or services that further the goals and objectives of the RWHAP are also allowable as incentives for eligible program participants. Sub-recipient contractors must administer voucher and store gift card programs in a manner which assures that vouchers or gift cards cannot be exchanged for cash or used for anything other than allowable goods or services, and must have systems in place to account for disbursed vouchers and store gift cards. Note: General-use prepaid are considered "cash equivalent" and are therefore unallowable. Such cards generally bear the logo of a payment network, such as Visa, MasterCard or American Express, and are accepted by any merchant that accepts those credit or debit cards as payments. Gift cards that are cobranded with the logo of a payment network and the logo of a merchant or affiliated group of merchants are general-use prepaid cards, not store gift cards and therefore are also unallowable.

8.0 HRSA requires grant recipients and sub-recipients to use the following acknowledgement and disclaimer on all products produced by HRSA grant funds:

"*This project is/was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number and HIV Emergency Relief Project Grants for grant amount (specify grant number, title, total award amount and percentage financed with nongovernmental sources). This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government"*

Sub-recipient contractors are also required to use this language when issuing statements, press releases, requests for proposals, bid solicitations, and other HRSA supported publications and forums describing projects or programs funded in whole or in part with HRSA funding. Examples of HRSA-supported publications include, but are not limited to, manuals, toolkits, resource guides, case studies and issues briefs.

9.0 The Consolidated Appropriations Act, 2016, Division H, § 202, (P.L. 114-113) enacted December 18, 2015, limits the salary amount that may be awarded and charged to HRSA grants and cooperative agreements to the Federal Executive Pay Scale Level II rate set at $185,100 , effective January 10, 2016. This amount reflects an individual's base salary

exclusive of fringe benefits. An individual's institutional base salary is the annual compensation that the recipient organization pays an individual and excludes any income an individual may be permitted to earn outside the application organization duties. HRSA funds may not be used to pay a salary in excess of this rate. This salary limitation also applies to sub-recipients under a HRSA grant or cooperative agreement. The salary limitation does not apply to payments made to consultants under this award though, as with all costs, those payments, must meet the test of reasonableness and be consistent with recipient's institutional policy. None of the awarded funds may be used to pay an individual's salary at a rate in excess of the salary limitation. Note: an individual's base salary, per se, is NOT constrained by the legislative provision for a limitation of salary. The rate limitation simply limits the amount that may be awarded and charged to HRSA grants and cooperative agreements.

10.0 In any grant-related activity in which family, marital or household considerations are, by statue or regulation, relevant for purposes of determining beneficiary eligibility or participation, grantees must treat same-sex spouses, marriages, and households on the same terms as opposite-sex spouses, marriages, and households, respectively. By "same-sex spouses" US DHHS means individuals of the same sex who entered into marriages that are valid in the jurisdiction where performed, including any of the 50 states, the District of Columbia, or a U.S. territory or in a foreign country, regardless of whether or not the couple resides in a jurisdiction that recognizes same-sex marriage. By "same-sex marriages," US DHHS means marriages between two individuals validly entered into in the jurisdiction where performed, including any of the 50 states, the District of Columbia, or a U.S. territory or in a foreign country, regardless of whether or not the couple resides in a jurisdiction that recognizes same-sex marriage. By "marriage," US DHHS does not mean registered domestic partnerships, civil unions or similar formal relationships recognized under the law of the jurisdiction of celebration as something other than a marriage. This term applies to all grant programs except block grants governed by 45 CFR Part 96 or 45 CFR Part 98, or grant awards made under titles IV-A, XIX, and XXI of the Social Security Act, and grant programs with approved deviations.

11.0 In the event Contractor expends $750,000 or more in a year in federal awards, Contractor shall have a single or program specific audit conducted in accordance with Chapter 200, Subpart F, of Title 2 of the Code of Federal Regulations as required by the Single Audit Act of 1984, as amended (Single Audit Act), and shall submit to the City a complete set of audited financial statements and the auditor's opinion and management letters in accordance with Chapter 200, Subpart F, of Title 2 of the Code of Federal Regulations and any guidance issued by the federal Office of Management and Budget covering Contractor's fiscal year until the end of the term of this Agreement.

Agencies must submit copies of these audits, if required, in accordance with 45 CFR Part 75, to:
Instructions, account setup, and forms link:
https://harvester.census.gov/facides/(S(4yuhvcdxh1kbi4ahkrs4ci5e))/account/login.aspx

General information link: https://harvester.census.gov/facweb/Default.aspx

Federal Audit Clearinghouse, Bureau of the Census
1201 East 10th Street Jefferson, IN 47132
phone: (310) 457-1551
(800) 253-0696 toll free

12.0 In the FY 2012 full contract boilerplate; Remove Item 5 on p. 4 and replace with:

5. Contractor agrees to participate in HHSD Clinical Quality Improvement Management Program including site visits, Clinical Quality Improvement Management Committee and subcommittee meetings, needs assessments, annual client satisfaction surveys with survey minimum of 15 percent of unduplicated client count on most recent Ryan White Services Report (RSR), service utilization reviews, and other case reviews and chart audits as identified by HHSD through the Clinical Quality Improvement Process. Contractor agrees to actively participate in and use the Plan, Do, Study, Act (PDSA) model for service improvements. Contractor agrees to participate in quality improvement training or meetings conducted by the Austin Area Comprehensive HIV Planning Council and the HHSD. Contractor agrees to provide the HHSD with a Contractor-specific Clinical Quality Improvement Plan that is updated annually, reflects changes/improvements in care, addresses identified client needs, and is consistent with the overall Austin Transitional Grant Area (TGA) Quality Management Plan and Quality Goals. Contractor will provide a copy of this plan to the City's Contract Manager of the Austin TGA no later than ninety (90) calendar days of the effective date of this Agreement. Contractor has reviewed the Austin TGA Quality Management Plan and Quality Goals, agrees to comply with them, and they are incorporated by reference.

13.0 In accordance with the RWHAP client eligibility determination and recertification requirements (Policy 13-02), HRSA expects clients' eligibility be assessed during the initial eligibility determination, at least every six months, and at least once a year (whether defined as a 12-month period or calendar year) to ensure that the program only serves eligible clients, and that the RWHAP is the payer of last resort. Recipients are not allowed to provide RWHAP services under presumptive eligibility; eligibility must be confirmed prior to enrollment/recertification. Contractor must notify City within fifteen (15) days of determining a client is deemed ineligible for services under RWHAP. In such cases all costs paid by RWHAP must be credited back to RWHAP within 60 days of incurring the expense.

14.0 Minority Business Enterprises/Women's Business Enterprises (MBE/WBE) goals were not established for this Contract.

15.0 Pursuant to Office of Management and Budget (OMB) circular #087-2004/#31, the City will allow eligible pre-award and pre-contract costs incurred by Contractor for ninety (90) days following the effective date of this Contract term.

16.0 Based upon the criteria in the City of Austin Living Wage Resolution #020509-91, the Living Wage requirement does not apply to this Agreement.

17.0 By signing this Contract, the Contractor warrants that Contractor and its principals or officers are not currently suspended or debarred from doing business with the Federal government as indicated by the Exclusion records found at SAM.gov, the State of Texas, or the City of Austin.

18.0 All other terms and conditions remain the same.

BY THE SIGNATURES affixed below, this Amendment is hereby incorporated into and made a part of the above-referenced Contract.

CONTRACTOR:

Signature Paul S. Scott

Print Name: Paul Scott

Title: Executive Director
Authorized Representative
AIDS Services of Austin
7213 Cameron Road
Austin, TX 78752

Date March 31, 2016

CITY:

Signature

Print Name MARTY JAMES

Title BUYER II
City of Austin
Purchasing Office
P.O. Box 1088
Austin, Texas 78767

Date 04/07, 2016

Risk Management Insurance Summary for Human Services ("RM Summary for HHSD")

Contract 2015-16
AIDS Services of Austin – Ryan White Part A
March 23, 2016

Issue Date: 1/6/16

General Liability
Limits- ok
Additional Insured – ok
Waiver of Subrogation - ok
Thirty Day Notice of Cancellation – ok
Sexual Abuse & Molestation – *Not Required; Scope of Work*

Auto Liability
Limits - ok
Additional Insured - ok
Waiver of Subrogation - ok
Thirty Day Notice of Cancellation - ok

Workers Compensation
Limits - ok
Waiver of Subrogation - ok
Thirty Day Notice of Cancellation – ok

Professional Liability
Limit – ok

Crime Insurance
Limit – $2,446,878 yes $1,983,784

Directors & Officers Liability
Limit - ok

Risk Management approves the evidence of coverage as submitted.

Please confirm the limit shown for Crime Insurance is adequate. A note on this form with your initials is adequate documentation.

Benny VandenAvond
City of Austin Risk Management

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 6/16/2015

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER	CONTACT NAME: Carol Manhart
Stephens Insurance, LLC 100 Congress Ave Suite 750 Austin TX 78701	PHONE (A/C, No, Ext): (512) 542-3207 FAX (A/C, No): (512) 542-3238 E-MAIL ADDRESS: carol.manhart@stephens.com
INSURED	INSURER(S) AFFORDING COVERAGE / NAIC #
A.I.D.S. Services of Austin, Inc. P.O. Box 4874 Austin TX 78765	INSURER A: Philadelphia Indemnity Insurance 18058 INSURER B: Texas Mutual Insurance Company INSURER C: Federal Insurance Company 20281 INSURER D: INSURER E: INSURER F:

COVERAGES **CERTIFICATE NUMBER:** CL1561609821 **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	X COMMERCIAL GENERAL LIABILITY CLAIMS-MADE X OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: X POLICY PRO-JECT LOC OTHER:	X	Y	PHPK1349963	6/18/2015	6/18/2016	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ 1,000,000 $ 100,000 $ 5,000 $ 1,000,000 $ 3,000,000 $ 3,000,000
A	AUTOMOBILE LIABILITY X ANY AUTO ALL OWNED AUTOS SCHEDULED AUTOS HIRED AUTOS NON-OWNED AUTOS	X	Y	PHPK1349963	6/18/2015	6/18/2016	COMBINED SINGLE LIMIT Ea accident BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE Per accident	$ 1,000,000 $ $ $
A	X UMBRELLA LIAB X OCCUR EXCESS LIAB CLAIMS-MADE DED X RETENTION $ 10,000			PHUB502935	6/18/2015	6/18/2016	EACH OCCURRENCE AGGREGATE	$ 3,000,000 $ 3,000,000
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	N/A	Y	TSF0001063916	6/18/2015	6/18/2016	X PER STATUTE OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	$ 1,000,000 $ 1,000,000 $ 1,000,000
C	Directors & Officers			82428799	6/18/2015	6/18/2016	Each Claim/Aggregate	$2mil/$2mil
A	Professional Liability			PHPK1349963	6/18/2015	6/18/2016	Each Incident/Aggregate	$1mil/$3mil

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

CERTIFICATE HOLDER

City of Austin
Attn: HIV Resources Administration
7201 Levander Loop
Building H
Austin, TX 78702

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

Greg Meserole/WOAL

COMMENTS/REMARKS

30 day Notice of Cancellation is provided to Certificate Holder per written contract or agreement. Subject to policy terms, conditions, and exclusions.

Additional Named Insureds

Other Named Insureds	
A.I.D.S. Services of Austin, Inc	Doing Business As
AIDS Services of Austin Inc 403(b) Plan	Other, Additional Named Insured

USER NAME PASSWORD

LOG IN

Forgot Username? Forgot Password?

Create an Account

Entity Dashboard

Entity Overview

Entity Record

Core Data

Assertions

Reps & Certs

POCs

Reports

Service Contract Report

BioPreferred Report

Exclusions

Active Exclusions

Inactive Exclusions

Excluded Family Members

RETURN TO SEARCH

AIDS SERVICES OF AUSTIN, INC
DUNS: 782220941 CAGE Code: 356A8
Status: Active

7215 CAMERON RD
AUSTIN, TX, 78752-2911,
UNITED STATES

Expiration Date: 04/26/2016
Purpose of Registration: All Awards

Entity Overview

Entity Information

Name: AIDS SERVICES OF AUSTIN, INC
Business Type: Business or Organization
POC Name: Paul Scott
Registration Status: Active
Activation Date: 04/27/2015
Expiration Date: 04/26/2016

Exclusions

Active Exclusion Records? No

ATTACHMENT A

STATEMENT OF WORK

Work Statement

Service Category Name

Food Bank Services

Client Eligibility

To qualify for Food Bank Services through Ryan White Part A funding, clients must be case-managed at AIDS Services of Austin (ASA) or another AIDS Services Organization. Clients who receive case management at other agencies are screened for eligibility and need by those agencies through an interagency referral form and referred to ASA for a complete intake. Eligibility and Intake staff verifies that they are being case managed. It is the responsibility of the organization providing case management and the client to provide updated eligibility information at six month intervals.

In order to enter ASA case management services, clients must be HIV positive, a resident of the five county area in the Austin Transitional Grant Area (Travis, Williamson, Bastrop, Hays, and Caldwell), and willing to work on HIV service plan goals. Preference is given to clients who are symptomatic with HIV disease or have an AIDS diagnosis.

ASA has Eligibility and Intake staff specifically trained to determine clients' level of need for services and eligibility status (every 6 months) for all ASA programs as well as programs at partner HIV services organizations and other social service organizations. ASA's Eligibility and Intake staff determine eligibility by securing verification of HIV status and residency. Staff will secure proof of identity, income, and insurance status as required intake documents.

i. **Documentation of HIV Status:** Staff obtain verification of HIV status through:
   - a signed statement from the medical provider;
   - a positive Western Blot laboratory result with the name of the client;
   - a printed document from the ARIES database indicating verification of HIV status by another provider;
   - HIV detectable viral load lab results; or,
   - a hospital discharge summary or medical records from previous provider(s).

ii. **Proof of Identity:** Proof of identity includes: Texas driver's license, Texas State identification card, a passport, Military or Student identification card, Social Security card, birth certificate or other official document as listed on the Austin TGA Ryan White Client Eligibility Form

iii. **Residency Verification:** In order to establish residency, clients can provide unexpired documents such as a Texas driver's license, Texas State or Tribal identification cards, Social Security award letter, rental/mortgage agreement, utility bill, or similar forms accepted by the Ryan White Part A Austin TGA.

Documentation of HIV status must be presented within 30 days and residency documentation must be presented within 60 days. Clients may be granted conditional eligibility if they present with an urgent need and lack the necessary eligibility documentation. ASA will make reasonable efforts to assist clients in obtaining the necessary documentation.

iv. **Income Verification: S**taff use the MAGI or Mock MAGI form for client income verification. Clients that have filed a tax return in the previous year complete the MAGI form and submit their tax transcript as income verification. Clients that did not submit a tax return or have had a change in income complete a Mock MAGI form and submit an IRS proof of non-filing and income verification document. Income verification documents include Social Security Award letter, Veterans/Public Assistance or Worker's Compensation benefits statements, wage payment stubs, signed zero income verification letter or other document listed in the Austin TGA Ryan White Part A Client Eligibility Form. There are some populations that are excluded from having to obtain tax transcripts or IRS proof of non-filing, these include: homeless, recently released from incarceration (3 months), undocumented, emancipated minors, and SSI and/or SSDI recipients. Food Bank clients must be at or below 150 percent of the federal poverty line to qualify. The Food and Nutritional Services Manager will approve Food Bank income eligibility, on a case by case basis, for clients at or below 200 percent of FPL when they are experiencing serious co-morbidities, or a weight decrease of 10 percent or more than 125 percent above ideal body weight.

v. **Health Insurance Coverage:** Cards verifying coverage by private medical insurance, Medicare, Medicaid, Veteran's Health Benefits, and Indian Health services will be accepted. Signed no insurance attestation statements will also be accepted. Should a client receive City of Austin Medical Assistance Program (MAP), a copy of the card will be made and a attestation of no insurance will be signed.

Diagnoses that increase nutritional risk may include but are not limited to:

- Scheduled chemotherapy or radiation for cancer treatment;
- Acute or chronic renal failure;
- Visible unintentional wasting
- Recent hospitalization, or emergency room visit for opportunistic infection or other destabilizing health situation;
- Recent diagnosis of opportunistic infection;
- Persistent albumin less than 3.5 or pre-albumin less than 19;
- Severe difficulty in chewing or swallowing;
- Severe thrush.
- CD4 count of 200 or less in last three years

When determining income eligibility for clients at increased nutritional risk, cost of medical expenses such as medications, health care premiums, and medical expense deductibles, or medical provider co-payments will be deducted from client income

prior to calculating the income percentage of FPL. This allows clients more resources to purchase nutrient-rich food in order to reach an acceptable level of nutritional status.

Eligibility and Intake Staff will use the Austin TGA Ryan White Part A Client Eligibility Form to reassess clients in the program every six months for determination of continued eligibility. At that time, client residency, income, and health insurance will be updated and/or new documentation obtained as indicated. Clients presenting with a change to income, residency or health insurance status within the six month review period will complete the Change in Circumstances: Eligibility Verification Addendum form. All required eligibility and intake documents, as well as periodic updates, are stored in the client's paper file and documented electronically in the agency's electronic client database, Provide Enterprise®. Client identifying information is also entered into the ARIES client database. Eligibility and Intake staff completes a form verifying eligibility documents were collected, and an administrative assistant enters this data into ARIES.

Clients may continue to access food bank services as long as they remain eligible for the service.

Target Population

The target population for AIDS Services of Austin's (ASA) Food Bank Services program is low-income[1] people residing in the five counties of the Austin Transitional Grant Area (TGA) (Travis, Williamson, Bastrop, Hayes, and Caldwell). The following table (Table 1) compares the 2015 calendar year demographics of ASA's Food Bank program to the demographics of people living with HIV and AIDS in the Austin TGA. Table 1 illustrates ASA's work in reaching women, people of color, and people aging with HIV and AIDS.

Table 1

	ASA Clients	**Austin TGA PLWH/A**
Gender		
Male	56%	85%
Female	40%	15%
Transgender	4%	(unavailable)
Race/Ethnicity		
White	36%	46%
Black	32%	22%
Hispanic	28%	29%
Other	4%	3%

[1] At or below 150 percent of the Federal Poverty Guideline

	ASA Clients	Austin TGA PLWH/A
Age Group		
0 – 12	0%	0%
13 – 24	0%	4%
25 – 34	16%	17%
35 – 44	20%	27%
45 – 54	40%	34%
55 and over	24%	18%

Table 2

ASA Top 10 Client Zip Codes	Prevalence Range of HIV/AIDS
78723	675-1,199/100,000
78741	314-674/100,000
78752	675-1,199/100,000
78702	675-1,199/100,000
78753	314-674/100,000
78758	675-1,199/100,000
78704	115-313/100,000
78744	314-674/100,000
78756	314-674/100,000
78724	115-313/100,000

Austin TGA data suggest that 84 percent of clients have medical comorbidities, while others report social and health-related co-factors that complicate medical and other service delivery for HIV.[2] Recent studies have shown that 67 to 96 percent of HIV positive individuals have comorbidities.[3] Co-morbidities and conditions for the Food Bank program's target population include STDs, substance abuse, mental health issues, commercial sex work, poverty, homelessness, domestic violence, Hepatitis B and C, heart disease, diabetes, and tuberculosis (TB).

Service Category Activities

Service activities linked to Budget Justification

AIDS Services of Austin (ASA) has been implementing a food pantry program since 1987. Given ASA's history of providing this program in the Austin TGA, necessary mechanisms for implementation are already in place. Long-standing mechanisms include:

- A Board of Directors and strong organizational governance structure

[2] ARIES database, provided by the City of Austin (Addendum 5 to Ryan White Part A RFA 2012-13)
[3] "Prevalence and Patient Awareness of Medical Comorbidities in an Urban AIDS Clinic," Weiss, Jeffery J., PhD, et al

- An experienced leadership team
- Trained and experienced staff (see *Staffing* section)
- A physical location near public transportation and well-known in the HIV field
- A programmatic structure offering a comprehensive continuum of care including HIV Prevention, Outreach Services, Case Management (medical and non-medical), Food Bank, Medical Nutrition Therapy, Oral Health Care, Health Insurance Assistance, special programs for women living with HIV and AIDS and legal services
- Strong community partnerships providing access to services not offered at ASA

The primary tasks and activities necessary to accomplish the program plan for Food Bank services are:

- ***Screen for eligibility and need, complete Food Bank intake and refer clients into services***

Initial screening for eligibility is performed by Eligibility and Intake staff, which uses the Eligibility for Services Screen. This screening tool inquires about clients' current health status, the name of a primary medical care provider and immediate interest in accessing ASA's services, including food bank services, and screening for eligibility for food stamps, Medicaid, Medicare or Veteran's Health Benefits. Eligibility and Intake staff determine eligibility for services by securing proof of HIV status, residency, food stamp eligibility, and income.

Once the Eligibility and Intake staff confirms eligibility and client need, they complete the Food Bank Intake Form and set up the client profile in the electronic database.. The Eligibility staff also provides clients who are new to services with a brief overview of Food & Nutrition Services and the Helping Hands Food Bank, along with a calendar written in English and Spanish, indicating days and hours of operation.

Eligibility and Intake staff scores clients using the Nutritional Health Risk Screen tool. For those clients scoring a five or higher on the tool, staff schedules an appointment with the Dietitian, which begins the Medical Nutrition Therapy (MNT) intervention process. MNT is a valuable service enhancement to the food bank program, currently funded by Ryan White Part A.

During eligibility, screening, and intake services, clients are also referred to an appropriate level of assistance in ASA's Case Management Program using the acuity guidelines as defined by the Standards of Care in the Austin TGA continuum of care. Case Managers assist clients with developing a service plan, which includes access to food bank services. Eligible clients who request help with food are referred to the food bank. Clients who are case managed at other AIDS service organizations (ASOs) are screened for eligibility and need by those agencies and are referred to ASA if eligible. Eligibility and Intake staff verify that clients are case managed outside the agency and relay clients' level of health risk to food bank staff and the Dietitian.

Since ASA is the primary Food Bank program specifically for PLWHA, there is no risk for duplication of services. While Project Transitions (PT) offers food pantry services, the program

is only open and available to those residing at PT. Addionally; ASA's Food Bank is a supplemental program and encourages clients to access alternative food bank programs to supplement their remaining nutritional needs.

- ***Meet with food bank staff and delivery of initial food allotment***

Once the client is deemed eligible for food bank services, the client is free to access food allotments twice per month on a convenient day and time during business hours – Tuesday (2-7pm), Wednesday (1-5pm), or Thursday (12-4pm). The client then completes a food bank menu, with assistance from the Food bank staff and volunteers as needed, which is designed to provide nutritional balance and variety of choice. Based on analysis by the Dietitian and food bank staff, a unit of service of food provides a client with a variety of foods that last seven days, depending on client selection. Staff retains completed menus for one year and keeps blank menu templates indefinitely in electronic files.

ASA menus are developed and organized in such a way that clients may choose items from different food groups with allotment limits per food group such as dairy, meats, beans, eggs, grains, vegetables, fruits, etc. After clients have made their menu selections, a volunteer pulls the individual items off the shelves to make an allotment. When the client's order is complete, a second volunteer checks the order against the items pulled from the shelves and the menu of items the client selected. This check and balance system ensures accuracy and client satisfaction with services.

If a client is physically unable to enter the facility or is considered homebound, the Case Manager will contact the client and fill out the menu, pull the order and deliver the order to the client while the client remains outside of the facility or at home. Case Managers can also provide food outside of food bank distribution hours on a case by case basis and in an approved emergency situation.

- ***Plan menu, order, purchase and stock food, nutritional supplements and personal hygiene items***

Food bank staff plans menus and orders food items in accordance with American Dietetic Association HIV Practice Group guidelines. Products cycle onto menus according to nutritional content and balance, seasonal variation, availability, and cost. Ordering and purchasing begins with the Capital Area Food Bank (CAFB), which offers food items at or below cost. The Dietitian still does an annual menu analysis and sets goals for the following year based on the results and findings. The Dietitian also makes recommendations for improving the menu choices in order to reach the goal(s).Through a partnership with Meals on Wheels Association of America, ASA purchases nutritional supplements at a discounted rate.

- ***How Clients Receive Food Bank Services***

Clients may access the Food Bank twice per month during business hours as previously listed. Case Managers or volunteers deliver food to homebound clients during the weeks that the food bank is open. Case Managers can also provide food outside of Food Bank distribution hours and dates on a case by case basis and in an emergency.

When they visit the Food Bank, clients receive a menu designed to provide nutritional balance and variety of choice. Written menus are provided in both English and Spanish. Staff or volunteers are available to assist clients with low literacy levels or visual impairments. Based on analysis by the Dietitian and Food Bank staff, a unit of service of food provides a client with a healthy variety of foods that last seven days, depending on client selection. Staff retains completed menus in locked cabinets for one year and keeps blank menu templates indefinitely in electronic files.

The Food Bank menu offers nutritionally sound choices. The Food & Nutrition Services Manager, with the support from the Food Bank Coordinator, is in charge of planning, ordering, and purchasing nutritional products such as seasonal fruits; vegetables and herbs; grains and cereals; foods high in protein to meet the requirements such as meat, fish, poultry and legumes; dairy products and nutritional products convenient to prepare yet highly nutritious such as nuts and dried fruits.

In addition to quality nutritional products, the Food Bank program offers personal and household products such as quality tooth brushes, floss, and toothpaste approved for use by the Dental Clinic's Registered Dental Hygienist; deodorant, shaving supplies, body lotion, laundry detergent, household cleaning supplies, toilet paper, paper towels, foil, and other similar items. These products help to offset the limited income of clients accessing the Food Bank program.

- ***Maintain client files as needed to deliver care, access services***

ASA's Eligibility and Intake staff open a client file in the agency's automated client tracking system, Provide Enterprise®, and a paper file for clients case managed at non-ASA agencies. When clients access food bank services, the Data Entry Specialist enters this information into the system.

- ***Review documentation for quality assurance and alter program as needed***

Once a year, the Dietitian conducts a nutrient analysis on completed menus selected at random, documents and interprets results, and makes recommendations for adjustments to current menu selections based on findings. The process is designed to ensure quality and nutritional value of foodstuffs. Program supervisors review the analysis of nutrients with the Dietitian and optimize the service by adjusting product selection. Supervisors monitor program operations for continuous quality improvement. ASA conducts an annual agency satisfaction survey. The Data Analyst at the HIV Resource Administration Unit, City of Austin Health and Human Services tabulates satisfaction results and forwards the data summary to the Food Bank and Nutrition Services Manager. This Manager, in turn, identifies trends in survey data within one month of receiving the data and makes feasible adjustments to the program based on client input.

- ***Flexibility and sensitivity to varying individual circumstances, including cultural sensitivity***

Staff provides food and nutritional supplements outside food bank distribution hours on a case

by case basis and in an emergency. Through client feedback, staff makes changes to the menu and makes allowances based on availability, cost, and feasibility. ASA provides a variety of foods to meet preferences based on the cultural diversity of the community, including various types of beans, rice, wheat tortillas, collard greens, and kale, as well as seasonings such as parsley, peppers, limes, lemons, cilantro, garlic, jalapeno peppers, and paprika. The staff or volunteers take suggestions from clients and adjustments to the menu are done based on availability and feasibility.
Frequency of these service activities Clients may access the Food Bank when it is open twice per month during Food Bank scheduled hours–Tuesday (2-7pm), Wednesday (1-5pm), or Thursday (12-4pm).
Location(s) of these service activities The Food Bank is located at ASA's primary facility – 7215 Cameron Road, Austin, TX 78752

Staffing

The Associate Director of Direct Services supervises the Food and Nutrition Services Manager. The Food and Nutrition Services Manager supervises the Dietitian, and the Food Bank Coordinator. The Food Bank Coordinator supervises the program volunteers. The Associate Director is responsible for the overall program design, development, implementation, and evaluation. This staff person interfaces with the Austin/Travis County Health and Human Services Department (A/TCHHSD), Health Resources Administration Unit on programmatic issues such as outcome and output measures. The Food and Nutrition Services Manager is responsible for supervising staff and oversight of volunteers, monitoring and evaluating program design, and program development and implementation.

The Executive Director is the primary contact with the City of Austin Health and Human Services Department (AHHSD) HIV Resource Administration Unit and has final authority in negotiating and approving contracts. The Chief Programs Officer interacts with AHHSD on matters relating to programs and is authorized to enter into negotiations with AHHSD regarding program issues, grant reporting, and performance measures. The Chief Financial Officer interfaces with AHHSD HIV Resource Administration on grant billings. The Grants Manager ensures contract compliance.

Staff qualifications, primary work assignment, and percentage of time allocated to this service are reflected in the following chart:

Table 4

Name/Position	Qualifications	Primary Work Assignment	% Time Allocated

Name/Position	Qualifications	Primary Work Assignment	% Time Allocated
Chavez/Associate Director of Direct Services	BA in Psychology: over 13 years of experience in mental health services and case management, 6 years of working experience with low-income and high-risk populations in the HIV/AIDS field; and 10 years of managerial/supervisory experience.	Provides overall management and direction of all direct services programs. Develops program content and supervises program coordinators. Responsible for recruiting, training, and staff retention.	0.9%
Simmons/Food & Nutrition Services Manager	Bachelors of Arts in Communications; Experience in management and supervision; Over 10 years experience in Food and Nutrition Field; Experience with low-income and high risk populations in the HIV/AIDS field; responsible for purchasing, food donations and nutritional quality. Completed Capital Area Food Bank training on Civil Rights and Discrimination; Safe Food Handling; Reporting and Policies/Procedures. Completed SafeServe training; Certified Food Manager.	Plans, coordinates, assesses, evaluates and manages daily operations of Food Bank and Medical Nutritional Therapy programs, supervises Dietitian, Food Bank Volunteer Coordinator and food bank volunteers, responsible for food acquisition, food and nutrition program quality assurance activities, checks data reports on performance activity and generates reports. Conducts quality assurance activities. Member of QMGT and Management Team	24.72%
Searight/Food Bank Coordinator	Bachelors of Arts in Global Studies, experience with HIV, low-income people, and people of color; 2.5 years experience with immigrants and people experiencing homelessness; proficient in Spanish.	Delivers food bank services directly to clients; interviews, selects, and trains food bank volunteers; receives foodstuffs and dry goods from a variety of vendors and donors; and, assists with food bank daily operations; drives truck	25.8%
Casstevens/Access Services Administrative Assistant	23 years with ASA; 8 years of banking experience; experience with AIDS care teams and vulnerable populations with chronic illness	Provides direct support to Food Bank and Medical Nutrition Therapy through coordinating required eligibility documents for interagency clients.	1.03%
Medina/Intake Coordinator	BSW; 1 year at ASA, including experience with mental health, low-income people, and people of color.	Performs eligibility and intake, makes referrals and provides information, performs quality assurance activities.	1.33%
Marquette/Dietitian	Registered Dietitian, Licensed Dietitian, Certified LEAP Therapist; Bachelor of Science Degree in Dietetics with a	Provides scheduled, walk-in, and referred Medical Nutritional Therapy, counseling and assessments for	1.83%

Name/Position	Qualifications	Primary Work Assignment	% Time Allocated
	major in Nutrition from the University of Texas; certified Health Fitness Specialist through the American College of Sports Medicine; advanced certification in Food Sensitivities; more than 40 hours of additional training in the management of Polycystic Ovarian Syndrome; trained in intrinsic coaching® methodology; USA Fit certified marathon coach; bilingual.	HIV+ persons; performs body composition analysis using BIA and assesses indicators of nutritional health change as reported by clients; instructs clients on appropriate diets for chronic diseases related to lifestyle assesses special nutritional needs of clients with advanced HIV disease and AIDS and recommends optimal nutritional supplementation, provides comprehensive nutrition analysis of foodstuffs annually and quality assurance of stock quarterly, provides individual nutrition education.	

- The supervisor to staff ratio is 0.009 to 0.547 FTE.

Table 5

Number of Volunteers	~/year138 year
Number of Volunteer Hours	~/year (5,500)year
Volunteer Responsibilities	Receive bulk food deliveries, rotate products, stock shelves, breakdown/repackage bulk items for individual distribution, assist clients with menu selections, quality assurance of menu selections, deliver food to homebound clients, and carry food to client transportation. See below for further description.

Approximately 25 to 35 volunteers work in the Food Bank in any given month and about 45 percent of these volunteers are persons of color. For clients accessing services, these volunteers are the "face" of the food bank program. Each month, volunteers collectively provide an average of 458 hours of support, ranging from receiving bulk food deliveries, product rotation and shelf stocking, portion breakdown of bulk items/repackaging for individual allotment distribution, direct assistance for clients with menu selections and delivery of food items, checking orders for quality assurance before final delivery, food delivery and grocery carryout, and providing home deliveries to homebound clients. Other duties include regular cleaning and sanitation of equipment and food preparation areas; checking and logging refrigeration temperatures; documenting damaged and/or spoiled stock and disposing of it; picking up donated items from area businesses, schools, and neighborhood associations; preparing packages of miscellaneous stock for distribution as an extra give away item, and hosting food drives. The 458 hour average of volunteer support each month accounts for 5,496 hours per year. At an hourly in-kind rate of

$23.40, per Independent Sector, a nonpartisan coalition of organizations, these volunteers contribute $128,606 to ASA annually and are essential to maintaining Food Bank operations.

The Food Bank program does not use subcontractors.

ASA's Food Bank program addresses cultural and linguistic barriers by hiring staff and recruiting volunteers that reflect the demographics of HIV and have experience and training in cultural competency, providing services that are responsive to cultural needs, and establishing ongoing training opportunities for staff and volunteers.

The agency continuously works to recruit volunteers from culturally diverse populations. On-site Case Managers are available to assist Spanish-speaking clients. Services are provided by request in American Sign Language, and deaf interpreting services can be provided for deaf Spanish-speaking clients. Interpretation in the preferred language of the client is offered at no cost to the client. All Food Bank menus and quarterly operations calendars are provided in both English and Spanish. Handouts, notices, and most educational materials are provided in English and Spanish. The Food Bank team has over 35 years of combined experience in serving the needs of individuals with HIV and AIDS.

Client Access

Eligible clients are referred to the Food Bank program by AIDS Services of Austin (ASA) Eligibility and Intake staff, ASA case managers, or case managers from other AIDS Services Organizations. Current—and potential—clients for the ASA's programs are located and identified through Ryan White Part A Outreach Program Services. Outreach staff identify individuals with unknown HIV status and those with known HIV positive status who are late to care or "out-of-care." *HRSA defines an individual as being out-of-care if there is no evidence of a client accessing any one of the following three components of HIV primary medical care during a defined 12-month time frame: viral load testing, CD4 count, or provision of anti-retroviral therapy.*

- **Area Hospitals and Emergency Rooms:** AIDS Services of Austin (ASA) Outreach team members are placed at area hospitals to train staff in referring to agency programs and to follow-up on referrals made by hospital staff. Outreach is called at least biweekly to link HIV positive individuals to medical care and support services such as Case Management Non-Medical . Hospitals identified include University Medical Center Brackenridge, and Seton Medical Center Austin of the Seton Family of Hospitals; and St David's Medical Center, St. David's North Austin Medical Center, and St. David's South Austin Medical Center. Outreach workers visit these hospitals and emergency rooms at the frequency of contact and hours agreed upon with hospital staff.

- **Correctional Facilities:** At Travis County Correctional Complex (TCCC), Travis State Jail, and Del Valle Correctional Facility, ASA outreach team members identify at-risk for

HIV or HIV positive individuals who are pre-release from incarceration or recently released from incarceration and link them into medical and supportive services. Outreach workers engage in a broad range of activities include working with correctional facility staff to refer HIV positive individuals.

Outreach staff receiving service inquiry letters from HIV positive individuals due to be released encourages those individuals to contact the agency upon release. Once contacted, the outreach staff immediately begins the process of linking the individual to medical care and with Case Managers. In cases where a person who has been recently released comes to or phones the agency directly, staff is deployed to the site of preference as identified by the individual who is contacting the agency for services.

- **CommUnity Care at David Power Clinic:** Several times monthly or sometimes on a weekly basis, Outreach staff links identified HIV positive individuals to primary medical care . Staff provides targeted individuals with a transition from outreach to case management services through building on the trust already established during outreach.

- **Community and Peer Referrals:** Due to the high quality of services provided by ASA, 14 percent of clients that receive case management intake assessments identify themselves and initiate contact for services as a result of referrals from family, friends, or peers who have received agency services. For the same reason, 24 percent of clients are referred to case management from local health care providers.

- **ASA Prevention Programs:** ASA offers a variety of HIV prevention and testing programs that reach over 7,500 individuals annually. Prevention programs include:
  - Mpowerment, a prevention program for young gay, bisexual, and questioning men;
  - Healthy Relationships, an evidence-based intervention focused on prevention with positives;
  - HIV testing;
  - Hepatitis C and syphilis testing for targeted populations;
  - Linkage to care and patient navigation;
  - Condom Distribution Network;
  - Testing, Linkage, and Care, a program that brings HIV testing to sites where high risk populations frequent; and,
  - CLEAR, a risk reduction counseling program.

  All of ASA's Prevention programs refer HIV positive individuals into Outreach services or case management services through eligibility and intake.

- **Other:** ASA receives referrals through the United Way's 211, a non-emergency human services access phone line. ASA also receives referrals through HIV service directories. Please see *Section k. Other Linkages, Collaboration, and Referrals* for further description of ASA's referral system.

Clients will begin access to Food Bank services when they are enrolled in case management services and meet eligibility requirements. As described in *Section e. Service Category Activities*, Eligibility and Intake staff completes service eligibility screening to determine appropriateness for the program. They conduct eligibility screenings and assessments Monday through Friday primarily during agency business hours (8:30 am to 5:30 pm) and outside business hours as necessary. Eligibility and Intake staff strives to schedule intake appointments within one week of initial contact and rarely allows for a wait time of more than two weeks. The Non-Medical Case Managers will contact clients referred into their services within two weeks of the referral, at a minimum, with exceptions noted.

Access Barriers and Reducing Barriers to Access

One of the most difficult barriers to service delivery is lack of basic needs, such as food, housing, and transportation, which interferes with the client focusing on linkage to access medical case management, medical care and supportive services. Other barriers are described below. Case management staff assists clients in overcoming barriers.

Table 10

Barrier	Description of Reduction/Elimination of Barrier
Eligibility Documentation	1. Eligibility and Intake staff or case managers provide reasonable assistance to clients to obtain identifying documentation. 2. Documentation may be a challenge for undocumented Hispanics or homeless individuals – ASA staff is trained to assist them is accessing appropriate documentation.
Basic Needs*: *Food*	1. Client intake and case manager assessment for eligibility for ASA's Helping Hand Food Bank services; 2. Assisting clients with Food Stamp applications; 3. Assisting clients with accessing emergency food needs through referrals to area agencies and food programs.
Basic Needs*: *Housing and Homelessness*	1. Access to short-term and long-term housing assistance needs to stabilize clients through ASA HOPWA and Best Single Source Plus Programs. 2. Case Manager coordination and referral to: Housing service providers such as Project Transitions, Foundation Communities, area boarding homes, Austin area public housing and emergency shelters. .
Basic Needs*: *Transportation*	1. ASA main facility located on two major bus routes as well as located in a zip code area where a high number HIV infections are located (78752); 2. ASA Intake, Outreach, and Tier 2 Client/Patient Navigators conduct home visits when necessary and work with clients who are unable to transport to office location; 3. ASA Intake (or Client/Patient Navigators) complete client applications for Special Transportation Services through

Barrier	Description of Reduction/Elimination of Barrier
	Capital Metro; 4. Access to bus passes through the Basic Transportation Needs Fund
Health Literacy and Education	1. Assess client's health and language literacy; 2. Work with client through verbal communication and with health education materials tailored to client's level of understanding and language needs.
Unique Cultural & Linguistic Issues	1. Extensive training in cultural awareness and responsiveness related to communities of color, specifically African-American and Hispanic; 2. ASA has established working relationship with qualified interpreters to assist clients whose primary language is not adequately represented by a staff person; 3. Tier 2 staff build trust with undocumented Hispanic clients by explaining that this status will not affect eligibility for agency services.
Substance Abuse Treatment	1. Consumer information about possible side effects of illicit drugs and HIV medications; 2. Access to appropriate case manager(s) with substance abuse assessment experience; 3. Collaborate with CARE program and other related agencies to provide support and treatment services.
Mental Health Treatment	1. Collaboration with and referrals to mental health providers including Waterloo Counseling and CARE program at ATCIC.
Historical Mistrust of Medical and Social Service Providers	1. ASA case managers work with client through skills building to mitigate mistrust and to improve the client health literacy through education.
HIV Disease Stigma	1. Frequent and prompt contact with individuals in target populations to build trust while relying on 24 years of established history of trust with ASA as an HIV provider for African-American and Hispanic populations; 2. Client-centered approach, emphasizing client strengths, respect for client self-determination – this approach is particularly effective in African-American and Hispanic communities; 3. Referrals of HIV positive women of color to Women Rising Project to educate women in making healthcare decisions – 60 percent of the women served are African-American.

* Basic needs as a barrier is more likely to affect African-American and Hispanic communities due to disproportionate poverty levels among communities of color.

Service Linkage, Referral, and Collaboration

Linkage to Primary Medical Care

While this service category's key activity is to link clients to HIV primary medical care, at ASA, this is usually done through Outreach and/or the case management programs. Food Bank is essential for ongoing retention of clients in medical care.

Referral Mechanism:

- Many clients are first assisted with initial access and linkage to HIV primary medical care through Outreach team efforts. The goal of the Outreach team is to successfully link clients to primary medical care in three months or less, in accordance with the National HIV/AIDS Strategy. To open a dialog with individuals about initial access to medical care, outreach staff will initiate rapport by providing information about general HIV transmission, risk reduction, and the benefits of early medical intervention. Once the Outreach team links the client into medical care, as evidenced by successful attendance at the first medical appointment, and the client is enrolled in the appropriate case management program depending on the individual needs (i.e. N-MCM, Medical Case Management and PLUS Program). Once assigned to a case manager they then work with the client on strategies to maintain their medical care as part of their service plan.

- A client who contacts the agency directly and do not meet the eligibility requirements for the Outreach program is linked with Eligibility and Intake staff that assess the client's immediate needs for basic needs services and link them to community resources to stabilize their situation and refers them to primary medical care, if needed. A Non-Medical Case Manager may coordinate the clients medical care appointments and visits and assist them with any housing, identification documentation, or financial assistance needs.

Service Coordination and Integration of Resources

The Non-Medical Case Managers addresses crucial barriers to access to primary care by providing referrals for immediate basic needs such as transportation, food, and/or housing. Clients may be assisted through agency resources such as bus passes/taxi vouchers, one of several housing assistance programs, and/or the Food Bank program. In addition, they may be referred to community support services such as area food pantries, Capital Metro for transportation access, and churches for financial assistance with rent and/or utilities.

To address fear of medical providers, the medical care system, or fears related to limited English or health literacy proficiency, staff discusses with clients any resistance to medical care and may be accompanied to their intake medical care visit.Once the client has successfully kept the initial intake appointment at David Powell Clinic[4], the Non-Medical Case Managers work with clients on continued follow-up that may include accompanying clients to subsequent doctor visits. Non-

[4] Clients entering services through Outreach rarely have private insurance and for those that do, the Outreach team will ensure they make a follow-up appointment with their private medical provider.

Medical Case Managers build upon the trust developed with Outreach staff and the developing trust with medical providers to coordinate care with David Powell Clinic staff by assisting in appointment scheduling /rescheduling and conferencing around continued barriers to care.

In addition to working with the David Powell Clinic, ASA has long-standing referral relationships with other HIV-related medical providers including the Blackstock Family Clinic (a SETON non-profit practice); Austin Infectious Disease Consultants (a private specialty care practice); Academic Physicians at Trinity; South Austin Medical Clinic; Jefferson Street Family Practice; and, Austin Regional Clinic-South, Far West, and Quarry Lake locations.

Projected Results
As indicated in the *Service Coordination and Integration of Resources* section, clients are referred to primary medical care services by different agency staff depending upon their place in the broad continuum of services offered at ASA. In most cases, Outreach staff tracks primary care referrals by accompanying clients to appointments. When they do not attend appointments with clients, the staff calls health care providers to verify kept appointments or verifies the visit through the ARIES database. Non-Medical Case Managers attend primary medical care appointments with clients or call agencies to track and verify successful referrals.

Clients are considered successfully linked to medical care upon completing an intake session with CommUnity Care at David Powell Clinic or other medical providers. The Non-Medical Case Managers report on retention in medical care as measured through the HRSA/HAB HIV Performance Measures: two or more medical visits in an HIV care setting in the measurement year. All staff will document client progress in progress notes and successful outcomes in the service provided feature of the Provide Enterprise® electronic client database (ASA's internal electronic database). Non-Medical Case Managers will complete a referral tracking form that includes date of referral and completion date and keep the form updated in the paper client file. The desired outcome results are linkage to and retention in primary medical care services.

ASA also participates in the Return to Care Collaborative with CommUnityCare at David Powell Clinic, Austin/Travis County Integral Care Program, Community Action, Waterloo Counseling, and the Wright House Wellness Center. Through this partnership, the collaborative partners seek to improve information sharing to determine the reasons why people have fallen out of care and to use this data to predict out-of-care trends. As participants in the collaborative effort, ASA and CommUnityCare at David Powell Clinic will monitor and share out-of-care information on a bi-monthly basis, when able, and work together to return clients to medical care. When out-of-care clients are identified, they will be referred to ASA's Outreach Program when they have not received HIV primary medical care for one year or more. This staff will facilitate their reentry into the Medical Case Management, as this is typically the level of case management required for clients contacted through the Return to Care Collaborative. Once the Medical Case Manager is assigned, they must contact the client within 10 days, although it is typically sooner.

Other Linkages, Collaboration, and Referral

Food Bank Linkages and Collaborations
AIDS Services of Austin (ASA) is part of the Basic Needs Coalition of Central Texas, an organization committed to securing basic resources for people in need.

"As members of the Basic Needs Coalition, it is our mission to lead the community in creating solutions that secure basic resources - food and housing - for our neighbors in need. Member agencies work collaboratively to assist, advise and educate policymakers, service providers, funders, community groups and citizens to address basic needs in Austin and Travis County."
- Beth Atherton, Chair, Basic Needs Coalition of Central Texas

Other local partnerships promoting advocacy and education include the Sustainable Food Center Collaborative (organic food gardening, relationships with area farmers, interactive cooking classes and nutrition education), Urban Roots (working to nourish East Austin residents who currently have limited access to healthy foods), the Capital Area Food Bank (provides food and grocery products to partner agencies), and Community Action Network (create a healthy, safe, educated, just and compassionate community), CrossFit Central (gym), Sun Flower (supermarket) and Home & Heart Realty Inc. (conducted food drives and donated all food to the ASA Food Bank), ASA also contributes to local Poverty Awareness publications. The Executive Director serves on the executive committee of One Voice Central Texas - a basic needs health and human services advocacy organization.

On a national level, ASA is a member of the Meals On Wheels Association of America (MOWAA).

ASA works with local organizations to meet the complex nutritional needs of PLWH/A. The agency obtains food from its partnership with the Capital Area Food Bank at a nominal fee, saving the agency about $1,000 each month on items such as packaged protein, canned foods and personal/household hygiene items. In partnership with Urban Roots, ASA receives free fresh organic produce during spring and summer months. ASA purchases quality fruits, nuts, and vegetables from local fresh produce distributors at retail prices year round.

Agency Linkages and Collaborations
ASA has collaborative agreements, letters of support, and/or Memoranda of Understanding (MOU) in place with several agencies, mostly with respect to specific programs. The MOUs guide referrals between agencies and allow smooth transitions of clients for additional services. ASA maintains MOUs with Waterloo Counseling Center, Project Transitions, the Housing Authority of the City of Austin, Austin Energy, the CARE Program of Austin/Travis County Integral CARE, and the Communicable Disease Unit at Austin/Travis County Health and Human Services Department (A/TCHHSD). For MOUs that require annual renewal, ASA contacts the partner agency 30 days prior to expiration of these agreements.

ASA also has long-standing referral relationships with HIV-related social service providers, including the CARE Program at Austin/Travis County Integral Care for substance abuse counseling and treatment referral for individuals that are dually diagnosed; Project Transitions

for transitional housing and hospice; South Austin Marketplace for transitional and long-term housing; the Customer Assistance Program (Austin Energy) for utilities payment assistance; Waterloo Counseling Center for mental health counseling; the Wright House Wellness Center for holistic/alternative health services; Salvation Army and the Austin Resource Center for the Homeless for emergency housing; the Social Security Administration for disability benefit applications and appeals; Del Valle Correctional Facility, Travis State Jail, and the University of Texas Medical Branch State Penitentiary for services to inmates upon their release; the Communicable Disease Unit at A/TCHHSD for HIV/ STI/TB screening; and SafePlace for domestic violence assistance.

Eligible clients are also referred to the broad continuum of ASA services: the Capital Area AIDS Legal Project (CAALP) for legal assistance; Medical Nutrition Therapy for nutritional assessment, counseling, and supplements; the Jack Sansing Dental clinic for oral health services; HOPWA for housing assistance; Comprehensive Risk Reduction Counseling Services for support for individuals to reduce the risk of HIV transmission; and the Health Insurance Program for premium, medication copayment and medication deductible financial assistance.

Referral Process and Follow Up

ASA staff assists clients with completing and submitting other agencies' referral forms, communicates with those agencies to clarify client eligibility, and advocates for client service delivery. For those clients who are case managed at ASA, staff ensures that referrals are followed through on in one of the following ways:

- performs follow up at the next client contact by asking the client about the referral and the results;
- accompanies the client to appointments;
- checks the ARIES database to ensure appointment was attended; or,
- calls the agency the client was referred to and confirms client attendance.

All staff document client progress regarding follow-through on referrals in the progress log feature of the Provide Enterprise® electronic client database (ASA's internal electronic database). Non-Medical Case Managers will complete a referral tracking form that includes date of referral and completion date and keep the form updated in the paper client file. The desired outcome results are linkage to and retention in support services.

Goals of Collaborative Activities, Integration of Resources, and Projected Results

The goal of collaborative activities is the provision of comprehensive services through the HIV provider community and other social service agencies using linkages and referrals. These activities ensure clients have access to all needed services that are not offered by ASA. In addition, they allow clients to overcome barriers to accessing and remaining in primary medical care and moving toward self-sufficiency in managing their HIV disease.

Integration of resources and services includes the dedication of ASA staff time toward the completion of other agency intake forms, assisting clients with the intake process, accompanying clients to support service appointments, reporting required data, and working with clients on

mutual goals in service plans. These mutual goals may be related to support services that client receive from other agencies, such as financial assistance, substance abuse or mental health counseling, housing, etc.

The projected results of collaborative activities, integration of resources, linkages, and referrals are:

- Client achievement of housing stability
- Meeting food intake needs
- Mental health services access and stability
- Independent management of substance use issues
- Financial stability
- Decreased recidivism
- Personal safety and security

Client Input and Involvement

Clients have several opportunities to offer input into the Food Bank program. Staff's rapport with the target community enables them to respond to client comments and needs on an ongoing basis. During these encounters, staff works with clients to offer input and identify needs and services they want to pursue. Clients have ready access to a Food Bank Comment and Suggestion notebook located at the food counter, in the food bank lobby. Clients have written suggestions for products that have worked well for them, such as lotions and soaps, as well as specific food items such as avocados and ranch beans. Clients also leave comments of praise of staff and staff volunteers.

Staff surveys clients using the standardized questionnaire developed by the Ryan White Quality Management Group to solicit feedback for improving case management services. As of current, ASA has not received results from 2015 Ryan White Survey, though ASA Food Bank staff conducted its own client satisfaction survey in 2015 yielding results of client satisfaction of services overall at 98%. Supervisors will use survey results and staff feedback semiannually to evaluate the effectiveness of referral systems, barriers to service, and other service delivery components. The team will then plan, as appropriate, for service modification, especially actions to remove barriers.
All agency clients may register concerns with supervisors and through the client grievance process. All clients are provided a copy of the client grievance policy and procedure upon entry into services and it is posted in English and Spanish in the agency reception area.

ASA routinely incorporates client feedback and suggestions into planning activities. In developing the agency's 2011 – 2014 Strategic Plan, ASA used interviews and focus groups with current clients to ensure their active participation in the strategic direction of the agency. ASA's Strategic Plan specifically defines "client satisfaction with programs and services" as a key measure of success in alignment with our strategy to "maintain and strengthen existing programs

and services through quality improvement." The 2011-2014 Strategic Plan has been extended for one year so that ASA is able to fully analyze the impact of the Affordable Care Act. ASA is currently developing its new strategic plan.

A suggestion box located in the client lobby is available for clients to submit anonymous feedback. The box is routinely monitored by the Eligibility Services Supervisor. Client feedback is given to appropriate staff for use in program improvements. The Quality Management Guidance Team reviews the feedback from the suggestion box quarterly to evaluate trends and making agency improvements.

Cultural Competency

Service activities will be delivered so that cultural and language differences do not constitute a barrier to services in full compliance with the National Standards on Culturally and Linguistically Appropriate Services (CLAS) described at: http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15.

AIDS Services of Austin (ASA) is in compliance with all 15 CLAS Standards.

Table 6

CLAS Standards	ASA Compliance
1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.	▪ Staff members are proficient in Spanish, culturally reflective of the Hispanic clientele and available to interpret daily ▪ Staff members are from diverse backgrounds including African-Americans and individuals that are immigrants to the USA. ▪ One staff member proficient in American Sign Language and others with basic skills ▪ Interpretation services in any language are offered to clients free of charge; interpreters culturally reflect clients ▪ Staff assigned to clients are reflective of clients' cultural background, as feasible ▪ Client materials are written at a fifth to eighth grade literacy level and in Spanish at third to fifth grade level ▪ Client materials are provided in Spanish and English ▪ A professional volunteer translates materials from English to Spanish ▪ Organization includes "diversity" as one of its core values
2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy,	▪ A Cultural Appropriateness Action Team with staff from varied levels and departments is tasked with ensuring CLAS and health equity are promoted ▪ The agency maintains a tracking mechanism to ensure CLAS compliance

CLAS Standards	ASA Compliance
practices, and allocated resources.	▪ Agency policies are cognitive of cultural appropriateness and those that are applicable to clients are provided in English and Spanish at an appropriate literacy level ▪ Resources are allocated based on community need and assessment ensuring targeting of demographics most affected by the epidemic ▪ 2011-2015 board approved organizational strategic plan includes goals, objectives, and action steps prioritizing staff cultural awareness and competency trainings ▪ Executive Director serves on the Central Health *Health Equity Council* for HIV issues
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.	▪ Compliance with Equal Employment Opportunity Commission (EEOC) guidelines since inception ▪ Compliance with The Americans with Disabilities Act (ADA) since inception ▪ EEOC and ADA language reflected on all job postings ▪ Staff are fluent in Spanish, culturally reflective of the Hispanic clientele, and available to interpret daily ▪ Staff members are from diverse backgrounds including African-Americans, Latino, and individuals that are immigrants to the USA. Organizational staffing is reflective of the demographics of the HIV epidemic in the Austin TGA ▪ One staff member proficient in American Sign Language and others with basic skills ▪ Committed to promoting from within for job openings ▪ Evaluation of the potential of current staff for leadership development in order to promote direct service staff ▪ Structured Action Teams provide leadership development opportunities for all staff members ▪ Candidates for positions where bi-lingual (Spanish) skills are preferred are offered a salary premium for demonstrating appropriate proficiency in the language ▪ Organization recruits diverse candidates by networking with higher education institutions of color and advertising and conducting outreach into appropriate publications in communities of color ▪ 2011-2015 board approved organizational strategic plan includes goals, objectives, and action steps prioritizing recruiting, hiring, and training diverse staff and recruiting board members from communities of color ▪ Board officers are demographically and culturally diverse ▪ Agency participation in multicultural career expos for staff

CLAS Standards	ASA Compliance
	recruitment
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.	▪ The agency's Cultural Appropriateness Action Team and Professional Development Action Team research and implement ongoing training ▪ Agency support of language skills development when resources are available ▪ Executive Director serves on the Central Health *Health Equity Council* for HIV issues
5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.	▪ Staff are proficient in Spanish, culturally reflective of the Hispanic clientele, and available to interpret daily ▪ Staff are from diverse backgrounds including African-Americans, Latino, and individuals that are foreign-born ▪ One staff member proficient in American Sign Language and others with basic skills ▪ Interpretation services in any language are offered to clients free of charge; interpreters culturally reflect clients ▪ Client materials are written at a fifth to eighth grade literacy level and in Spanish at a third to fifth grade level ▪ Client materials are provided in Spanish and English ▪ A professional volunteer translates client materials from English to Spanish ▪ The agency uses an independently certified system to evaluate the language proficiency of staff ▪ Organization's central voice mail and Dental Clinic voice mail systems are recorded in Spanish ▪ Key program staff have recorded voicemails in Spanish
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.	▪ Interpretation policy offering services free of charge posted in all locations ▪ Reception and Intake and Eligibility staff trained to notify clients of their right to receive language assistance services free of charge ▪ Front desk and key staff voicemail messages are recorded in English and Spanish ▪ Interpretation services in any language are offered to clients free of charge; interpreters culturally reflect clients ▪ Client materials are provided in Spanish and English ▪ Reception staff have access to language cards to identify need for interpretation services
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals	▪ The agency uses an independently certified system to evaluate the language proficiency of staff ▪ Written policy offers interpretation at no cost to the client in order to prevent the use of family and friends as interpreters

CLAS Standards	ASA Compliance
and/or minors as interpreters should be avoided.	▪ Staff is trained to inform clients of their right to interpretation services at no cost and that family and friends are not a preferred source for interpretation in order to protect client confidentiality ▪ The agency hires professional, certified trainers to assist in interpretation upon request
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.	▪ Client materials are provided in Spanish and English ▪ Client materials are written at a fifth to eighth grade literacy level and in Spanish at a third to fifth grade level ▪ Key client information/policies and grievance information is posted in English and Spanish in common areas and available in hard copy from reception desks ▪ Quality Management Guidance Team reviews and updates materials to increase understandability
9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.	▪ ASA's 2011 – 2015 Strategic Plan identifies compliance with CLAS Standards as a priority: o "Strategy #3: Ensure culturally appropriate programs and services ▪ Agency programs and services meet Culturally and Linguistically Appropriate Services (CLAS) standards ▪ Collaborative partners recognize ASA for delivery of programs and services to reduce stigma and for innovative and collaborative relationships" o Strategic plan action step is to implement an Organizational Cultural Appropriateness Committee representative of diversity of staff and management to further formalize cultural appropriateness trainings and action steps
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.	▪ Self-assessment of CLAS-related activities conducted in 2007; results continue to be used to improve services ▪ Cultural Appropriateness Action Team to survey annually and report to staff and board of directors of outcomes from strategic planning goals/objectives related to cultural appropriateness work
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health	▪ Collection of data and documentation on each consumer's race, ethnicity, disabilities, spoken and written language, and literacy level; information entered into client paper file, Provide Enterprise® internal electronic database, and ARIES; information updated periodically

CLAS Standards	ASA Compliance
equity and outcomes and to inform service delivery.	▪ Use of the Austin Transitional Grant Area HIV Planning Council's periodic consumer needs assessment ▪ Use of the Brazos Valley Council of Government's periodic consumer needs assessment ▪ Provision of HIV testing data to the Texas Department of State Health Services, (DSHS) and the Centers for Disease Control and Prevention, (CDC)
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.	▪ Collection of data and documentation on each consumer's race, ethnicity, disabilities, spoken and written language, and literacy level; information entered into client paper file, Provide Enterprise® internal electronic database, and ARIES; information updated periodically ▪ Annual review and assessment of HIV epidemiology profile of epidemic as prepared by Texas Department of State Health Services (TDSHS) and the Austin/Travis County Health and Human Services Department ▪ Use of the Austin Transitional Grant Area HIV Planning Council's and Brazos Valley Council of Government's periodic consumer needs assessment ▪ Annual report to staff and board of directors on Austin TGA HIV epidemic in comparison to organization's client demographic profile, staff demographics, and board demographics
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.	▪ Collection and updating of data and documentation on each consumer's race, ethnicity, disabilities, spoken and written language, and literacy level; information entered into client paper file, Provide Enterprise® client electronic database, and ARIES. ▪ Provision of HIV testing data results are reported to the DSHS and CDC ▪ Involvement in community events targeted to people of color to build collaborative partnerships in a participatory environment ▪ Staff shares lessons learned at above events with management and leadership staff to expand collective knowledge of local cultural practices and beliefs ▪ Organization is a member of the advisory committee to the Latino Commission on AIDS to develop training institutes on providing culturally appropriate HIV services to the Latino community in 2012 ▪ Executive Director serves on the Central Health *Health Equity Council* for HIV issues
14. Create conflict and	▪ Client materials are provided in Spanish and English

CLAS Standards	ASA Compliance
grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.	▪ Client materials are written at a fifth to eighth grade literacy level and in Spanish at a third to fifth grade level ▪ Client grievance procedures are posted in English and Spanish in common areas throughout the organization ▪ Organization has a formal grievance procedure in place that is reviewed annually by staff
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.	▪ Strategic Plan dissemination to donors and posted on website ▪ Community Impact Report disseminated to donors, posted to website, and available in hard copy to public ▪ Responsiveness and pursuit of opportunities to participate in ethnic media

Quality Management

Use of Output and Outcome Data

Using monthly data, AIDS Services of Austin (ASA) tracks progress on the total number of unduplicated clients served, units of service delivered, and achievement of outcome goals through the reporting feature of the Provide Enterprise® electronic client database. On a monthly and quarterly basis, supervisors analyze the data to determine if outputs and outcomes, respectively, are within a 10 percent variance of the elapsed period of the grant cycle. If not, supervisors determine reasons that program goals are not being met and develop plans to address the situation including staff training, supervision, and monitoring staff adherence to the standards of care for the service category. Supervisors also note trends in performance measures with emphasis on clients who do not meet outcome goals and develop appropriate quality management activities or document the reasons for such exceptions. Provide Enterprise® reports give aggregate data at the agency level that documents client trends in service utilization for use in planning for service delivery.

Supervisors will use reports from the ARIES client database to validate data on performance measures such as number of unduplicated clients served and units of service provided, and to compare, if needed, service utilization data in order to avoid duplication of services. ARIES will also provide aggregate data at the community level that documents client trends in service utilization for use in planning for service delivery.

Supervisors will use the service-specific client satisfaction survey to obtain data using client input on satisfaction with services provided. Supervisors review survey results including qualitative data at program area, Leadership Team, Quality Management Guidance Team, and the Program and Services Committee meetings. With input from these various teams, supervisors use suggestions from the survey to identify problems and/or concerns and implement quality improvement activities including service delivery changes when possible.

The Food Bank Client Visit Log tracks the number of clients receiving services and the number of visits made twice per month. The agency Data Entry Specialist enters information from the log into the Provide Enterprise® and ARIES databases for tracking and reporting purposes.

Quantitative measures regarding Food Bank visits, medical care, and case management access are entered into Provide® Enterprise. Client list with the number of visits and units of services are generated and the Food Bank Staff check them thoroughly against the Food Bank Client Visit Log. Monthly reports are run that provide the number of unduplicated clients that have received services and also the number of units of service that have been distributed for the month.

The resources and tools used to facilitate this process are staff time, the Provide Enterprise® database, the ARIES database, client satisfaction survey, and the Food Bank Client Visit Log.

Assurance of Compliance with Austin TGA Standards of Care

Food Bank Program staff has been trained on the following Standards of Care in the Austin TGA continuum of care for Food Bank/Nutritional Supplements:

Standard 1: Accrual of food available received by Dietitian. Annually, the Dietitian randomly selects 30 completed client menu forms from a twelve month period to conduct a menu analysis. She runs nutrient analysis using standardized software —The Food Processor, Version Version 10.15.0 (Copyright 2015) and provides an overview of the findings, making recommendations for adjustments to menu choices in each of the food groups. ASA uses the Association of Nutrition Services Agencies' (ANSA) *Nutrition Guidelines for Agencies Providing Food to People Living with HIV Disease* as a reference for general nutrition needs of persons living with HIV and AIDS. Clients receive handouts on nutritional value of food, safe food handling, and food storage techniques periodically with food allotments. The Dietitian also provides these handouts and other individualized written materials to clients during nutritional counseling sessions.

Selection of food items are based in part on Nutrition Guidelines for Agencies Providing Food to People Living with HIV Disease, Second Edition, September 2002, developed by the AIDS Nutrition Services Alliance (ANSA). The agency's Dietitian employs these guidelines as well as recommendations from the American Dietetic Association HIV/AIDS Practice Group in advising the agency about food selection from vendors. To ensure that minimum standards are met, the Food Bank and Nutrition Services Manager, with guidance from the Director of Direct Services, annually reviews all of these requirements and establishes that the agency is in compliance.

Standard 2: Culturally and ethnically diverse choices in foodstuffs. To honor clients' cultural and ethnic differences, the Food Bank makes a variety of foods available, including beans, rice, tortillas, collard greens, cabbage, and kale, as well as seasonings such as black pepper, parsley, garlic, ginger root, peppers, and cilantro. Kosher food items are offered as

practicable. The Dietitian learns from clients about individual and cultural food needs, likes and dislikes during consultation. Clients may verbally provide feedback to agency staff and volunteers. Verbal feedback is logged in the food bank logbook stationed in the food bank distribution area. Staff makes adjustments to the menu selection based on client input and feedback as feasible.

Standard 3: Pantry items checked for shelf life (expiration) and damage. ASA adheres to the following Texas State Health Codes: DSHS, Bureau of HIV and STD Prevention, Minimum Standards for Food Services – FOP-PS-003; A/TCHHSD – City code section 12-2-61 (formerly section 6-5-5); DSHS Retail Foods Division, Health and Safety Code, Chapter 438 Public Health Measures Related to Food, Subchapter D. Food Service Programs, Food Protection Management Program; and CAFB Guidelines for Evaluating Canned Food Containers and Guidelines for Perishable and Non-Perishable Food Items. Staff reviews and rotates foodstuffs bi-monthly and document expired, damaged, and discarded items. Damaged items purchased through HEB are exchanged, and unusable donated food items are available for ASA Case Mangers to access on an emergency basis for clients on non Food Bank weeks.

Standard 4: Case Managers assess need for food with client. Eligibility and Intake staff assesses clients' eligibility and level of nutritional health risk and generate a Service Request to Food Bank staff via email documentation through the Provide® client database. Clients not case managed at other ASOs are referred to a Case Manager who creates a service plan, including access to food bank/nutritional supplement services. Eligible clients receive food and/or nutritional supplement services twice per month during business hours. Food is provided outside food bank distribution hours on a case by case basis and in an emergency. Staff maintains documentation of referral to food bank/nutritional supplement services in the Provide® client database.

Quality Management Plan

Quality Management Guidance Team

The overall responsibility and leadership for ASA's Quality Management (QM) program lies with the Chief Program Officer, who authorizes the Quality Management Guidance Team (QMGT) to plan, assess, measure, and implement performance improvements throughout the entire agency, while providing the necessary resources and support to fulfill these functions.

The membership of the QMGT reflects the diverse service areas within AIDS Services of Austin (ASA). The agency's quality team is comprised of the Chief Programs Officer, Board Members, and other members of ASA staff, ranging from upper management to direct service staff. Other ASA staff members, such as Program Supervisors and Coordinators, Case Managers, and Prevention Specialists are involved, when appropriate. Nominations for membership are decided upon by the QMGT. The QMGT meets every other month. Additional meetings may be called, as needed. Minutes of meetings are distributed directly to each member of the committee and to all necessary internal and external stakeholders. A written summary is routinely made available to staff.

The Quality Management Plan
The Quality Management Plan seeks to improve service performance through collecting and evaluating data, identifying service problems based on the collected data, using quality improvement processes to address service delivery issues, and following up to ensure improvements will be sustained. The agency plan is designed annually with target goals and service specific quality improvement activities. It calls for a review of service performance measures, an analysis of this data, and recommendations for service improvements. The plan indicates that the team will oversee an annual update and revision of program policies and procedures. At the end of each year, the plan is evaluated to determine the achievement of goals and service specific improvement activities and to make recommendations for further follow-up.

The following sections describe other components in the Quality Management Plan:

Activities to Collect Data

The Associate Director of Direct Services and the Food and Nutrition Service Manager will collect data on the program's performance in achieving service goals and meeting standards of care through results from the following sources: outcome and output measures, the agency client satisfaction survey, client file reviews, the client suggestion box, client/staff feedback, and client grievances.

Supervisors review performance measures quarterly and report measures not meeting contract objectives to the Quality Management Guidance Team, along with suggestions on planned action steps.

Client satisfaction surveys are an important way to identify quality issues. The Food Bank staff administers an annual satisfaction survey to clients. The agency distributes the standardized survey, after approval by the HIV Resource Administration Unit, City of Austin Health and Human Services Department, at the Food Bank and Dental Clinic sites to collect data on all Ryan White Service Categories offered at ASA.

Client input from registered grievances is documented by program supervisors and reviewed at department staff meetings.

The Food Bank also has a yellow note book in which allows the clients to write concerns, questions, suggestions, complaints or appreciation notes directly to the Food Bank.

Twenty Percent (20%) of interagency food bank client files are reviewed annually to ensure collection and updating of required eligibility documents.

Evaluation of Performance and Assuring Delivery of Quality Services
As data and input are received and problems are identified, the QMGT evaluate concerns and suggestions in order to assure the delivery of quality services.

The QMGT analyzes the output/outcome data and makes recommendations for improvement to program supervisors. When quality improvement activities around performance measures are designed and completed, the results are then sent to the team and reported in the annual evaluation of the Quality Management Plan.

Supervisors will evaluate survey results to identify trends for improvements and advocate for unmet client need. To guide decisions about quality improvement activities, survey results are discussed at the program level in department/program meetings and at QMGT meetings. The Programs and Services Committee of the Board of Directors also reviews survey results and gives guidance when appropriate.

Supervisors adhere to the agency's policy on client grievances, which includes review by the Executive Director and/or the Board of Directors, when indicated. Program supervisors utilize grievance input from these reviews and from clients, when feasible.

Suggested actions taken based on this data could include staff development training in an identified area, development of organization tracking tools, additional interventions to reduce barriers, or design client/patient forms to capture data and service performance measures better.

Identification of Quality Improvement Activities

At the beginning of the year, supervisors and the QMGT identify specific service quality improvement activities based on staff and client feedback and the data already discussed. Activities are written using SMART objectives in that they are specific, measureable, attainable, relevant and time-bound.

Quality improvement activities for the Food Bank grocery program will include an annual menu analysis with the goal of providing 60 percent of the daily caloric intake needs of a person with HIV. The 2016 quality improvement activity identified for Food Bank/Medical Nutrition Therapy is: maintain Medical Nutrition Therapy kept appointment rates at 85%. The responsible staff is the Associate Director of Direct Services and Food and Nutrition Services Manager.

Additionally, the Associate Director of Direct Services, Food and Nutrition Services Manager and Dietitian identify opportunities for improvement with Food Bank services by using information directly reported from the clients, the agency's annual client satisfaction survey, and information provided by clients' Case Managers. Staff/volunteers also considers feedback from one-on-one interviews with clients during food bank visits input from food bank staff and volunteers, data from dietary and nutrition menu analysis, and information from national counterparts providing similar services.

When input is received and problems are identified, the Associate Director of Direct Services and the Food & Nutrition Services Manager evaluate concerns and suggestions and design and implement appropriate program changes/activities or plans of correction. Supervisors work with

program and agency staff to implement and track changes/outcomes or plans of correction. Three months after activities are designed and implemented, supervisors follow-up to ensure that these activities have been effective in dealing with the problem and that no new problems have developed. The Food & Nutrition Services Manager documents program improvement and activities to address problem areas.

The agency's Administrative Assistant collects information from the suggestion box monthly and forwards this data to the appropriate supervisor for review and problem identification. Management staff review results at Management Team meetings, and the Board of Director's Programs and Services Committee annually reviews results from the client satisfaction survey. Supervisors use suggestions from the annual survey, the committee, management team, and from case management staff to identify problems/concerns and implement modifications when possible.

Client file review results may indicate Standard of Care or performance deficiencies that are systemic. In these situations, supervisors will design quality improvement activities to address these areas and request that the activities are integrated into the annual Quality Management Plan.

Addressing Identified Problems

Once a problem or an area that needs further assessment is identified, the team will use, when appropriate, the Plan-Do-Study-Act cycle (PDSA), a four-step model for carrying out change. This process will be used in identified quality improvement activities as detailed in the annual Quality Management Plan. The components are as follows:

1. Plan by recognizing an opportunity and planning a change.
2. Do by testing the change and carrying out a small-scale study.
3. Study by reviewing the test, analyzing the results/data and identifying what has been learned.
4. Act by taking action based on what you learned as a result of data analysis in the study step.

If the change does not work, the cycle will be repeated again with a different plan.

To address client file review results, supervisors will implement a plan of correction.

Follow Up

Supervisors will follow up to ensure the effectiveness of improvement activities and the maintenance of improvement results. On identified quality improvement activities, supervisors follow up on a quarterly basis to ensure that these activities have been effective in resolving the problem, that no new problems have developed, and that there is sustained improvement in identified areas.

For file review results, supervisors work with staff to develop plans of correction within 15 working days of the file review. Staff has ten working days to implement corrections after

notification of needed corrections. At the next quarterly file review supervisors monitor the maintenance of the previous quarter's improvements to ensure problems do not reoccur.

Monitoring and Standardized Tools

Tools used in monitoring and standardization include the file review tool and Provide Enterprise® reports with features to track reporting of performance measures, completion of assessments, service plans, as well as a feature to describe content of progress notes for easy tracking. The annual client satisfaction survey is a standardized tool that the Ryan White Quality Management workgroup evaluates and standardizes across HIV service providers.

Compliance with Ryan White Part A Program Monitoring Standards

i. Maintain and make available to grantee documentation of:
    - Services provided by type of service, number of clients served, and levels of service

All service data including type of service, number of clients served, and level of service are entered into Provide Enterprise® and ARIES electronic client databases. The Administrative Agent has ready access to ARIES client data and may pull specific reports which make available all service level data, at any given time.

    - Amount and use of funds for purchase of non-food items, including use of funds only for allowable non-food items

The Food Bank program is partially funded through Ryan White Part A Funds. ASA tracks funding separately in order to ensure that Ryan White funds are the payer of last resort for allowable non-food items. Both internal and external auditing procedures are used to fulfill this mandate. AIDS Services of Austin (ASA) has internal financial controls to monitor the expenditure of funds. Grant funds are accounted for separately to provide documentation of expenditures.

    - Compliance with all federal, state, and local laws regarding the provision of food bank, home-delivered meals, and food voucher programs, including any required licensure and/or certifications

ASA's Food Bank is permitted as a "Food Enterprise" to operate food product distribution (Permit No. 2006 000387 FP) by the Austin/Travis County Health and Human Services Department – Environmental & Consumer Health Unit and must comply with all applicable laws and regulations annually. The permit is due for renewal on or before September 16, 2016 when it expires. The permit is posted, as required, in the Food Bank distribution area for public viewing.

As a permitted Food Establishment, the Food Bank is inspected by the above named department on average, twice per year and has a strong history of scoring highly (90%-100%), with little to no follow-up action required post inspection. Maintained indefinitely in agency files are the inspection reports which are readily available for review.

Local laws/ordinances as mandated by the City of Austin require that Food Establishments have at least one Food Manager certified with the City of Austin/Travis County. ASA has two individuals who hold valid Food Manager Certificates; the Food and Nutrition Services Manager and a key volunteer who leads other volunteers in separating bulk foods into individual portions for distribution. Valid certificates must be posted in plain sight for health department inspector reviews and ASA posts the certificates in the food preparation area of the food bank.

A Food Handler registration is also required by the Austin/Travis County Health and Human Services Department – Public Health and Community Services Division. As such, ASA has two Food Handlers, both key volunteers, who completed the National Restaurant Association's ServSafe Employee Food Safety Training. The Certificates do not expire and are posted in the food preparation area of the Food Bank.

ii. Provide assurance that Ryan White funds were used only for allowable purposes and Ryan White was the payer of last resort

ASA's eligibility and intake process and case management are the primary methods ASA uses to coordinate between Ryan White Part A and third party payers and to assure that Part A funds are the payer of last resort. The agency has a comprehensive intake process that includes screening for assessment of financial status and eligibility for Medicaid, Veteran's benefits, private health insurance, and other public assistance. ASA works with clients to ensure that they are availing themselves of the third party benefits for which they are eligible.

ASA will not subcontract for provision of Food Bank services.

Food Bank services do not qualify for either Medicare or Medicaid reimbursements as these services are delivered by ASA.

The Food Bank program is not fully funded through Ryan White Part A Funds. ASA tracks funding separately in order to make sure that Ryan White funds are the payer of last resort. Both internal and external auditing procedures are used to fulfill this mandate. ASA has internal financial controls to monitor the expenditure of funds. Grant funds are accounted for separately to provide documentation of expenditures.

Work Statement

NOTE: This Statement of Work is subject to change, pending the finalization of the HRAU Health Insurance Policy.

Service Category Name
Health Insurance Premium and Cost-sharing Assistance

Client Eligibility
To be eligible for the Health Insurance Premium and Cost-Sharing Assistance (HI), clients must be HIV-positive, a resident of the five county area in the Austin Transitional Grant Area (Travis, Williamson, Bastrop, Hayes, Caldwell), living between 100% and 350% of the individual Federal Poverty Level in accordance with Health Insurance programming provided through the Brazos Valley Council of Governments and AIDS Services of Austin's (ASA) approved waiver with the State of Texas and at risk of losing health insurance coverage due to financial hardship.

ASA has Eligibility and Intake staff specifically trained to determine clients' level of need for services and eligibility status (every 6 months) for all ASA programs as well as programs at partner HIV services organizations and other social service organizations. ASA's Eligibility and Intake staff determine eligibility by securing verification of HIV status and residency. Staff will secure proof of identity, income, and insurance status as required intake documents.

vi. **Documentation of HIV Status:** Staff obtain verification of HIV status through:
   - a signed statement from the medical provider;
   - a positive Western Blot laboratory result with the name of the client;
   - a printed document from the ARIES database indicating verification of HIV status by another provider;
   - HIV detectable viral load lab results; or,
   - a hospital discharge summary or medical records from previous provider(s).

vii. **Proof of Identity:** Proof of identity includes: Texas driver's license, Texas State identification card, a passport, Military or Student identification card, Social Security card, birth certificate or other official document as listed on the Austin TGA Ryan White Client Eligibility Form

viii. **Residency Verification:** In order to establish residency, clients can provide unexpired documents such as a Texas driver's license, Texas State or Tribal identification cards, Social Security award letter, rental/mortgage agreement, utility bill, or similar forms accepted by the Ryan White Part A Austin TGA.

Documentation of HIV status must be presented within 30 days and residency documentation must be presented within 60 days. Clients may be granted conditional eligibility if they present with an urgent need and lack the necessary eligibility documentation. ASA will make reasonable efforts to assist clients in obtaining the necessary documentation.

ix. **Income Verification: S**taff use the MAGI or Mock MAGI form for client income verification. Clients that have filed a tax return in the previous year complete the MAGI form and submit their tax transcript as income verification. Clients that did not submit a tax return or have had a change in income complete a Mock MAGI form and submit an IRS proof of non-filing and income verification document. Income verification documents include Social Security Award letter, Veterans/Public Assistance or Worker's Compensation benefits statements, wage payment stubs, signed zero income verification letter or other document listed in the Austin TGA Ryan White Part A Client Eligibility Form. There are some populations that are excluded from having to obtain tax transcripts or IRS proof of non-filing, these include: homeless, recently released from incarceration (3 months), undocumented, emancipated minors, and SSI and/or SSDI recipients.

x. **Health Insurance Coverage:** Cards verifying coverage by private insurance (ACA, COBRA or employer provided) including proof of comprehensive HIV coverage and HIV medication formulary, Medicare, City of Austin Medical Assistance Program (MAP) or Medicaid will be obtained. MAP and Medicaid will be for use for medication copay assistance only.

Eligibility and Intake Staff will use the Austin TGA Ryan White Part A Client Eligibility Form to reassess clients in the program every six months for determination of continued eligibility. At that time, client residency, income, and health insurance will be updated and/or new documentation obtained as indicated. Clients presenting with a change to income, residency or health insurance status within the six month review period will complete the Change in Circumstances: Eligibility Verification Addendum form. All required eligibility and intake documents, as well as periodic updates, are stored in the client's paper file and documented electronically in the agency's electronic client database, Provide Enterprise®. Client identifying information is also entered into the ARIES client database. Eligibility and Intake staff completes a form verifying eligibility documents were collected, and an administrative assistant enters this data into ARIES.

Case management is not a requirement for eligibility for Health Insurance Premium and Cost-sharing Assistance.

Eligibility and Intake or Health Insurance staff will verify the eligibility criteria and determine the client's portion of the payment before intake into Health Insurance Premium and Cost-sharing Assistance services.

AIDS Services of Austin provides Health Insurance Premium and Cost-sharing Assistance ("HI") at 100% for individuals with income between 100 and 250% of Federal Poverty Level (FPL). Clients with income between 250 and 350% FPL who were receiving HI in the previous grant year will be eligible to continue to receive HI for a discount of 50%. New clients with income between 250 and 350% FPL who are requesting HI will be assisted on a case by case basis as capacity and funding availability allow.

Restrictions and Allowable Uses of HI Funds

HIA payments may be made for premiums, deductibles and co-payments/co-insurance payments. Deductibles and co-payments/co-insurance payments are collectively referred to as out of pocket payments (OOP) in this policy. With the execution of the Affordable Health Care Act (ACA), clients with pre-existing conditions are not excluded from health insurance assistance. Funds may be used to cover the cost of private health insurance premiums, deductibles, and co-payments associated with the Health Insurance Marketplace to help eligible low -income clients get and keep health insurance. Funds can be used to cover insurance costs for Silver Level Plans with drug benefits equal to those provided by the DSHS AIDS Drug Assistance Program (ADAP). Clients must take subsidies/premium credit in advance (at plan enrollment). Clients enrolled in COBRA may receive a maximum of two months of premium assistance during which they will be advised to identify and enroll in an alternative health insurance program through ACA.

Funds will not be used to pay fines or tax obligations incurred by clients not maintaining the health insurance coverage required by the ACA. HI funds will not be used to make OOP payments for inpatient hospitalization and emergency department care. HI payments are made only for outpatient medical care. Payments will not be made to clients. Premium payments will be made directly to insurance companies, and OOP payments must be made directly to the provider of services, such as a clinic, physician office, or pharmacy. Payment will not be made for co-payments or co-insurance costs when clients elect to use out-of-network providers or fill prescriptions for drugs that incur higher co-pays or co-insurance because they are outside their health plan's formulary. Exceptions may be made for payments for HIV-related care if an in-network provider is not available or appointment wait time for an in-network provider exceeds standards for delivery of care as documented by the client's HIV primary care provider

Clients will be informed of covered and non-covered costs.

ASA partners with Austin Outreach and Community Service, a Certified Applications Counselor Organization for the Texas Marketplace. Engaged by the City's Health and Human Services Department, Austin Outreach provides assistance specifically to the HIV community with enrollment into Qualified Health Plans. ASA also refers clients to Insure Central Texas' local services provided by Foundation Communities' Enrollment Manager specializing in patients with high medical needs.

Target Population

The target population for AIDS Services of Austin's (ASA) Health Insurance Premium and Cost-sharing Assistance (HI) program is all persons residing in the five counties of the Austin Transitional Grant Area (TGA) (Travis, Williamson, Bastrop, Hayes, and Caldwell) and living with HIV disease who meet the eligibility requirements listed under the Client Eligibility section. The following table (Table 1) compares

the 2015 grant year demographics of ASA's HI program to the demographics of people living with HIV and AIDS in the Austin TGA.

Table 1

	ASA Clients	Austin TGA PLWH/A
Gender		
Male	83%	85%
Female	17%	15%
Transgender	0%	(unavailable)
Race/Ethnicity		
White	47%	46%
Black	28%	22%
Hispanic	24%	29%
Other	2%	3%
Age Group		
0 – 12	0%	0%
13 – 24	1%	4%
25 – 34	14%	17%
35 – 44	18%	27%
45 – 54	36%	34%
55 and over	31%	18%

ASA client geographic concentration aligns with areas of high prevalence of HIV/AIDS in the Austin TGA. ASA's five most common zip codes for HI clients are all located in Travis County.

Table 2

ASA Top 5 Client Zip Codes	Prevalence Range of HIV/AIDS
78741	314-674/100,000
78723	675-1,199/100,000
78758	314-674/100,000
78753	314-674/100,000
78724	115-313/100,000

Austin TGA data suggest that 84 percent of clients have medical comorbidities, while others report social and health-related co-factors that complicate medical and other service delivery for HIV.[5] Recent studies have shown that 67 to 96 percent of HIV positive individuals have comorbidities.[6] Co-morbidities and conditions for the HI program's target population include STDs, substance abuse, mental health issues, commercial sex work, poverty, homelessness, domestic violence, Hepatitis B and C, heart disease, diabetes, and tuberculosis (TB).

[5] ARIES database, provided by the City of Austin (Addendum 5 to Ryan White Part A RFA 2012-13)
[6] "Prevalence and Patient Awareness of Medical Comorbidities in an Urban AIDS Clinic," Weiss, Jeffery J., PhD, et al

Service Category Activities

Service activities linked to Budget Justification

The Health Insurance Premium and Cost-Sharing Assistance (HI) Program provides financial assistance for eligible individuals living with HIV for private insurance, Medicare supplement, and Medicare-Part D premiums and private insurance.; private insurance and Medicare copayments, coinsurance and deductibles; and private insurance, MAP, and Medicare-Part D medication copayments.. The HI program assistance enables clients to maintain continuity of health insurance coverage or to receive medication benefits.

AIDS Services of Austin has been providing HI Program assistance in the Austin TGA since 1990. Given ASA's long history with this program, necessary mechanisms for implementation are already in place. Long-standing mechanisms include:

- A Board of Directors and strong organizational governance structure
- An experienced leadership team
- Trained and experienced staff (see *Staffing* section)
- A physical location near public transportation, within high HIV incidence zip codes, and well-known in the HIV field
- A programmatic structure offering a comprehensive continuum of care including HIV Prevention, Outreach Services, Case Management (medical and non-medical), Food Bank, Medical Nutrition Therapy, Oral Health Care, Health Insurance Assistance, special programs for women living with HIV and AIDS, and legal services
- Strong community partnerships providing access to services not offered at ASA

New staff will be trained within 30 days of hire on the performance measures and trained on an ongoing basis on the information from the Program Monitoring Standards.

The primary tasks and activities necessary to accomplish the service category plan for Health Insurance Premium and Cost-sharing Assistance (HI) are:

- ***Refer Clients Into Service and Determine Service Eligibility for Financial Assistance***
  Clients are referred into health insurance assistance services through ASA's Eligibility and Intake screening program, Medical Case Management and Case Management Non-Medical programs at ASA or other HIV/AIDS service organizations, medical providers, or self-referral. Clients work with Eligibility and Intake staff or their assigned case manager to identify the need for eligible health insurance assistance services. ASA provides updated HI eligibility information and program parameters to Insure Central Texas and Austin Outreach. Certified Applications Counselors use this information to assist clients in making informed decisions when selecting ACA Marketplace plans and to make appropriate referrals to the HI program.

- ***Verify Client Eligibility Documents***
  Clients are required to present verification of the following upon intake in order to access services: HIV status, identity, residency, individual income between 100 and 250 percent of federal poverty income guidelines (with exceptions noted up to 350 percent FPL), private insurance premium and/or medication copayment/deductible amount and other required insurance information, and primary medical care provider. The Eligibility and Intake Specialist

obtains income verification every six months as well as updates the Austin TGA Ryan White Part A Client Eligibility Form with corresponding eligibility documents.

- ***Identify Specific Premium and Copayment/Deductible Assistance Needs and Enroll in Service***
  The assigned Medical or Non-Medical Case Manager, Health Insurance staff at ASA completes the Health Insurance Assistance Request Form for medication assistance requests. Health Insurance staff complete the Health Insurance Assistance Request form for copay, coinsurance, or premium assistance requests. The sheet includes the insurance company and/or pharmacy information necessary to disburse the assistance check and outlines the portion of the payment that is the responsibility of the client based on individual income according to ASA's Health Insurance Assistance Sliding Scale.

- ***Refer to Other Agencies/Programs for Needed Services***
  The Health Insurance/Eligibility and Intake staff reviews the individual's current plan benefits and discusses available options. This intervention often results in referrals for eligible clients to the Texas HIV Medication program, the State Pharmaceutical Assistance Program, ACA Marketplace, patient assistance programs and/or pharmacy discount cards. Any client who presents to staff as not having insurance benefits will be referred to appropriate resources, if eligible. Staff will vigorously pursue all resources available for clients who attest ineligibility for health insurance through the health insurance marketplace created by the Patient Protection and Affordable Care Act. Referrals will be made to Insure Central Texas and Austin Outreach as appropriate for clients to speak with Certified Application Counselors.

- ***Process the Assistance Request***
  The request form is then sent to the Programs Specialist for disbursement to the client's insurance, medical, or pharmacy provider. In order to protect client confidentiality, checks are titled "Insurance Assistance Fund" and have no mention of AIDS Services of Austin on them. The Programs Specialist will continue to process requests for premium assistance at regular intervals, unless otherwise notified by the Health Insurance staff. Checks are always made payable to and, in most instances, always mailed directly to the carrier; checks are never made payable directly to the client.

- ***Maintain Client Files and Contact as Needed to Deliver Services***
  The Health Insurance staff or case managers include in the paper file the request form, ARIES consent form, ASA Consent form, consents to release client information, health insurance premium/medication copayment/deductible information, Austin TGA Ryan White Part A Client Eligibility Form with corresponding eligibility documents, HI Program Agreement , and letters to clients. The Health Insurance/Intake Specialist manages all health insurance premium client files to ensure consistency in documentation verification, continuity of coverage, and timely file reviews. In the electronic client file, staff documents follow-up with clients, the private insurance company, or the medical provider and actions taken to address barriers to service such as negotiating with the insurance carrier to continue benefits. Client contacts include monitoring client utilization of insurance benefits, maintenance of outpatient primary medical care appointments, accuracy of private insurance information, and verification of continued eligibility.

    - ***Reevaluation of Need and Updating Client Information***

Once every six months, the Health Insurance staff will update pharmacy and premium information with clients, update income and expenses, verify that client continues to access primary medical care through a form signed by their doctor, and re-evaluates the need for assistance in order to maintain continuity of health insurance benefits. Staff will notify the Programs Specialist of any relevant changes such as increase/decrease in premium, termination of benefits, change in health insurance company name, etc.

- ***Closure***

Clients who are no longer engaged in active services or whose need for health insurance assistance has ended will be evaluated by the case manager or Health Insurance Staff for closure. Clients achieve graduation from the program when the client is able to independently maintain health insurance benefits and payments, or when public benefits are received and both client and case manager agree that services are no longer needed.

Case Managers or Health Insurance Staff will complete a closure summary documenting case closure and reason for closure. Clients are considered non-compliant with the program if they do not respond to three attempts to contact them within 30 days via phone, e-mail, or written correspondence. The case manager or Health Insurance staff will notify clients of closure through in-person meeting, phone contact, or written correspondence. Clients will be provided with written documentation explaining closure and the process to be followed if services are needed in the future. Case managers will offer appropriate referrals to the client and obtain signed client release(s) of health information for new providers to assist in transfers. Staff will conduct exit interviews in their preferred language (through interpretation services at no charge to the client, if necessary) with clients upon case closure or graduation from the program, if appropriate. In situations in which closure is involuntary, case managers will review the client situation with supervisors to secure approval for termination of services.

In order to avoid any lapse in medical coverage or care, staff will make reasonable efforts to engage clients in services. However, if a client is not actively engaging or providing required eligibility and other documents required for health insurance continuation, the service will be discontinued and the file will be closed.

Frequency of these service activities

- For determination of service eligibility for HI assistance, the eligibility and intake staff perform this activity during phone screenings. Case Managers screen for service eligibility any time there is a change in client situation or income that would make them eligible for the HI Program. This varies greatly with each client situation but will happen at a minimum of every six months for each client.

- During the HI intake, clients furnish eligibility documents for staff review and staff identifies the specific premium and medication copayment/deductible assistance needs, enrolls the client in the program, and refers clients to other programs such as SPAP.

- In the rare situations where there is a change in or a missing eligibility document, staff asks that the individual brings or sends the document to the agency within 5 business days or sooner in cases where premium benefits may be terminated or medications will be exhausted.

- Occasionally, referrals to other programs are provided within 5 business days of the HI intake in the event that further information is needed.

- Health Insurance staff and case managers process the assistance request within 1 to 2 business days of the request.

- Maintaining client files and providing client contact to deliver services is an ongoing activity that can happen several times per week for new clients or clients with significant changes or once per month or every six months depending upon the particular client situation.

- Once every six months, the Health Insurance Specialist or case manager will reevaluate client need and update client information.

Location(s) of these service activities

Most services are rendered at the agency office through office visits or phone contacts. Staff will visit clients at their homes, the clinic or hospital as needed although this is rarely requested for this service.

Staffing

Leadership for the Health Insurance Premium and Cost-sharing Assistance program includes:

i. **Director of Access Services:** The Director of Access Services provides direct supervision to the Non-Medical Programs Manager, the Medical Programs Manager, the Outreach Coordinator, the Intake Coordinator and the Health Insurance Coordinator. She also responds to grant requirements and outcomes reporting; assists in the completion of grant proposals; participates in Quality Management meetings; and coordinates and implements quality management activities, including participating in the development of community-wide standards of care.

ii. **Health Insurance Coordinator:** The Health Insurance Coordinator provides direct supervision to the Health Insurance Specialist. She also responds to grant requirements and outcomes reporting; assists in the completion of grant proposals; and assists in coordination and implementation of quality management activities such as client file reviews.

iii. **Executive Team Members:** The Executive Director is the primary contact with the City of Austin Health and Human Services Department (AHHSD) HIV Resource Administration Unit and has final authority in negotiating and approving contracts. The Chief Programs Officer interacts with AHHSD on matters relating to programs and is authorized to enter into negotiations with AHHSD regarding program issues, grant reporting, and performance measures. The Chief Financial Officer interfaces with AHHSD HIV Resource Administration on grant billings. The Grants Manager ensures contract compliance.

Table 3 below indicates key staffing for the Health Insurance Premium and Cost-sharing Assistance Program:

Table 3

Name/Position	Qualifications	Primary Work Assignment	% Time Allocated

Williams-Price/Director of Access Services	Master in Public Health Policy and Management; 5 years of nonprofit management experience; 10 years of human services, grants management, program development, and fiscal management experience; 5 years of case management/social work supervisory experience	Supervises all Case Management, including MCM, Health Insurance, and Outreach programs; manages service delivery and evaluation; reviews financial assistance; budgets and implements program modifications; coordinates QM activities and develops policy and procedures.	4.41%
Braglia/Medical Programs Manager	MSSW; 10.5 years at ASA; 11.5 yrs in social services; 11 years experience with substance abuse, mental health, and persons of color; 11+ yrs in HIV; and 11 yrs with LGBT community.	Supervises all Medical Case Managers; Coordinates, approves and tracks financial requests, evaluates program outcome/service delivery, completes grant reporting requirements, and coordinates and implements QM activities. Provides back up to Director for health insurance support.	0.02%
Rios/Non-Medical Programs Manager	Master Degree in Healthcare Administration; 9yrs of experience in human services field; 7 yrs of experience in non-profit management. 5yrs of experience in case management.	Supervises all Non-Medical Case Managers; Coordinates, approves and tracks financial requests, evaluates program outcome/service delivery, completes grant reports, reviews client files, covers for advocacy staff when absent. Provides back up to Director for health insurance support.	0.02%
Gentle/Health Insurance Coordinator		Supervises Health Insurance Specialist. Coordinates, approves and tracks HI assistance requests, performs intake and six month reviews, makes referrals and provides information, performs quality assurance activities, and completes HI activities, such as data entry of required ARIES fields and reports performance measures	52.48%

Vacant/ Health Insurance Specialist		Performs intake and six month reviews, makes referrals and provides information, performs quality assurance activities, and completes HI activities, such as data entry of required ARIES fields and reports performance measures	52.48%
Casstevens/Access Services Administrative Assistant	24 years with ASA; 8 years of banking experience; experience with AIDS care teams and vulnerable populations with chronic illness	Support direct service delivery by preparing and distributing checks for client assistance. Support program staff and clients with periodic reporting and analysis.	0.52%
Campion/Chief Programs Officer	BS in Education; 22 years with ASA as staff and/or volunteer, 12 years with MHMR, serving consumers from diverse backgrounds; 3 years with DSHS/TCADA developing and implementing HIV/substance use prevention and early intervention programs statewide; 3029+ years experience with HIV/AIDS.	Responsible for overall strategic direction and implementation of agency programs and services. Ultimately has responsibility for the success of agency programs, adherence to all legal and regulatory compliance, and the successful integration and delivery of services.	0%

- The supervisor to staff ratio is 0.446 to 1.06 FTE.

Table 4

Number of Volunteers	1 (social work intern or volunteer, if available)
Number of Volunteer Hours	20
Volunteer Responsibilities	Complete file review for completeness of eligibility and other required documents and assist with administration of client satisfaction survey

ASA will not use subcontractors for this service category.

ASA makes efforts to hire staff that are reflective of the populations served and that speak Spanish. In addition, all staff members are provided ongoing cultural competency training. Please see *Cultural Competency* section for more details on ASA's training and organizational efforts around cultural competency.

Client Access

Eligible clients are most often located, identified and directed to this service in this order: through HIV specialty care medical providers, CommUnity Care at David Powell Clinic, and client-initiated referrals for friends. The Ryan White Part A Outreach Program also refers clients newly diagnosed from the agency HIV Counseling and Testing services. The Outreach , Eligibility and Intake, or case management staff refers to the Heath Insurance Specialist who screens for eligibility for the Health Insurance Premium and Cost-sharing Assistance (HI) program and reviews prescription benefits with the individual. Sometimes these individuals are scheduled for intake for HI assistance and sometimes they are given information on how to decrease prescription expenses through pharmacy discount cards. Several individuals have been referred from the CARE Program at Austin/Travis County Integral Care and the Wright House Wellness Center. The HI Specialist coordinates with these agencies to receive required information for service eligibility and communicates with case managers when there is difficulty in getting client responses for requested data.

The agency proactively outreaches to other AIDS Service Organizations, ACA Certified Application Counselors, medical providers, and their clients by detailing service and eligibility criteria; necessary required documentation; and offering instruction on completing HI assistance referral information. Such efforts include presentations at community agency staff meetings, email communications, orientation of new employees as requested by collaborating agencies, and quarterly community meetings (e.g. Austin TGA Quality Clinical Improvement Committee). The Director of Access Services provides information at various community venues about agency/program services, as well as the steps needed to initiate the referral process for linkage of their clients into the HI program. Executive Directors of area HIV service providers meet monthly to discuss current programs and services, as well as ways to facilitate communication between collaborating agencies in the HIV service delivery area.

Service Linkage, Referral, and Collaboration

Linkage to Primary Medical Care

Health insurance assistance clients who seek services are already linked into medical care or are reconnected to medical care through the Health Insurance Premium and Cost-sharing Assistance (HI) program. If there is any lapse in retaining medical visits, it is because clients did not have resources to pay for COBRA premiums and did not attend appointments during this lapse in coverage. When this situation presents itself, staff expedites current and past COBRA payments to reinstate health insurance coverage. They then discuss with the client plans for scheduling a primary medical care appointment to re-initiate access to care.

After clients are enrolled into HI assistance, staff follows up with clients every six months to determine if they are accessing primary medical care and to encourage them to maintain care. Verification documents for accessing and maintaining medical care include laboratory results on viral load, medical care billing forms with client diagnosis and date of service, and noting kept appointments from the ARIES database when clients agree to share information. The agency continues to experience difficulty in obtaining such documentation from providers but continues to build relationships to support the collaborative effort to assist clients in remaining in care. Additionally, clients are requested to provide such documentation upon bi-annual updates to maintain eligibility for the program and to ease the administrative burden on

the one Health Insurance Staff who is tasked with obtaining this information. Case managed clients work with their Medical or Non-Medical Case Managers to establish goals that facilitate access to and retention of primary medical care. Clients enrolled in the HI program tend to remain in primary care, as is verified through bi-annual report from medical providers and/or the ARIES database.

Other Linkages, Collaboration, and Referral

AIDS Services of Austin (ASA) has collaborative agreements, letters of support, and/or Memoranda of Understanding (MOU) in place with several agencies, mostly with respect to specific programs. The MOUs guide referrals between agencies and allow smooth transitions of clients for additional services. ASA maintains MOUs with Waterloo Counseling Center, Project Transitions, the Housing Authority of the City of Austin, Austin Energy, the CARE Program of Austin/Travis County Integral CARE, and the Communicable Disease Unit at Austin/Travis County Health and Human Services Department (A/TCHHSD). For MOUs that require annual renewal, ASA contacts the partner agency 30 days prior to expiration of these agreements.

ASA also has long-standing referral relationships with many HIV-related social service providers. The more common referrals for HI clients include pharmaceutical Patient Assistance Programs, the State Pharmaceutical Assistance Program through the Texas Department of State Health Services, the CARE Program at Austin/Travis County Integral Care for substance abuse counseling and treatment referral for individuals that are dually diagnosed; Waterloo Counseling Center for mental health counseling; the Wright House Wellness Center for holistic/alternative health services; and the Communicable Disease Unit at A/TCHHSD for HIV/ STI/TB screening.

ASA coordinates health insurance services with the CARE Program at Austin/Travis County Integral Care (CARE), Wright House Wellness Center (WHWC), and CommUnityCare David Powell Clinic. CARE and WHWC make referrals for this service and send required eligibility information. The Health Insurance/Intake Specialist communicates with David Powell Clinic staff to confirm that the clinic is billing the private insurance policy for individuals receiving both services at the clinic and HI assistance.

Eligible clients are also referred to the broad continuum of ASA services: the Capital Area AIDS Legal Project (CAALP) for legal assistance; Food Bank; Medical Nutrition Therapy for nutritional assessment, counseling, and supplements; the Jack Sansing Dental clinic for oral health services; HOPWA for housing assistance; and Comprehensive Risk Reduction Counseling Services for support for individuals to reduce the risk of HIV transmission.

Referral Process and Follow Up
ASA staff assists clients with completing and submitting other agencies' referral forms, communicates with those agencies to clarify client eligibility, and advocates for client service delivery. For those clients who are case managed at ASA, staff ensures that referrals are followed through on in one of the following ways:

- performs follow up at the next client contact by asking the client about the referral and the results;
- accompanies the client to appointments;
- checks the ARIES database to ensure appointment was attended; or,
- calls the agency the client was referred to and confirms client attendance.

All staff document client progress regarding follow-through on referrals in the progress log feature of the Provide Enterprise® electronic client database (ASA's internal electronic database). Case Managers will complete a referral tracking form that includes date of referral and completion date and keep the form updated in the paper client file. The desired outcome results are linkage to and retention in support services.

Goals of Collaborative Activities, Integration of Resources, and Projected Results
The goal of collaborative activities is the provision of comprehensive services through the HIV provider community and other social service agencies using linkages and referrals. These activities ensure clients have access to all needed services that are not offered by ASA. In addition, they allow clients to overcome barriers to accessing and remaining in primary medical care and moving toward self-sufficiency in managing their HIV disease.

Integration of resources and services includes the dedication of ASA staff time toward the completion of other agency intake forms, assisting clients with the intake process, accompanying clients to support service appointments, reporting required data, and working with clients on mutual goals in service plans. These mutual goals may be related to support services that client receive from other agencies, such as financial assistance, substance abuse or mental health counseling, housing, etc.

The projected results of collaborative activities, integration of resources, linkages, and referrals are:
- Client achievement of housing stability
- Meeting food intake needs
- Mental health services access and stability
- Independent management of substance use issues
- Financial stability
- Decreased recidivism
- Personal safety and security

Client Input and Involvement

Clients have several opportunities to offer input into the Health Insurance Premium and Cost-Sharing Assistance (HI) Program. Staff's rapport with the target community, cultural backgrounds, and language abilities enables them to respond to client comments and needs on an ongoing basis. During these encounters, staff works with clients to offer input and identify needs and services they want to pursue.

Staff surveys clients using the standardized questionnaire developed by the Ryan White Quality Management Group to solicit feedback for improving Health Insurance services. The survey is offered in both English and Spanish and interpretation services, at no cost to the client, are offered for clients whose preferred language is not offered in the written format.

The 2013 survey yielded positive feedback, with 90 percent of clients reporting that through the support of AIDS Services of Austin (ASA), their ability to manage their health has improved and 94 percent reporting they are satisfied or very satisfied with case management services. Supervisors will use survey results and staff feedback semiannually to evaluate the effectiveness of referral systems, barriers to service, and other service delivery components. The team will then plan, as appropriate, for service

modification, especially actions to remove barriers. Although no 2014 survey was completed, surveys were distributed in 2015 and is awaiting the results from the administrative agent.

All agency clients may register concerns with supervisors and through the client grievance process. Grievances and formal complaints are reported to the City of Austin HIV Resource Administration Unit (HRAU). All clients are provided a copy of the client grievance policy and procedure upon entry into services and it is posted in English and Spanish in the agency reception area. The interpretation policy is also posted in the reception area, offering clients interpretation services free of charge so that they may file a grievance in their preferred language.

ASA routinely incorporates client feedback and suggestions into planning activities. In developing the agency's 2011 – 2014 Strategic Plan, ASA used interviews and focus groups with current clients to ensure their active participation in the strategic direction of the agency. ASA's Strategic Plan specifically defines "client satisfaction with programs and services" as a key measure of success in alignment with our strategy to "maintain and strengthen existing programs and services through quality improvement." The 2011-2014 Strategic Plan has been extended for one year so that ASA is able to fully analyze the impact of the Affordable Care Act. A suggestion box located in the client lobby is available for clients to submit anonymous feedback. The box is routinely monitored by the Eligibility Services Supervisor. Client feedback is given to appropriate staff for use in program improvements. The Quality Management Guidance Team reviews the feedback from the suggestion box quarterly to evaluate trends and making agency improvements.

Cultural Competency

Service activities will be delivered so that cultural and language differences do not constitute a barrier to services in full compliance with the National Standards on Culturally and Linguistically Appropriate Services (CLAS) described at: http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15.

AIDS Services of Austin (ASA) is in compliance with all 14 CLAS Standards.

Table 5

CLAS Standards	ASA Compliance
16. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.	▪ Staff members are proficient in Spanish, culturally reflective of the Hispanic clientele and available to interpret daily ▪ Staff members are from diverse backgrounds including African-Americans and individuals that are immigrants to the USA. ▪ One staff member proficient in American Sign Language and others with basic skills ▪ Interpretation services in any language are offered to clients free of charge; interpreters culturally reflect clients ▪ Staff assigned to clients are reflective of clients' cultural background, as feasible ▪ Client materials are written at a fifth to eighth grade literacy level and in Spanish at third to fifth grade level ▪ Client materials are provided in Spanish and English ▪ A professional volunteer translates materials from English to Spanish

CLAS Standards	ASA Compliance
	▪ Organization includes "diversity" as one of its core values
17. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.	▪ A Cultural Appropriateness Action Team with staff from varied levels and departments is tasked with ensuring CLAS and health equity are promoted ▪ The agency maintains a tracking mechanism to ensure CLAS compliance ▪ Agency policies are cognitive of cultural appropriateness and those that are applicable to clients are provided in English and Spanish at an appropriate literacy level ▪ Resources are allocated based on community need and assessment ensuring targeting of demographics most affected by the epidemic ▪ 2011-2015 board approved organizational strategic plan includes goals, objectives, and action steps prioritizing staff cultural awareness and competency trainings ▪ Executive Director serves on the Central Health *Health Equity Council* for HIV issues
18. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.	▪ Compliance with Equal Employment Opportunity Commission (EEOC) guidelines since inception ▪ Compliance with The Americans with Disabilities Act (ADA) since inception ▪ EEOC and ADA language reflected on all job postings ▪ Staff are fluent in Spanish, culturally reflective of the Hispanic clientele, and available to interpret daily ▪ Staff members are from diverse backgrounds including African-Americans, Latino, and individuals that are immigrants to the USA. Organizational staffing is reflective of the demographics of the HIV epidemic in the Austin TGA ▪ One staff member proficient in American Sign Language and others with basic skills ▪ Committed to promoting from within for job openings ▪ Evaluation of the potential of current staff for leadership development in order to promote direct service staff ▪ Structured Action Teams provide leadership development opportunities for all staff members ▪ Candidates for positions where bi-lingual (Spanish) skills are preferred are offered a salary premium for demonstrating appropriate proficiency in the language ▪ Organization recruits diverse candidates by networking with higher education institutions of color and advertising and conducting outreach into appropriate publications in communities of color ▪ 2011-2015 board approved organizational strategic plan includes goals, objectives, and action steps prioritizing recruiting, hiring, and training diverse staff and recruiting board members from communities of color ▪ Board officers are demographically and culturally diverse

CLAS Standards	ASA Compliance
	▪ Agency participation in multicultural career expos for staff recruitment
19. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.	▪ The agency's Cultural Appropriateness Action Team and Professional Development Action Team research and implement ongoing training ▪ Agency support of language skills development when resources are available ▪ Executive Director serves on the Central Health *Health Equity Council* for HIV issues
20. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.	▪ Staff are proficient in Spanish, culturally reflective of the Hispanic clientele, and available to interpret daily ▪ Staff are from diverse backgrounds including African-Americans, Latino, and individuals that are foreign-born ▪ One staff member proficient in American Sign Language and others with basic skills ▪ Interpretation services in any language are offered to clients free of charge; interpreters culturally reflect clients ▪ Client materials are written at a fifth to eighth grade literacy level and in Spanish at a third to fifth grade level ▪ Client materials are provided in Spanish and English ▪ A professional volunteer translates client materials from English to Spanish ▪ The agency uses an independently certified system to evaluate the language proficiency of staff ▪ Organization's central voice mail and Dental Clinic voice mail systems are recorded in Spanish ▪ Key program staff have recorded voicemails in Spanish
21. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.	▪ Interpretation policy offering services free of charge posted in all locations ▪ Reception and Intake and Eligibility staff trained to notify clients of their right to receive language assistance services free of charge ▪ Front desk and key staff voicemail messages are recorded in English and Spanish ▪ Interpretation services in any language are offered to clients free of charge; interpreters culturally reflect clients ▪ Client materials are provided in Spanish and English ▪ Reception staff have access to language cards to identify need for interpretation services
22. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.	▪ The agency uses an independently certified system to evaluate the language proficiency of staff ▪ Written policy offers interpretation at no cost to the client in order to prevent the use of family and friends as interpreters ▪ Staff is trained to inform clients of their right to interpretation services at no cost and that family and friends are not a preferred source for interpretation in order to protect client confidentiality ▪ The agency hires professional, certified trainers to assist in

CLAS Standards	ASA Compliance
	interpretation upon request
23. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.	▪ Client materials are provided in Spanish and English ▪ Client materials are written at a fifth to eighth grade literacy level and in Spanish at a third to fifth grade level ▪ Key client information/policies and grievance information is posted in English and Spanish in common areas and available in hard copy from reception desks ▪ Quality Management Guidance Team reviews and updates materials to increase understandability
24. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.	▪ ASA's 2011 – 2015 Strategic Plan identifies compliance with CLAS Standards as a priority: o "Strategy #3: Ensure culturally appropriate programs and services ▪ Agency programs and services meet Culturally and Linguistically Appropriate Services (CLAS) standards ▪ Collaborative partners recognize ASA for delivery of programs and services to reduce stigma and for innovative and collaborative relationships" o Strategic plan action step is to implement an Organizational Cultural Appropriateness Committee representative of diversity of staff and management to further formalize cultural appropriateness trainings and action steps
25. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.	▪ Self-assessment of CLAS-related activities conducted in 2007; results continue to be used to improve services ▪ Cultural Appropriateness Action Team to survey annually and report to staff and board of directors of outcomes from strategic planning goals/objectives related to cultural appropriateness work
26. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.	▪ Collection of data and documentation on each consumer's race, ethnicity, disabilities, spoken and written language, and literacy level; information entered into client paper file, Provide Enterprise® internal electronic database, and ARIES; information updated periodically ▪ Use of the Austin Transitional Grant Area HIV Planning Council's periodic consumer needs assessment ▪ Use of the Brazos Valley Council of Government's periodic consumer needs assessment ▪ Provision of HIV testing data to the Texas Department of State Health Services, (DSHS) and the Centers for Disease Control and Prevention, (CDC)
27. Conduct regular assessments of community health assets and needs and use the results	▪ Collection of data and documentation on each consumer's race, ethnicity, disabilities, spoken and written language, and literacy level; information entered into client paper file, Provide

CLAS Standards	ASA Compliance
to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.	Enterprise® internal electronic database, and ARIES; information updated periodically ▪ Annual review and assessment of HIV epidemiology profile of epidemic as prepared by Texas Department of State Health Services (TDSHS) and the Austin/Travis County Health and Human Services Department ▪ Use of the Austin Transitional Grant Area HIV Planning Council's and Brazos Valley Council of Government's periodic consumer needs assessment ▪ Annual report to staff and board of directors on Austin TGA HIV epidemic in comparison to organization's client demographic profile, staff demographics, and board demographics
28. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.	▪ Collection and updating of data and documentation on each consumer's race, ethnicity, disabilities, spoken and written language, and literacy level; information entered into client paper file, Provide Enterprise® client electronic database, and ARIES. ▪ Provision of HIV testing data results are reported to the DSHS and CDC ▪ Involvement in community events targeted to people of color to build collaborative partnerships in a participatory environment ▪ Staff shares lessons learned at above events with management and leadership staff to expand collective knowledge of local cultural practices and beliefs ▪ Organization is a member of the advisory committee to the Latino Commission on AIDS to develop training institutes on providing culturally appropriate HIV services to the Latino community in 2012 ▪ Executive Director serves on the Central Health *Health Equity Council* for HIV issues
29. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.	▪ Client materials are provided in Spanish and English ▪ Client materials are written at a fifth to eighth grade literacy level and in Spanish at a third to fifth grade level ▪ Client grievance procedures are posted in English and Spanish in common areas throughout the organization ▪ Organization has a formal grievance procedure in place that is reviewed annually by staff
30. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.	▪ Strategic Plan dissemination to donors and posted on website ▪ Community Impact Report disseminated to donors, posted to website, and available in hard copy to public ▪ Responsiveness and pursuit of opportunities to participate in ethnic media

Quality Management

Use of Output and Outcome Data

Using monthly data, AIDS Services of Austin (ASA) tracks progress on the total number of unduplicated clients served, units of service delivered, and meeting outcome goals through monthly data collection through the reporting feature of the Provide Enterprise® electronic client database. On a monthly and quarterly basis, supervisors analyze the data to determine if outputs and outcomes, respectively, are within a 10 percent variance of the elapsed period of the grant cycle. If not, supervisors determine reasons that program goals are not being met and develop plans to address the situation including staff training, supervision, and monitoring staff adherence to the standards of care for the service category. Supervisors also note trends in performance measures with emphasis on clients who do not meet outcome goals and develop appropriate quality management activities or document the reasons for such exceptions. Provide Enterprise® reports give aggregate data at the agency level that documents client trends in service utilization for use in planning for service delivery.

Supervisors will use reports from the ARIES client database to validate data on performance measures such as number of unduplicated clients served and units of service provided. With the client's signed permission to share client information in ARIES, supervisors will use ARIES reports to facilitate getting complete data on services accessed by clients, to document successful linkages to primary medical care and other HIV provider services, and to compare, if needed, client service utilization data in order to avoid duplication of services. ARIES will also provide aggregate data at the community level that documents client trends in service utilization for use in planning for service delivery.

Supervisors will use the service-specific client satisfaction survey to obtain data using client input on satisfaction with services provided. Supervisors review survey results including qualitative data at program area, Leadership Team, Quality Management Guidance Team, and the Program and Services Committee meetings. With input from these various teams, supervisors use suggestions from the survey to identify problems and/or concerns and implement quality improvement activities including service delivery changes when possible.

The resources and tools used to facilitate this process are staff time, the Provide Enterprise® database, ARIES database, and the client satisfaction survey.

Assurance of Compliance with Policies and GuidanceASA develops and follows HI policy and procedure compliant with current Department of State Health Services (DSHS), Brazos Valley Council of Governments (BVCOG), and City of Austin's HIV Resource Administration Unit (HRAU) policies. ASA seeks guidance from BVCOG and/or HRAU staff in the event that clarification may be necessary. Per ASA quality management guidelines, HI policy is revised as needed and reviewed annually.

Quality Management Plan

Quality Management Guidance Team

The overall responsibility and leadership for ASA's Quality Management (QM) program lies with the Chief Programs Officer, who authorizes the Quality Management Guidance Team (QMGT) to plan, assess, measure, and implement performance improvements throughout the entire agency, while providing the necessary resources and support to fulfill these functions.

The membership of the QMGT reflects the diverse service areas within AIDS Services of Austin (ASA). The agency's quality assurance team is comprised of the Chief Programs Officer and other members of ASA staff, ranging from upper management to direct service staff. Other ASA staff members, such as Program Supervisors and Coordinators, Case Managers, and Prevention Specialists are involved, as appropriately indicated. Nominations for membership are decided upon by the QMGT. The QMGT meets every other month. Additional meetings may be called, as needed. Minutes of meetings will be kept and distributed to each member of the committee and to all necessary internal and external stakeholders. A written summary is routinely made available to staff.

The Quality Management Plan
The Quality Management Plan seeks to improve service performance through collecting and evaluating data, identifying service problems based on the collected data, using quality improvement processes to address service delivery issues, and following up to ensure improvements will be sustained. The agency plan is designed annually with target goals and service specific quality improvement activities. It calls for a review of service performance measures, an analysis of this data, and recommendations for service improvements. The plan indicates that the team will oversee an annual update and revision of program policies and procedures. At the end of each year, the plan is evaluated to determine the achievement of goals and the service specific activities and to make recommendations for further follow-up.

The following sections describe other components in the Quality Management Plan:

Activities to Collect Data
The Chief Programs Officer, the Director of Access Services, the Medical Programs Manager, and the Non-Medical Programs Manager will collect data on the program's performance in achieving service goals and meeting standards of care through results from the following sources: outcome and output measures, the agency client satisfaction survey, client file reviews, client/staff feedback, and client grievances.

Managers review performance measures quarterly and report measures not meeting contract objectives to the Quality Management Guidance Team, along with suggestions on planned action steps.

Client satisfaction surveys are an important way to identify quality issues. The agency distributes the standardized survey, after approval by the HIV Resource Administration Unit, City of Austin Health and Human Services Department, at the Food Bank and Dental Clinic sites to collect data on all Ryan White Service Categories offered at ASA. Trained social work interns and volunteers administer the survey during a selected two week period. The survey data is tabulated by the Data Manager-System Support Technician at the HIV Resource Administration Unit, AHHSD.

File reviews are essential to the quality of client data. Supervisors review 50 percent of client intakes and 20 percent of files on clients served in case management programs during the grant cycle to evaluate pertinent Health Insurance Premium and Cost-sharing Assistance program activities and compliance with indicators for the standards of care.

Client input from registered grievances is documented by program supervisors and reviewed at department staff meetings. Managers adhere to the agency's policy on client/patient grievances, which includes review by the Executive Director and/or the Board of Directors, if necessary.

Evaluation of Performance and Assuring Delivery of Quality Services

As data and input are received and problems are identified, the QMGT evaluate concerns and suggestions in order to assure the delivery of quality services.

The QMGT analyzes the output/outcome data and makes recommendations for improvement to program managers. When quality improvement activities around performance measures are designed and completed, the results are then sent to the team and reported in the annual evaluation of the Quality Management Plan.

Program Managers will evaluate survey results to identify trends for improvements and advocate for unmet client need. Supervisors will be careful to note any client feedback related to the culturally appropriateness of service delivery especially with respect to policies and procedures and case manager interventions. To guide decisions about quality improvement activities, survey results are discussed at the program level in department/program meetings and at QMGT meetings. The Programs and Services Committee of the Board of Directors also reviews survey results and gives guidance when appropriate.

Managers utilize grievance input obtained from clients and managers at the different grievance levels to make appropriate service changes, when feasible. Supervisors will be careful to note any client feedback related to the culturally appropriateness of service delivery.

Suggested actions taken based on this data could include staff development training in an identified area, development of organization tracking tools, identification of a different site for service delivery, additional interventions to reduce barriers, or design of client/patient forms to better capture data and service performance measures.

Identification of Quality Improvement Activities
At the beginning of the year, supervisors and the QMGT identify specific service quality improvement activities based on staff and client feedback and the data already discussed. Activities are written using SMART objectives in that they are specific, measureable, attainable, relevant and time-bound.

Addressing Identified Problems
Once a problem or an area that needs further assessment is identified, the team will use, when appropriate, the Plan-Do-Study-Act cycle (PDSA), a four-step model for carrying out change. This process will be used in identified quality improvement activities as detailed in the annual Quality Management Plan. The components are as follows:

1. Plan by recognizing an opportunity and planning a change.
2. Do by testing the change and carrying out a small-scale study.
3. Study by reviewing the test, analyzing the results/data and identifying what has been learned.
4. Act by taking action based on what you learned as a result of data analysis in the study step.

If the change does not work, the cycle will be repeated again with a different plan.

To address client file review results, supervisors will implement a plan of correction when deficiencies in delivering services or lack of compliance to standards have been identified.

Follow Up
Program Managers will follow up to ensure the effectiveness of improvement activities and the maintenance of improvement results. On identified quality improvement activities, supervisors follow up on a quarterly basis to ensure that these activities have been effective in resolving the problem, that no new problems have developed, and that there is sustained improvement in identified areas.

For file review results, supervisors work with staff to develop plans of correction within 15 working days of the file review. Staff has ten working days to implement corrections. At the next quarterly file review supervisors monitor the maintenance of the previous quarter's improvements to ensure problems do not reoccur.

Monitoring and Standardized Tools
Tools used in monitoring and standardization include the file review tool and Provide Enterprise® reports with features to track reporting of performance measures as well as a feature to describe content of progress notes for easy tracking. The annual client satisfaction survey is a standardized tool that the Ryan White Quality Management workgroup evaluates and standardizes across HIV service providers.

Compliance with Ryan White Part A Program Monitoring Standards

ASA will review monitoring standards provided annually by BVCOG and HRAU to ensure compliance.

i. Conduct an annual cost benefit analysis (if not done by the grantee) that addresses noted criteria

Criteria: "the greater benefit in purchasing public or private health insurance, pharmacy benefits, co-pays, and/or deductibles for eligible low-income clients, compared to the costs of having the client in the ADAP program"

AIDS Services of Austin (ASA) will work with the grantee to assist in the completion of an annual cost benefit analysis that addresses the cost of assistance with private health insurance, Medicare Supplement insurance, private health insurance copayments, Medicare Part D copayments and medication deductibles compared to the annual costs of ADAP per individual with HIV.

ii. Where premiums are covered by Ryan White funds, provide proof that the insurance policy provides comprehensive primary care and formulary with a full range of HIV medications to clients

Health Insurance staff will require that clients bring in a copy of the insurance policy to indicate coverage for primary care and a copy of the formulary for HIV medications.

iii. Maintain proof of low-income status

Clients with an individual income between 100 and 250 percent of the Federal Poverty Level (FPL) guideline are eligible for up to 100 percent of assistance for allowable costs Clients with an income between 250 and 350 percent of FPL may receive up to 50 percent assistance towards allowable costs if they were receiving the assistance in the previous grant year or on a case by case basis in extenuating circumstances. Eligibility and Intake or Health Insurance staff requires income verification during intake to services and maintains the documentation in the client paper file. Every six months thereafter, the staff updates client income and asks for proof of income when clients indicate that it has changed.

iv. Provide documentation that demonstrates that funds were not used to cover costs of liability risk pools, or social security

Funds are never approved for checks made to federal or state entities including direct payments to Medicare and Medicaid. Review of check payees from the check register will verify that funds are not distributed to these entities.

v. Coordinate with CMS, including entering into appropriate agreements, to ensure that funds are appropriately included in TrOOP or donut hole costs.

Most Health Insurance Premium and Cost-sharing Assistance (HI) clients qualify for the State Pharmaceutical Assistance Program (SPAP) which covers Medicare Part D donut hole expenses. HI staff will coordinate with Center for Medicare and Medicaid Services (CMS) by referring clients with Medicare Part D medication coverage to pharmacies that participate in data exchanges for prescription drug coverage with the CMS. One of the new entities entering into agreements with CMS is the SPAP. The agency provides referrals to SPAP as needed.

vi. When funds are used to cover co-pays for prescription eyewear, provide a physician's written statement that the eye condition is related to HIV infection

Health Insurance Staff will obtain documentation related to all copay requests as outlined in the HRAU Health Insurance Assistance policy. If clients present with request for non- HIV related prescription eyeglass co-payments, they can be assisted through a private client special needs fund, if eligible.

Work Statement

Service Category Name

Medical Case Management Services

Client Eligibility

To be eligible for Medical Case Management, clients must be HIV-positive, a resident of the five county area in the Austin Transitional Grant Area (Travis, Williamson, Bastrop, Hayes, Caldwell), and willing to work on HIV service plan goals.

ASA has Eligibility and Intake staff specifically trained to determine clients' level of need for services and eligibility status (every 6 months) for all ASA programs as well as programs at partner HIV services organizations and other social service organizations. ASA's Eligibility and Intake staff determine eligibility by securing verification of HIV status and residency. Staff will secure proof of identity, income, and insurance status as required intake documents.

xi. **Documentation of HIV Status:** Staff obtain verification of HIV status through:
- a signed statement from the medical provider;
- a positive Western Blot laboratory result with the name of the client;
- a printed document from the ARIES database indicating verification of HIV status by another provider;
- HIV detectable viral load lab results; or,
- a hospital discharge summary or medical records from previous provider(s).

xii. **Proof of Identity:** Proof of identity includes: Texas driver's license, Texas State identification card, a passport, Military or Student identification card, Social Security card, birth certificate or other official document as listed on the Austin TGA Ryan White Client Eligibility Form

xiii. **Residency Verification:** In order to establish residency, clients can provide unexpired documents such as a Texas driver's license, Texas State or Tribal identification cards, Social Security award letter, rental/mortgage agreement, utility bill, or similar forms accepted by the Ryan White Part A Austin TGA.

Documentation of HIV status must be presented within 30 days and residency documentation must be presented within 60 days. Clients may be granted conditional eligibility if they present with an urgent need and lack the necessary eligibility documentation. ASA will make reasonable efforts to assist clients in obtaining the necessary documentation.

xiv. **Income Verification: S**taff use the MAGI or Mock MAGI form for client income verification. Clients that have filed a tax return in the previous year complete the MAGI form and submit their tax transcript as income verification. Clients that did not submit a tax return or have had a change in income complete a Mock MAGI form and submit an IRS proof of non-filing and income verification document. Income verification documents include Social Security Award letter, Veterans/Public Assistance or Worker's Compensation benefits statements, wage payment stubs, signed zero income verification letter or other document listed in the Austin TGA Ryan White Part A Client Eligibility Form. There are some populations that are excluded from having to obtain tax transcripts or IRS proof of non-filing, these include: homeless, recently released from incarceration (3 months), undocumented, emancipated minors, and SSI and/or SSDI recipients.

xv. **Health Insurance Coverage:** Cards verifying coverage by private medical insurance, Medicare, Medicaid, Veteran's Health Benefits, and Indian Health services will be accepted. Signed no insurance attestation statements will also be accepted. Should a client receive City of Austin Medical Assistance Program (MAP), a copy of the card will be made and a attestation of no insurance will be signed.

Eligibility and Intake Staff will use the Austin TGA Ryan White Part A Client Eligibility Form to reassess clients in the program every six months for determination of continued eligibility. At that time, client residency, income, and health insurance will be updated and/or new documentation obtained as indicated. Clients presenting with a change to income, residency or health insurance status within the six month review period will complete the Change in Circumstances: Eligibility Verification Addendum form. All required eligibility and intake documents, as well as periodic updates, are stored in the client's paper file and documented electronically in the agency's electronic client database, Provide Enterprise®. Client identifying information is also entered into the ARIES client database. Eligibility and Intake staff completes a form verifying eligibility documents were collected, and an administrative assistant enters this data into ARIES.

The intake and eligibility staff utilizes the Intake Screening Tool for Appropriate Referral for Medical Case Management behavioral health case management to ensure that clients will engage in services. The tool addresses client willingness and readiness to work on behaviors to promote treatment adherence and address barriers to HIV adherence; the existence of mental health symptoms, especially depression and anxiety, or substance abuse that present as barriers to HIV treatment adherence; client being at risk for lack of adherence such as experiencing significant medication side-effects; and client willingness to meet or talk to the medical case managers at a minimum of twice monthly.

Clients seeking services need to express willingness to work on HIV disease management and support service goals such as attending scheduled primary medical care, lab, oral health, medical nutrition therapy, and support service appointments. Clients should agree to follow the goals in the medical case management individualized service plan. Clients who identify as African American or Hispanic will be enrolled into the Minority AIDS Initiative (MAI) case management programs as space allows; however all ASA case management will provide culturally and linguistically appropriate services.

Case managers assess the client acuity and appropriateness for transfer to other programs based on the two acuity scales required by the Austin TGA Case Management Standards of Care:

- Medical Case Management Acuity Scale; and
- Non-Medical Case Management Acuity Scale

The client's score on each acuity scale determines what case management services will be provided, which can be comprised of either medical case management, non-medical case management, or a combination of case management services. When the client's acuity score is one, two, or three for the Medical Case Management acuity scale and the client expresses

willingness to participate in programmatic goals, he/she will be assigned to a Behavioral Health Medical Case Manager (BHMCM) and a Registered Nurse Medical Case Manager (RN MCM) with special attention to clients with identified medication adherence difficulties and complex medical issues. When capacity is limited, clients with a score of one may have to wait for either the RN or the BHMCM. Clients who do not express a willingness to participate in program goals will be assigned to either regular Medical Case Management and/or Non Medical Case Management (N-MCM) if they score a one, two or three on the respective scale Case management supervisors or assigned case managers, based on professional judgment, may determine that a client's unique situation and needs qualify he/she for a higher level of service than indicated by the acuity score provided that the rationale is documented in the client's record.

Clients are only assigned more than one case manager when there is capacity within each case manager position. Clients scoring a one, two, or three on the N-MCM acuity scale will be assigned to a non-medical case manager as capacity allows. Clients scoring a zero on either scale will not be assigned to that respective service.

Target Population

The target population for AIDS Services of Austin's (ASA) Medical Case Management Program is primarily low-income[7] people residing in the five counties of the Austin Transitional Grant Area (TGA) (Travis, Williamson, Bastrop, Hayes, and Caldwell) and living with HIV disease. The Medical Case Management Program will target and serve people living with HIV and AIDS of all races and ethnicities, although African-American and Hispanic individuals will be enrolled under the Minority AIDS Initiative (MAI) portion of the program.

The following table (Table 1) compares the 2015 calendar year demographics of ASA's Case Management programs to the demographics of people living with HIV and AIDS in the Austin TGA. Table 1 illustrates ASA's work in reaching women, people of color, and people aging with HIV and AIDS.

Table 1

	ASA Clients	**Austin TGA PLWH/A**
Gender		
Male	77%	85%
Female	20%	15%
Transgender	3%	(unavailable)
Race/Ethnicity		
White	32%	46%

[7] ASA defines low-income as a household that is at or below 80% of the U.S. Department of Housing and Urban Development's Area Median Income guideline for Travis County.

Black	41%	22%
Hispanic	25%	29%
Other	2%	3%
Age Group		
0 – 12	0%	0%
13 – 24	2%	4%
25 – 44	27%	44%
45 +	71%	52%

ASA client geographic concentration aligns with areas of high prevalence of HIV/AIDS in the Austin TGA. ASA's ten most common ZIP Codes for ASA's Case Management clients are located in Travis and Williamson counties.

Table 2

ASA Top 10 Client ZIP Codes	Prevalence Range of HIV/AIDS*
78752	314-674/100,000
78741	675-1,199/100,000
78723	675-1,199/100,000
78753	314-674/100,000
78758	675-1,199/100,000
78744	675-1,199/100,000
78702	115-313/100,000
78704	314-674/100,000
78721	115-313/100,000
78724	314-674/100,000

**Source: Enhanced HIV Reporting: S. Arbona and S. Novello (Travis County)*

Austin TGA data suggest that 84 percent of clients have medical comorbidities, while others report social and health-related co-factors that complicate medical and other service delivery for HIV.[8] Recent studies have shown that 67 to 96 percent of HIV positive individuals have comorbidities.[9] Due to past experience, ASA predicts that co-morbidities and conditions for the Medical Case Management Program's target population will include STDs, substance abuse, mental health issues, commercial sex work, poverty, homelessness, domestic violence, Hepatitis B and C, heart disease, diabetes, and tuberculosis (TB). Due to stricter eligibility requirements, Austin Travis County Integral Care is offering case management to fewer clients with chronic mental illness. Consequently, ASA is serving a higher percentage of clients experiencing chronic mental health issues.

Service Category Activities

[8] ARIES database, provided by the City of Austin (Addendum 5 to Ryan White Part A RFA 2012-13)
[9] "Prevalence and Patient Awareness of Medical Comorbidities in an Urban AIDS Clinic," Weiss, Jeffery J., PhD, et al

Service activities linked to Budget Justification

The Medical Case Management Program (MCM Program) will enhance the continuum of care offered through AIDS Services of Austin (ASA) and the HIV service provider community in the Austin Transitional Grant Area (TGA). The purpose of the MCM Program is to provide community-based medical case management outside a clinical setting in order to facilitate client's access to and retention in medical care and adherence to HIV medication regimens.

The MCM Program at ASA will be comprised of *two different levels of medical case management:*

- The Registered Nurse Medical Case Manager (RN MCM)
- The Behavioral Health Medical Case Manager (BHMCM) – a Licensed Master Social Worker (LMSW)

The two medical case managers will assist clients in developing knowledge and skills in order to independently adhere to their medical treatment plan. Services will be offered in a culturally and linguistically appropriate manner and in the preferred language of the client. If case managers with the appropriate language skills are not available, interpretation services will be provided at no cost to the client.

ASA has dedicated 1 FTE through Ryan White Non-Medical Case Management (MAI and Non-MAI) to provide Non-Medical Case Management services to clients receiving – RN or BHMCM services, as capacity allows. The Non-Medical Case Manager will coordinate services and provide the advocacy required for service plan implementation by communication and multidisciplinary consultation on client goals and needs with all of the appropriate members of the client's team. The Non-Medical Case Manager will advocate for the client to ensure timely and coordinated access to appropriate levels of medical care.

Service coordination will include sharing the individualized service plan and progress on plan goals with the assigned RN and BHMCM when part of the team as well as accepting their input into the development and revision of the service plan. Non-Medical Case Manager will focus on coordination of services and client advocacy related to mental health, substance abuse, and psychosocial needs.

This comprehensive array of services offered at one location will improve the quality of care provided to clients with multiple complex health-related and basic psychosocial needs with the ultimate goal of keeping HIV positive individuals in primary medical care and improving their health outcomes.

Most clients with a Medical Case Management acuity score of two or three will have both these levels of case management when there is capacity. The medical case managers will focus on treatment adherence counseling, addressing complex client needs, assisting the client in developing increased skills in disease management, and interventions to promote behavioral

change.

Staff Training
The RN Medical Case Manager and the Behavioral Health Medical Case Manager will complete at least 12 hours annually of continuing education targeting the 20 core competencies outlined on pages 13 and 14 of the Austin TGA Ryan White Part A Case Management Standards of Care.

Key activities for both levels of medical case management service are:

- Screening and intake;
- Initial assessment of service need;
- Development of a comprehensive, individualized service plan;
- Coordination of services and medical treatments required to implement the plan;
- Client monitoring to assess plan effectiveness; and,
- Follow-up on medical treatment, re-assessment, and service plan revision.

Screening and Intake with Initial Basic Assessment of Service Needs

- **Initial Screening:** Eligibility and Intake staff screens all new and returning clients to determine eligibility and need for case management services. A screening and intake appointment will be scheduled within 10 working days of the initial contact with the client or designated agent requesting services. In the interim, clients who are eligible for Outreach are connected with Outreach staff to be connected with community resources. In certain circumstances, clients are provided an emergency intake. Screening must include the eligibility parameters already described in *Client Eligibility*; the presenting problem as indicated by the client and referral source; HIV disease stage and medical need; household size; and history of mental health, substance abuse, and/or domestic violence when indicated.

- **Client Intake Process:** Once eligibility screening is complete and the client is determined to qualify for case management, Eligibility and Intake staff gather information about the client level of functioning, willingness to participate in case management and service plan goals, the quality of support given by family and significant others, and public/private benefit eligibility. Additional documentation will include such items as languages spoken by the client, literacy level, household members, emergency contacts, health care and social service providers, a signed consent to receive services, the client bill of rights, the Client Confidentiality Policy, and the ASA Client Grievance Policy and Procedure.

  The collection of race and ethnicity information allows Eligibility and Intake staff to determine which clients to place in MAI programs. The Eligibility and Intake Coordinator places clients of all races and ethnicities with case mangers that reflect their preferred languages and have experience working with clients with diverse

backgrounds. In the event that ASA does not have a case manager available that speaks the preferred language of the client, interpretation services will be offered to the client free of charge. Clients are discouraged from using family and friends as interpreters unless requested due to confidentiality and stigma concerns. The interpretation services will be offered during the intake process as well as at all succeeding meetings with case managers. Documentation and client materials will be provided in the preferred language of the client to the extent possible.

- **Acuity Scale Assessment:** Case management staff will use two acuity scales as described in the Austin Transitional Grant Area (TGA) Ryan White Part A Case Management Standards of Care. One acuity scale is for Medical Case Management and one for Non-Medical Case Management. The two scales are used to determine the appropriate type and level of services needed by the client. Staff rates the client situation according to 12 parameters of life situation or functioning in the Non-Medical Case Management Acuity Scale and six parameters of life situation or functioning in the Medical Case Management Acuity Scale that have four scores assigned to them. Totaling the scores for each parameter results in a weighted acuity score that assigns the client to an acuity level of zero, one, two, or three. ASA's Case Management staff are trained and experienced at taking into account information collected from the client, significant others, and medical/support service providers in order to determine appropriate individualized acuity scores for each client. Those at zero acuity are not eligible for case management services.

- **SAMISS Assessment:** Case Management staff will perform the Substance Abuse and Mental Illness Symptoms Screener (SAMISS) during the comprehensive assessment process per the Austin TGA Ryan White Part A Case Management Standards of Care. If the client screens positive on the SAMISS, case management staff immediately refer clients to mental health (Waterloo Counseling Center or ATCIC) or substance abuse (ATCIC) services.

- **Emergency/Critical Referrals:** Intake and Eligibility staff is expected to make immediate referrals in the following situations: client is in acute need of psychiatric or medical care, has less than 10 days of prescribed medications left, indicates they could be a danger to themselves or others, is homeless, faces an impending eviction or utility termination, or indicates he/she has no food. A temporary service plan may be executed following completion of the initial screening based upon immediate needs or concerns.

<u>For the Registered Nurse Medical Case Manager (RN MCM) level of service, the RN MCM will take a client-centered approach to the following activities:</u>

Initial Comprehensive Assessment

- The RN MCM, after obtaining a signed client consent to medical treatment, will complete an initial comprehensive nursing assessment that includes a client medical history to cover HIV and other diagnoses, the overall physical health status, and

pertinent family history; client primary medical problem to include measures taken to manage HIV; client's strengths and skills; a review of HIV medications and lab values; physical examination including vital signs and observation of client physical status; and client symptoms and measures taken to address them. The RN MCM will also collect basic information on client support systems as they relate to disease management and complete a psychosocial/emotional screening. The RN Medical Case Manager will refer clients with basic needs to a Medical or Non-Medical Case Manager depending upon the acuity level of medical versus psychosocial issues.

- Communicating with other health care and social service professionals involved in a client's care is vital to the assessment, especially when a patient is transferred from another location (such as a clinic, hospital, or residence) or has had a significant change in health status. Based on all information collected during the comprehensive nursing assessment, the RN MCM will develop a nursing diagnosis. A nursing diagnosis "is a clinical judgment about actual or potential individual, family, or community experiences/responses to health problems/life processes."[10] As part of the comprehensive assessment, the RN MCM will review the acuity level score determined at intake and revise it as necessary given the more thorough information collected from the client and other sources.

- The RN MCM will begin the comprehensive assessment within 10 working days of the referral from intake and will complete it within 30 days of the first assessment contact with exceptions noted. This period of time allows the nurse case manager to assess client health status over time and collect more in-depth information in order to address complex client medical needs.

Comprehensive Individualized Service Plan

- Based on the nursing assessment and diagnosis, the RN MCM creates an individualized, comprehensive, culturally and linguistically appropriate service plan relevant to the client's particular needs with goals that are measurable and time-specific. A **nursing service plan** outlines the nursing care to be provided to a client and describes a set of appropriate nursing interventions that the RN MCM will implement to improve or resolve identified client health problems from the assessment. It guides in the ongoing provision of nursing care and assists in the evaluation of that care.

- Service plans will include, at a minimum, nursing plan goals developed with client input for HIV medication treatment adherence, increasing client skills in managing HIV disease, increasing client knowledge of HIV disease and transmission, follow up on specialty care referrals, access to appropriate levels of medical care, and meeting other outcomes such as dietary or exercise as recommended by the primary medical care physician.

[10] North American Nursing Diagnosis Association, http://www.nanda.org/Home.aspx

- Common nursing interventions listed in the plan will include guiding client to fill medication boxes; medical counseling on medication adherence, side-effects, and lab results; referral to clinical trials or specialty care; addressing health literacy issues; and actions related to serving as a medical liaison between the primary medical care physician, the pharmacy, and specialty care when appropriate. Plans will also detail client expectations in meeting goals.

- The individualized service plan must be completed within 45 days of the intake with exceptions noted.

Service Coordination for Plan Implementation and Client-Specific Advocacy

- Once the service plan is developed and reviewed with the client, the RN MCM will coordinate services and provide the advocacy required for plan implementation through communication and multidisciplinary consultation on client goals and needs with the clinical team: client's primary and specialty care medical providers, BHMCM, non-medical case manager, support service social worker, registered dietician, oral care health professional, and/or other health care and supportive service professionals, when appropriate. Service coordination will include sharing the individualized care/service plan and progress on plan goals with the primary medical care team and the assigned case manager(s) as well as accepting input into the development and revision of the care plan.

    - This RN MCM will advocate with health care professionals to ensure that the client's medical needs are met especially in complex medical situations and to ensure timely and coordinated access to appropriate levels of medical care. The RN MCM will focus on nursing responsibilities for service coordination and client advocacy such as the need for specialty care referrals, medical nutrition therapy, suggestions to medical provider on medications taking into account medication side effects, need for durable medical equipment, etc. The RN MCM will have primary responsibility for making referrals related to necessary client physical medical goals and will work in conjunction with the assigned BHMCM or non-medical case manager for referrals to meet support service needs.

- Service coordination and client advocacy will be provided whenever the client needs such interventions. These actions, in more complex situations, could occur several times weekly until the client stabilizes to weekly or monthly when clients have a consistent health status or are functioning more independently.

- Where appropriate and feasible, the agency will work with healthcare providers to develop a system to access the client's medical information and to provide updates to medical professionals to inform the provision of care while maintaining compliance with HIPAA and confidentiality policies.

Comprehensive Reassessment

- The RN MCM will reassess client health status and complete a basic screening on psychosocial functioning, note changes since the last assessment, and identify new needs. Reassessment includes noting barriers to treatment adherence, and evaluating the success of nursing case management interventions. This is also a time to reevaluate the current level of case management services and the need for additional levels such as a Non-Medical Case Management or BHMCM. The assessment will include a review of service utilization such as frequency of hospitalizations, emergency room visits, kept primary medical and specialty care appointments, use of medial nutrition therapy services, and adherence to oral health visits. If a client has both an RN and BH MCMs, then the RN MCM will focus on utilization of hospitals and emergency rooms.

Client Monitoring to Assess Plan Effectiveness and Plan Re-Evaluation/Revision

- The RN MCM will continuously monitor client follow through on service plan goals and reevaluate the effectiveness of the service plan as treatment continues, making revisions to the plan when indicated.
- The RN MCM will also incorporate client input into the service plan as well as feedback from the primary medical care team, other assigned case manager(s), and other support service professionals. The agency will establish formal linkages through MOUs to assist with team conferencing.
- Based on the reassessment and as needed, the service plan goals and tasks will be revised, with client input, and will include actions to address any service utilization issues noted.
- Reassessment and service plan reevaluation/revision will occur in the frequencies noted below with exceptions noted:

Table 3

RN Medical Case Management	Acuity Level 2	Acuity Level 3
Reevaluation of Comprehensive Assessment	Annually (every 12 months)	Every 6 months
Service Plan Reevaluation & Revision	Every 6 months	Quarterly (every 3 months)

For the Behavioral Health Medical Case Manager (BH MCM) level of service, the case manager will take a client-centered approach to the following activities:

Initial Comprehensive Assessment

- The BHMCM will develop a more in-depth initial assessment building upon the basic intake assessment to include at a minimum: client health and psychosocial history, presenting problem, current health and psychosocial status, barriers to medical and support services, clients strengths and skills, extent of support system, mental health screening, diagnosis according to the DSM IV TR (when indicated), and substance abuse evaluation. The BHMCM will also expand upon the psychosocial areas of client

information at a more intensive level than the RN MCM, especially as they relate to barriers to medical care.

- As part of the comprehensive assessment, the BHMCM will review the acuity level score determined at intake and revise it as necessary given the more thorough information collected from the client and other sources. If the client's psychosocial issues are extremely unstable (acuity level three), then the BHMCM will refer the client for non-medical case management to work toward client stabilization.
- The BHMCM will begin the assessment within 10 working days of the referral from intake and will complete it within 30 days of the first assessment contact. This period of time allows the case manager to assess client health status over time and collect more in-depth information in order to address complex client medical, mental health, and substance abuse needs.

Comprehensive Individualized Service Plan

- Based on the assessment and mental health diagnosis, the BHMCM then creates an individualized, comprehensive, culturally and linguistically appropriate service plan relevant to the client's particular needs with goals that are measurable and time-specific. A **client service plan** outlines the client goals developed with client input and includes, at a minimum, goals related to HIV medication treatment adherence, increasing client skills in managing HIV disease, increasing client knowledge of HIV disease and transmission, addressing barriers to treatment adherence, follow up on specialty care referrals, access to appropriate levels of medical care, and meeting other outcomes such as dietary or exercise as recommended by the primary medical care physician.
- Common case manager interventions listed in the plan will include education on HIV disease, transmission, and risk reduction; addressing barriers to medication adherence and follow up on specialty care referrals; addressing health literacy issues; clinical (mental health/substance abuse) interventions to promote behavior change; and actions related to serving as a mental health/support services liaison with the primary medical, specialty care physicians, and support service providers. Plans will also detail client expectations in meeting goals.
- When a client has both an RN MCM and a BHMCM, the two professionals will consult at least weekly and as often as biweekly to avoid duplication of interventions relating to service plan goals. In general, the RN MCM will focus more on physical health status and clinical medication issues while the BHMCM will focus on mental health, substance abuse, and psychosocial barriers to service plan and treatment adherence.
- As part of the comprehensive assessment, the BHMCM will review the acuity level score determined at intake and revise it as necessary, given the more thorough information collected from the client and other sources. The individualized service plan must be completed within 45 days of the intake with exceptions noted.

Service Coordination for Plan Implementation and Client-Specific Advocacy

- Once the service plan is developed and reviewed with the client, the BHMCM will coordinate services and provide the advocacy required for plan implementation by

communication and interdisciplinary consultation on client goals and needs with the client's clinical team: primary and specialty care medical providers, RN MCM, non-medical case manager, social worker, registered dietician, oral care health professional, and/or other health care and supportive service professionals when appropriate. The BHMCM will advocate for the client to ensure timely and coordinated access to appropriate levels of medical care.

- Service coordination will include sharing the individualized care/service plan and progress on plan goals with the primary medical care team and other assigned medical or non-medical case managers as well as accepting input into the development and revision of the service plan. The BHMCM will focus on coordination of services and client advocacy related to mental health, substance abuse, and psychosocial needs. If the client is found to have intense psychosocial needs, then a referral to a non-medical case manager is indicated. The medical and non-medical case manager will work together as a team to clarify responsibilities for actions taken with clients.
- Service coordination and client advocacy will be provided whenever the client needs such interventions. These actions, in more complex situations, could occur several times weekly until the client stabilizes and reduces their need for services to weekly or monthly due to stable health, mental health, and substance use status and/or more independent functioning.

Comprehensive Reassessment

- The BHMCM will reassess the client health, mental health, and psychosocial functioning, note changes since the last assessment, and identify new needs. If client household size or income has changed, the case manger will screen for eligibility for public/private benefit programs.
- Reassessment includes noting barriers to treatment adherence, and evaluating the success of case management interventions. This is also a time to reevaluate the current level of case management services and the need for additional levels such as client/patient navigation and/or non-medical case management. The assessment will also include a review of service utilization such as frequency of hospitalizations, emergency room visits, kept primary medical and specialty care appointments, use of medial nutrition therapy services, and adherence to oral health care visits. If a client has both an RN and BHMCM, then the BHMCM will focus on attendance at primary medical/specialty care, medical nutrition therapy, and oral health appointments.
- The BHMCM will incorporate client input into the assessment as well as feedback from the primary medical care team, the other assigned case manager, and other support service professionals. The agency will establish formal linkages through MOUs to assist with team conferencing.

Client Monitoring to Assess Plan Effectiveness and Plan Re-Evaluation/Revision

- The BHMCM will closely monitor client follow through on service plan goals and reevaluate the effectiveness of the service plan as services continue.
- Based on the reassessment, as needed, the service plan goals and tasks will be revised

with client input, and will include actions to address any service utilization issues noted.

- Reassessment and plan reevaluation/revision will occur in the frequencies noted below with exceptions noted:

Table 4

Behavioral Health Medical Case Management	Acuity Level 2	Acuity Level 3
Reevaluation of Comprehensive Assessment	Annually (every 12 months)	Every 6 months
Service Plan Reevaluation & Revision	Every 6 months	Quarterly (every 3 months)

Access and Coordination of Services

All activities at both levels of medical case management will take place in the environment most appropriate to the client situation such as the client residence, the primary medical care clinic, specialty care office, AIDS Services of Austin's offices, or the hospital (if client has been admitted). Types of client contact will include telephone, in person, email, and/or fax communication (when agreed to by the client). All contact will be in the client's preferred language. If medical case managers are not proficient in the client's preferred language, interpretation services will be offered at no cost to the client.

Both medical case managers will act as part of a multidisciplinary clinical team to include primary medical care providers, the registered dietician, and oral health care professionals. This is primarily accomplished through basic case conferencing and consultation and sharing of clinical information that is used in the development and revision of comprehensive assessments and service plans. Weekly, the MCM team meets with the Non-Medical Case Managers and the Registered Dietician to review, discuss, and plan activities for shared clients. This meeting allows for the team to work together to support the client without the duplication of services.

The RN MCM will work under the supervision of a Medical Doctor (MD) through standing orders for medical treatments as indicated and through phone conferencing on medications/side-effects and other aspects of clinical nursing. The BHMCM will formulate mental health diagnoses and clinical (mental health/substance abuse) interventions to promote behavior change under the supervision of a Licensed Clinical Social Work - Supervisor (LCSW-S).

Case Closure

Clients who are no longer engaged in active case management services will be evaluated by the case manager for closure. Clients achieve graduation from the program when all service plan goals are successfully met, the client is able to independently resolve his/her needs, and both client and case manager agree that services are no longer needed. Other reasons for closure may include: client completion of case management goals, client ability to resolve needs independently, referral to another case management program, client relocation outside of the counties in the Austin TGA, incarceration for greater than three months, client choice, ineligibility for services, client lost to care or not engaging, agency-initiated termination due to

behavioral violations, or client death. Clients that are lost to care or not engaging in their care will be contacted through the Return to Care Collaborative, and reasonable attempts will be made to bring them back into care. (Please see. *Linkage to Primary Medical Care* section for further explanation.)

Case Managers will complete a closure summary documenting case closure and reason for closure. Clients are considered non-compliant with case management if they do not respond to three attempts to contact them within 30 days via phone, e-mail, or written correspondence. The case manager will notify clients of closure through in-person meeting, phone contact, or written correspondence. Clients will be provided with written documentation explaining closure and the process to be followed if services are needed in the future. Case managers will offer appropriate referrals to the client and obtain signed client release(s) of health information for new providers to assist in transfers. Staff will conduct exit interviews in their preferred language (through interpretation services at no charge to the client, if necessary) with clients upon case closure or graduation from the program, if appropriate. In situations in which closure is involuntary, case managers will review the client situation with supervisors to secure approval for termination of services.

Frequency of these service activities

- Eligibility and Intake staff screens all new and returning clients to determine eligibility and need for case management services. A screening and intake appointment will be scheduled within 10 working days of the initial contact with the client or designated agent requesting services. The intake, which includes emergency/critical referrals occurs initially two to three times per week after staff is hired and trained and decreases to two to three times per month as the program progresses.

- The Medical Case Managers will begin the comprehensive assessment within 10 working days of the referral from intake and will complete it within 30 days of the intake.

- The individualized service plan must be completed within 45 days of the intake.

- Service coordination and client advocacy, in more complex situations, could occur several times weekly until the client stabilizes and reduces their need for services to weekly or monthly due to stable health, mental health, and substance use status and/or more independent functioning.

- Clients will be reviewed for case closure at six months of program participation and at the time that they are no longer engaged in active case management services.

- Reassessment of continued eligibility for services (including residency, income and health insurance) will occur every six months, or as changes occur.

- Reassessment and plan reevaluation/revision will occur in the frequencies noted below with exceptions noted:

Table 5

Medical Case Management	Acuity Level 2	Acuity Level 3
Reevaluation of Comprehensive Assessment	Annually (every 12 months)	Every 6 months
Service Plan Reevaluation & Revision	Every 6 months	Quarterly (every 3 months)

- Medical Case Managers will assess clients for case closure at six months of program participation and at the time they are no longer engaged in active case management services.

Location(s) of these service activities

Staff provides services through telephone and visit contacts in venues that are convenient to the client, which include the ASA office, primary care and specialty clinics, hospitals, nursing facilities, and the client's home.

Staffing

Leadership for the Medical Case Management Program includes:

iv. **Director of Access Services:** The Director of Access Services provides direct supervision to the Non-Medical Programs Manager, the Medical Programs Manager, the Outreach Coordinator, the Intake Coordinator and the Health Insurance Coordinator. She also responds to grant requirements and outcomes reporting; assists in the completion of grant proposals; participates in Quality Management meetings; and coordinates and implements quality management activities, including participating in the development of community-wide standards of care.

v. **Executive Team Members: The** Executive Director is the primary contact with the City of Austin Health and Human Services Department (AHHSD) HIV Resource Administration Unit and has final authority in negotiating and approving contracts. The Chief Programs Officer interacts with AHHSD on matters relating to programs is authorized to enter into negotiations with AHHSD regarding program issues, grant reporting, and performance measures. The Chief Financial Officer interfaces with AHHSD HIV Resource Administration on grant billings. The Grants Manager ensures contract compliance.

Table 6

Name/Position	Qualifications	Primary Work Assignment	% Time Allocated
Williams-Price/Director of Access Services	Master in Public Health Policy and Management; 5 years of nonprofit management experience; 10 years of human services, grants management, program development, and fiscal management experience; 5 years of case management/social work supervisory experience	Supervises all Case Management, including MCM, and Outreach programs; manages service delivery and evaluation; reviews financial assistance; budgets and implements program modifications; coordinates QM activities and develops policy and procedures.	2% (Non-MAI)/1% (MAI)
Rios/Non-Medical Programs Manager	Master Degree in Healthcare Administration; 9yrs of experience in human services field; 7 yrs of experience in non-profit management. 5yrs of experience in case management.	Supervises all Non-Medical Case Management Programs, up to 2 interns, approves and tracks financial requests, evaluates program outcomes and service delivery, completes grant reporting requirements, and coordinates and implements QM activities.	1% (Non-MAI)/0.2% MAI
Braglia/Medical Programs Manager	MSSW; 10.5 years at ASA; 11.5 yrs in social services; 11 years experience with substance abuse, mental health, and persons of color; 11+ yrs in HIV; and 11 yrs with LGBT community.	Supervises all Medical Case Management Programs, up to 2 interns, approves and tracks financial requests, evaluates program outcomes and service delivery, completes grant reporting requirements, and coordinates and implements QM activities	16% (Non-MAI)/7% (MAI)
Martin, Andrew/RN Medical Case Manager	Licensed as a Registered Nurse, 4 years of experience with HIV/AIDS disease nursing	Perform initial comprehensive medical assessment, make referrals to additional levels of care/social services as appropriate, work in an interdisciplinary clinical team for client care, develop and assist client in achieving nursing care service plan goals, provide client education, reassess and reevaluate client needs periodically.	68% (Non-MAI)/32% (MAI)
Flores/Behavioral Health Medical Case Manager	Licensed Master Social Worker; 12 yrs in social services; 12 years experience with substance abuse, 12 mental health, and 12 persons of color; 12 yrs in HIV care; and 12 yrs with LGBT community.	Perform in-depth client assessment to determine level of need for medical and psychosocial support services, make referrals to additional levels of care/social services as appropriate, work in an interdisciplinary clinical team for client care, develop and	68% (Non-MAI)/32% (MAI)

Name/Position	Qualifications	Primary Work Assignment	% Time Allocated
		assist client in achieving client service plan goals, provide client education, assess and address client barriers to achieving treatment adherence including mental health concerns, reassess and reevaluate client needs periodically.	
Medina/Eligibility and Intake Coordinator	BSW; 1 year at ASA, including experience with mental health, low-income people, and people of color.	Performs eligibility and intake, makes referrals and provides information, performs quality assurance activities.	1% (Non-MAI)/0.4% (MAI)
Crilos/ Eligibility and Intake Specialist		Provides Tier 1 Non-Medical Case Management to assist clients with issues related to HIV/AIDS in accessing medical care and social services through advocacy, resource linkage, and supportive counseling.	3% (Non-MAI)/1% (MAI)
Lindgren/Eligibility Screener/Receptionist	HIV, Substance Use, Mental Health Experience as direct receptionist	Provides programmatic support to clients in the verification and updates of eligibility documents and handles fees related to client services	0.3% (Non-MAI)/0.2% (MAI)
Lambert/LCSW Supervisor	LCSW Supervisor	Provide clinical supervision and oversight to the Behavioral Medical Case Manager	Contract

- The supervisor to staff ratio for the MAI portion of the program is 0.08 to 0.654 FTE
- The supervisor to staff ratio for the non-MAI portion of the program is 0.18 to 1.4 FTE.
- The overall supervisor to staff ratio for the program is 0.27 to 2.06 FTE.

ASA will contract with one Licensed Clinical Social Worker – Supervisor who will provide clinical supervision to the Behavioral Health Medical Case Manager. Supervision will occur off site in a private location where confidentiality is ensured for up to two hours per week.

ASA makes efforts to hire staff that is reflective of the populations served. In addition, all staff members are provided ongoing cultural competency training. Please see *Cultural Competency* section for more details on ASA's training and organizational efforts around cultural competency.

Client Access

Current—and potential—clients for Medical Case Management can access services via several points of entry as outlined below:

- Potential clients are being located and identified through Ryan White, Part A Outreach Program Services. Outreach staff identifies individuals with unknown HIV status and those with known HIV positive status who are late to care or "out-of-care." *HRSA defines an individual as being out-of-care if there is no evidence of a client accessing any one of the following three components of HIV primary medical care during a defined 12-month time frame: viral load testing, CD4 count, or provision of anti-retroviral therapy.* However, the Ryan White Quality Management Workgroup has agreed that clients without these three components need intervention prior to one year. As a result, the outreach team also identifies individuals with HIV who have not received primary medical care for six months or longer.

    - **Area Hospitals and Emergency Rooms:** AIDS Services of Austin (ASA) Outreach team members are placed at area hospitals to train staff in referring to agency programs and to follow-up on referrals made by hospital staff. Outreach is called at least biweekly to link HIV positive individuals to medical care and support services such as Case Management Non-Medical . Hospitals identified include University Medical Center Brackenridge, and Seton Medical Center Austin of the Seton Family of Hospitals; and St David's Medical Center, St. David's North Austin Medical Center, and St. David's South Austin Medical Center. Outreach workers visit these hospitals and emergency rooms at the frequency of contact and hours agreed upon with hospital staff.

    - **Correctional Facilities:** At Travis County Correctional Complex (TCCC), Travis State Jail, and Del Valle Correctional Facility, ASA outreach team members identify at-risk for HIV or HIV positive individuals who are pre-release from incarceration or recently released from incarceration and link them into medical and supportive services. Outreach workers engage in a broad range of activities include working with correctional facility staff to refer HIV positive individuals.

Outreach staff receiving service inquiry letters from HIV positive individuals due to be released encourages those individuals to contact the agency upon release. Once contacted, the outreach staff immediately begins the process of linking the individual to medical care and with Case Managers. In cases where a person who has been recently released comes to or phones the agency directly, staff is deployed to the site of preference as identified by the individual who is contacting the agency for services.

    - **CommUnity Care at David Power Clinic:** Several times monthly or sometimes on a weekly basis, Outreach staff links identified HIV positive individuals to primary medical care . Staff provides targeted individuals with a transition from outreach to case management services through building on the trust already established during outreach.

    - **Community and Peer Referrals:** Due to the high quality of services provided by ASA, 14 percent of clients that receive case management intake assessments identify

themselves and initiate contact for services as a result of referrals from family, friends, or peers who have received agency services. For the same reason, 24 percent of clients are referred to case management from local health care providers.

- **ASA Prevention Programs:** ASA offers a variety of HIV prevention and testing programs that reach over 7,500 individuals annually. Prevention programs include:
    - Mpowerment, a prevention program for young gay, bisexual, and questioning men;
    - Healthy Relationships, an evidence-based intervention focused on prevention with positives;
    - HIV testing;
    - Hepatitis C and syphilis testing for targeted populations;
    - Linkage to care and patient navigation;
    - Condom Distribution Network;
    - Testing, Linkage, and Care, a program that brings HIV testing to sites where high risk populations frequent; and,
    - CLEAR, a risk reduction counseling program.

All of ASA's Prevention programs refer HIV positive individuals into Outreach services or case management services through eligibility and intake.

- **Other:** ASA receives referrals through the United Way's 211, a non-emergency human services access phone line. ASA also receives referrals through HIV service directories. Please see *Section k. Other Linkages, Collaboration, and Referrals* for further description of ASA's referral system.

Clients will begin access Medical Case Management services when they call or walk into the agency or transfer by another program.As described in *Section e. Service Category Activities*, Eligibility and Intake staff completes service eligibility screening to determine appropriateness for the program. They conduct eligibility screenings and assessments Monday through Friday primarily during agency business hours (8:30 am to 5:30 pm) and outside business hours as necessary. Eligibility and Intake staff strives to schedule intake appointments within one week of initial contact and rarely allows for a wait time of more than two weeks. The Medical Case Managers will contact clients referred into their services within two weeks of the referral, at a minimum, with exceptions noted.

Access Barriers and Reducing Barriers to Access
One of the most difficult barriers to service delivery is lack of basic needs, such as food, housing, and transportation, which interferes with the client focusing on linkage to access medical case management, medical care and supportive services. Other barriers are described below:

Table 10

Barrier	Description of Reduction/Elimination of Barrier
Eligibility	3. Eligibility and Intake staff or case managers provide reasonable

Barrier	Description of Reduction/Elimination of Barrier
Documentation	assistance to clients to obtain identifying documentation. 4. Documentation may be a challenge for undocumented Hispanics or homeless individuals – ASA staff is trained to assist them is accessing appropriate documentation.
Basic Needs*: *Food*	4. Client intake and case manager assessment for eligibility for ASA's Helping Hand Food Bank services; 5. Assisting clients with Food Stamp applications; 6. Assisting clients with accessing emergency food needs through referrals to area agencies and food programs.
Basic Needs*: *Housing and Homelessness*	3. Access to short-term and long-term housing assistance needs to stabilize clients through ASA HOPWA and Best Single Source Plus Programs. 4. Case Manager coordination and referral to: Housing service providers such as Project Transitions, Foundation Communities, area boarding homes, Austin area public housing and emergency shelters. .
Basic Needs*: *Transportation*	5. ASA main facility located on two major bus routes as well as located in a zip code area where a high number HIV infections are located (78752); 6. ASA Intake, Outreach, and Case Managers conduct home visits when necessary and work with clients who are unable to transport to office location; 7. ASA Intake (or Case Managers) complete client applications for Special Transportation Services through Capital Metro; 8. Access to bus passes through the Basic Transportation Needs Fund
Health Literacy and Education	3. Assess client's health and language literacy; 4. Work with client through verbal communication and with health education materials tailored to client's level of understanding and language needs.
Unique Cultural & Linguistic Issues	4. Extensive training in cultural awareness and responsiveness related to communities of color, specifically African-American and Hispanic; 5. ASA has established working relationship with qualified interpreters to assist clients whose primary language is not adequately represented by a staff person; 6. MCM staff build trust with undocumented Hispanic clients by explaining that this status will not affect eligibility for agency services.
Substance Abuse Treatment	4. Consumer information about possible side effects of illicit drugs and HIV medications;

Barrier	Description of Reduction/Elimination of Barrier
	5. Access to appropriate case manager(s) with substance abuse assessment experience; 6. Collaborate with CARE program and other related agencies to provide support and treatment services.
Mental Health Treatment	2. Collaboration with and referrals to mental health providers including Waterloo Counseling and CARE program at ATCIC.
Historical Mistrust of Medical and Social Service Providers	2. ASA case managers work with client through skills building to mitigate mistrust and to improve the client health literacy through education.
HIV Disease Stigma	4. Frequent and prompt contact with individuals in target populations to build trust while relying on 24 years of established history of trust with ASA as an HIV provider for African-American and Hispanic populations; 5. Client-centered approach, emphasizing client strengths, respect for client self-determination – this approach is particularly effective in African-American and Hispanic communities; 6. Referrals of HIV positive women of color to Women Rising Project to educate women in making healthcare decisions – 60 percent of the women served are African-American.

* Basic needs as a barrier is more likely to affect African-American and Hispanic communities due to disproportionate poverty levels among communities of color.

Service Linkage, Referral, and Collaboration

Service category's key activity is to link clients to HIV primary medical care, at ASA, this can be accomplished in two ways the Outreach program and/or the case management programs. The Medical Case Managers interventions are essential for ongoing retention of clients in medical care.

Referral Mechanism:

- Many clients are first assisted with initial access and linkage to HIV primary medical care through Outreach team efforts. The goal of the Outreach team is to successfully link clients to primary medical care in three months or less, in accordance with the National HIV/AIDS Strategy. To open a dialog with individuals about initial access to medical care, outreach staff will initiate rapport by providing information about general HIV transmission, risk reduction, and the benefits of early medical intervention. Once the Outreach team links the client into medical care, as evidenced by successful attendance at the first medical appointment, and the client is enrolled in the appropriate case management program depending on the individual needs (i.e. N-MCM, Medical Case Management and PLUS Program). Once assigned to a case manager they then work with the client on strategies to maintain their medical care as part of their service plan.

- A client who contacts the agency directly and do not meet the eligibility requirements for the Outreach program is linked with Eligibility and Intake staff that assess the client's immediate needs for basic needs services and link them to community resources to stabilize their situation and refers them to primary medical care, if needed. A Non-Medical Case Manager may coordinate the clients medical care appointments and visits and assist them with any housing, identification documentation, or financial assistance needs.

Service Coordination and Integration of Resources
The Medical Case Managers address crucial barriers to access to primary care by providing referrals for immediate basic needs such as transportation, food, and/or housing. Clients may be assisted through agency resources such as bus passes/taxi vouchers, one of several housing assistance programs, and/or the Food Bank program. In addition, they may be referred to community support services such as area food pantries, Capital Metro for transportation access, and churches for financial assistance with rent and/or utilities.

To address fear of medical providers, the medical care system, or fears related to limited English or health literacy proficiency, staff discusses with clients any resistance to medical care and may be accompanied to their intake medical care visit. Once the client has successfully kept the initial intake appointment at David Powell Clinic[11], the Medical Case Managers work with clients on continued follow-up that may include accompanying clients to subsequent doctor visits. Medical Case Managers build upon the trust developed with Outreach staff and the developing trust with medical providers to coordinate care with David Powell Clinic staff by assisting in appointment scheduling /rescheduling and conferencing around continued barriers to care.

In addition to working with the David Powell Clinic, ASA has long-standing referral relationships with other HIV-related medical providers including the Blackstock Family Clinic (a SETON non-profit practice); Austin Infectious Disease Consultants (a private specialty care practice); Academic Physicians at Trinity; South Austin Medical Clinic; Jefferson Street Family Practice; and, Austin Regional Clinic-South, Far West, and Quarry Lake locations.

Projected Results
As indicated in the *Service Coordination and Integration of Resources* section, clients are referred to primary medical care services by different agency staff depending upon their place in the broad continuum of services offered at ASA. In most cases, Outreach staff tracks primary care referrals by accompanying clients to appointments. When they do not attend appointments with clients, the staff calls health care providers to verify kept appointments or verifies the visit through the ARIES database. Medical Case Managers attend primary medical care appointments with clients or call agencies to track and verify successful referrals.

[11] Clients entering services through Outreach rarely have private insurance and for those that do, the Outreach team will ensure they make a follow-up appointment with their private medical provider.

Clients are considered successfully linked to medical care upon completing an intake session with CommUnity Care at David Powell Clinic or other medical providers. The Medical Case Managers report on retention in medical care as measured through the HRSA/HAB HIV Performance Measures: two or more medical visits in an HIV care setting in the measurement year. All staff will document client progress in progress notes and successful outcomes in the service provided feature of the Provide Enterprise® electronic client database (ASA's internal electronic database). Medical Case Managers will complete a referral tracking form that includes date of referral and completion date and keep the form updated in the paper client file. The desired outcome results are linkage to and retention in primary medical care services.

ASA also participates in the Return to Care Collaborative with CommUnityCare at David Powell Clinic, Austin/Travis County Integral Care Program, Community Action, Waterloo Counseling, and the Wright House Wellness Center. Through this partnership, the collaborative partners seek to improve information sharing to determine the reasons why people have fallen out of care and to use this data to predict out-of-care trends. As participants in the collaborative effort, ASA and CommUnityCare at David Powell Clinic will monitor and share out-of-care information on a bi-monthly basis, when able, and work together to return clients to medical care. When out-of-care clients are identified, they will be referred to ASA's Outreach Program when they have not received HIV primary medical care for one year or more. This staff will facilitate their reentry into the Medical Case Management, as this is typically the level of case management required for clients contacted through the Return to Care Collaborative. Once the Medical Case Manager is assigned, they must contact the client within 10 days, although it is typically sooner.

Other Linkages, Collaboration, and Referral

Linkages and Collaborations

AIDS Services of Austin (ASA) has collaborative agreements, letters of support, and/or Memoranda of Understanding (MOU) in place with several agencies, mostly with respect to specific programs. The MOUs guide referrals between agencies and allow smooth transitions of clients for additional services. ASA maintains MOUs with Waterloo Counseling Center, Project Transitions, the Housing Authority of the City of Austin, Austin Energy, the CARE Program of Austin/Travis County Integral CARE, and the Communicable Disease Unit at Austin/Travis County Health and Human Services Department (A/TCHHSD). For MOUs that require annual renewal, ASA contacts the partner agency 30 days prior to expiration of these agreements.

ASA also has long-standing referral relationships with HIV-related social service providers, including the CARE Program at Austin/Travis County Integral Care for substance abuse counseling and treatment referral for individuals that are dually diagnosed; Project Transitions for transitional housing and hospice; South Austin Marketplace for transitional and long-term housing; the Customer Assistance Program (Austin Energy) for utilities payment assistance; Waterloo Counseling Center for mental health counseling; the Wright House Wellness Center for

holistic/alternative health services; Salvation Army and the Austin Resource Center for the Homeless for emergency housing; the Social Security Administration for disability benefit applications and appeals; Del Valle Correctional Facility, Travis State Jail, and the University of Texas Medical Branch State Penitentiary for services to inmates upon their release; the Communicable Disease Unit at A/TCHHSD for HIV/ STI/TB screening; and SafePlace for domestic violence assistance.

Eligible clients are also referred to the broad continuum of ASA services: the Capital Area AIDS Legal Project (CAALP) for legal assistance; Medical Nutrition Therapy for nutritional assessment, counseling, and supplements; the Jack Sansing Dental clinic for oral health services; HOPWA for housing assistance; Comprehensive Risk Reduction Counseling Services for support for individuals to reduce the risk of HIV transmission; and the Health Insurance Program for premium, copayment and deductible financial assistance.

Referral Process and Follow Up
ASA staff assists clients with completing and submitting other agencies' referral forms, communicates with those agencies to clarify client eligibility, and advocates for client service delivery. For those clients who are case managed at ASA, staff ensures that referrals are followed through on in one of the following ways:

- performs follow up at the next client contact by asking the client about the referral and the results;
- accompanies the client to appointments;
- checks the ARIES database to ensure appointment was attended; or,
- calls the agency the client was referred to and confirms client attendance.

All staff document client progress regarding follow-through on referrals in the progress log feature of the Provide Enterprise® electronic client database (ASA's internal electronic database). Non-Medical Case Managers will complete a referral tracking form that includes date of referral and completion date and keep the form updated in the paper client file. The desired outcome results are linkage to and retention in support services.

Goals of Collaborative Activities, Integration of Resources, and Projected Results
The goal of collaborative activities is the provision of comprehensive services through the HIV provider community and other social service agencies using linkages and referrals. These activities ensure clients have access to all needed services that are not offered by ASA. In addition, they allow clients to overcome barriers to accessing and remaining in primary medical care and moving toward self-sufficiency in managing their HIV disease.

Integration of resources and services includes the dedication of ASA staff time toward the completion of other agency intake forms, assisting clients with the intake process, accompanying clients to support service appointments, reporting required data, and working with clients on mutual goals in service plans. These mutual goals may be related to support services that client receive from other agencies, such as financial assistance, substance abuse or mental health counseling, housing, etc.

The projected results of collaborative activities, integration of resources, linkages, and referrals are:

- Client achievement of housing stability
- Meeting food intake needs
- Mental health services access and stability
- Independent management of substance use issues
- Financial stability
- Decreased recidivism
- Personal safety and security

Client Input and Involvement

Clients have several opportunities to offer input into the Medical Case Management Program services. Staff's rapport with the target community enables them to respond to client comments and needs on an ongoing basis. During these encounters, staff works with clients to offer input and identify needs and services they want to pursue.

Clients are surveyed using the standardized questionnaire developed by the Ryan White Quality Management Group to solicit feedback for improving case management services. The 2013 survey yielded positive feedback, with 90 percent of clients reporting that through the support of AIDS Services of Austin (ASA), their ability to manage their health has improved and 94 percent reporting they are satisfied or very satisfied with case management services. Supervisors will use survey results and staff feedback semiannually to evaluate the effectiveness of referral systems, barriers to service, and other service delivery components. The team will then plan, as appropriate, for service modification, especially actions to remove barriers. No 2014 survey was completed, ASA did distribute surveys in 2015 and is awaiting final results.

African-American and Hispanic individuals with HIV who access Medical Case Management services work closely with case managers to develop individualized culturally and linguistically appropriate service plans. Service plans are written in the client's preferred language and at an appropriate literacy level, depending on the need to the client. In addition, cultural beliefs such as alternative medicine practices are taken into account. Client input is integral to developing the service plan, which includes only those issues and needs the client chooses to address.

All agency clients may register concerns with supervisors and through the client grievance process. All clients are provided a copy of the client grievance policy and procedure upon entry into services and it is posted in English and Spanish in the agency reception area. The interpretation policy is also posted in the reception area, offering clients interpretation services free of charge so that they may file a grievance in their preferred language.

ASA routinely incorporates client feedback and suggestions into planning activities. In developing the agency's 2011 – 2014 Strategic Plan, ASA used interviews and focus groups with current clients to ensure their active participation in the strategic direction of the agency. ASA's Strategic Plan specifically defines "client satisfaction with programs and services" as a key measure of success in alignment with our strategy to "maintain and strengthen existing programs and services through quality improvement." The 2011-2014 Strategic Plan has been extended for one year so that ASA is able to fully analyze the impact of the Affordable Care Act. A suggestion box located in the client lobby is available for clients to submit anonymous feedback. The box is routinely monitored by the Eligibility Services Supervisor. Client feedback is given to appropriate staff for use in program improvements. The Quality Management Guidance Team reviews the feedback from the suggestion box quarterly to evaluate trends and making agency improvements.

Cultural Competency

Service activities will be delivered so that cultural and language differences do not constitute a barrier to services in full compliance with the National Standards on Culturally and Linguistically Appropriate Services (CLAS) described at: http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15.

AIDS Services of Austin (ASA) is in compliance with all 15 CLAS Standards.

Table 9

CLAS Standards	ASA Compliance
31. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.	▪ Staff members are proficient in Spanish, culturally reflective of the Hispanic clientele and available to interpret daily ▪ Staff members are from diverse backgrounds including African-Americans and individuals that are immigrants to the USA. ▪ One staff member proficient in American Sign Language and others with basic skills ▪ Interpretation services in any language are offered to clients free of charge; interpreters culturally reflect clients ▪ Staff assigned to clients are reflective of clients' cultural background, as feasible ▪ Client materials are written at a fifth to eighth grade literacy level and in Spanish at third to fifth grade level ▪ Client materials are provided in Spanish and English ▪ A professional volunteer translates materials from English to Spanish ▪ Organization includes "diversity" as one of its core values
32. Advance and sustain organizational governance	▪ A Cultural Appropriateness Action Team with staff from varied levels and departments is tasked with ensuring

CLAS Standards	ASA Compliance
and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.	CLAS and health equity are promoted ▪ The agency maintains a tracking mechanism to ensure CLAS compliance ▪ Agency policies are cognitive of cultural appropriateness and those that are applicable to clients are provided in English and Spanish at an appropriate literacy level ▪ Resources are allocated based on community need and assessment ensuring targeting of demographics most affected by the epidemic ▪ 2011-2015 board approved organizational strategic plan includes goals, objectives, and action steps prioritizing staff cultural awareness and competency trainings ▪ Executive Director serves on the Central Health *Health Equity Council* for HIV issues
33. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.	▪ Compliance with Equal Employment Opportunity Commission (EEOC) guidelines since inception ▪ Compliance with The Americans with Disabilities Act (ADA) since inception ▪ EEOC and ADA language reflected on all job postings ▪ Staff are fluent in Spanish, culturally reflective of the Hispanic clientele, and available to interpret daily ▪ Staff members are from diverse backgrounds including African-Americans, Latino, and individuals that are immigrants to the USA. Organizational staffing is reflective of the demographics of the HIV epidemic in the Austin TGA ▪ One staff member proficient in American Sign Language and others with basic skills ▪ Committed to promoting from within for job openings ▪ Evaluation of the potential of current staff for leadership development in order to promote direct service staff ▪ Structured Action Teams provide leadership development opportunities for all staff members ▪ Candidates for positions where bi-lingual (Spanish) skills are preferred are offered a salary premium for demonstrating appropriate proficiency in the language ▪ Organization recruits diverse candidates by networking with higher education institutions of color and advertising and conducting outreach into appropriate publications in communities of color ▪ 2011-2015 board approved organizational strategic plan includes goals, objectives, and action steps prioritizing recruiting, hiring, and training diverse staff and recruiting

CLAS Standards	ASA Compliance
	board members from communities of color ▪ Board officers are demographically and culturally diverse ▪ Agency participation in multicultural career expos for staff recruitment
34. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.	▪ The agency's Cultural Appropriateness Action Team and Professional Development Action Team research and implement ongoing training ▪ Agency support of language skills development when resources are available ▪ Executive Director serves on the Central Health *Health Equity Council* for HIV issues
35. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.	▪ Staff are proficient in Spanish, culturally reflective of the Hispanic clientele, and available to interpret daily ▪ Staff are from diverse backgrounds including African-Americans, Latino, and individuals that are foreign-born ▪ One staff member proficient in American Sign Language and others with basic skills ▪ Interpretation services in any language are offered to clients free of charge; interpreters culturally reflect clients ▪ Client materials are written at a fifth to eighth grade literacy level and in Spanish at a third to fifth grade level ▪ Client materials are provided in Spanish and English ▪ A professional volunteer translates client materials from English to Spanish ▪ The agency uses an independently certified system to evaluate the language proficiency of staff ▪ Organization's central voice mail and Dental Clinic voice mail systems are recorded in Spanish ▪ Key program staff have recorded voicemails in Spanish
36. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.	▪ Interpretation policy offering services free of charge posted in all locations ▪ Reception and Intake and Eligibility staff trained to notify clients of their right to receive language assistance services free of charge ▪ Front desk and key staff voicemail messages are recorded in English and Spanish ▪ Interpretation services in any language are offered to clients free of charge; interpreters culturally reflect clients ▪ Client materials are provided in Spanish and English ▪ Reception staff have access to language cards to identify need for interpretation services
37. Ensure the competence of individuals providing	▪ The agency uses an independently certified system to evaluate the language proficiency of staff

CLAS Standards	ASA Compliance
language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.	▪ Written policy offers interpretation at no cost to the client in order to prevent the use of family and friends as interpreters ▪ Staff is trained to inform clients of their right to interpretation services at no cost and that family and friends are not a preferred source for interpretation in order to protect client confidentiality ▪ The agency hires professional, certified trainers to assist in interpretation upon request
38. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.	▪ Client materials are provided in Spanish and English ▪ Client materials are written at a fifth to eighth grade literacy level and in Spanish at a third to fifth grade level ▪ Key client information/policies and grievance information is posted in English and Spanish in common areas and available in hard copy from reception desks ▪ Quality Management Guidance Team reviews and updates materials to increase understandability
39. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.	▪ ASA's 2011 – 2015 Strategic Plan identifies compliance with CLAS Standards as a priority: o "Strategy #3: Ensure culturally appropriate programs and services ▪ Agency programs and services meet Culturally and Linguistically Appropriate Services (CLAS) standards ▪ Collaborative partners recognize ASA for delivery of programs and services to reduce stigma and for innovative and collaborative relationships" o Strategic plan action step is to implement an Organizational Cultural Appropriateness Committee representative of diversity of staff and management to further formalize cultural appropriateness trainings and action steps
40. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.	▪ Self-assessment of CLAS-related activities conducted in 2007; results continue to be used to improve services ▪ Cultural Appropriateness Action Team to survey annually and report to staff and board of directors of outcomes from strategic planning goals/objectives related to cultural appropriateness work
41. Collect and maintain accurate and reliable	▪ Collection of data and documentation on each consumer's race, ethnicity, disabilities, spoken and written language,

CLAS Standards	ASA Compliance
demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.	and literacy level; information entered into client paper file, Provide Enterprise® internal electronic database, and ARIES; information updated periodically ▪ Use of the Austin Transitional Grant Area HIV Planning Council's periodic consumer needs assessment ▪ Use of the Brazos Valley Council of Government's periodic consumer needs assessment ▪ Provision of HIV testing data to the Texas Department of State Health Services, (DSHS) and the Centers for Disease Control and Prevention, (CDC)
42. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.	▪ Collection of data and documentation on each consumer's race, ethnicity, disabilities, spoken and written language, and literacy level; information entered into client paper file, Provide Enterprise® internal electronic database, and ARIES; information updated periodically ▪ Annual review and assessment of HIV epidemiology profile of epidemic as prepared by Texas Department of State Health Services (TDSHS) and the Austin/Travis County Health and Human Services Department ▪ Use of the Austin Transitional Grant Area HIV Planning Council's and Brazos Valley Council of Government's periodic consumer needs assessment ▪ Annual report to staff and board of directors on Austin TGA HIV epidemic in comparison to organization's client demographic profile, staff demographics, and board demographics
43. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.	▪ Collection and updating of data and documentation on each consumer's race, ethnicity, disabilities, spoken and written language, and literacy level; information entered into client paper file, Provide Enterprise® client electronic database, and ARIES. ▪ Provision of HIV testing data results are reported to the DSHS and CDC ▪ Involvement in community events targeted to people of color to build collaborative partnerships in a participatory environment ▪ Staff shares lessons learned at above events with management and leadership staff to expand collective knowledge of local cultural practices and beliefs ▪ Organization is a member of the advisory committee to the Latino Commission on AIDS to develop training institutes on providing culturally appropriate HIV services to the Latino community in 2012

CLAS Standards	ASA Compliance
	▪ Executive Director serves on the Central Health *Health Equity Council* for HIV issues
44. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.	▪ Client materials are provided in Spanish and English ▪ Client materials are written at a fifth to eighth grade literacy level and in Spanish at a third to fifth grade level ▪ Client grievance procedures are posted in English and Spanish in common areas throughout the organization ▪ Organization has a formal grievance procedure in place that is reviewed annually by staff
45. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.	▪ Strategic Plan dissemination to donors and posted on website ▪ Community Impact Report disseminated to donors, posted to website, and available in hard copy to public ▪ Responsiveness and pursuit of opportunities to participate in ethnic media

Quality Management

Use of Output and Outcome Data

Using monthly data, AIDS Services of Austin (ASA) tracks progress on the total number of unduplicated clients served, units of service delivered, and achievement of outcome goals through the reporting feature of the Provide Enterprise® electronic client database. On a monthly and quarterly basis, supervisors analyze the data to determine if outputs and outcomes, respectively, are within a 10 percent variance of the elapsed period of the grant cycle. If not, supervisors determine reasons that program goals are not being met and develop plans to address the situation including staff training, supervision, and monitoring staff adherence to the standards of care for the service category. Supervisors also note trends in performance measures with emphasis on clients who do not meet outcome goals and develop appropriate quality management activities or document the reasons for such exceptions. Provide Enterprise® reports give aggregate data at the agency level that documents client trends in service utilization for use in planning for service delivery.

Supervisors will use reports from the ARIES client database to validate data on performance measures such as number of unduplicated clients served and units of service provided. With the client's signed permission to share client information in ARIES, supervisors will use ARIES reports to facilitate getting complete data on services accessed by clients, to document successful linkages to primary medical care and other HIV provider services, and to compare, if needed, client service utilization data in order to avoid duplication of services. ARIES will also provide aggregate data at the community level that documents client trends in service utilization for use in planning for service delivery.

Supervisors will use the service-specific client satisfaction survey to obtain data using client input on satisfaction with services provided. Supervisors review survey results including qualitative data at the program area, Leadership Team, Quality Management Guidance Team, and the Program and Services Committee meetings. With input from these various teams, supervisors use suggestions from the survey to identify problems and/or concerns and implement service specific improvement activities including service delivery changes when possible.

The resources and tools used to facilitate this process are staff time, the Provide Enterprise® database, ARIES database, and the client satisfaction survey.

Assurance of Compliance with Austin TGA Standards of Care

In accordance with Austin TGA Ryan White Part A HIV Case Management Standards, Medical Case Management staff will complete training as outlined in the Standards.

All Medical Case Managers funded by Ryan White Part A complete the initial seven required courses as listed on page 12 of the standards and a minimum of 12 hours of ongoing required continuing education aimed at the 20 core competencies listed on page 13 of the standards in grant year. Medical Case Managers will annually complete 12 hours of ongoing continuing education in the 2014-2015 grant year.

Case Management supervisors are responsible for case manager compliance with training requirements including the Standards of Care and for ensuring that evidence of training completion is retained in the employee's personnel file.

Agency supervisors and managers ensure that direct service staff and supervisors are qualified individuals as evidenced by the documentation of degree(s), length of experience and type of experience in the staff personnel file.

To assure that services are delivered consistent with the Austin TGA Standards of Care, supervisors annually review a total of 20 percent of client files served during the grant cycle. Supervisors complete reviews quarterly on a portion of client files. The results of file reviews can be found in the paper and electronic file review tool. Within 15 working days of the file review, supervisors review with Medical Case Managers any indicators that are not in compliance. Supervisors and staff develop plans of correction that require completion within ten working days and note reasons for exceptions. The evaluation of staff performance is linked to compliance with the standards of care and follow-up on plans of corrections from file reviews. During monthly supervision, Case Managers and their supervisor review any deficiencies in compliance with standards.

Quality Management Plan

Quality Management Guidance Team

The overall responsibility and leadership for ASA's Quality Management (QM) program lies with the Chief Programs Officer, who authorizes the Quality Management Guidance Team (QMGT) to plan, assess, measure, and implement performance improvements throughout the entire agency, while providing the necessary resources and support to fulfill these functions.

The membership of the QMGT reflects the diverse service areas within AIDS Services of Austin (ASA). The agency's quality team is comprised of the Chief Programs Officer and other members of ASA staff, ranging from upper management to direct service staff. Other ASA staff members, such as Program Supervisors and Coordinators, Case Managers, and Prevention Specialists are involved, when appropriate. Nominations for membership are decided upon by the QMGT. The QMGT meets every other month. Additional meetings may be called, as needed. Minutes of meetings are distributed directly to each member of the committee and to all necessary internal and external stakeholders. A written summary is routinely made available to staff.

The Quality Management Plan
The Quality Management Plan seeks to improve service performance through collecting and evaluating data, identifying service problems based on the collected data, using quality improvement processes to address service delivery issues, and following up to ensure improvements will be sustained. The agency plan is designed annually with target goals and service specific quality improvement activities. It calls for a review of service performance measures, an analysis of this data, and recommendations for service improvements. The plan indicates that the team will oversee an annual update and revision of program policies and procedures. At the end of each year, the plan is evaluated to determine the achievement of goals and service specific improvement activities and to make recommendations for further follow-up.

The following sections describe other components in the Quality Management Plan:

Activities to Collect Data
The Chief Programs Officer and Director of Access Services will collect data on the program's performance in achieving service goals and meeting standards of care through results from the following sources: outcome and output measures, the agency client satisfaction survey, client file reviews, client/staff feedback, and client grievances.

Supervisors review performance measures quarterly and report measures not meeting contract objectives to the Quality Management Guidance Team, along with suggestions on planned action steps.

Client satisfaction surveys are an important way to identify quality issues. The agency distributes the standardized survey, after approval by the HIV Resource Administration Unit, Austin Health and Human Services Department, at the Food Bank and Dental Clinic sites to collect data on all Ryan White Service Categories offered at ASA. Trained social work interns and volunteers administer the survey during a selected two week period. The survey data is tabulated by the Data Manager-System Support Technician at the HIV Resource Administration Unit, AHHSD.

File reviews are essential to the quality of client data. Supervisors review 50 percent of client intakes and 20 percent of files on clients served during the grant cycle to evaluate pertinent Medical Case Management Program activities and compliance with indicators for the standards of care.

Client input from registered grievances is documented by program supervisors and reviewed at department staff meetings. Supervisors adhere to the agency's policy on client/patient grievances, which includes review by the Executive Director and/or the Board of Directors, if necessary.

Evaluation of Performance and Assuring Delivery of Quality Services
As data and input are received and problems are identified, the QMGT evaluate concerns and suggestions in order to assure the delivery of quality services.
The QMGT analyzes the output/outcome data and makes recommendations for improvement to program supervisors. When quality improvement activities around performance measures are designed and completed, the results are then sent to the team and reported in the annual evaluation of the Quality Management Plan.

Supervisors will evaluate survey results to identify trends for improvements and advocate for unmet client need. Supervisors will be careful to note any client feedback related to the culturally appropriateness of service delivery especially with respect to policies and procedures and case manager interventions. To guide decisions about quality improvement activities, survey results are discussed at the program level in department/program meetings and at QMGT meetings. The Programs and Services Committee of the Board of Directors also reviews survey results and gives guidance when appropriate.

Program supervisors utilize grievance input obtained from clients and managers at the different grievance levels to make appropriate service changes, when feasible. Supervisors will be careful to note any client feedback related to the culturally appropriateness of service delivery.

Suggested actions taken based on this data could include staff development training in an identified area, development of organization tracking tools, identification of a different site for service delivery, additional interventions to reduce barriers, or design of client/patient forms to better capture data and service performance measures.

Identification of Program/Service Specific Quality Improvement Activities
At the beginning of the year, supervisors and the QMGT identify specific service quality improvement activities based on staff and client feedback and on data already mentioned. Activities are written using SMART objectives in that they are specific, measureable, attainable, relevant and time-bound.

Quality improvement activities for the Medical Case Management Program will include a continued evaluation of the effectiveness of the program. Specifically, the team will monitor viral load suppression of clients served.

Addressing Identified Problems

Once a problem or an area that needs further assessment is identified, the team will use, when appropriate, the Plan-Do-Study-Act cycle (PDSA), a four-step model for carrying out change. This process will be used in identified quality improvement activities as detailed in the annual Quality Management Plan. The components are as follows:

1. Plan by recognizing an opportunity and planning a change.
2. Do by testing the change and carrying out a small-scale study.
3. Study by reviewing the test, analyzing the results/data and identifying what has been learned.
4. Act by taking action based on what you learned as a result of data analysis in the study step.

If the change does not work, the cycle will be repeated again with a different plan.

To address client file review results, supervisors will implement a plan of correction when deficiencies in delivering services or lack of compliance to standards have been identified.

Follow Up

Case manager supervisors will follow up to ensure the effectiveness of improvement activities and the maintenance of improvement results. On identified quality improvement activities, supervisors follow up on a quarterly basis to ensure that these activities have been effective in resolving the problem, that no new problems have developed, and that there is sustained improvement in identified areas.

For file review results, supervisors work with staff to develop plans of correction within 15 working days of the file review. Staff has ten working days to implement corrections. At the next quarterly file review supervisors monitor the maintenance of the previous quarter's improvements to ensure problems do not reoccur.

Monitoring and Standardized Tools

Tools used in monitoring and standardization include the file review tool and Provide Enterprise® reports with features to track reporting of performance measures, completion of assessments, service plans, as well as a feature to describe content of progress notes for easy tracking. The annual client satisfaction survey is a standardized tool that the Ryan White Quality Management workgroup evaluates and standardizes across HIV service providers.

Compliance with Ryan White Part A Program Monitoring Standards

i. Provide written assurances and maintain documentation showing that medical case management services are provided by trained professionals who are either medically credentialed or trained health care staff and operate as part of the clinical care team

AIDS Services of Austin (ASA) will follow requirements as listed in the Austin TGA Ryan White Part A HIV Case Management Standards of Care. The RN Medical Case Manager (RN MCM) must be licensed as a Registered Nurse. The Behavioral Health Medical Case Manager (BH MCM) must be licensed as Licensed Master Social Worker, Licensed Professional Counselor (LPC), and/or LPC intern. Copies of licensures are updated annually and licensures, diplomas, and copies of ongoing training are maintained in personnel file. Documentation of training for case managers and supervisors is completed no later than 90 days following the date of hire.

Any newly hired case managers will complete the required courses per the Austin TGA Standards of Care. Case managers will complete a minimum of 12 hours of continuing education annually as outlined in the Austin TGA Ryan White Part A HIV Case Management Standards of Care.

A Memorandum of Understanding is in effect with CommUnity Care at David Powell Clinic indicating that both the RN MCM and BH MCM will function as part of a multidisciplinary medical care clinical team.

ii. Maintain client charts that include the required elements for compliance with contractual and Ryan White programmatic requirements, including required case management activities such as services and activities, the type of contact, and the duration and frequency of the encounter

Medical Case Managers will maintain client files that include the required ARIES data elements as listed in the 2009 ARIES Taxonomy and required activities such as initial assessment of service needs, the comprehensive individualized assessment and service (care) plan, service coordination for plan implementations, ongoing monitoring to evaluate plan effectiveness, and the review and revision of the plan at least every six months.

Eligibility and Intake staff will include required eligibility documents, the intake form that collects required ARIES information, and the initial client services agreement in the client paper file. The initial assessment of service need will be documented in the client electronic file. Medical Case Managers will record coordination of required services for plan implementation, monitoring to assess the effectiveness of the service plan, and the service plan and re-assessment in the progress notes of the client file. Staff will also include service coordination such as linkage to health care, support services, public and private benefit programs, coordination of primary and specialty care medical appointments, and comprehensive assessment components such as ongoing evaluation of client/significant other needs/support system and interventions, such as treatment adherence counseling and advocacy necessary to implement the plan. Plan revisions are noted in the paper service plan that is signed by the client and kept in the client paper file.

Medical Case Managers will document type, date and a summary of the contact on the progress log function of the electronic client file. Frequency of contact is illustrated through the activity

view feature that shows dates of each client contact. Duration of contact is measured in 15 minute increments and recorded in the service provided section of the electronic file. Fifteen (15) minutes is equal to one unit of service.

An extract developed by Groupware Technologies, Inc, will bridge to the ARIES client database the required ARIES data on units of service provided. Client identifying information and other required data is entered directly into ARIES by ASA staff.

Work Statement

Service Category Name

Medical Nutrition Therapy

Client Eligibility

Clients enter the Medical Nutrition Therapy (MNT) component of AIDS Services of Austin's (ASA) Food and Nutrition Services program primarily through a request for Food Bank services where they are then screened for MNT program eligibility. To receive Food Bank, MNT, and nutritional supplement services, clients must have positive HIV status or have an AIDS diagnosis, reside in the five-county Austin Transitional Grant Area (Travis, Williamson, Bastrop, Hayes, and Caldwell), be receiving primary medical care, have an annual income at or below 150 percent of the Federal Poverty Guideline, and be case managed at ASA or another HIV/AIDS service organization. Proof of symptomatic HIV disease or AIDS diagnosis and residency are stored in the client's permanent paper file.

ASA's Eligibility and Intake staff determine eligibility by securing proof of HIV status; income, including food stamp eligibility; health insurance status; and residency. Eligibility and Intake staff completes an In-Care Verification Form to determine whether a client has been receiving primary medical care or is "out-of-care." *HRSA defines an individual as being out-of-care if there is no evidence of a client accessing any one of the following three components of HIV primary medical care during a defined 12-month period: viral load testing, CD4 count, or provision of anti-retroviral therapy.* Clients who are in care authorize their physician to release proof of HIV status and symptoms through a Medical Certification Form. The ASA Prevention Department can administer an HIV test and arrange medical appointments to determine symptoms for clients who are not in care or lack documentation of status and symptoms.

ASA has Eligibility and Intake staff specifically trained to determine clients' level of need for services and eligibility status (every 6 months) for all ASA programs as well as programs at partner HIV services organizations and other social service organizations. ASA's Eligibility and Intake staff determine eligibility by securing verification of HIV status and residency. Staff will secure proof of identity, income, and insurance status as required intake documents. During intake for Food Bank/ Medical Nutrition services, this staff will screen for eligibility for Food Stamps (SNAP); and Medicaid, Medicare, Veteran's Health Benefits or other forms of health insurance coverage. If a client appears eligible, then they will be referred to their case manager for follow-up on applications for said services.

xvi. **Documentation of HIV Status:** Staff obtain verification of HIV status through:
- a signed statement from the medical provider;
- a positive Western Blot laboratory result with the name of the client;

- a printed document from the ARIES database indicating verification of HIV status by another provider;
- HIV detectable viral load lab results; or,
- a hospital discharge summary or medical records from previous provider(s).

xvii. **Proof of Identity:** Proof of identity includes: Texas driver's license, Texas State identification card, a passport, Military or Student identification card, Social Security card, birth certificate or other official document as listed on the Austin TGA Ryan White Client Eligibility Form

xviii. **Residency Verification:** In order to establish residency, clients can provide unexpired documents such as a Texas driver's license, Texas State or Tribal identification cards, Social Security award letter, rental/mortgage agreement, utility bill, or similar forms accepted by the Ryan White Part A Austin TGA.

Documentation of HIV status must be presented within 30 days and residency documentation must be presented within 60 days. Clients may be granted conditional eligibility if they present with an urgent need and lack the necessary eligibility documentation. ASA will make reasonable efforts to assist clients in obtaining the necessary documentation.

xix. **Income Verification: S**taff use the MAGI or Mock MAGI form for client income verification. Clients that have filed a tax return in the previous year complete the MAGI form and submit their tax transcript as income verification. Clients that did not submit a tax return or have had a change in income complete a Mock MAGI form and submit an IRS proof of non-filing and income verification document. Income verification documents include Social Security Award letter, Veterans/Public Assistance or Worker's Compensation benefits statements, wage payment stubs, signed zero income verification letter or other document listed in the Austin TGA Ryan White Part A Client Eligibility Form. There are some populations that are excluded from having to obtain tax transcripts or IRS proof of non-filing, these include: homeless, recently released from incarceration (3 months), undocumented, emancipated minors, and SSI and/or SSDI recipients.

xx. **Health Insurance Coverage:** Cards verifying coverage by private medical insurance, Medicare, Medicaid, Veteran's Health Benefits, and Indian Health services will be accepted. Signed no insurance attestation statements will also be accepted. Should a client receive City of Austin Medical Assistance Program (MAP), a copy of the card will be made and a attestation of no insurance will be signed.

The Food and Nutritional Services Manager will approve MNT income eligibility, on a case by case basis, for clients at or below 200 percent of FPL when they are experiencing serious co-morbidities, or a weight decrease of 10% or more than125% above ideal body weight. Diagnoses that increase nutritional risk may include but are not limited to:

- Scheduled chemotherapy or radiation for cancer treatment;
- Acute or chronic renal failure;
- Visible unintentional wasting
- Recent hospitalization, or emergency room visit for opportunistic infection or other destabilizing health situation;
- Recent diagnosis of opportunistic infection;
- Persistent albumin less than 3.5 or prealbumin less than 19;
- Severe difficulty in chewing or swallowing;
- Severe thrush.

When determining income eligibility for clients at increased nutritional risk, cost of medications, medical expense deductibles, or medical provider co-payments will be deducted from client income prior to determining income. This allows clients more resources to purchase nutrient-rich food in order to reach an acceptable level of nutritional status.

Eligibility and Intake Staff will use the Austin TGA Ryan White Part A Client Eligibility Form to reassess clients in the program every six months for determination of continued eligibility. At that time, client residency, income, and health insurance will be updated and/or new documentation obtained as indicated. Clients presenting with a change to income, residency or health insurance status within the six month review period will complete the Change in Circumstances: Eligibility Verification Addendum form. All required eligibility and intake documents, as well as periodic updates, are stored in the client's paper file and documented electronically in the agency's electronic client database, Provide Enterprise®. Client identifying information is also entered into the ARIES client database. Eligibility and Intake staff completes a form verifying eligibility documents were collected, and an administrative assistant enters this data into ARIES.

Client Eligibility and File Documentation: All required eligibility and intake documents, as well as periodic updates, are stored in the client's paper file and documented electronically in the agency's electronic client database, Provide Enterprise®. Client identifying information is also entered into the ARIES client database. Intake staff completes a form verifying eligibility documents were collected, and an administrative assistant enters this data into ARIES.

Clients may continue to access Food Bank, MNT, and nutritional supplement services as long as they remain eligible.

All new clients entering Food and Nutrition Services are administered a screening tool, entitled the Nutrition Health Risk Screen, by Eligibility and Intake staff or their case manager. The client's total score on the nutrition profile must be five or higher in order for the client to be scheduled for an MNT visit with the Dietitian so that an initial nutritional assessment can be performed. Results of the client's initial assessment are used as a basis to develop the client's nutritional management plan, as appropriate.

Clients who are case managed at other agencies are screened for eligibility and need by those agencies. If eligible, clients are referred to ASA for MNT services by their case managers by submitting an interagency packet. ASA Eligibility and Intake staff verify client enrollment in a case management program and the completeness of the interagency packet.

Target Population

The target population for AIDS Services of Austin's (ASA) Medical Nutrition Therapy (MNT) program is low-income (annual income at or below 150 percent of Federal Poverty Income Level guidelines) persons with symptomatic HIV disease who reside in the five counties of the Austin Transitional Grant Area (TGA) (Travis, Williamson, Bastrop, Hayes, and Caldwell). Clients must be symptomatic with HIV disease or diagnosed with AIDS, be receiving primary medical care, show proof of residency in the Austin TGA, and be receiving case management services at ASA or another HIV/AIDS service organization.

The following table (Table 1) compares the 2015 calendar year demographics of ASA's MNT program to the demographics of people living with HIV and AIDS in the Austin TGA. Table 1 illustrates ASA's work in reaching the transgender community, people of color, and people aging with HIV and AIDS.

Table 1

	ASA Clients	**Austin TGA PLWH/A**
Gender		
Male	92%	85%
Female	8%	15%
Transgender	0%	(unavailable)
Race/Ethnicity		
White	32%	46%
Black	36%	22%
Hispanic	32%	29%
Other	0%	3%
Age Group		
0 – 12	0%	0%
13 – 24	0%	4%
25 – 34	4%	17%
35 – 44	20%	27%
45 – 54	40%	34%
55 and over	36%	18%

While client demographics are anticipated to remain the same, ASA expects overall demand for MNT to continue to steadily increase as the direct effect of poverty on proper nutrition becomes a greater co-factor complicating care for clients coming into services. The agency also anticipates a steady increase in the rate of numbers of African-Americans, women, and Hispanic/Latino(a) populations needing these services as the profile of clients with HIV and AIDS from these particular communities continues to increase in the Austin TGA.

Historically hard-to-reach populations, including African Americans; Latino/as; women; formerly incarcerated individuals; and substance users, including injecting drug users (IDUs) and alcohol users; and clients with acute or untreated mental illness, are served by the MNT program. Clients with mental health issues and active substance using or visibly intoxicated individuals continue to be difficult to reach for effective Medical Nutrition Therapy.

Table 2

ASA Top 10 Client Zip Codes	Prevalence Range of HIV/AIDS
78723	675-1,199/100,000
78741	314-674/100,000
78752	675-1,199/100,000
78702	675-1,199/100,000
78724	115-313/100,000
78753	314-674/100,000
78758	
78744	115-313/100,000
78701	675-1,199/100,000
78721	

Austin TGA data suggest that 84 percent of clients have medical comorbidities, while others report social and health-related co-factors that complicate medical and other service delivery for HIV.[12] Recent studies have shown that 67 to 96 percent of HIV positive individuals have comorbidities.[13] Co-morbidities and conditions for the MNT program's target population include malnutrition, cancer, hypertension and heart disease, neuropathy, difficulties with thought/memory, PCP, asthma, high cholesterol, diabetes, Hepatitis B and C, sexually transmitted diseases, and pancreatic and renal problems, substance abuse, mental health issues, commercial sex work, poverty, homelessness, domestic violence, and tuberculosis (TB). Linking clients to primary medical care and MNT can help with providing support for pain management, diet-planning specific to health issues, educational information and take home print materials that help with meal planning and making food choices that support optimal health, and referral to other needed services.

Service Category Activities

[12] ARIES database, provided by the City of Austin (Addendum 5 to Ryan White Part A RFA 2012-13)
[13] "Prevalence and Patient Awareness of Medical Comorbidities in an Urban AIDS Clinic," Weiss, Jeffery J., PhD, et al

Service activities linked to Budget Justification

AIDS Services of Austin (ASA) has been providing nutritional education and counseling through a Nutritionist/Dietitian since 1989. Given ASA's history of providing this program in the Austin TGA, necessary mechanisms for implementation are already in place. Long-standing mechanisms include:

- A Board of Directors and strong organizational governance structure
- An experienced leadership team
- Trained and experienced staff (see *Staffing* section)
- A physical location near public transportation and well-known in the HIV field
- A programmatic structure offering a comprehensive continuum of care including HIV Prevention, Outreach Services, Case Management (medical and non-medical), Food Bank, Medical Nutrition Therapy, Oral Health Care, Health Insurance Assistance, special programs for women living with HIV and AIDS and legal services
- Strong community partnerships providing access to services not offered at ASA

MNT is an essential service provided by ASA for people living with HIV and AIDS (PLWH/A). A 2014 HRSA position paper states that nutritional status is strongly predictive of survival and functional status among PLWH/A. Nutritional problems may occur at any stage of HIV disease and can contribute to impaired immune response, accelerate disease progression, increase the frequency and severity of opportunistic infections, and impede the effectiveness of medications. Fortunately, many nutritional disturbances are preventable and manageable. A range of nutritional interventions, from nutrition assessments, counseling, therapy, and access to food, can have a positive impact on morbidity, mortality, and quality of life. Nutritional interventions can also decrease or delay hospitalizations, emergency room visits, and costly and invasive treatments.[14] Proper nutrition is instrumental in enhancing health and well-being and preventing general and opportunistic infections, involuntary weight loss, muscle wasting, and general decline and decomposition of health status.

ASA's MNT program is designed to assess client health, determine client nutritional needs, identify how nutrition will enhance the client's well-being, create a plan to use nutritional tools to support client health, and ensure that clients have access to the resources they need to implement the nutritional plan. HRSA states that nutritional screening and a complete baseline nutrition assessment should be part of every care plan, as should ongoing reassessment, and lists the key components of nutritional care are as: 1) risk screening, 2) comprehensive baseline evaluation or assessment by a registered dietitian, and 3) ongoing assessment and treatment (including self-care training, nutrition education, and various interventions).[15] ASA's MNT program follows this recommendation and cites the following as the program's primary tasks and activities as:

[14] HRSA Care Action, Providing HIV/AIDS Care in a Changing Environment, August 2004, p. 1.

[15] HRSA Care Action, Providing HIV/AIDS Care in a Changing Environment, August 2004, p. 1.

- ***Screen for Eligibility and Need and Refer Clients into Care***

Initial screening for eligibility is performed by Eligibility and Intake staff using the Eligibility for Services Screen. This intake tool inquires about clients' current health status, the name of a primary medical care provider, and immediate interest in accessing ASA's services, including MNT and Food Bank services. The eligibility staff will also screen for eligibility for Food Stamps (SNAP) and Medicaid, Medicare, Veteran's Health Benefits or other forms of health insurance coverage. If a client appears eligible, then they will be referred to their case manager for follow-up on applications for said services.

Eligibility and Intake staff determine eligibility for services by securing proof of HIV status, symptomatic illness or AIDS diagnosis, verification of being in care, proof of residency in the agency's service area, proof of identification, food stamp eligibility, and verification of income (clients must have an annual income at or below 150% of Federal Poverty Level (FPL) Guidelines to receive Medical Nutrition Therapy and Food Bank services). (See *Client Eligibility* section for a complete description of the Eligibility and Intake process.)

Clients are referred to an appropriate level of assistance in ASA's Case Management Program using the acuity guidelines as defined by the Austin Transitional Grant Area Ryan White Part A Standards of Care for Case Management. Case Managers assist clients with developing a service plan, which includes access to food bank and MNT services. Eligible clients who request help with food and MNT are referred to the Food Bank and MNT when needed.

Eligibility and Intake staff provide eligible clients with an overview of Food Bank services and a schedule indicating hours of operation. They also screen them for nutritional risk factors using the Nutritional Health Risk Screen. The Nutritional Health Risk Screen is a standardized form with 14 statements pertaining to health status, each answered with "yes" or "no"; yes being one point and no being zero.. Statements include recent weight loss ; nausea, stomach pain, or cramping ; poor eating habits. . For those clients scoring a five or higher on the Nutritional Health Risk Screen tool, Eligibility and Intake staff or the Case Manager (if they are ASA clients) schedules an appointment with the Dietitian which begins the MNT intervention process.

ASA avoids duplication of MNT services in being the only Ryan White Part A funded provider of this service. ASA coordinates with other HIV service organizations to offer this service for eligible clients, such as the David Powell Clinic which provides Dietitian services for clients receiving healthcare from the clinic. The David Powell Clinic does not offer the same variety and availability of supplements that ASA's program offers; however, their Dietitian provides services to clients who would otherwise not qualify for MNT services.
Eligibility and Intake staff schedules an initial appointment using the Dietitian's nutrition scheduling Outlook calendar and gives the client an appointment reminder card, as well as a list of items to bring to the appointment (most recent lab values, current diagnoses, medication list, and a list of questions/concerns). Case Managers, the Dietitian, and the Food and Nutrition Services Manager may also assist clients with scheduling/rescheduling MNT appointments. For

clients who have telephone service, reminder calls are made about their upcoming appointment one to two business days in advance of their appointment.

The MNT program offers two levels of support for clients new to Food Bank and for existing clients continuing with the supplemental grocery service. Client demand for MNT services coupled with limited funding to support the service requires additional restrictions in order to offer the service to clients at greatest risk of poor health due to improper nutrition. The primary focus of the MNT program will be on clients with the greatest risk for decline, as assessed by the Dietitian.

- ***Assess Nutritional Needs; Determine Baseline for Care***

The first level of MNT services falls under general nutrition education and individual support and offers limited Medical Nutrition Therapy services. Those services include an in-depth baseline assessment conducted by the Dietitian, access to the Dietitian during program operation drop-in hours, and brief follow-up support. The second level offers extensive MNT services and nutritional supplement support.

All clients referred for MNT services receive an in-depth initial assessment within the first three months of accessing food bank services or within three weeks of referral for clients whose nutritional health status changes after three months of Food Bank access. The Dietitian conducts a baseline assessment on all referred new clients to this service who score five or above on the Nutritional Health Risk Screen to determine nutritional gaps and create a nutritional management plan aimed at helping clients to improve their overall nutritional health. The initial nutritional assessment involves interviewing clients to gain an understanding of their psychosocial background and support systems, to gauge interest in changing their food habits, to collect specific information on foods clients consumed with the last 24 hours (24 hour recall), and to determine the level of physical activity clients' are actively engaged in. The Dietitian will determine if the client will have a body composition analysis by using Bioelectrical Impedance Analysis (BIA) test results, a benchmark procedure for detecting wasting in clients, which can be subtle and sometimes occurs in the presence of normal or excess weight due to increased body fluid. For Level One MNT services, BIA assessments are recommended every six months for clients who have values within normal limits. From this assessment, the Dietitian determines whether clients will remain in Level One MNT services or are in need of further, Level Two MNT interventions.

If the client is deemed appropriate for nutritional supplements, the Dietitian will inform the client's primary HIV physician via a secure faxed medical note indicated the recommended supplements prescribed to the client. The Dietitian receives a secure fax back from the client's physician indicating whether or not they agree with the recommendations.

Level One MNT Services – Clients identified as being in need of Level One MNT are not in need of nutritional supplementation. This is because they are typically within a healthy weight range, appropriate for their height and body type; consume fresh and nutritious foods (not convenience foods such as "fast foods"); have a good understanding of proper nutrition; and

have a history of managing side effects of HIV medication. Level One MNT clients are generally doing well with managing their HIV disease or the effects of AIDS, are engaged in their medical care, are adherent to taking HIV medications, and may have viral loads that are undetectable. Clients in this level of service will be few and will usually have good self-determination skills, strong psychosocial support systems, follow regular routines concerning activities of daily living, and will have low incomes that necessitate the need for Food Bank grocery services.

Clients engaged in Level One MNT will be encouraged to participate in upcoming nutrition education classes and to access the MNT program anytime they feel they have unmet nutritional needs. Clients will leave the visit with the Dietitian's business card and will be encouraged to contact the Dietitian by phone, email and/or fax, should they have any questions about their nutrition or if any aspect of their health changes, due to changes in medications/side effects, diagnoses of co-morbidities, etc, in the future. These clients will be welcome to schedule periodic follow-up visits, such as three month follow ups and the six month BIA follow-up, as space allows, with the Dietitian. Clients are welcome to drop in during non-Food bank weeks without an appointment for brief nutritional education/counseling visits.

Level Two MNT Services – Clients whose initial nutritional assessment indicates a need for a deeper level of intervention will fall into Level Two MNT services. A body composition analysis will be conducted by using Bioelectrical Impedance Analysis (BIA) test results and used as a benchmark for future care. For clients with malnutrition and mal-absorption issues, this process is essential to measuring change in the body over time. The procedure is performed by standing on a scale while holding onto two handlebars, then initiating an undetectable low voltage electrical current that quantifies total body composition as a measurement. The BIA allows the Dietitian to obtain information on the nutritional status immediately, without drawing blood samples or having biochemical analysis performed. The client is given a copy of the detailed analysis of their body's lean muscle mass, bone, fluid, and fat composition, which reinforces and reminds the client of the Dietitian's dietary recommendations.

For Level Two MNT services, the frequency of BIA testing will be greater. For a person whose results indicate undesired change, such as muscle wasting/lean body mass or obesity, the BIA is repeated in six month increments to assess the effectiveness of the Dietitian's recommendations, including diet, specific nutritional supplement pairings, appetite stimulants, steroids/hormones, weight resistance exercise, and, ultimately, client compliance. However, if an existing client goes through a major trauma or is hospitalized, the Dietitian will conduct a BIA after the client is discharged to see how much muscle mass they may have lost.
BIA results from ASA's Dietitian are provided to the client, who is then encouraged to provide a copy to their primary HIV physician. The Dietitian will include

The Dietitian also assesses the psychosocial history of the client by discussing their cultural background and lifestyle, weight history, eating and food preparation habits, food storage capacity, and available cooking facilities. These factors are considered, along with the client's health history, diagnosis, current health, and medications in making dietary recommendations

about food choices and the use of nutritional supplements.

- ***Level Two MNT - Deliver Medical Nutrition Therapy Services***

Based on information gathered during the initial assessment, the Dietitian develops a nutritional management plan with each client and provides follow up on the BIA and their individualized plan. The Dietitian works with clients in 15-minute sessions at a minimum, with sessions typically lasting 60 to 75 minutes. Clients receive literature to take home to read and reference, and the Dietitian is available by telephone and by email to address follow up questions or concerns. Nutritional Management Plans reflect the Dietitian's recommendations, client objectives, and plans to follow up with clients, their physician, and/or case manager. The Dietitian reviews the plan with the client at each appointed visit and reflects changes in health status or the plan, including progress plan, in the client's nutritional file.

The Nutritional Supplement component of the MNT program targets clients whose health is unstable and who are at highest risk for further deterioration without this level of intervention. Clients indicated for and receiving nutritional supplements are required to meet with the Dietitian quarterly to assess changes in health status and to determine the efficiency and effectiveness of the nutritional supplement intervention. Further, clients are weighed by the Food and Nutrition Services Manager, the Dietitian, or nutrition student interns in two week intervals, usually when they are accessing Food Bank services or while at the agency visiting their case manager. Client weight is recorded on a confidential centralized weight log and transferred to the client's nutrition file at the end of each week. At the next appointment with the Dietitian, the client's record of recent weight history is used to help assess the effectiveness of the supplement intervention. The Dietitian also discusses with the client the implementation of specific dietary recommendations made at the last visit. Because clients are adopting behavior change in making dietary changes, they often require three to six months or longer to make the recommendations routine and to see positive results. The Dietitian also consults with Food and Nutrition Services Manager on menu planning, nutritional analysis of menu selections, and general nutrition issues.

- ***Deliver Food/Nutritional Supplements***

The MNT program shares the same clientele as ASA's Food Bank. The goals of both programs work in tandem to combat clients' inadequate access to sufficient food to manage their nutritional health. Access to nutritious food is essential to preserving clients' compromised immune systems, decreasing the risk of opportunistic infections, and increasing the effectiveness of medical and nutritional treatment interventions. Side effects from HIV medications are best managed with the Dietitian, clients' case managers, and primary care providers, working together to successfully integrate all aspects of treatment adherence, including appropriate diet and exercise.

In a calendar year, on average, 70 clients receive nutritional supplements on a monthly basis. While clients new to the service are being added weekly, the program serves a number of clients who have been accessing the service for an extended period (12 months or more) who move off the program due to dietary stabilization, they have moved out of the service area, or

are deceased. Inadequate intake of enough food (calories) and poor absorption of nutrients are two primary factors affecting clients on Level Two MNT services. Altered metabolism is the primary mitigating factor for clients with diabetes and kidney disease who may also be affected by poor absorption of nutrients and inadequate nutrition.

To address issues of malnutrition and HIV as a chronic disease, ASA uses a variety of nutritional supplements that not only address nutritional gaps, but also, according to clients, taste good, which contributes to compliance. Ensure Plus® contains concentrated calories and protein to help gain or maintain a healthy weight by aiding in digestion and nutrient absorption. A cost effective supplement, its therapeutic actions assist the body in building lean muscle mass. Most clients new to the program are started on this supplement before progressing to other varieties. The Dietitian may recommend two cans per day (60 cans per month), for clients with muscle wasting and/or whose health is so unstable that they need the supplement as their sole source of nutrition and report not preparing foods and, therefore, not eating.

The MNT program expanded nutritional supplementation by supplying clients with nutrition bars, dense with high protein and additional vitamins and minerals. The extra calories help clients' with their energy levels while offering supplementation that is satisfying to chew in addition to liquid nutritional support. . A seven day supply of liquid supplements generally at a rate of one product a day is given to clients twice per month. A six day supply of nutritional bars is given to clients twice per month.

Diabetics and clients with Lipodystrophy Syndrome (LDS) are provided with a specialty product aimed at countering glucose dysregulation. Glucerna® shakes are specifically formulated for people with diabetes or abnormal glucose tolerance and contain a unique blend of slowly digested carbohydrates that have been clinically shown to produce a lower blood glucose response compared to a standard medical nutritional beverage. For clients with kidney disease, Nepro® with Carb Steady™ therapeutic nutrition is specifically designed to help meet the needs and altered metabolism of patients on dialysis (stage five-kidney disease). Because excess fluid and waste can build up in clients' blood when their kidneys are not working properly, this supplement provides the right amount of nutrients and slowly digested carbohydrates to help manage blood sugar levels.

Lastly, while clients are meeting with the Dietitian for any type of visit, the Dietitian provides nutrition bars, and/or a cold liquid nutritional supplement to consume as a healthy snack during the visit when is available. Many clients enrolled in the supplement program do not eat enough calories daily to maintain body weight, especially those with little or no income. The Dietitians report that clients have arrived to appointments and not eaten yet that day. By offering clients a healthy snack, clients are apt to be actively engaged in their nutritional health during the visit. ASA also notes that the agency's genuine care and concern for client well-being coupled with counseling and support improves client retention in care.

- Integrated Service Coordination

As needed based on shared client load, the Dietitian, twice per month, reviews client nutritional

status, shares client weight histories, and shares service plan goals with the Pilot Registered Nurse Medical Case Manager. The two health professionals will began to receive copies of nutritional service plan goals and nursing care plan goals to further integrate client services. The Dietitian consults with medical and non medical case managers, as needed, around medical and psychosocial client needs.

- ***Group Nutrition Education***

The Dietitian provides client group educational sessions that target various populations and nutritional topics. In the past the nutrition education program has focused on the topics such asFluids and Hydration for people living with HIV/AIDS, Fruits and Vegetable during Summer, How to Read Food Labels, and Food Safety during Holidays. The program has partnered with Capital Area Food Bank to provide hands-on cooking demonstrations during the group class utilizing the food items provided at the Food Bank. This allows clients to learn new recipes and ways to cook the food they are provided at the Food Bank. Each class focuses on a particular food group, such as grains or healthy fats.

- ***Program Schedule***

Currently, client access to the Medical Nutrition Therapy program is available by appointment every Tuesday, Wednesday, and Thursday. During the weeks that Food Bank is open for distribution of groceries, unscheduled drop-in time for MNT is available Tuesday from 2:00 – 6:00 p.m., Wednesday from 1:00 – 4:30 p.m., and Thursday from 12:00 – 4:00 p.m. on a first come, first serve basis when the Dietitian is available. Much of the Dietitian's time is spent doing assessments and follow up for clients whose supplement prescriptions have expired and are therefore in need of reassessment. The Dietitian is available for scheduled appointments on non Food Bank weeks or drop-in appointments as available. With Ryan White Part A funding, the current MNT program hours are 24 hours per week.

- ***Culture and Language Considerations***

ASA provides a variety of foods within its food and nutrition programs to meet the cultural differences of the community, including various types of meats such as pork chops, lean ground beef, and chicken. Fish such as catfish, pollock, and tilapia are popular. Fresh fruit and vegetables are reflective of the season, and staples such as beans, rice, wheat tortillas, and wheat bread are carried on the menu regularly. Fresh and canned collard greens, as well as seasonings such as black pepper, paprika, oregano, red and yellow onions, basil, green and red peppers, cilantro, garlic, jalapeno peppers, and ginger root are made readily available. The Dietitian learns from clients about their individual and cultural food needs during consultation and recommends adjustments to the menu selection based on client input and feedback as feasible. Her ability to accommodate and be respectful of client needs has resulted in an expanded number and diversity of clients seeking MNT.

The agency makes accommodations for hearing impaired clients who require and consent to sign language interpretation during their appointments by hiring an American Sign Language (ASL) proficient interpreter through Communication Service for the Deaf. One agency staff is also proficient in ASL and assists with translation. Staff uses the Relay Texas telephone

network to communicate with hearing impaired individuals who use TTY equipment. If other language help is required, the agency contacts Austin Area Translators and Interpreters Association for assistance in finding an appropriate interpreter to facilitate client services at no cost to the client. Confidentiality of clients who require translation skills is addressed by having the contractor read, agree to, and sign the agency's Pledge of Confidentiality form.

- ***Maintain Client Files as Needed to Deliver Care, Access Services***

ASA Intake and Eligibility staff opens a client file in the agency's automated client tracking system, Provide Enterprise®. Case managers use this system to track client contacts and access to services. When clients access MNT, this information is recorded by the Food and Nutrition Services Manager. The nutritional management plan is part of the client's paper nutritional file and is maintained in the Dietitian's office. The Dietitian writes progress notes summarizing the nutritional management plan and documenting progress directly into clients' Provide Enterprise® file. For clients case managed at other CBOs, progress notes are forwarded upon request to the client's case manager if a current release of information is in the client's file.

- ***Review Documentation for Quality Assurance and Alter Program as Needed***

The Associate Director of Direct Services and Food and Nutrition Services Manager monitor program operations for continuous quality improvement quarterly. To ensure quality and nutritional value of foodstuffs, the Dietitian conducts an annual nutrient analysis on menus completed by clients and selected at random and documents findings. Program supervisors review the analysis of nutrients and meet to discuss results with the Dietitian at least annually. Modifications in the food bank menu are made accordingly and implemented immediately, as feasible.

The menu analysis was completed in February of 2016 and included 60 menus completed by clients receiving services between January 2015 and December 2015 who were randomly selected. The division of the menus was 40 males and 20 females. The 40 male menus analyzed for 2015 offered approximately 88% of calories and 94% of the protein needed for a male HIV + adult. The 20 female menus analyzed for 2015 offered approximately 119% calories and 110% of the protein needed for a female HIV+ adult, therefore exceeding the goal of 60 percent of HIV nutritional needs meet for both males and females.

Frequency of these service activities

Currently, client access to the Medical Nutrition Therapy program is available by appointment every Tuesday, Wednesday, and Thursday. During the weeks the Food Bank is open for distribution of groceries, limited unscheduled drop-in time for MNT is available Tuesday from 2:00 –6:00 p.m., Wednesday from 1:00 – 4:30 p.m., and Thursday from 12:00 – 4:00 p.m. on a first come, first serve basis. With Ryan White Part A funding, the current MNT program hours are 24 hours per week. The Dietitian is available for additional scheduled appointments on non Food Bank Weeks on Tuesdays, Wednesdays, and Thursdays and available by appointment before the start of Food Bank.

Location(s) of these service activities

The MNT program is located at ASA's primary facility: 7215 Cameron Road, Austin, TX 78752. The Dietitian is also available for home visits when warranted.

Staffing

The Executive Director is the primary contact with the City of Austin Health and Human Services Department (AHHSD) HIV Resource Administration Unit and has final authority in negotiating and approving contracts. The Chief Programs Officer interacts with AHHSD on matters relating to programs is authorized to enter into negotiations with AHHSD regarding program issues, grant reporting, and performance measures. The Chief Financial Officer interfaces with AHHSD HIV Resource Administration on grant billings. The Grants Manager ensures contract compliance.

The Dietitian for Medical Nutrition Therapy is Christine Marquette, RD, LD who provides scheduled and walk-in medical nutrition therapy and counseling for HIV positive clients under the guidance of Sandra Chavez, Associate Director of Direct Services and Caitlin Simmons, Food and Nutrition Services Manager. As the Manager who oversees the Food and Nutrition Services program activities, Ms. Simmons is also responsible for the Medical Nutritional Therapy program. Ms. Marquette works closely with food and nutrition services staff and ASA case managers by recommending nutritional foodstuffs, spot checking stock for nutritional value, and by providing nutritional analysis of a variety of completed client menus annually.

The Associate Director of Direct Services supervises Caitlin Simmons, Food and Nutrition Services Manager, who supervises the Dietitian, Volunteer Services Coordinator, and agency volunteers. This Associate Director is responsible for the overall program design, development, implementation, quality assurance oversight, program improvement and evaluation. The Food and Nutrition Services Manager is responsible for supervising staff and volunteers, quality assurance monitoring and evaluating program design, and program development and implementation, and daily programmatic operations. Staff qualifications, primary work assignment, and percent of time allocated to this service are reflected in the following chart:

Table 3

Name/Position	Qualifications	Primary Work Assignment	% Time Allocated
Chavez/Associate Director of Direct Services	BA in Psychology: over 13 years of experience in mental health services and case management, 6 years of working experience with low-income and high risk populations in the HIV/AIDS field; and 10 years of managerial/supervisory experience.	Provides overall management and direction of all direct services programs. Develops program content and supervise program coordinators. Responsible for recruiting, training, staff retention.	0.06%

Name/Position	Qualifications	Primary Work Assignment	% Time Allocated
Simmons/Food and Nutrition Services Manager	BA in Communications;; Experience in management and supervision; Over 10 years of experience in Food and Nutrition field; experience with low-income and high risk populations in the HIV/AIDS field; responsible for purchasing, food donations and nutritional quality. Completed Capital Area Food Bank training on Civil Rights and Discrimination; Safe Food Handling; Reporting and Policies/Procedures. Completed SafeServe training; Certified Food Manager.	Plans, assess, coordinates, evaluates, and manages daily operations of Food Bank and Medical Nutritional Therapy programs, supervises Dietitian, Volunteer Services Coordinator, and food bank volunteers, responsible for food acquisition, food and nutrition program quality assurance activities, oversees the input of performance activity data and generates reports, as needed. Member of QMGT and Management Team	5.29%
Marquette/Dietitian	Registered Dietitian, Licensed Dietitian, Certified LEAP Therapist; Bachelor of Science Degree in Dietetics with a major in Nutrition from the University of Texas; certified Health Fitness Specialist through the American College of Sports Medicine; advanced certification in Food Sensitivities; more than 40 hours of additional training in the management of Polycystic Ovarian Syndrome; trained in intrinsic coaching® methodology; USA Fit certified marathon coach; bilingual.	Provides scheduled, walk-in, and referred Medical Nutritional Therapy, counseling and assessments for HIV+ persons; performs body composition analysis using BIA and assesses indicators of nutritional health change as reported by clients; instructs clients on appropriate diets for chronic diseases related to lifestyle assesses special nutritional needs of clients with advanced HIV disease and AIDS and recommends optimal nutritional supplementation, provides comprehensive nutrition analysis of foodstuffs annually and quality assurance of stock quarterly, provides individual nutrition education.	36.0%

- The supervisor to staff ratio is 0.0006 to 0.4129 FTE.

Table 4

Number of Volunteers/Interns	4
Number of Volunteer/Intern Hours	500
Volunteer Responsibilities	Assist with file reviews of Level Two MNT client files such as monitoring compliance with Standards of Care. File documents

	in client files; prepare files with standardized documents; Assist with dispensing nutritional supplements, taking client weights, observing initial, follow-up and annual nutritional assessments, entering weight information into client's nutrition files.

Subcontractors are not used for this service.

The food and nutrition team has over a decade of combined experience in serving the needs of individuals with HIV and AIDS. ASA periodically hosts local university-level dietetic students for internships, some of whom remain as nutrition volunteers with the MNT program under the supervision of the Dietitian. Medical Nutrition Therapy services are delivered in a manner such that cultural and linguistic differences do not present a barrier to client access. The Food and Nutrition Services Manager is a Licensed Master of Social Work who has extensive experience serving low-income clients living with HIV/AIDS who have experienced multiple vulnerabilities. She holds some proficiency in Spanish which allows her to communicate with monolingual clients.

The Dietitian is very efficient in communicating with clients with different backgrounds, needs and disabilities. She is bilingual Spanish which allows her to communicate with monolingual clients. Her experience working with clients living in poverty who experience co-morbidities gives her the skill to handle clients that are under a lot of stress and/or suffer from depression and anxiety disorders. Her ability to work in team with the case managers, the medical nurses and other members of the health team allows her to perform her duties in an excellent manner.

Client Access

Accessing AIDS Services of Austin Case Management Services
Current—and potential—clients for the Medical Nutrition Therapy (MNT) program will be located and identified through Ryan White Part A Outreach Program Services, which brings clients into case management services. Outreach staff identifies individuals with unknown HIV status and those with known HIV positive status who are late to care or "out-of-care." *HRSA defines an individual as being out-of-care if there is no evidence of a client accessing any one of the following three components of HIV primary medical care during a defined 12-month time frame: viral load testing, CD4 count, or provision of anti-retroviral therapy.*

- **Area Hospitals and Emergency Rooms:** AIDS Services of Austin (ASA) Outreach team members are placed at area hospitals to train staff in referring to agency programs and to follow-up on referrals made by hospital staff. Outreach is called at least biweekly to link HIV positive individuals to medical care and support services such as Case Management Non-Medical . Hospitals identified include University Medical Center Brackenridge, and Seton Medical Center Austin of the Seton Family of Hospitals; and St David's Medical Center, St. David's North Austin Medical Center, and St. David's South

Austin Medical Center. Outreach workers visit these hospitals and emergency rooms at the frequency of contact and hours agreed upon with hospital staff.

- **Correctional Facilities:** At Travis County Correctional Complex (TCCC), Travis State Jail, and Del Valle Correctional Facility, ASA outreach team members identify at-risk for HIV or HIV positive individuals who are pre-release from incarceration or recently released from incarceration and link them into medical and supportive services. Outreach workers engage in a broad range of activities include working with correctional facility staff to refer HIV positive individuals.

  Outreach staff receiving service inquiry letters from HIV positive individuals due to be released encourages those individuals to contact the agency upon release. Once contacted, the outreach staff immediately begins the process of linking the individual to medical care and with Case Managers. In cases where a person who has been recently released comes to or phones the agency directly, staff is deployed to the site of preference as identified by the individual who is contacting the agency for services.

  - **CommUnity Care at David Power Clinic:** Several times monthly or sometimes on a weekly basis, Outreach staff links identified HIV positive individuals to primary medical care . Staff provides targeted individuals with a transition from outreach to case management services through building on the trust already established during outreach.

- **Community and Peer Referrals:** Due to the high quality of services provided by ASA, 14 percent of clients that receive case management intake assessments identify themselves and initiate contact for services as a result of referrals from family, friends, or peers who have received agency services. For the same reason, 24 percent of clients are referred to case management from local health care providers.

- **ASA Prevention Programs:** ASA offers a variety of HIV prevention and testing programs that reach over 7,500 individuals annually. Prevention programs include:
  - Mpowerment, a prevention program for young gay, bisexual, and questioning men;
  - Healthy Relationships, an evidence-based intervention focused on prevention with positives;
  - HIV testing;
  - Hepatitis C and syphilis testing for targeted populations;
  - Linkage to care and patient navigation;
  - Condom Distribution Network;
  - Testing, Linkage, and Care, a program that brings HIV testing to sites where high risk populations frequent; and,
  - CLEAR, a risk reduction counseling program.

  All of ASA's Prevention programs refer HIV positive individuals into Outreach services where they are prepared to enter case management services through eligibility and intake.

Clients will begin access to MNT services when they are enrolled in case management services at ASA or other HIV service organizations and determined to be eligible. As described in *Section e. Service Category Activities*, Eligibility and Intake staff completes service eligibility screening to determine appropriateness for the program. They conduct eligibility screenings and assessments Monday through Friday primarily during agency business hours (8:30 am to 5:30 pm) and outside business hours as necessary. Eligibility and Intake staff strives to schedule intake appointments within one week of initial contact and rarely allows for a wait time of more than two weeks. The Non-Medical Case Managers will contact clients referred into their services within two weeks of the referral, at a minimum, with exceptions noted.

Access Barriers and Reducing Barriers to Access

One of the most difficult barriers to service delivery is lack of basic needs, such as food, housing, and transportation, which interferes with the client focusing on linkage to access medical case management, medical care and supportive services. Other barriers are described below. Case management staff assists clients in overcoming barriers.

Table 6

Barrier	Description of Reduction/Elimination of Barrier
Eligibility Documentation	5. Eligibility and Intake staff or case managers provide reasonable assistance to clients to obtain identifying documentation. 6. Documentation may be a challenge for undocumented Hispanics or homeless individuals – ASA staff is trained to assist them is accessing appropriate documentation.
Basic Needs*: *Food*	7. Client intake and case manager assessment for eligibility for ASA's Helping Hand Food Bank services; 8. Assisting clients with Food Stamp applications; 9. Assisting clients with accessing emergency food needs through referrals to area agencies and food programs.
Basic Needs*: *Housing and Homelessness*	5. Access to short-term and long-term housing assistance needs to stabilize clients through ASA HOPWA and Best Single Source Plus Programs. 6. Case Manager coordination and referral to: Housing service providers such as Project Transitions, Foundation Communities, area boarding homes, Austin area public housing and emergency shelters. .
Basic Needs*: *Transportation*	9. ASA main facility located on two major bus routes as well as located in a zip code area where a high number HIV infections are located (78752); 10. ASA Intake, Outreach, and Tier 2 Client/Patient Navigators conduct home visits when necessary and work with clients who are unable to transport to office location; 11. ASA Intake (or Client/Patient Navigators) complete client applications for Special Transportation Services through

Barrier	Description of Reduction/Elimination of Barrier
	Capital Metro; 12. Access to bus passes through the Basic Transportation Needs Fund
Health Literacy and Education	5. Assess client's health and language literacy; 6. Work with client through verbal communication and with health education materials tailored to client's level of understanding and language needs.
Unique Cultural & Linguistic Issues	7. Extensive training in cultural awareness and responsiveness related to communities of color, specifically African-American and Hispanic; 8. ASA has established working relationship with qualified interpreters to assist clients whose primary language is not adequately represented by a staff person; 9. Tier 2 staff build trust with undocumented Hispanic clients by explaining that this status will not affect eligibility for agency services.
Substance Abuse Treatment	7. Consumer information about possible side effects of illicit drugs and HIV medications; 8. Access to appropriate case manager(s) with substance abuse assessment experience; 9. Collaborate with CARE program and other related agencies to provide support and treatment services.
Mental Health Treatment	3. Collaboration with and referrals to mental health providers including Waterloo Counseling and CARE program at ATCIC.
Historical Mistrust of Medical and Social Service Providers	3. ASA case managers work with client through skills building to mitigate mistrust and to improve the client health literacy through education.
HIV Disease Stigma	7. Frequent and prompt contact with individuals in target populations to build trust while relying on 24 years of established history of trust with ASA as an HIV provider for African-American and Hispanic populations; 8. Client-centered approach, emphasizing client strengths, respect for client self-determination – this approach is particularly effective in African-American and Hispanic communities; 9. Referrals of HIV positive women of color to Women Rising Project to educate women in making healthcare decisions – 60 percent of the women served are African-American.

* Basic needs as a barrier is more likely to affect African-American and Hispanic communities due to disproportionate poverty levels among communities of color.

Accessing Medical Nutrition Therapy
Eligible clients are referred to MNT by ASA case managers, case managers from other HIV service organizations, or Food and Nutrition Services staff. All new Food Bank clients are required to receive a nutritional screening and, if indicated, an initial assessment within three months of their first visit to the Food Bank to determine need for MNT Services. Clients whose health status changes after three months of access to Food Bank will receive another screening by their respective case manager and a nutritional assessment within three weeks. Clients case managed at non ASA agencies will also provide updated eligibility documents at the time of this referral.

With an office located next to the Food Bank lobby, the Dietitian is readily available when clients access food through ASA's Food Bank. This allows the Dietitian to engage clients in informal conversations that can help educate hard-to-reach clients about the connection between nutrition and improved health. Nutritional management plans for clients take into consideration cultural needs and habits, as well as cooking facilities and storage (refrigeration), support systems and supplies available to the client.

MNT services and educational classes are provided through group sessions that are scheduled at times that are convenient for the clientele. Individual client support is offered through scheduled visits and during service delivery drop-in hours. Clients are encouraged to drop in to see the Dietitian when she is available and not doing annual assessments; office hours are posted on the office door and distributed to clients at their initial visit. Group nutrition education classes generally focus on issues affecting hard-to-reach clients who may be hesitant to bring up questions or concerns in individual sessions. A healthy snack, full lunch, and nominal gifts (random items of <$20.00 value, donated to the agency), may be provided as an incentive to continue to participate in future group nutrition education seminars.

Family members or members of the client's support system are encouraged to attend with the client, thus reducing fear and building trust between the client and the program staff. Topics for group seminars are selected annually by the Dietitian and Food and Nutrition Services Manager to address medical co-morbidities or co-factors that specifically affect hard to reach clients. Trends in client nutritional health help to identify topics for the year. With prevention of malnutrition and mal-absorption issues in mind, the Dietitian developed presentations for clients on Fluids & Hydration, Fruits and Vegetable for the Summer, How to Read Food Labels and Food Safety during Holidays. Collaboration with Capital Area Food Bank allowed clients to experience hands-on cooking demonstrations utilizing the food items offered at the Food Bank. Practical issues such as portion control, food safety and proper food storage were included in each group session.

<u>Service Linkage, Referral, and Collaboration</u>

Linkage to Primary Medical Care

While this service category's key activity is to link clients to HIV primary medical care, at ASA, this is usually done through Outreach and/or Case Management programs. Medical Nutritional Therapy is essential for ongoing retention of clients in medical care.

Referral Mechanism:

- Many clients are first assisted with initial access and linkage to HIV primary medical care through Outreach team efforts. The goal of the Outreach team is to successfully link clients to primary medical care in three months or less, in accordance with the National HIV/AIDS Strategy. To open a dialog with individuals about initial access to medical care, outreach staff will initiate rapport by providing information about general HIV transmission, risk reduction, and the benefits of early medical intervention. Once the Outreach team links the client into medical care, as evidenced by successful attendance at the first medical appointment, and the client is enrolled in the appropriate case management program depending on the individual needs (i.e. N-MCM, Medical Case Management and PLUS Program). Once assigned to a case manager they then work with the client on strategies to maintain their medical care as part of their service plan.

- A client who contacts the agency directly and do not meet the eligibility requirements for the Outreach program is linked with Eligibility and Intake staff that assess the client's immediate needs for basic needs services and link them to community resources to stabilize their situation and refers them to primary medical care, if needed. A Non-Medical Case Manager may coordinate the clients medical care appointments and visits and assist them with any housing, identification documentation, or financial assistance needs.

Service Coordination and Integration of Resources

The Non-Medical Case Managers addresses crucial barriers to access to primary care by providing referrals for immediate basic needs such as transportation, food, and/or housing. Clients may be assisted through agency resources such as bus passes/taxi vouchers, one of several housing assistance programs, and/or the Food Bank program. In addition, they may be referred to community support services such as area food pantries, Capital Metro for transportation access, and churches for financial assistance with rent and/or utilities.

To address fear of medical providers, the medical care system, or fears related to limited English or health literacy proficiency, staff discusses with clients any resistance to medical care and may be accompanied to their intake medical care visit.Once the client has successfully kept the initial intake appointment at David Powell Clinic[16], the Non-Medical Case Managers work with clients on continued follow-up that may include accompanying clients to subsequent doctor visits. Non-Medical Case Managers build upon the trust developed with Outreach staff and the developing

[16] Clients entering services through Outreach rarely have private insurance and for those that do, the Outreach team will ensure they make a follow-up appointment with their private medical provider.

trust with medical providers to coordinate care with David Powell Clinic staff by assisting in appointment scheduling /rescheduling and conferencing around continued barriers to care.

In addition to working with the David Powell Clinic, ASA has long-standing referral relationships with other HIV-related medical providers including the Blackstock Family Clinic (a SETON non-profit practice); Austin Infectious Disease Consultants (a private specialty care practice); Academic Physicians at Trinity; South Austin Medical Clinic; Jefferson Street Family Practice; and, Austin Regional Clinic-South, Far West, and Quarry Lake locations.

Projected Results
As indicated in the *Service Coordination and Integration of Resources* section, clients are referred to primary medical care services by different agency staff depending upon their place in the broad continuum of services offered at ASA. In most cases, Outreach staff tracks primary care referrals by accompanying clients to appointments. When they do not attend appointments with clients, the staff calls health care providers to verify kept appointments or verifies the visit through the ARIES database. Non-Medical Case Managers attend primary medical care appointments with clients or call agencies to track and verify successful referrals.

Clients are considered successfully linked to medical care upon completing an intake session with CommUnity Care at David Powell Clinic or other medical providers. The Non-Medical Case Managers report on retention in medical care as measured through the HRSA/HAB HIV Performance Measures: two or more medical visits in an HIV care setting in the measurement year. All staff will document client progress in progress notes and successful outcomes in the service provided feature of the Provide Enterprise® electronic client database (ASA's internal electronic database). Non-Medical Case Managers will complete a referral tracking form that includes date of referral and completion date and keep the form updated in the paper client file. The desired outcome results are linkage to and retention in primary medical care services.

ASA also participates in the Return to Care Collaborative with CommUnityCare at David Powell Clinic, Austin/Travis County Integral Care Program, Community Action, Waterloo Counseling, and the Wright House Wellness Center. Through this partnership, the collaborative partners seek to improve information sharing to determine the reasons why people have fallen out of care and to use this data to predict out-of-care trends. As participants in the collaborative effort, ASA and CommUnityCare at David Powell Clinic will monitor and share out-of-care information on a bi-monthly basis, when able, and work together to return clients to medical care. When out-of-care clients are identified, they will be referred to ASA's Outreach Program when they have not received HIV primary medical care for one year or more. This staff will facilitate their reentry into the Medical Case Management, as this is typically the level of case management required for clients contacted through the Return to Care Collaborative. Once the Medical Case Manager is assigned, they must contact the client within 10 days, although it is typically sooner.

Other Linkages, Collaboration, and Referral

Food and Nutrition Services Linkages and Collaborations
The Dietitian currently collaborates with the client's case manager and the David Powell Clinic clinical staff on clients' nutritional health concerns, as well as clients' primary care physicians located elsewhere in the Austin Transitional Grant Area. AIDS Services of Austin (ASA) and the Dietitian have strong referral relationships with local emergency rooms, ASA's Jack Sansing Dental Clinic, Central Texas Gastroenterology Group, Austin Infectious Disease Associates, and Red River Family Practice. Most Medical Nutritional Therapy clients, whether new or current, are indigent or working poor, with primary medical care being provided through the David Powell Clinic.

Since 2000, ASA had been a member of the Association of Nutrition Services Agency (ANSA) which served as a conduit for national advocacy around food and nutrition services for PLWHA. Due to funding changes, ANSA no longer exists yet God's Love We Deliver, based in New York City leads the Advocacy Capacity Building Project that includes the Advocacy Committee. ASA participates in this committee whose focus is now on assisting Food and Nutrition providers in recommending Food and Nutrition services as part of the Essential Benefits package for the chronically ill for each state-based Health Insurance Exchange program. Work with this group still affords ASA with the opportunity to respond to advocacy action alerts at the federal level to ensure funds continue to support the provision of food and nutrition services for people living with HIV and AIDS (PLWH/A) including through the Ryan White Program.

In 2012 ASA became a member of Meals on Wheels Association of America (MOWAA) and through that membership the agency receives discounted supplements from Abbot Nutrition Laboratories.

Other local partnerships promoting advocacy and education include the Sustainable Food Center Collaborative (organic food gardening, relationships with area farmers, interactive cooking classes and nutrition education), Urban Roots (working to nourish East Austin residents who currently have limited access to healthy foods), the Capital Area Food Bank (provides food and grocery products to partner agencies), and Community Action Network (create a healthy, safe, educated, just and compassionate community). The Executive Director serves on the executive committee of One Voice Central Texas - a basic needs health and human services advocacy organization.

Agency Linkages and Collaborations
ASA has collaborative agreements, letters of support, and/or Memoranda of Understanding (MOU) in place with several agencies, mostly with respect to specific programs. The MOUs guide referrals between agencies and allow smooth transitions of clients for additional services. ASA maintains MOUs with Waterloo Counseling Center, Project Transitions, the Housing Authority of the City of Austin, Austin Energy, the CARE Program of Austin/Travis County Integral CARE, and the Communicable Disease Unit at Austin/Travis County Health and Human Services Department (A/TCHHSD). For MOUs that require annual renewal, ASA contacts the partner agency 30 days prior to expiration of these agreements.

ASA also has long-standing referral relationships with HIV-related social service providers, including the CARE Program at Austin/Travis County Integral Care for substance abuse counseling and treatment referral for individuals that are dually diagnosed; Project Transitions for transitional housing and hospice; South Austin Marketplace for transitional and long-term housing; the Customer Assistance Program (Austin Energy) for utilities payment assistance; Waterloo Counseling Center for mental health counseling; the Wright House Wellness Center for holistic/alternative health services; Salvation Army and the Austin Resource Center for the Homeless for emergency housing; the Social Security Administration for disability benefit applications and appeals; Del Valle Correctional Facility, Travis State Jail, and the University of Texas Medical Branch State Penitentiary for services to inmates upon their release; the Communicable Disease Unit at A/TCHHSD for HIV/ STI/TB screening; and SafePlace for domestic violence assistance.

Eligible clients are also referred to the broad continuum of ASA services: the Capital Area AIDS Legal Project (CAALP) for legal assistance; the Jack Sansing Dental clinic for oral health services; HOPWA for housing assistance; Comprehensive Risk Reduction Counseling Services for support for individuals to reduce the risk of HIV transmission; and the Health Insurance Program for premium, medication copayment and medication deductible financial assistance.

Referral Process and Follow Up
ASA staff assists clients with completing and submitting other agencies' referral forms, communicates with those agencies to clarify client eligibility, and advocates for client service delivery. For those clients who are case managed at ASA, staff ensures that referrals are followed through on in one of the following ways:

- performs follow up at the next client contact by asking the client about the referral and the results;
- accompanies the client to appointments;
- checks the ARIES database to ensure appointment was attended; or,
- calls the agency the client was referred to and confirms client attendance.

All staff document client progress regarding follow-through on referrals in the progress log feature of the Provide Enterprise® electronic client database (ASA's internal electronic database). Non-Medical Case Managers will complete a referral tracking form that includes date of referral and completion date and keep the form updated in the paper client file. The desired outcome results are linkage to and retention in support services.

Goals of Collaborative Activities, Integration of Resources, and Projected Results
The goal of collaborative activities is the provision of comprehensive services through the HIV provider community and other social service agencies using linkages and referrals. These activities ensure clients have access to all needed services that are not offered by ASA. In addition, they allow clients to overcome barriers to accessing and remaining in primary medical care and moving toward self-sufficiency in managing their HIV disease.

Integration of resources and services includes the dedication of ASA staff time toward the completion of other agency intake forms, assisting clients with the intake process, accompanying clients to support service appointments, reporting required data, and working with clients on mutual goals in service plans. These mutual goals may be related to support services that client receive from other agencies, such as financial assistance, substance abuse or mental health counseling, housing, etc.

The projected results of collaborative activities, integration of resources, linkages, and referrals are:

- Client achievement of housing stability
- Meeting food intake needs
- Mental health services access and stability
- Independent management of substance use issues
- Financial stability
- Decreased recidivism
- Personal safety and security

Client Input and Involvement

All Medical Nutrition Therapy (MNT) clients have continuous input into the services they receive. Clients participate in a nutritional assessment delivered by the Dietitian. Together, they determine clients' nutritional needs based on information gathered during the assessment and the BIA. Clients and Dietitian(s) develop an individualized nutritional management plan that they can follow and that fits within clients' cultural framework. The Dietitian works with clients in 15-minute sessions at a minimum, with many sessions (initial and annual nutritional assessment) being 90 minutes in duration. Clients receive literature to take home to read and reference, and the Dietitian is available by telephone and email to address follow up questions or concerns. Nutritional management plans reflect the Dietitian's recommendations, client objectives, and plans for client follow up with their physician and/or case manager. The Dietitian develops the plan with the client, and reviews it at every client visit to reflect changes in health status.

Clients have several opportunities to offer input into the MNT program. The Dietitian solicits feedback during Food Bank hours on topics for nutritional education classes. Staff's rapport with the target community enables them to respond to client comments and needs on an ongoing basis. During these encounters, staff works with clients to offer input and identify needs and services they want to pursue. Clients also have the opportunity to utilize the suggestion log book as a way to offer suggestions around preferred food items or to share the positive comments about the program.

Staff surveys clients using the standardized questionnaire developed by the Ryan White Quality Management Group to solicit feedback for improving MNT services. The 2013 survey yielded positive feedback, with 90 percent of clients reporting that through the support of AIDS Services of Austin (ASA), their ability to manage their health has improved. Clients reported a 91 percent

overall satisfaction rate with MNT services. As of current, ASA has not received results from 2015 Ryan White Survey, though ASA Food Bank staff conducted its own client satisfaction survey in 2015 yielding results of client satisfaction of services overall at 98%. Supervisors will use survey results and staff feedback semiannually to evaluate the effectiveness of referral systems, barriers to service, and other service delivery components. The team will then plan, as appropriate, for service modification, especially actions to remove barriers.

All agency clients may register concerns with supervisors and through the client grievance process. All clients are provided a copy of the client grievance policy and procedure upon entry into services and it is posted in English and Spanish in the agency reception area.

ASA routinely incorporates client feedback and suggestions into planning activities. In developing the agency's Strategic Plan, ASA uses interviews and focus groups with current clients to ensure their active participation in the strategic direction of the agency. ASA's Strategic Plan specifically defines "client satisfaction with programs and services" as a key measure of success in alignment with our strategy to "maintain and strengthen existing programs and services through quality improvement." The 2011-2014 Strategic Plan was extended for one year so that ASA is able to fully analyze the impact of the Affordable Care Act. ASA is currently developing a new strategic plan for the agency. A suggestion box located in the client lobby is available for clients to submit anonymous feedback. The box is routinely monitored by the Eligibility Services Supervisor. Client feedback is given to appropriate staff for use in program improvements. The Quality Management Guidance Team reviews the feedback from the suggestion box quarterly to evaluate trends and making agency improvements.

Cultural Competency

Service activities will be delivered so that cultural and language differences do not constitute a barrier to services in full compliance with the National Standards on Culturally and Linguistically Appropriate Services (CLAS) described at: http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15.

AIDS Services of Austin (ASA) is in compliance with all 15 CLAS Standards.

Table 5

CLAS Standards	ASA Compliance
46. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication	▪ Staff members are proficient in Spanish, culturally reflective of the Hispanic clientele and available to interpret daily ▪ Staff members are from diverse backgrounds including African-Americans and individuals that are immigrants to the USA. ▪ One staff member proficient in American Sign Language and others with basic skills ▪ Interpretation services in any language are offered to

CLAS Standards	ASA Compliance
needs.	clients free of charge; interpreters culturally reflect clients ▪ Staff assigned to clients are reflective of clients' cultural background, as feasible ▪ Client materials are written at a fifth to eighth grade literacy level and in Spanish at third to fifth grade level ▪ Client materials are provided in Spanish and English ▪ A professional volunteer translates materials from English to Spanish ▪ Organization includes "diversity" as one of its core values
47. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.	▪ A Cultural Appropriateness Action Team with staff from varied levels and departments is tasked with ensuring CLAS and health equity are promoted ▪ The agency maintains a tracking mechanism to ensure CLAS compliance ▪ Agency policies are cognitive of cultural appropriateness and those that are applicable to clients are provided in English and Spanish at an appropriate literacy level ▪ Resources are allocated based on community need and assessment ensuring targeting of demographics most affected by the epidemic ▪ 2011-2015 board approved organizational strategic plan includes goals, objectives, and action steps prioritizing staff cultural awareness and competency trainings ▪ Executive Director serves on the Central Health *Health Equity Council* for HIV issues
48. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.	▪ Compliance with Equal Employment Opportunity Commission (EEOC) guidelines since inception ▪ Compliance with The Americans with Disabilities Act (ADA) since inception ▪ EEOC and ADA language reflected on all job postings ▪ Staff are fluent in Spanish, culturally reflective of the Hispanic clientele, and available to interpret daily ▪ Staff members are from diverse backgrounds including African-Americans, Latino, and individuals that are immigrants to the USA. Organizational staffing is reflective of the demographics of the HIV epidemic in the Austin TGA ▪ One staff member proficient in American Sign Language and others with basic skills ▪ Committed to promoting from within for job openings ▪ Evaluation of the potential of current staff for leadership development in order to promote direct service staff ▪ Structured Action Teams provide leadership development

CLAS Standards	ASA Compliance
	opportunities for all staff members ▪ Candidates for positions where bi-lingual (Spanish) skills are preferred are offered a salary premium for demonstrating appropriate proficiency in the language ▪ Organization recruits diverse candidates by networking with higher education institutions of color and advertising and conducting outreach into appropriate publications in communities of color ▪ 2011-2015 board approved organizational strategic plan includes goals, objectives, and action steps prioritizing recruiting, hiring, and training diverse staff and recruiting board members from communities of color ▪ Board officers are demographically and culturally diverse ▪ Agency participation in multicultural career expos for staff recruitment
49. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.	▪ The agency's Cultural Appropriateness Action Team and Professional Development Action Team research and implement ongoing training ▪ Agency support of language skills development when resources are available ▪ Executive Director serves on the Central Health *Health Equity Council* for HIV issues
50. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.	▪ Staff are proficient in Spanish, culturally reflective of the Hispanic clientele, and available to interpret daily ▪ Staff are from diverse backgrounds including African-Americans, Latino, and individuals that are foreign-born ▪ One staff member proficient in American Sign Language and others with basic skills ▪ Interpretation services in any language are offered to clients free of charge; interpreters culturally reflect clients ▪ Client materials are written at a fifth to eighth grade literacy level and in Spanish at a third to fifth grade level ▪ Client materials are provided in Spanish and English ▪ A professional volunteer translates client materials from English to Spanish ▪ The agency uses an independently certified system to evaluate the language proficiency of staff ▪ Organization's central voice mail and Dental Clinic voice mail systems are recorded in Spanish ▪ Key program staff have recorded voicemails in Spanish
51. Inform all individuals of the availability of language assistance services clearly	▪ Interpretation policy offering services free of charge posted in all locations ▪ Reception and Intake and Eligibility staff trained to notify

CLAS Standards	ASA Compliance
and in their preferred language, verbally and in writing.	clients of their right to receive language assistance services free of charge ▪ Front desk and key staff voicemail messages are recorded in English and Spanish ▪ Interpretation services in any language are offered to clients free of charge; interpreters culturally reflect clients ▪ Client materials are provided in Spanish and English ▪ Reception staff have access to language cards to identify need for interpretation services
52. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.	▪ The agency uses an independently certified system to evaluate the language proficiency of staff ▪ Written policy offers interpretation at no cost to the client in order to prevent the use of family and friends as interpreters ▪ Staff is trained to inform clients of their right to interpretation services at no cost and that family and friends are not a preferred source for interpretation in order to protect client confidentiality ▪ The agency hires professional, certified trainers to assist in interpretation upon request
53. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.	▪ Client materials are provided in Spanish and English ▪ Client materials are written at a fifth to eighth grade literacy level and in Spanish at a third to fifth grade level ▪ Key client information/policies and grievance information is posted in English and Spanish in common areas and available in hard copy from reception desks ▪ Quality Management Guidance Team reviews and updates materials to increase understandability
54. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.	▪ ASA's 2011 – 2015 Strategic Plan identifies compliance with CLAS Standards as a priority: o "Strategy #3: Ensure culturally appropriate programs and services ▪ Agency programs and services meet Culturally and Linguistically Appropriate Services (CLAS) standards ▪ Collaborative partners recognize ASA for delivery of programs and services to reduce stigma and for innovative and collaborative relationships" o Strategic plan action step is to implement an Organizational Cultural Appropriateness Committee representative of diversity of staff and management to further formalize cultural

CLAS Standards	ASA Compliance
	appropriateness trainings and action steps
55. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.	▪ Self-assessment of CLAS-related activities conducted in 2007; results continue to be used to improve services ▪ Cultural Appropriateness Action Team to survey annually and report to staff and board of directors of outcomes from strategic planning goals/objectives related to cultural appropriateness work
56. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.	▪ Collection of data and documentation on each consumer's race, ethnicity, disabilities, spoken and written language, and literacy level; information entered into client paper file, Provide Enterprise® internal electronic database, and ARIES; information updated periodically ▪ Use of the Austin Transitional Grant Area HIV Planning Council's periodic consumer needs assessment ▪ Use of the Brazos Valley Council of Government's periodic consumer needs assessment ▪ Provision of HIV testing data to the Texas Department of State Health Services, (DSHS) and the Centers for Disease Control and Prevention, (CDC)
57. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.	▪ Collection of data and documentation on each consumer's race, ethnicity, disabilities, spoken and written language, and literacy level; information entered into client paper file, Provide Enterprise® internal electronic database, and ARIES; information updated periodically ▪ Annual review and assessment of HIV epidemiology profile of epidemic as prepared by Texas Department of State Health Services (TDSHS) and the Austin/Travis County Health and Human Services Department ▪ Use of the Austin Transitional Grant Area HIV Planning Council's and Brazos Valley Council of Government's periodic consumer needs assessment ▪ Annual report to staff and board of directors on Austin TGA HIV epidemic in comparison to organization's client demographic profile, staff demographics, and board demographics
58. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic	▪ Collection and updating of data and documentation on each consumer's race, ethnicity, disabilities, spoken and written language, and literacy level; information entered into client paper file, Provide Enterprise® client electronic database, and ARIES. ▪ Provision of HIV testing data results are reported to the

CLAS Standards	ASA Compliance
appropriateness.	DSHS and CDC ▪ Involvement in community events targeted to people of color to build collaborative partnerships in a participatory environment ▪ Staff shares lessons learned at above events with management and leadership staff to expand collective knowledge of local cultural practices and beliefs ▪ Organization is a member of the advisory committee to the Latino Commission on AIDS to develop training institutes on providing culturally appropriate HIV services to the Latino community in 2012 ▪ Executive Director serves on the Central Health *Health Equity Council* for HIV issues
59. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.	▪ Client materials are provided in Spanish and English ▪ Client materials are written at a fifth to eighth grade literacy level and in Spanish at a third to fifth grade level ▪ Client grievance procedures are posted in English and Spanish in common areas throughout the organization ▪ Organization has a formal grievance procedure in place that is reviewed annually by staff
60. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.	▪ Strategic Plan dissemination to donors and posted on website ▪ Community Impact Report disseminated to donors, posted to website, and available in hard copy to public ▪ Responsiveness and pursuit of opportunities to participate in ethnic media

Quality Management

Use of Output and Outcome Data

Using monthly data, AIDS Services of Austin (ASA) tracks progress on the total number of unduplicated clients served, units of service delivered, and meeting outcome goals through monthly data collection through the reporting feature of the Provide Enterprise® electronic client database. On a monthly and quarterly basis, supervisors analyze the data to determine if outputs and outcomes, respectively, are within a 10 percent variance of the elapsed period of the grant cycle. If not, supervisors determine reasons that program goals are not being met and develop plans to address the situation including staff training, supervision, and monitoring staff adherence to the standards of care for the service category. Supervisors also note trends in performance measures with emphasis on clients who do not meet outcome objectives and develop appropriate quality management activities or document the reasons for such exceptions.

Provide Enterprise® reports give aggregate data at the agency level that documents client trends in service utilization for use in planning for service delivery.

Supervisors will use reports from the ARIES client database to validate data on performance measures such as number of unduplicated clients served and units of service provided. With the client's signed permission to share client information in ARIES, supervisors will use ARIES reports to facilitate getting complete data on services accessed by clients, to document successful linkages to primary medical care and other HIV provider services, and to compare, if needed, client service utilization data in order to avoid duplication of services. ARIES will also provide aggregate data at the community level that documents client trends in service utilization for use in planning for service delivery.

Supervisors will use the service-specific client satisfaction survey to obtain data using client input on satisfaction with services provided. Supervisors review survey results including qualitative data at program area, Leadership Team, Quality Management Guidance Team, and the Program and Services Committee meetings. With input from these various teams, supervisors use suggestions from the survey to identify problems and/or concerns and implement quality improvement activities including service delivery changes when possible.

The Associate Director of Direct Services, the Food and Nutrition Services Manager, and the Dietitian evaluate the Medical Nutrition Therapy (MNT) program's performance in achieving goals and meeting MNT standards of care by analyzing results from output and outcome measures, the agency client satisfaction survey, and client feedback. Based on these data reports, supervisors and staff assess the effectiveness of overall Food and Nutrition Services activities, compliance with Food Bank and Medical Nutrition Therapy quality benchmarks and the structure of service delivery.

The goal of the MNT program is to educate persons with HIV illness about how to maximize their health through food selection and preparation, inform clients about appropriate diets for chronic diseases related to lifestyle (i.e. diabetes, insulin resistance, hypertension, hyperlipidemia, osteoporosis, hepatitis, pancreatitis, and obesity), and enhance the ability of ASA's food bank supplemental food program to improve and maintain client health. ASA evaluates the agency's ability to meet these goals by analyzing results from outcome and output measures data, direct client feedback at the time of service, annual agency client satisfaction survey, and from client suggestions taken from agency suggestion box located in the main lobby.

The resources and tools used to facilitate this process are staff time, the Provide Enterprise® database, ARIES database, direct client feedback, suggestion box, and the client satisfaction survey.

Assurance of Compliance with Austin TGA Standards of Care

All staff participating in Medical Nutrition Therapy has been trained on the following Standards of Care in the Austin TGA continuum of care for Medical Nutrition Therapy:

Standard 1: Clients will have a baseline nutritional assessment. All new food bank clients (100 percent of those clients who score 5 or higher on the Nutritional Health Risk Screen) are required to have a baseline nutritional assessment within three months of first accessing food bank services. The Initial Nutritional Assessment for all clients includes: visual appraisal; weight measurement; body mass index; lab values; medical history; medications, including adherence to ART/HAART; alternative therapies; BIA (a benchmark procedure for detecting wasting in clients, which can be subtle and sometimes occurs in the presence of normal or excess weight due to increased body fluid); gastrointestinal and oral health factors; nutrition history; exercise pattern and recommendations; psychosocial and economic issues; nutrition management plan to address deficits; vitamin recommendations; interventions; supports and readiness to learn; and evaluation of need for specialized nutritional supplements.

Standard 2: Patients and Nutritionists will collaborate on individualized nutrition management plans. The Dietitian works with clients to address individual problems as they occur, decrease nutritional deficiencies, optimize nutritional status and immune system, maintain Ideal Body Weight range and body cell mass, and empower clients with self-management strategies for chronic disease diagnosis. If clients bring copies of medication regimen to the nutrition appointment, the Dietitian will discuss food/drug interactions with the client and provide handouts. This indicator is particularly difficult for the Dietitian to cover in the allotted Initial Nutritional Assessment timeframe (60 minutes). An additional constraint is that approximately 50 percent of clients do not know or remember the names of their medications. With the use of the ARIES client database; clients who elect to share their personal information between ASA and their HIV primary care provider will be readily provided with ways to manage food/drug interactions through Medical Nutrition Therapy because of the availability of current lab values, recent diagnosis, and current medication list on the database.

Quality Management Plan

Quality Management Guidance Team

The overall responsibility and leadership for ASA's Quality Management (QM) program lies with the Chief Program Officer, who authorizes the Quality Management Guidance Team (QMGT) to plan, assess, measure, and implement performance improvements throughout the entire agency, while providing the necessary resources and support to fulfill these functions.

The membership of the QMGT reflects the diverse service areas within AIDS Services of Austin (ASA). The agency's quality team is comprised of the Chief Program Officer, Board Members, and other members of ASA staff, ranging from upper management to direct service staff. Other ASA staff members, such as Program Supervisors and Coordinators, Case Managers, and Prevention Specialists are involved, when appropriate. Nominations for membership are decided upon by the QMGT. The QMGT meets every other month. Additional meetings may be called, as needed. Minutes of meetings are distributed directly to each member of the committee and to all necessary internal and external stakeholders. A written summary is routinely made available to staff.

The Quality Management Plan
The Quality Management Plan seeks to improve service performance through collecting and evaluating data, identifying service problems based on the collected data, using quality improvement processes to address service delivery issues, and following up to ensure improvements will be sustained. The agency plan is designed annually with target goals and service specific quality improvement activities. It calls for a review of service performance measures, an analysis of this data, and recommendations for service improvements. The plan indicates that the team will oversee an annual update and revision of program policies and procedures. At the end of each year, the plan is evaluated to determine the achievement of goals and the service specific activities and to make recommendations for further follow-up.

The following sections describe other components in the Quality Management Plan:

Activities to Collect Data
The Associate Director of Direct Services and the Food and Nutrition Services Manager, will collect data on the program's performance in achieving service goals and meeting standards of care through results from the following sources: outcome and output measures, the agency client satisfaction survey, client file reviews, the client suggestion box, client/staff feedback, and client grievances.

Supervisors review performance measures quarterly and report measures not meeting contract objectives to the Quality Management Guidance Team, along with suggestions on planned action steps.

Client satisfaction surveys are an important way to identify quality issues. The agency distributes the standardized survey, after approval by the HIV Resource Administration Unit, City of Austin Health and Human Services Department, at the Food Bank and Dental Clinic sites to collect data on all Ryan White Service Categories offered at ASA. Trained social work interns and volunteers administer the survey during a selected two week period. The data is tabulated by an administrative assistant.

File reviews are essential to the quality of client data. The Food and Nutrition Services Manager reviews 30 client files annually of MNT client files for those receiving nutritional supplements during the grant cycle, to evaluate pertinent MNT program activities and compliance with indicators for the standards of care.

Client input from registered grievances is documented by program supervisors and reviewed at department staff meetings. Supervisors adhere to the agency's policy on client/patient grievances, which includes review by the Executive Director and/or the Board of Directors, if necessary.

Evaluation of Performance and Assuring Delivery of Quality Services

As data and input are received and problems are identified, the QMGT evaluate concerns and suggestions in order to assure the delivery of quality services.

The QMGT analyzes the output/outcome data and makes recommendations for improvement to program supervisors. When quality improvement activities around performance measures are designed and completed, the results are then sent to the team and reported in the annual evaluation of the Quality Management Plan.

Supervisors will evaluate survey results to identify trends for improvements and advocate for unmet client need. To guide decisions about quality improvement activities, survey results are discussed at the program level in department/program meetings and at QMGT meetings. The Programs and Services Committee of the Board of Directors also reviews survey results and gives guidance when appropriate.

Program supervisors utilize grievance input obtained from clients and managers at the different grievance levels to make appropriate service changes, when feasible. Supervisors will be careful to note any client feedback related to the culturally appropriateness of service delivery.

Suggested actions taken based on this data could include staff development training in an identified area, development of organization tracking tools, identification of a different site for service delivery, additional interventions to reduce barriers, or design of client/patient forms to better capture data and service performance measures.

Identification of Quality Improvement Activities

At the beginning of the year, supervisors and the QMGT identify specific service quality improvement activities based on staff and client feedback and the data already discussed. MNT also identifies activities through information from nutrition assessment, dietary and nutritional analysis of menus and data from national counterparts providing similar services. Activities are written using SMART objectives in that they are specific, measureable, attainable, relevant and time-bound.

The 2016 quality improvement activity identified for Food Bank/Medical Nutrition Therapy is: increase Medical Nutrition Therapy kept appointment rate from the 2015 level goal of 85%.

Addressing Identified Problems

Once a problem or an area that needs further assessment is identified, the team will use, when appropriate, the Plan-Do-Study-Act cycle (PDSA), a four-step model for carrying out change. This process will be used in identified quality improvement activities as detailed in the annual Quality Management Plan. The components are as follows:

1. Plan by recognizing an opportunity and planning a change.
2. Do by testing the change and carrying out a small-scale study.
3. Study by reviewing the test, analyzing the results/data and identifying what has been learned.

4. Act by taking action based on what you learned as a result of data analysis in the study step.

If the change does not work, the cycle will be repeated again with a different plan.

To gather accurate data, the Food & Nutrition Services Manager, or her designee, reviews nutrition files from clients taking nutritional supplements, quarterly to evaluate pertinent program activities and compliance with indicators for the Standards of Care. Any deficiencies in delivering services, documentation of services or lack of compliance with standards will require plans of correction and timelines for correction.

The Dietitian, supervised by the Food and Nutrition Services Manager, tracks the number of clients who have an initial nutritional assessment plan in their nutrition file. To achieve this outcome, staff developed an electronic tracking system to capture the data for reporting. Individualized nutritional management plans are developed with the client at the initial Medical Nutrition Therapy appointment.

Client file review results may indicate Standard of Care or performance deficiencies that are systemic. In these situations, supervisors will identify and design quality improvement activities to address these areas and request that the activities are integrated into the annual Quality Management Plan.

Follow Up

The Food and Nutrition Services Manager will follow up to ensure the effectiveness of improvement activities and the maintenance of improvement results. On identified quality improvement activities, supervisors follow up on a quarterly basis to ensure that these activities have been effective in resolving the problem, that no new problems have developed, and that there is sustained improvement in identified areas.

For file review results, supervisors work with staff to develop plans of correction within 15 working days of the file review. Staff has ten working days to implement corrections. At the next quarterly file review supervisors monitor the maintenance of the previous quarter's improvements to ensure problems do not reoccur.

Additionally, the Dietitian collects data directly from clients receiving nutritional supplements through self report at the initial visit to the food bank and at subsequent Medical Nutrition Therapy visits to measure nutritional progress, record clients' weight, perform follow-up Bioimpedence Analysis (BIA), and provide additional one-on-one therapeutic counseling support. The Dietitian administers food, eating habits and nutrition questionnaires that help assess client improvement in nutritional health. The Dietitian follows up with individual client progress, through one-on-one visits during different points in the delivery of services, including required weigh-in prior to distribution of bi-weekly nutritional supplements, drop-in visits during drop in hours, and scheduled follow-up visit appointments.

Monitoring and Standardized Tools

Tools used in monitoring and standardization include the MNT file review tool and Provide Enterprise® reports with features to track reporting of performance measures, as well as a feature to describe content of progress notes for easy tracking. The annual client satisfaction survey is a tool designed and standardized across service providers by the Ryan White Quality Management Workgroup and the Evaluation/Quality Management Committee of the Austin Area Comprehensive HIV Planning Council.

Compliance with Ryan White Part A Program Monitoring Standards

i. Maintain and make available to the grantee copies of the dietician's license and registration

Licenses, certifications and State registrations for all professional staff and independent contractors are maintained in confidential agency personnel files, and are updated annually. State of Texas licenses and registrations for Dietitians are also readily available through the internet from the Texas State Board of Examiners for Dietitians. The Food and Nutrition Services Manager maintains desk files on Dietitian information including a copy of the Dietitian license, liability insurance or liability, employment application form, interviews and contract.

ii. Document services provided, number of clients, and quantity of nutritional supplements and food provided to clients

The Medical Nutrition Therapy program maintains a logbook used during service delivery operations, which identifies names of the clients currently eligible for nutritional supplements and for MNT counseling services. The date the client receives the supplements, the amount and type of nutritional supplement received, client weight, and the due date for next nutritional assessment is recorded during service delivery in the logbook.

iii. Document in each client file:
   - Services provided and dates
   - Nutritional plan as required, including required information and signature
   - Physician's recommendation for the provision of supplements

Each MNT client file documents clients' agreement of their individualized nutritional plan and is signed and dated by the client; contains the Nutritional Risk Screen administered by Eligibility and Intake and case management staff; the initial nutritional assessment performed by the RD/LD Dietitian including 24-Hour Dietary Recall assessment, anthropometrics, BIA results, progress notes, psychosocial screening, and documented follow-up activities (on three, six, nine month and annual intervals) as applicable to clients' individual nutritional plans; recorded weights; and laboratory results.

Work Statement

Service Category Name

Case Management Non-Medical : MAI

Client Eligibility

AIDS Services of Austin (ASA) will provide Case Management Non-Medical: MAI services) to persons living with HIV in order to meet their immediate health and psychosocial needs and reduce and/or eliminate gaps in service. Throughout this document, N-MCM MAI refers to the provision of culturally and linguistically appropriate advice and assistance in obtaining medical, social, community, legal, financial, and other needed services for HIV positive persons engaged in case management services.

To be eligible for the Case Management Non-Medical:MAI, clients must be HIV-positive, a resident of the five county area in the Austin Transitional Grant Area (Travis, Williamson, Bastrop, Hayes, Caldwell), and willing to work on HIV service plan goals.

ASA has Eligibility and Intake staff specifically trained to determine clients' level of need for services and eligibility status (every 6 months) for all ASA programs as well as programs at partner HIV services organizations and other social service organizations. ASA's Eligibility and Intake staff determine eligibility by securing verification of HIV status and residency. Staff will secure proof of identity, income, and insurance status as required intake documents.

xxi. **Documentation of HIV Status:** Staff obtain verification of HIV status through:
- a signed statement from the medical provider;
- a positive Western Blot laboratory result with the name of the client;
- a printed document from the ARIES database indicating verification of HIV status by another provider;
- HIV detectable viral load lab results; or,

- a hospital discharge summary or medical records from previous provider(s).

xxii. **Proof of Identity:** Proof of identity includes: Texas driver's license, Texas State identification card, a passport, Military or Student identification card, Social Security card, birth certificate or other official document as listed on the Austin TGA Ryan White Client Eligibility Form

xxiii. **Residency Verification:** In order to establish residency, clients can provide unexpired documents such as a Texas driver's license, Texas State or Tribal identification cards, Social Security award letter, rental/mortgage agreement, utility bill, or similar forms accepted by the Ryan White Part A Austin TGA.

Documentation of HIV status must be presented within 30 days and residency documentation must be presented within 60 days. Clients may be granted conditional eligibility if they present with an urgent need and lack the necessary eligibility documentation. ASA will make reasonable efforts to assist clients in obtaining the necessary documentation.

xxiv. **Income Verification: S**taff use the MAGI or Mock MAGI form for client income verification. Clients that have filed a tax return in the previous year complete the MAGI form and submit their tax transcript as income verification. Clients that did not submit a tax return or have had a change in income complete a Mock MAGI form and submit an IRS proof of non-filing and income verification document. Income verification documents include Social Security Award letter, Veterans/Public Assistance or Worker's Compensation benefits statements, wage payment stubs, signed zero income verification letter or other document listed in the Austin TGA Ryan White Part A Client Eligibility Form. There are some populations that are excluded from having to obtain tax transcripts or IRS proof of non-filing, these include: homeless, recently released from incarceration (3 months), undocumented, emancipated minors, and SSI and/or SSDI recipients.

xxv. **Health Insurance Coverage:** Cards verifying coverage by private medical insurance, Medicare, Medicaid, Veteran's Health Benefits, and Indian Health services will be accepted. Signed no insurance attestation statements will also be accepted. Should a client receive City of Austin Medical Assistance Program (MAP), a copy of the card will be made and a attestation of no insurance will be signed.

Eligibility and Intake Staff will use the Austin TGA Ryan White Part A Client Eligibility Form to reassess clients in the program every six months for determination of continued eligibility. At that time, client residency, income, and health insurance will be updated and/or new documentation obtained as indicated. Clients presenting with a change to income, residency or health insurance status within the six month review period will complete the Change in Circumstances: Eligibility Verification Addendum form. All required eligibility and intake documents, as well as periodic updates, are stored in the client's paper file and documented

electronically in the agency's electronic client database, Provide Enterprise®. Client identifying information is also entered into the ARIES client database. Eligibility and Intake staff completes a form verifying eligibility documents were collected, and an administrative assistant enters this data into ARIES.

N-MCM:MAI

Clients seeking services need to express willingness to work on HIV disease management and support service goals such as attending scheduled primary medical care, lab, oral health, medical nutrition therapy, and support service appointments. Clients should agree to follow the goals in the non-medical case management individualized service plan. Clients who identify as African American or Hispanic will be referred to the Case Management Non-Medical MAI program for culturally and linguistically appropriate services, depending on the availability of space.

Eligibility and Intake staff will utilize a screening tool with outlined criteria to designate which case management program clients are assigned to. Thereafter, case managers assess the client acuity based on the two acuity scales required by the Austin TGA Case Management Standards of Care.

The client's score on each acuity scale determines the level of contact that will be provided. When the client's acuity score is one, two, or three for the Medical Case Management acuity scale and the client expresses willingness to participate in programmatic goals, he/she may be assigned to a Behavioral Health Medical Case Manager (BHMCM) and a Registered Nurse Medical Case Manager (RN MCM) with special attention to clients with identified medication adherence difficulties and complex medical issues. When capacity is limited, clients with a score of one may have to wait for either the RN or the BHMCM. Clients who do not express a willingness to participate in this program's goals will be assigned to either regular Medical Case Management and/or Non Medical Case Management (N-MCM) if they score a one, two or three on the respective scale Case management supervisors or assigned case managers, based on professional judgment, may determine that a client's unique situation and needs qualify he/she for a higher level of service than indicated by the acuity score provided that the rationale is documented in the client's record. Clients are only assigned two medical case managers when there is capacity within each case manager position. Clients scoring a one, two, or three on the N-MCM acuity scale will be assigned to a non-medical case manager as capacity allows. Clients scoring a zero on either scale will not be assigned to that respective service.

N-MCM Target Population

The target population for AIDS Services of Austin's (ASA) Case Management Non-Medical (N-MCM) Program is low-income[17] (primarily) African-American and Hispanic individuals residing in the five-county area of the Austin Transitional Grant Area (TGA) and living with HIV disease.

[17] ASA defines low-income as a household that is at or below 80% of the U.S. Department of Housing and Urban Development's Area Median Income guideline for Travis County.

The following table compares the 2015 calendar year demographics of ASA's N-MCM MAI program to the demographics of people living with HIV and AIDS in the Austin Transitional Grant Area (TGA).

Table 2

	ASA Clients	Austin TGA PLWH/A
Gender		
Male	65%	85%
Female	27%	15%
Transgender	8%	(unavailable)
Race/Ethnicity		
White	0%	46%
Black/African-American	68%	22%
Hispanic	32%	29%
Other	0%	3%
Age Group		
0 – 12	0%	0%
13 – 24	8%	4%
25 – 34	4%	17%
35 – 44	4%	27%
45 – 54	48%	34%
55 and over	36%	18%

ASA client geographic concentration aligns with areas of high prevalence of HIV/AIDS in the Austin TGA. ASA's most common zip codes for Non-Medical Case Management MAI clients are located in Travis County and also reflect the highest concentrations of African-American and Hispanic clients with HIV/AIDS.

Table 3

ASA Top Client Zip Codes	Prevalence Range of HIV/AIDS*
78704	314-674/100,000
78752	675-1,199/100,000
78753	115-313/100,000
78721	314-674/100,000
78741	675-1,199/100,000

**Source: Enhanced HIV Reporting: S. Arbona and S. Novello (Travis County)*

Austin TGA data suggest that 84 percent of clients have medical comorbidities, while others report social and health-related co-factors that complicate medical and other service delivery for

HIV. [18] Recent studies have shown that 67 to 96 percent of HIV positive individuals have comorbidities.[19] Based on past experience, ASA predicts that co-morbidities and conditions for the Case Management Non-Medical: MAI program's target population will include STDs, substance abuse, mental health issues, commercial sex work, poverty, homelessness, domestic violence, Hepatitis B and C, heart disease, diabetes, and tuberculosis (TB).

Service Category Activities

Service activities linked to Budget Justification

ASA has been implementing a N-MCM program since 2008 and psychosocial case management since 1988. Given ASA's history of providing these programs in the Austin TGA, necessary mechanisms for implementation are already in place. Long-standing mechanisms include:

- A Board of Directors and strong organizational governance structure
- An experienced leadership team
- Trained and experienced staff (see *Staffing section*)
- A physical location near public transportation and well-known in the HIV field
- A programmatic structure offering a comprehensive continuum of care including HIV Prevention, Outreach Services, Case Management (medical and non-medical), Food Bank, Medical Nutrition Therapy, Oral Health Care, Health Insurance Assistance, special programs for women living with HIV and AIDS and legal services
- Strong community partnerships providing access to services not offered at ASA

Eligibility and Intake staff and Non-Medical Case Managers receive training on the Austin TGA Standards of Care for Non-Medical Case Management services and the use of acuity scales for both Non-Medical and Medical Case Management services. This staff also received training on the use of the Substance Abuse and Mental Illness Symptoms Screener (SAMISS) tool. Eligibility and Intake staff and Non-Medical Case Managers employed have completed the initial required courses on core competencies as listed in the Austin TGA Ryan White Part A Case Management Standards of Care (page 12). All Eligibility and Intake staff and Non-Medical Case Managers complete at least 12 hours annually of continuing education targeting the 20 core competencies outlined on pages 13 and 14 of the Austin TGA Ryan White Part A Case Management Standards of Care within six months of hire or start of the grant year. Any newly hired Eligibility and Intake staff will complete specific requirements within 30 days of hire.

Case Management Non-Medical is responsive to the immediate needs of low-income individuals living with HIV and includes the provision of culturally and linguistically

[18] ARIES database, provided by the City of Austin (Addendum 5 to Ryan White Part A RFA 2012-13)
[19] "Prevalence and Patient Awareness of Medical Comorbidities in an Urban AIDS Clinic," Weiss, Jeffery J., PhD, et al

appropriate advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. AIDS Services of Austin's (ASA) N-MCM program uses a client-centered, strengths-based model designed to address the specific needs of each client. N-MCM may involve the coordination and follow-up of medical treatments.

Key activities for Non-Medical Case Management include:

- Initial Screening of Service Needs
- Development of Initial Comprehensive Assessment
- Development of Comprehensive, Individualized Service Plan
- Coordination of Services Required to Implement the plan
- Client Monitoring to Assess the Efficacy of the Plan
- Comprehensive Reassessment
- Periodic Reevaluation and Adaptation of the Plan
- Coordination with Multidisciplinary Team
- Case Closure

i. Screening of Service Needs:

- **Initial Screening and Client Intake:** Eligibility and Intake staff screens all new and returning clients to determine eligibility and need for case management services. A intake appointment will be scheduled within 10 working days of the initial contact with the client or designated agent requesting services. In the interim, clients who are eligible for Outreach are connected with Outreach staff and are to be connected with community resources. In certain circumstances, clients are provided an emergency intake. Screening must include the eligibility parameters already described in *Eligibility Criteria section*; the presenting problem as indicated by the client and referral source; HIV disease stage and medical need; household size; and history of mental health, substance abuse, and/or domestic violence when indicated.

- **Client Intake Process:** Once eligibility screening is complete and the client is determined to qualify for case management, Eligibility and Intake staff gather information about the client level of functioning, willingness to participate in case management and service plan goals, the quality of support given by family and significant others, and public/private benefit eligibility. Additional documentation will include such items as client preferred language, literacy level, household members, emergency contacts, health care and social service providers, a signed consent to receive services, the client Bill of Rights, the Client Confidentiality Policy, HIPAA Policy and the ASA Client Grievance Policy and Procedure.

- **Emergency/Critical Referrals:** Intake and Eligibility staff is expected to make immediate referrals in the following situations: client is in acute need of psychiatric or medical care, has less than 10 days of prescribed medications left, indicates they could be a danger to themselves or others, is homeless, faces an impending eviction or utility termination, or indicates he/she has no food. A temporary service plan may be executed

following completion of the initial screening based upon immediate needs or concerns.

- Eligibility Reassessment: Eligibility and Intake staff will reevaluate the five areas of eligibility as required in the Austin TGA Ryan White Part A HIV Case Management Standards. Every six months Non Medical Case Managers will inform clients that they are due for an eligibility update and will make an appointment for the client with the Eligibility and Intake Specialist. During this appointment the client's eligibility documents will be collected and stored in the client's paper file and documented electronically in the agency's electronic client database, Provide Enterprise®.

ii. Development of Initial Comprehensive Assessment:

Expanding upon the information gathered during the initial intake visit, case management staff completes an initial comprehensive assessment for all clients entering into Services. The initial assessment provides a broader base of knowledge needed to address complex, longer-standing psychosocial needs. Information obtained during the initial assessment, as well as ongoing reassessments conducted by assigned case managers, is used to develop a comprehensive, individualized service plan, which assists in the coordination of the continuum of care.

The Austin TGA HIV services program is a needs-based program which strives to provide the appropriate type and level of case management support to clients with the greatest level of need to help them access and maintain quality medical care and manage their disease effectively. As part of the comprehensive assessment, the non-medical case manager will review the acuity level score determined at intake and revise it as necessary given the more thorough information collected from the client and other sources.

- **Client Assessment:** The non-medical case manager will begin the assessment and will complete it within 30 calendar days of intake date. This period of time allows the case manager to assess client health status over time and collect more in-depth information in order to address complex client medical, mental health and substance abuse needs.
    - **SAMISS Assessment:** Non-Medical Case Managers will perform the Substance Abuse and Mental Illness Symptoms Screener (SAMISS) during the assessment process per the Austin TGA Ryan White Part A Case Management Standards of Care. If the client screens positive on the SAMISS, staff will immediately refer clients to mental health (Waterloo Counseling Center or Austin Travis County Integral Care) or substance abuse (Austin Travis County Integral Care) services and will follows through on the referrals.

iii. Development of Comprehensive, Individualized Service Plan:

Service plans are a critical component of case management activities, as they guide both the client and the case manager with an approach that is proactive to addressing the client's needs. The case manager and the client use the intake screening/brief assessment and the Initial Comprehensive Assessment to collaboratively develop a

service plan for the client based on need and client readiness. Client needs identified in the Assessment/ Reassessment are prioritized and translated into a service plan which defines specific goals, objectives, and activities to meet those needs. The client and the case manager actively work together to develop and implement the service plan.

Service plans are negotiated in person with clients to further encourage their active participation and self-empowerment. Both the client and the case manager sign off on the service plan to verify agreement and understanding. Service plans are living documents for planning and tracking the client goals, tasks, and outcomes for specified and identified needs. A copy is offered to the client to emphasize the client participation in partnership with the case manager. The service plan is updated when outcomes are achieved and revised/amended in response to changes in the client's life circumstances or goals. Tasks and referrals are updated as identified or completed, and not at set intervals. The individualized service plan must also be completed within 45 calendar days of the client's intake date.

- **Acuity Scale Assessment:** Staff will use two acuity scales as described in the Austin Transitional Grant Area (TGA) Ryan White Part A Case Management Standards of Care. One acuity scale is for Non-Medical Case Management and one is for Medical Case Management. The two scales are used to determine the appropriate type and level of services needed by the client. Staff rates the client situation according to14 parameters of life situation or functioning that have four scores assigned to them. Totaling the scores for each parameter results in a weighted acuity score that assigns the client to an acuity level of zero, one, two, or three. ASA's staff are trained and experienced at taking into account information collected from the client, significant others, and medical/support service providers in order to determine appropriate individualized acuity scores for each client. Those at zero acuity are not eligible for case management services.

Table 5

Acuity Level	**1**	**2**	**3**
Minimum Contact with Case Manager	Every 3 months	Monthly	Two times a month

iv. Coordination of Services Required to Implement the plan

Non-Medical Case Managers coordinate services required to implement service plans by referring clients to appropriate resources and ensuring resource linkage. Staff ensures linkage by educating clients about the eligibility criteria and process, assisting in completion of applications, advocating on the client's behalf, and following up on referrals to monitor client progress and address barriers, as needed. The Non-Medical Case Manager provides advice and assistance in obtaining medical, public benefits (e.g. Medicare, Medicaid), social, community, legal, financial, and other needed services.

Case managers assist clients in the completion of applications for commonly needed

services, such as food stamps, taxi vouchers, housing through Project Transitions (an Austin-area nonprofit that provides hospice, housing and support to people living with HIV and AIDS), Housing Opportunities for People Living with AIDS, Section 8 and public housing, Meals on Wheels and More, Capital Area AIDS Legal Project (CAALP), Texas HIV Medication Program, and Capital Metro's Metro Access transportation program. Regular communication (per table below), either by telephone or in person, is maintained with clients to establish rapport, as well as to foster self-advocacy and increase self-sufficiency skills. Staff provides services in venues that are convenient to the client, which include telephone contact and office, clinic, hospital, and home visits.

Case managers provide referrals to clients as determined appropriate or necessary. Referrals are a mutual decision between the client and case manager in which the client agrees to accept a service referral from the case manager for services not currently being accessed. The case manager utilizes a referral tracking mechanism to monitor completion of all case management referrals to ensure the client follows up and accesses services. The case manager identifies and resolves any barriers clients may have in following through with their referrals service plan goals.

v. Comprehensive Reassessment

The Non-Medical Case Managers will reassess the client health, mental health, and psychosocial functioning, note changes since the last assessment, and identify new needs. If client household size or income has changed, the case manger will screen for eligibility for public/private benefit programs. Noted below are the frequencies for the different acuity levels for the reevaluation of the comprehensive assessment that includes acuity update and service plan revisions:

Table 6

	Acuity Levels 1 & 2	**Acuity Level 3**
Reevaluation of Comprehensive Assessment	Every 12 months	Every 6 months

- Reassessment includes noting barriers to meeting service plan objectives and evaluating the success of case management interventions. This is also a time to reevaluate the current level of case management services and the need for additional levels. The assessment will also include a review of service utilization such as kept primary medical and specialty care appointments, use of medial nutrition therapy services, and adherence to oral health care visits.

- The Non-Medical Case Managers will incorporate client input into the assessment as well as feedback from the primary medical care team, the other assigned case manager, and other support service professionals.

vi. Client Monitoring to Assess Plan Effectiveness and Plan Re-Evaluation/Revision

The Non-Medical Case Manager will closely monitor client follow through on service plan goals and reevaluate the effectiveness of the service plan as services continue. Based on the reassessment, as needed, the service plan goals and tasks will be revised with client input, and will include actions to address any service utilization issues noted.

- Reassessment and plan reevaluation/revision will occur in the frequencies noted below:

Table 7

	Acuity Levels 1 & 2	Acuity Level 3
Reevaluation of Service Plan and Revisions	Every 6 months	Every 3 months

i. Coordination with Multidisciplinary Team

Clients in N-MCM experiencing a repeating cycle of the same medical crisis or problem are assessed for enrollment into MCM services, either onsite or offsite, and assisted in attaining these services. The goal of N-MCM is to meet the immediate health and psychosocial needs of the client at their level of readiness in order to restore or sustain client stability, and to establish a supportive relationship that can lead to enrollment in MCM services, if needed. Likewise, clients in MCM may be referred to receive N-MCM services as well.

Once the service plan is developed and reviewed with the client, the Non-Medical Case Manager will coordinate services and provide the advocacy required for plan implementation by communication and multidisciplinary consultation on client goals and needs with all of the appropriate members of the client's team, which can include:

- primary medical providers;
- Registered Nurse (RN) medical case manager;
- Social Work/Counselor medical case manager;
- community social worker;
- registered dietician;
- oral care health professional; and/or,
- other supportive service professionals when appropriate.

The Non-Medical Case Manager will advocate for the client to ensure timely and coordinated access to appropriate levels of medical care.

Service coordination will include sharing the individualized service plan and progress on plan goals with the assigned RN and Social Work/Counselor medical case managers when part of the team as well as accepting their input into the development and revision of the service plan. Tier 1 Non-Medical Case Manager will focus on coordination of services and client advocacy related to mental health, substance abuse, and psychosocial needs.

Service coordination and client advocacy will be provided whenever the client needs such interventions. These actions, in more complex situations, could occur several times weekly until the client stabilizes to weekly or monthly when clients have a stable health, mental health, and substance use status or are functioning more independently.
When appropriate and available, N-MCM clients may work jointly with a Medical Case Manager on the achievement of service plan goals and objectives. Depending on whether the client was first assigned to N-MCM or Medical Case Management, their first assigned case manager will be their primary case manager.

ii. Case Closure:

Clients who are no longer engaged in active case management services will be evaluated by the case manager for closure. Clients achieve graduation from the program when all service plan goals are successfully met, the client is able to independently resolve his/her needs, and both client and case manager agree that services are no longer needed. Other reasons for closure may include: referral to another case management program, client relocation outside of the counties of the Austin TGA, incarceration for greater than three months, client choice, ineligibility for services, client lost to care or not engaging; agency-initiated termination due to behavioral violations; or client death. Clients that are lost to care or not engaging in their care will be contacted through the Return to Care Collaborative, and reasonable attempts will be made to bring them back into care. (Please see *Section j. Linkage to Primary Medical Care* for further explanation.)

Case Managers will complete a closure summary documenting case closure and reason for closure. Clients are considered non-compliant with case management if they do not respond to three attempts to contact them within 30 days via phone, e-mail, or written correspondence. The case manager will notify clients of closure through an in-person meeting, phone contact, or written correspondence. Clients will be provided with written documentation explaining closure and the process to be followed if services are needed in the future. Case managers will offer appropriate referrals to the client and obtain a signed client release(s) of health information for new providers to assist in transfers. Staff will conduct exit interviews with clients upon case closure or graduation from the program, if appropriate. In situations in which closure is involuntary, case managers will review the client situation with supervisors to secure approval for termination of services.

Location(s) of these service activities for Non-Medical Case Management

Staff provides services in venues that are convenient to the client, which include telephone contact and office, clinic, hospital, nursing facility, and home visits.

<u>Staffing</u>

Leadership for the N-MCM:MAI program includes: Director of Access Services, Non-Medical Case Management Programs Manager, and Medical Case Management Programs Manager.

Executive Team Members: The Executive Director is the primary contact with the City of Austin Health and Human Services Department (AHHSD) HIV Resource Administration Unit and has final authority in negotiating and approving contracts. The Chief Programs Officer interacts with AHHSD on matters relating to programs and is authorized to enter into negotiations with AHHSD regarding program issues, grant reporting, and performance measures. The Chief Financial Officer interfaces with AHHSD HIV Resource Administration on grant billings. The Grants Manager ensures contract compliance.

Table 8 below indicates key staffing for the Case Management Non-Medical: MAI program:

Table 8

Name/Position	Qualifications	Primary Work Assignment	% Time Allocated
Williams-Price/Director of Access Services	Master in Public Health Policy and Management; 5 years of nonprofit management experience; 10 years of human services, grants management, program development, and fiscal management experience; 5 years of case management/social work supervisory experience	Supervises all Case Management, including MCM, and Outreach programs; manages service delivery and evaluation; reviews financial assistance; budgets and implements program modifications; coordinates QM activities and develops policy and procedures.	2.93%
Rios/Non-Medical Programs Manager	Master Degree in Healthcare Administration; 9yrs of experience in human services field; 7 yrs of experience in non-profit management. 5yrs of experience in case management.	Supervises all Non-Medical Case Management Programs, up to 2 interns, approves and tracks financial requests, evaluates program outcomes and service delivery, completes grant reporting requirements, and coordinates and implements QM activities.	10.94%
Braglia/Medical Programs Manager	MSSW; 10.5 years at ASA; 11.5 yrs in social services; 11 years experience with substance abuse, mental health, and persons of color; 11+ yrs in HIV; and 11 yrs with LGBT community.	Supervises all Medical Case Management Programs, up to 2 interns, approves and tracks financial requests, evaluates program outcomes and service delivery, completes grant reporting requirements, and coordinates and implements QM activities	1.05%
Medina/Intake Coordinator	BSW; 1 year at ASA, including experience with mental health, low-income people, and people of color .	Performs eligibility and intake, makes referrals and provides information, performs quality assurance activities.	1.67%

Name/Position	Qualifications	Primary Work Assignment	% Time Allocated
Maposa/Non-Medical Case Manager	Masters in Business Administration, 5 years Certified Nursing Assistant, 2 Women Rising Project Coordinator , 1.5 year experience Patient Navigation Services and Women's Empowerment	Provides Non-Medical Case Management to assist clients with issues related to HIV/AIDS in accessing medical care and social services through advocacy, resource linkage, and supportive counseling.	30.66%
Cirlos/ Eligibility and Intake Specialist		Performs eligibility and intake, makes referrals and provides information, performs quality assurance activities.	6.61%
Vacant/ Eligibility and Intake Specialist		Performs eligibility and intake, makes referrals and provides information, performs quality assurance activities.	30.66%
Lindgren/Receptionist	HIV, Substance Use, Mental Health Experience as direct receptionist	Provides programmatic support to clients in the verification and updates of eligibility documents and handles fees related to client services	1.51%

- The supervisor to staff ratio is 0.1492 to 0.696 FTE.

Table 9

Number of Volunteers	1 undergraduate/1 graduate from Texas State University (TSU)*
Number of Volunteer Hours	75/30**
Volunteer Responsibilities	ASA recruits social work interns each semester from The University of Texas and TSU. Interns provide case management services to a small caseload under the supervision of a licensed social worker. The graduate intern from TSU will work on Quality Management and Strategic Plan activities.

*All volunteer intern activities depend on availability of qualified interns placed at ASA.
**Number of hours dedicated to Case Management Non-Medical (Tier 1) depends on how case load is split with Medical Case Management and assignment.

ASA will not be using subcontractors for this service category.

ASA makes efforts to hire staff that are reflective of the populations served and that speak Spanish. In addition, all staff members are provided ongoing cultural competency training. Please see *Cultural Competency* section for more details on ASA's training and organizational efforts around cultural competency.

Client Access

Current—and potential—clients for Case Management Non-Medical can access services via several points of entry as outlined below:

- Potential clients are being located and identified through Ryan White, Part A Outreach Program Services. Outreach staff identifies individuals with unknown HIV status and those with known HIV positive status who are late to care or "out-of-care." *HRSA defines an individual as being out-of-care if there is no evidence of a client accessing any one of the following three components of HIV primary medical care during a defined 12-month time frame: viral load testing, CD4 count, or provision of anti-retroviral therapy.* However, the Ryan White Quality Management Workgroup has agreed that clients without these three components need intervention prior to one year. As a result, the outreach team also identifies individuals with HIV who have not received primary medical care for six months or longer.

    - **Area Hospitals and Emergency Rooms:** AIDS Services of Austin (ASA) Outreach team members are placed at area hospitals to train staff in referring to agency programs and to follow-up on referrals made by hospital staff. Outreach is called at least biweekly to link HIV positive individuals to medical care and support services such as Case Management Non-Medical . Hospitals identified include University Medical Center Brackenridge, and Seton Medical Center Austin of the Seton Family of Hospitals; and St David's Medical Center, St. David's North Austin Medical Center, and St. David's South Austin Medical Center. Outreach workers visit these hospitals and emergency rooms at the frequency of contact and hours agreed upon with hospital staff.

    - **Correctional Facilities:** At Travis County Correctional Complex (TCCC), Travis State Jail, and Del Valle Correctional Facility, ASA outreach team members identify at-risk for HIV or HIV positive individuals who are pre-release from incarceration or recently released from incarceration and link them into medical and supportive services. Outreach workers engage in a broad range of activities include working with correctional facility staff to refer HIV positive individuals.

      Outreach staff receiving service inquiry letters from HIV positive individuals due to be released encourages those individuals to contact the agency upon release. Once contacted, the outreach staff immediately begins the process of linking the individual to medical care and with Case Managers. In cases where a person who has been recently released comes to or phones the agency directly, staff is deployed to the site of preference as identified by the individual who is contacting the agency for services.

    - **CommUnity Care at David Power Clinic:** Several times monthly or sometimes on a weekly basis, Outreach staff links identified HIV positive individuals to primary medical care . Staff provides targeted individuals with a transition from outreach to case management services through building on the trust already established during outreach.

- **Community and Peer Referrals:** Due to the high quality of services provided by ASA, 14 percent of clients that receive case management intake assessments identify themselves and initiate contact for services as a result of referrals from family, friends, or peers who have received agency services. For the same reason, 24 percent of clients are referred to case management from local health care providers.

- **ASA Prevention Programs:** ASA offers a variety of HIV prevention and testing programs that reach over 7,500 individuals annually. Prevention programs include:
    - Mpowerment, a prevention program for young gay, bisexual, and questioning men;
    - Healthy Relationships, an evidence-based intervention focused on prevention with positives;
    - HIV testing;
    - Hepatitis C and syphilis testing for targeted populations;
    - Linkage to care and patient navigation;
    - Condom Distribution Network;
    - Testing, Linkage, and Care, a program that brings HIV testing to sites where high risk populations frequent; and,
    - CLEAR, a risk reduction counseling program.

  All of ASA's Prevention programs refer HIV positive individuals into Outreach services or case management services through eligibility and intake.

- **Other:** ASA receives referrals through the United Way's 211, a non-emergency human services access phone line. ASA also receives referrals through HIV service directories. Please see *Section k. Other Linkages, Collaboration, and Referrals* for further description of ASA's referral system.

Clients will begin access Case Management Non-Medical services when they call or walk into the agency or transfer by another program. As described in *Section e. Service Category Activities,* Eligibility and Intake staff completes service eligibility screening to determine appropriateness for the program. They conduct eligibility screenings and assessments Monday through Friday primarily during agency business hours (8:30 am to 5:30 pm) and outside business hours as necessary. Eligibility and Intake staff strives to schedule intake appointments within one week of initial contact and rarely allows for a wait time of more than two weeks. The Non-Medical Case Managers will contact clients referred into their services within two weeks of the referral, at a minimum, with exceptions noted.

Access Barriers and Reducing Barriers to Access
One of the most difficult barriers to service delivery is lack of basic needs, such as food, housing, and transportation, which interferes with the client focusing on linkage to access to medical case management, medical care and supportive services. Other barriers are described below:

Table 11

Barrier	Description of Reduction/Elimination of Barrier
Eligibility Documentation	7. Eligibility and Intake staff or case managers provide reasonable assistance to clients to obtain identifying documentation. 8. Documentation may be a challenge for undocumented Hispanics or homeless individuals – ASA staff is trained to assist them is accessing appropriate documentation.
Basic Needs*: *Food*	10. Client intake and case manager assessment for eligibility for ASA's Helping Hand Food Bank services; 11. Assisting clients with Food Stamp applications; 12. Assisting clients with accessing emergency food needs through referrals to area agencies and food programs.
Basic Needs*: *Housing and Homelessness*	7. Access to short-term and long-term housing assistance needs to stabilize clients through ASA HOPWA and Best Single Source Plus Programs. 8. Case Manager coordination and referral to: Housing service providers such as Project Transitions, Foundation Communities, area boarding homes, Austin area public housing and emergency shelters. .
Basic Needs*: *Transportation*	13. ASA main facility located on two major bus routes as well as located in a zip code area where a high number HIV infections are located (78752); 14. ASA Intake, Outreach, and Tier 2 Client/Patient Navigators conduct home visits when necessary and work with clients who are unable to transport to office location; 15. ASA Intake (or Client/Patient Navigators) complete client applications for Special Transportation Services through Capital Metro; 16. Access to bus passes through the Basic Transportation Needs Fund
Health Literacy and Education	7. Assess client's health and language literacy; 8. Work with client through verbal communication and with health education materials tailored to client's level of understanding and language needs.
Unique Cultural & Linguistic Issues	10. Extensive training in cultural awareness and responsiveness related to communities of color, specifically African-American and Hispanic; 11. ASA has established working relationship with qualified interpreters to assist clients whose primary language is not adequately represented by a staff person; 12. Tier 2 staff build trust with undocumented Hispanic clients by explaining that this status will not affect eligibility for agency services.

Barrier	Description of Reduction/Elimination of Barrier
Substance Abuse Treatment	10. Consumer information about possible side effects of illicit drugs and HIV medications; 11. Access to appropriate case manager(s) with substance abuse assessment experience; 12. Collaborate with CARE program and other related agencies to provide support and treatment services.
Mental Health Treatment	4. Collaboration with and referrals to mental health providers including Waterloo Counseling and CARE program at ATCIC.
Historical Mistrust of Medical and Social Service Providers	4. ASA case managers work with client through skills building to mitigate mistrust and to improve the client health literacy through education.
HIV Disease Stigma	10. Frequent and prompt contact with individuals in target populations to build trust while relying on 24 years of established history of trust with ASA as an HIV provider for African-American and Hispanic populations; 11. Client-centered approach, emphasizing client strengths, respect for client self-determination – this approach is particularly effective in African-American and Hispanic communities; 12. Referrals of HIV positive women of color to Women Rising Project to educate women in making healthcare decisions – 60 percent of the women served are African-American.

* Basic needs as a barrier is more likely to affect African-American and Hispanic communities due to disproportionate poverty levels among communities of color.

Service Linkage, Referral, and Collaboration

Service category's key activity is to link clients to HIV primary medical care, at ASA, this can be accomplished in two ways the Outreach program and/or the case management programs. The Non-Medical Case Managers interventions are essential for ongoing retention of clients in medical care.

Referral Mechanism:

- Many clients are first assisted with initial access and linkage to HIV primary medical care through Outreach team efforts. The goal of the Outreach team is to successfully link clients to primary medical care in three months or less, in accordance with the National HIV/AIDS Strategy. To open a dialog with individuals about initial access to medical care, outreach staff will initiate rapport by providing information about general HIV transmission, risk reduction, and the benefits of early medical intervention. Once the Outreach team links the client into medical care, as evidenced by successful attendance at the first medical appointment, and the client is enrolled in the appropriate case management program depending on the individual needs (i.e. N-MCM, Medical Case

Management and PLUS Program). Once assigned to a case manager they then work with the client on strategies to maintain their medical care as part of their service plan.

- A client who contacts the agency directly and do not meet the eligibility requirements for the Outreach program is linked with Eligibility and Intake staff that assess the client's immediate needs for basic needs services and link them to community resources to stabilize their situation and refers them to primary medical care, if needed. A Non-Medical Case Manager may coordinate the clients medical care appointments and visits and assist them with any housing, identification documentation, or financial assistance needs.

Service Coordination and Integration of Resources

The Non-Medical Case Managers addresses crucial barriers to access to primary care by providing referrals for immediate basic needs such as transportation, food, and/or housing. Clients may be assisted through agency resources such as bus passes/taxi vouchers, one of several housing assistance programs, and/or the Food Bank program. In addition, they may be referred to community support services such as area food pantries, Capital Metro for transportation access, and churches for financial assistance with rent and/or utilities.

To address fear of medical providers, the medical care system, or fears related to limited English or health literacy proficiency, staff discusses with clients any resistance to medical care and may be accompanied to their intake medical care visit.Once the client has successfully kept the initial intake appointment at David Powell Clinic[20], the Non-Medical Case Managers work with clients on continued follow-up that may include accompanying clients to subsequent doctor visits. Non-Medical Case Managers build upon the trust developed with Outreach staff and the developing trust with medical providers to coordinate care with David Powell Clinic staff by assisting in appointment scheduling /rescheduling and conferencing around continued barriers to care.

In addition to working with the David Powell Clinic, ASA has long-standing referral relationships with other HIV-related medical providers including the Blackstock Family Clinic (a SETON non-profit practice); Austin Infectious Disease Consultants (a private specialty care practice); Academic Physicians at Trinity; South Austin Medical Clinic; Jefferson Street Family Practice; and, Austin Regional Clinic-South, Far West, and Quarry Lake locations.

Projected Results

As indicated in the *Service Coordination and Integration of Resources* section, clients are referred to primary medical care services by different agency staff depending upon their place in the broad continuum of services offered at ASA. In most cases, Outreach staff tracks primary care referrals by accompanying clients to appointments. When they do not attend appointments with clients, the staff calls health care providers to verify kept appointments or verifies the visit

[20] Clients entering services through Outreach rarely have private insurance and for those that do, the Outreach team will ensure they make a follow-up appointment with their private medical provider.

through the ARIES database. Non-Medical Case Managers attend primary medical care appointments with clients or call agencies to track and verify successful referrals.

Clients are considered successfully linked to medical care upon completing an intake session with CommUnity Care at David Powell Clinic or other medical providers. The Non-Medical Case Managers report on retention in medical care as measured through the HRSA/HAB HIV Performance Measures: two or more medical visits in an HIV care setting in the measurement year. All staff will document client progress in progress notes and successful outcomes in the service provided feature of the Provide Enterprise® electronic client database (ASA's internal electronic database). Non-Medical Case Managers will complete a referral tracking form that includes date of referral and completion date and keep the form updated in the paper client file. The desired outcome results are linkage to and retention in primary medical care services.

ASA also participates in the Return to Care Collaborative with CommUnityCare at David Powell Clinic, Austin/Travis County Integral Care Program, Community Action, Waterloo Counseling, and the Wright House Wellness Center. Through this partnership, the collaborative partners seek to improve information sharing to determine the reasons why people have fallen out of care and to use this data to predict out-of-care trends. As participants in the collaborative effort, ASA and CommUnityCare at David Powell Clinic will monitor and share out-of-care information on a bi-monthly basis, when able, and work together to return clients to medical care. When out-of-care clients are identified, they will be referred to ASA's Outreach Program when they have not received HIV primary medical care for one year or more. This staff will facilitate their reentry into the Medical Case Management, as this is typically the level of case management required for clients contacted through the Return to Care Collaborative. Once the Medical Case Manager is assigned, they must contact the client within 10 days, although it is typically sooner.

Other Linkages, Collaboration, and Referral

Linkages and Collaborations

AIDS Services of Austin (ASA) has collaborative agreements, letters of support, and/or Memoranda of Understanding (MOU) in place with several agencies, mostly with respect to specific programs. The MOUs guide referrals between agencies and allow smooth transitions of clients for additional services. ASA maintains MOUs with Waterloo Counseling Center, Project Transitions, the Housing Authority of the City of Austin, Austin Energy, the CARE Program of Austin/Travis County Integral CARE, and the Communicable Disease Unit at Austin/Travis County Health and Human Services Department (A/TCHHSD). For MOUs that require annual renewal, ASA contacts the partner agency 30 days prior to expiration of these agreements.

ASA also has long-standing referral relationships with HIV-related social service providers, including the CARE Program at Austin/Travis County Integral Care for substance abuse counseling and treatment referral for individuals that are dually diagnosed; Project Transitions for transitional housing and hospice; South Austin Marketplace for transitional and long-term housing; the Customer Assistance Program (Austin Energy) for utilities payment assistance;

Waterloo Counseling Center for mental health counseling; the Wright House Wellness Center for holistic/alternative health services; Salvation Army and the Austin Resource Center for the Homeless for emergency housing; the Social Security Administration for disability benefit applications and appeals; Del Valle Correctional Facility, Travis State Jail, and the University of Texas Medical Branch State Penitentiary for services to inmates upon their release; the Communicable Disease Unit at A/TCHHSD for HIV/ STI/TB screening; and SafePlace for domestic violence assistance.

Eligible clients are also referred to the broad continuum of ASA services: the Capital Area AIDS Legal Project (CAALP) for legal assistance; Medical Nutrition Therapy for nutritional assessment, counseling, and supplements; the Jack Sansing Dental clinic for oral health services; HOPWA for housing assistance; CLEAR for support for individuals to reduce the risk of HIV transmission; and the Health Insurance Program for premium, medication copayment and medication deductible financial assistance.

Referral Process and Follow Up
ASA staff assists clients with completing and submitting other agencies' referral forms, communicates with those agencies to clarify client eligibility, and advocates for client service delivery. For those clients who are case managed at ASA, staff ensures that referrals are followed through on in one of the following ways:

- performs follow up at the next client contact by asking the client about the referral and the results;
- accompanies the client to appointments;
- checks the ARIES database to ensure appointment was attended; or,
- calls the agency the client was referred to and confirms client attendance.

All staff document client progress regarding follow-through on referrals in the progress log feature of the Provide Enterprise® electronic client database (ASA's internal electronic database). Non-Medical Case Managers will complete a referral tracking form that includes date of referral and completion date and keep the form updated in the paper client file. The desired outcome results are linkage to and retention in support services.

Goals of Collaborative Activities, Integration of Resources, and Projected Results
The goal of collaborative activities is the provision of comprehensive services through the HIV provider community and other social service agencies using linkages and referrals. These activities ensure clients have access to all needed services that are not offered by ASA. In addition, they allow clients to overcome barriers to accessing and remaining in primary medical care and moving toward self-sufficiency in managing their HIV disease.

Integration of resources and services includes the dedication of ASA staff time toward the completion of other agency intake forms, assisting clients with the intake process, accompanying clients to support service appointments, reporting required data, and working with clients on mutual goals in service plans. These mutual goals may be related to support services that client

receive from other agencies, such as financial assistance, substance abuse or mental health counseling, housing, etc.

The projected results of collaborative activities, integration of resources, linkages, and referrals are:

- Client achievement of housing stability
- Meeting food intake needs
- Mental health services access and stability
- Independent management of substance use issues
- Financial stability
- Decreased recidivism
- Personal safety and security

Client Input and Involvement

Clients have several opportunities to offer input into the Case Management Non-Medical MAI Program services. Staff's rapport with the target community enables them to respond to client comments and needs on an ongoing basis. During these encounters, staff works with clients to offer input and identify needs and services they want to pursue.

Clients are surveyed using the standardized questionnaire developed by the Ryan White Quality Management Group to solicit feedback for improving case management services. The 2013 survey yielded positive feedback, with 90 percent of clients reporting that through the support of AIDS Services of Austin (ASA), their ability to manage their health has improved and 94 percent reporting they are satisfied or very satisfied with case management services. Supervisors will use survey results and staff feedback semiannually to evaluate the effectiveness of referral systems, barriers to service, and other service delivery components. The team will then plan, as appropriate, for service modification, especially actions to remove barriers. No 2014 survey was completed, ASA did distribute surveys in 2015 and is awaiting final results.

African-American and Hispanic individuals with HIV who access Non-Medical Case Management: MAI services work closely with case managers to develop individualized culturally and linguistically appropriate service plans. Service plans are written in the client's preferred language and at an appropriate literacy level, depending on the need to the client. In addition, cultural beliefs such as alternative medicine practices are taken into account. Client input is integral to developing the service plan, which includes only those issues and needs the client chooses to address.

All agency clients may register concerns with supervisors and through the client grievance process. All clients are provided a copy of the client grievance policy and procedure upon entry into services and it is posted in English and Spanish in the agency reception area. The

interpretation policy is also posted in the reception area, offering clients interpretation services free of charge so that they may file a grievance in their preferred language.

ASA routinely incorporates client feedback and suggestions into planning activities. In developing the agency's 2011 – 2014 Strategic Plan, ASA used interviews and focus groups with current clients to ensure their active participation in the strategic direction of the agency. ASA's Strategic Plan specifically defines "client satisfaction with programs and services" as a key measure of success in alignment with our strategy to "maintain and strengthen existing programs and services through quality improvement." The 2011-2014 Strategic Plan has been extended for one year so that ASA is able to fully analyze the impact of the Affordable Care Act. A suggestion box located in the client lobby is available for clients to submit anonymous feedback. The box is routinely monitored by the Eligibility Services Supervisor. Client feedback is given to appropriate staff for use in program improvements. The Quality Management Guidance Team reviews the feedback from the suggestion box quarterly to evaluate trends and making agency improvements.

Cultural Competency

Service activities will be delivered so that cultural and language differences do not constitute a barrier to services in full compliance with the National Standards on Culturally and Linguistically Appropriate Services (CLAS) described at: http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15.

AIDS Services of Austin (ASA) is in compliance with all 15 CLAS Standards.

Table 10

CLAS Standards	ASA Compliance
61. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.	▪ Staff members are proficient in Spanish, culturally reflective of the Hispanic clientele and available to interpret daily ▪ Staff members are from diverse backgrounds including African-Americans and individuals that are immigrants to the USA. ▪ One staff member proficient in American Sign Language and others with basic skills ▪ Interpretation services in any language are offered to clients free of charge; interpreters culturally reflect clients ▪ Staff assigned to clients are reflective of clients' cultural background, as feasible ▪ Client materials are written at a fifth to eighth grade literacy level and in Spanish at third to fifth grade level ▪ Client materials are provided in Spanish and English ▪ A professional volunteer translates materials from English to Spanish

CLAS Standards	ASA Compliance
	▪ Organization includes "diversity" as one of its core values
62. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.	▪ A Cultural Appropriateness Action Team with staff from varied levels and departments is tasked with ensuring CLAS and health equity are promoted ▪ The agency maintains a tracking mechanism to ensure CLAS compliance ▪ Agency policies are cognitive of cultural appropriateness and those that are applicable to clients are provided in English and Spanish at an appropriate literacy level ▪ Resources are allocated based on community need and assessment ensuring targeting of demographics most affected by the epidemic ▪ 2011-2015 board approved organizational strategic plan includes goals, objectives, and action steps prioritizing staff cultural awareness and competency trainings ▪ Executive Director serves on the Central Health *Health Equity Council* for HIV issues
63. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.	▪ Compliance with Equal Employment Opportunity Commission (EEOC) guidelines since inception ▪ Compliance with The Americans with Disabilities Act (ADA) since inception ▪ EEOC and ADA language reflected on all job postings ▪ Staff are fluent in Spanish, culturally reflective of the Hispanic clientele, and available to interpret daily ▪ Staff members are from diverse backgrounds including African-Americans, Latino, and individuals that are immigrants to the USA. Organizational staffing is reflective of the demographics of the HIV epidemic in the Austin TGA ▪ One staff member proficient in American Sign Language and others with basic skills ▪ Committed to promoting from within for job openings ▪ Evaluation of the potential of current staff for leadership development in order to promote direct service staff ▪ Structured Action Teams provide leadership development opportunities for all staff members ▪ Candidates for positions where bi-lingual (Spanish) skills are preferred are offered a salary premium for demonstrating appropriate proficiency in the language ▪ Organization recruits diverse candidates by networking with higher education institutions of color and advertising and conducting outreach into appropriate publications in communities of color

CLAS Standards	ASA Compliance
	▪ 2011-2015 board approved organizational strategic plan includes goals, objectives, and action steps prioritizing recruiting, hiring, and training diverse staff and recruiting board members from communities of color ▪ Board officers are demographically and culturally diverse ▪ Agency participation in multicultural career expos for staff recruitment
64. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.	▪ The agency's Cultural Appropriateness Action Team and Professional Development Action Team research and implement ongoing training ▪ Agency support of language skills development when resources are available ▪ Executive Director serves on the Central Health *Health Equity Council* for HIV issues
65. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.	▪ Staff are proficient in Spanish, culturally reflective of the Hispanic clientele, and available to interpret daily ▪ Staff are from diverse backgrounds including African-Americans, Latino, and individuals that are foreign-born ▪ One staff member proficient in American Sign Language and others with basic skills ▪ Interpretation services in any language are offered to clients free of charge; interpreters culturally reflect clients ▪ Client materials are written at a fifth to eighth grade literacy level and in Spanish at a third to fifth grade level ▪ Client materials are provided in Spanish and English ▪ A professional volunteer translates client materials from English to Spanish ▪ The agency uses an independently certified system to evaluate the language proficiency of staff ▪ Organization's central voice mail and Dental Clinic voice mail systems are recorded in Spanish ▪ Key program staff have recorded voicemails in Spanish
66. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.	▪ Interpretation policy offering services free of charge posted in all locations ▪ Reception and Intake and Eligibility staff trained to notify clients of their right to receive language assistance services free of charge ▪ Front desk and key staff voicemail messages are recorded in English and Spanish ▪ Interpretation services in any language are offered to clients free of charge; interpreters culturally reflect clients ▪ Client materials are provided in Spanish and English ▪ Reception staff have access to language cards to identify

CLAS Standards	ASA Compliance
	need for interpretation services
67. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.	▪ The agency uses an independently certified system to evaluate the language proficiency of staff ▪ Written policy offers interpretation at no cost to the client in order to prevent the use of family and friends as interpreters ▪ Staff is trained to inform clients of their right to interpretation services at no cost and that family and friends are not a preferred source for interpretation in order to protect client confidentiality ▪ The agency hires professional, certified trainers to assist in interpretation upon request
68. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.	▪ Client materials are provided in Spanish and English ▪ Client materials are written at a fifth to eighth grade literacy level and in Spanish at a third to fifth grade level ▪ Key client information/policies and grievance information is posted in English and Spanish in common areas and available in hard copy from reception desks ▪ Quality Management Guidance Team reviews and updates materials to increase understandability
69. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.	▪ ASA's 2011 – 2015 Strategic Plan identifies compliance with CLAS Standards as a priority: o "Strategy #3: Ensure culturally appropriate programs and services ▪ Agency programs and services meet Culturally and Linguistically Appropriate Services (CLAS) standards ▪ Collaborative partners recognize ASA for delivery of programs and services to reduce stigma and for innovative and collaborative relationships" o Strategic plan action step is to implement an Organizational Cultural Appropriateness Committee representative of diversity of staff and management to further formalize cultural appropriateness trainings and action steps
70. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality	▪ Self-assessment of CLAS-related activities conducted in 2007; results continue to be used to improve services ▪ Cultural Appropriateness Action Team to survey annually and report to staff and board of directors of outcomes from strategic planning goals/objectives related to cultural appropriateness work

CLAS Standards	ASA Compliance
improvement activities.	
71. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.	▪ Collection of data and documentation on each consumer's race, ethnicity, disabilities, spoken and written language, and literacy level; information entered into client paper file, Provide Enterprise® internal electronic database, and ARIES; information updated periodically ▪ Use of the Austin Transitional Grant Area HIV Planning Council's periodic consumer needs assessment ▪ Use of the Brazos Valley Council of Government's periodic consumer needs assessment ▪ Provision of HIV testing data to the Texas Department of State Health Services, (DSHS) and the Centers for Disease Control and Prevention, (CDC)
72. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.	▪ Collection of data and documentation on each consumer's race, ethnicity, disabilities, spoken and written language, and literacy level; information entered into client paper file, Provide Enterprise® internal electronic database, and ARIES; information updated periodically ▪ Annual review and assessment of HIV epidemiology profile of epidemic as prepared by Texas Department of State Health Services (TDSHS) and the Austin/Travis County Health and Human Services Department ▪ Use of the Austin Transitional Grant Area HIV Planning Council's and Brazos Valley Council of Government's periodic consumer needs assessment ▪ Annual report to staff and board of directors on Austin TGA HIV epidemic in comparison to organization's client demographic profile, staff demographics, and board demographics
73. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.	▪ Collection and updating of data and documentation on each consumer's race, ethnicity, disabilities, spoken and written language, and literacy level; information entered into client paper file, Provide Enterprise® client electronic database, and ARIES. ▪ Provision of HIV testing data results are reported to the DSHS and CDC ▪ Involvement in community events targeted to people of color to build collaborative partnerships in a participatory environment ▪ Staff shares lessons learned at above events with management and leadership staff to expand collective knowledge of local cultural practices and beliefs ▪ Organization is a member of the advisory committee to the

CLAS Standards	ASA Compliance
	Latino Commission on AIDS to develop training institutes on providing culturally appropriate HIV services to the Latino community in 2012 ▪ Executive Director serves on the Central Health *Health Equity Council* for HIV issues
74. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.	▪ Client materials are provided in Spanish and English ▪ Client materials are written at a fifth to eighth grade literacy level and in Spanish at a third to fifth grade level ▪ Client grievance procedures are posted in English and Spanish in common areas throughout the organization ▪ Organization has a formal grievance procedure in place that is reviewed annually by staff
75. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.	▪ Strategic Plan dissemination to donors and posted on website ▪ Community Impact Report disseminated to donors, posted to website, and available in hard copy to public ▪ Responsiveness and pursuit of opportunities to participate in ethnic media

Quality Management

Use of Output and Outcome Data

Using monthly data, AIDS Services of Austin (ASA) tracks progress on the total number of unduplicated clients served, units of service delivered, and achievement of outcome goals through the reporting feature of the Provide Enterprise® electronic client database. On a monthly and quarterly basis, supervisors analyze the data to determine if outputs and outcomes, respectively, are within a 10 percent variance of the elapsed period of the grant cycle. If not, supervisors determine reasons that program goals are not being met and develop plans to address the situation including staff training, supervision, and monitoring staff adherence to the standards of care for the service category. Supervisors also note trends in performance measures with emphasis on clients who do not meet outcome goals and develop appropriate quality management activities or document the reasons for such exceptions. Provide Enterprise® reports give aggregate data at the agency level that documents client trends in service utilization for use in planning for service delivery.

Supervisors will use reports from the ARIES client database to validate data on performance measures such as number of unduplicated clients served and units of service provided. With the client's signed permission to share client information in ARIES, supervisors will use ARIES reports to facilitate getting complete data on services accessed by clients, to document successful linkages to primary medical care and support services, and to compare, if needed, client service utilization data in order to avoid duplication of services. ARIES will also provide aggregate data

at the community level that documents client trends in service utilization for use in planning for service delivery.

Supervisors will use the service-specific client satisfaction survey to obtain data using client input on satisfaction with services provided. Supervisors review survey results including qualitative data at the program area, Leadership Team, Quality Management Guidance Team, and the Program and Services Committee meetings. With input from these various teams, supervisors use suggestions from the survey to identify problems and/or concerns and implement service specific improvement activities including service delivery changes when possible.

The resources and tools used to facilitate this process are staff time, the Provide Enterprise® database, ARIES database, and the client satisfaction survey.

Assurance of Compliance with Austin TGA Standards of Care

In accordance with Austin TGA Ryan White Part A HIV Case Management Standards, all Non Medical Case Management staff will complete training as outlined in the Standards.

All newly hired Non-Medical Case Managers funded by Ryan White Part A will complete the initial four required courses as listed on page 12 of the standards and a minimum of 12 hours of ongoing required continuing education aimed at the 20 core competencies listed on page 13 of the standards in grant year 2016-2017. All Non-Medical Case Managers will annually complete 12 hours of ongoing continuing education in the 2016-2017 grant year.

Case Management supervisors are responsible for case manager compliance with training requirements including the Standards of Care and for ensuring that evidence of training completion is retained in the employee's personnel file.

Agency supervisors and managers ensure that direct service staff and supervisors are qualified individuals as evidenced by the documentation of degree(s), length of experience and type of experience in the staff personnel file.

To assure that services are delivered consistent with the Austin TGA Standards of Care, supervisors annually review a total of 20 percent of client files served during the grant cycle. Supervisors complete reviews quarterly on a portion of client files. The results of file reviews can be found in the paper and electronic file review tool. Within 15 working days of the file review, supervisors review with Non-Medical Case Managers any indicators that are not in compliance. Supervisors and staff develop plans of correction that require completion within ten working days and note reasons for exceptions. The evaluation of staff performance is linked to compliance with the standards of care and follow-up on plans of corrections from file reviews. During monthly supervision, Case Managers and their supervisor review any deficiencies in compliance with standards.

Quality Management Plan

Quality Management Guidance Team

The overall responsibility and leadership for ASA's Quality Management (QM) program lies with the agency's Chief Program Officer, who authorizes the Quality Management Guidance Team (QMGT) to plan, assess, measure, and implement performance improvements throughout the entire agency, while providing the necessary resources and support to fulfill these functions.

The membership of the QMGT reflects the diverse service areas within AIDS Services of Austin (ASA). The agency's quality team is comprised of the Chief Programs Officer and other members of ASA staff, ranging from upper management to direct service staff. Other ASA staff members, such as Program Supervisors and Coordinators, Case Managers, and Prevention Specialists are involved when appropriate. Nominations for membership are decided upon by the QMGT. The QMGT meets every other month. Additional meetings may be called, as needed. Minutes of meetings are distributed directly to each member of the committee and to all necessary internal and external stakeholders. A written summary is routinely made available to staff.

The Quality Management Plan

The Quality Management Plan seeks to improve service performance through collecting and evaluating data, identifying service problems based on the collected data, using quality improvement processes to address service delivery issues, and following up to ensure improvements will be sustained. The agency plan is designed annually with target goals and service specific quality improvement activities. It calls for a review of service performance measures, an analysis of this data, and recommendations for service improvements. The plan indicates that the team will oversee an annual update and revision of program policies and procedures. At the end of each year, the plan is evaluated to determine the achievement of goals and the service specific activities and to make recommendations for further follow-up.

The following sections describe other components in the Quality Management Plan:

Activities to Collect Data

The Chief Programs Officer, the Director of Access Services, the Case Management Program Manager, and the Eligibility Services Manager will collect data on the program's performance in achieving service goals and meeting standards of care through results from the following sources: outcome and output measures, the agency client satisfaction survey, client file reviews, client/staff feedback, and client grievances. The client suggestion box is located in the agency main reception lobby to allow clients the opportunity to provide feedback at any time. The Eligibility Services Manager checks the box monthly and provides any feedback to the appropriate program manager and to the Quality Management Guidance team for appropriate action or response.

Supervisors review performance measures quarterly and report measures not meeting contract objectives to the Quality Management Guidance Team, along with suggestions on planned action steps.

Client satisfaction surveys are an important way to identify quality issues. The agency distributes the standardized survey, after approval by the HIV Resource Administration Unit, City of Austin Health and Human Services Department, at the Food Bank and Dental Clinic sites to collect data on all Ryan White Service Categories offered at ASA. Trained social work interns and volunteers administer the survey during a selected two week period. The survey data is tabulated by the Data Manager-System Support Technician at the HIV Resource Administration Unit, AHHSD.

File reviews are essential to the quality of client data. Supervisors review 100 percent of client intakes and 20 percent of files on clients served during the grant cycle to evaluate pertinent Case Management Non-Medical (Tier 1 and Tier 2): MAI program activities and compliance with indicators for the standards of care.

Client input from registered grievances is documented by program supervisors and reviewed at department staff meetings. Supervisors adhere to the agency's policy on client/patient grievances, which includes review by the Executive Director and/or the Board of Directors, if necessary.

Evaluation of Performance and Assuring Delivery of Quality Services
As data and input are received and problems are identified, the QMGT evaluate concerns and suggestions in order to assure the delivery of quality services.

The QMGT analyzes the output/outcome data and makes recommendations for improvement to program supervisors. When quality improvement activities around performance measures are designed and completed, the results are then sent to the team and reported in the annual evaluation of the Quality Management Plan.

Supervisors will evaluate survey results to identify trends for improvements and advocate for unmet client need. Supervisors will be careful to note any client feedback related to the cultural appropriateness of service delivery especially with respect to policies and procedures and case manager interventions for African-Americans and Hispanics. To guide decisions about quality improvement activities, survey results are discussed at the program level in department/program meetings and at QMGT meetings. The Programs and Services Committee of the Board of Directors also reviews survey results and gives guidance when appropriate.

Program supervisors utilize grievance input obtained from clients and managers at the different grievance levels to make appropriate service changes, when feasible. Supervisors will be careful to note any client feedback related to the culturally appropriateness of service delivery for African-Americans and Hispanics.

Program supervisors utilize grievance input obtained from clients and managers at the different grievance levels to make appropriate service changes, when feasible. Supervisors will be careful to note any client feedback related to the cultural appropriateness of service delivery for African-American and Hispanics.

Suggested actions taken based on this data could include staff development training in an identified area such as cultural appropriateness in communication or interventions with African-Americans and Hispanics, development of organization tracking tools, identification of a different site for service delivery, additional interventions to reduce barriers, or design of client/patient forms to better capture data and service performance measures.

Identification of Quality Improvement Activities

At the beginning of the year, supervisors and the QMGT identify specific service quality improvement activities based on staff and client feedback and the data already discussed. Activities are written using SMART objectives in that they are specific, measureable, attainable, relevant and time-bound.

Quality improvement activities for the Case Management Non-Medical MAI will include monitoring on case manager completion of the client eligibility documents every six months.

Addressing Identified Problems

Once a problem or an area that needs further assessment is identified, the team will use, when appropriate, the Plan-Do-Study-Act cycle (PDSA), a four-step model for carrying out change. This process will be used in identified quality improvement activities as detailed in the annual Quality Management Plan. The components are as follows:

1. Plan by recognizing an opportunity and planning a change.
2. Do by testing the change and carrying out a small-scale study.
3. Study by reviewing the test, analyzing the results/data and identifying what has been learned.
4. Act by taking action based on what you learned as a result of data analysis in the study step.

If the change does not work, the cycle will be repeated again with a different plan.

To address client file review results, supervisors will implement a plan of correction when deficiencies in delivering services or lack of compliance to standards have been identified. Supervisors will require plans of correction and timelines for correction. If meeting the standard is systemic rather than related to one or two staff, then supervisors will design and require staff training and report quality improvement activity results to the QMGT.

Follow Up

Case manager supervisors will follow up to ensure the effectiveness of improvement activities and the maintenance of improvement results. On identified quality improvement activities, supervisors follow up on a quarterly basis to ensure that these activities have been effective in

resolving the problem, that no new problems have developed, and that there is sustained improvement in identified areas.

For file review results, supervisors work with staff to develop plans of correction within 15 working days of the file review. Staff has ten working days to implement corrections. At the next quarterly file review supervisors monitor the maintenance of the previous quarter's improvements to ensure problems do not reoccur.

Monitoring and Standardized Tools
Tools used in monitoring and standardization include the file review tool and Provide Enterprise® reports with features to track reporting of performance measures, completion of assessments, service plans, as well as a feature to describe content of progress notes for easy tracking. The annual client satisfaction survey is a standardized tool that the Ryan White Quality Management workgroup evaluates and standardizes across HIV service providers.

Compliance with Ryan White Part A Program Monitoring Standards

iv. Maintain client charts that include the required elements as detailed by the grantee, including:
    - Date of encounter
    - Type of encounter
    - Duration of encounter
    - Key activities, including benefits/entitlement counseling and referral services

N-MCM: MAI
N-MCM: MAI Non-Medical Case Managers will maintain client files that include the required ARIES data elements as listed in the 2009 ARIES Taxonomy and required activities such as initial assessment of service needs, the comprehensive individualized assessment and service plan, service coordination for plan implementations, ongoing monitoring to evaluate plan effectiveness, and the review and revision of the plan at least every six months.

Eligibility and Intake staff will include required eligibility documents, the intake form that collects required ARIES information and the initial client services agreement in the client paper file. The initial assessment of service need will be documented in the client electronic file. Non-Medical Case Managers will record coordination of required services for plan implementation, monitoring to assess the effectiveness of the service plan, plan and re-assessment in the progress notes of the client file. Staff will also include service coordination such as linkage to health care, support services, public and private benefit programs, coordination of primary and support service appointments, and comprehensive assessment components such as ongoing evaluation of client/significant other needs/ support system and interventions such as skill-building addressing barriers to support services, and advocacy necessary to implement the plan. Plan revisions are noted in the paper service plan that is signed by the client and kept in the client paper file.

Eligibility and Intake Staff and Non-Medical Case Managers provide benefits and entitlement counseling and referrals to clients for programs such as Texas HIV Medication Program (ADAP), State Pharmacy Assistance Program, Medicaid and/or Medicare Part D, City of Austin Medical Assistance Program, medication Patient Assistance Programs, Social Security, and Food Stamps, as appropriate. The case managers note such discussions in ongoing Progress Logs in the Provide Enterprise® client data base. Referrals are tracked on a tracking form kept in the client's paper file and reviewed at each encounter with the client until the referral is successfully followed up upon.

Non-Medical case managers will document type, date and a summary of the contact on the progress log function of the electronic client file. Frequency of contact is illustrated through the activity view feature that shows dates of each client contact. Duration of contact is measured in 15 minute increments and recorded in the service provided section of the electronic file. 15 minutes equals to one unit of service for or on behalf of the client.

An extract developed by Groupware Technologies, Inc, will bridge to the ARIES client database the required ARIES data on units of service provided. Client identifying information and other required data is entered directly into ARIES by ASA staff.

Work Statement

Service Category Name
Case Management Non-medical: Non-MAI

I. Client Eligibility

AIDS Services of Austin (ASA) will provide Case Management Non-Medical: Non-MAI (N-MCM) to persons living with HIV in order to meet their immediate health and psychosocial needs and reduce and/or eliminate gaps in service. Throughout this document, N-MCM refers to the provision of culturally and linguistically appropriate advice and assistance in obtaining medical, social, community, legal, financial, and other needed services for HIV positive persons engaged in case management services.

To be eligible for the Case Management Non-Medical, clients must be HIV-positive, a resident of the five county area in the Austin Transitional Grant Area (Travis, Williamson, Bastrop, Hayes, Caldwell), and willing to work on HIV service plan goals.

ASA has Eligibility and Intake staff specifically trained to determine clients' level of need for services and eligibility status (every 6 months) for all ASA programs as well as programs at partner HIV services organizations and other social service organizations. ASA's Eligibility and Intake staff determine eligibility by securing verification of HIV status and residency. Staff will secure proof of identity, income, and insurance status as required intake documents.

xxvi. **Documentation of HIV Status:** Staff obtain verification of HIV status through:
- a signed statement from the medical provider;
- a positive Western Blot laboratory result with the name of the client;
- a printed document from the ARIES database indicating verification of HIV status by another provider;
- HIV detectable viral load lab results; or,
- a hospital discharge summary or medical records from previous provider(s).

xxvii. **Proof of Identity:** Proof of identity includes: Texas driver's license, Texas State identification card, a passport, Military or Student identification card, Social Security card, birth certificate or other official document as listed on the Austin TGA Ryan White Client Eligibility Form

xxviii. **Residency Verification:** In order to establish residency, clients can provide unexpired documents such as a Texas driver's license, Texas State or Tribal identification cards, Social Security award letter, rental/mortgage agreement, utility bill, or similar forms accepted by the Ryan White Part A Austin TGA.

Documentation of HIV status must be presented within 30 days and residency documentation must be presented within 60 days. Clients may be granted conditional eligibility if they present with an urgent need and lack the necessary eligibility documentation. ASA will make reasonable efforts to assist clients in obtaining the necessary documentation.

xxix. **Income Verification: S**taff use the MAGI or Mock MAGI form for client income verification. Clients that have filed a tax return in the previous year complete the MAGI form and submit their tax transcript as income verification. Clients that did not

submit a tax return or have had a change in income complete a Mock MAGI form and submit an IRS proof of non-filing and income verification document. Income verification documents include Social Security Award letter, Veterans/Public Assistance or Worker's Compensation benefits statements, wage payment stubs, signed zero income verification letter or other document listed in the Austin TGA Ryan White Part A Client Eligibility Form. There are some populations that are excluded from having to obtain tax transcripts or IRS proof of non-filing, these include: homeless, recently released from incarceration (3 months), undocumented, emancipated minors, and SSI and/or SSDI recipients.

xxx. **Health Insurance Coverage:** Cards verifying coverage by private medical insurance, Medicare, Medicaid, Veteran's Health Benefits, and Indian Health services will be accepted. Signed no insurance attestation statements will also be accepted. Should a client receive City of Austin Medical Assistance Program (MAP), a copy of the card will be made and a attestation of no insurance will be signed.

Eligibility and Intake Staff will use the Austin TGA Ryan White Part A Client Eligibility Form to reassess clients in the program every six months for determination of continued eligibility. At that time, client residency, income, and health insurance will be updated and/or new documentation obtained as indicated. Clients presenting with a change to income, residency or health insurance status within the six month review period will complete the Change in Circumstances: Eligibility Verification Addendum form. All required eligibility and intake documents, as well as periodic updates, are stored in the client's paper file and documented electronically in the agency's electronic client database, Provide Enterprise®. Client identifying information is also entered into the ARIES client database. Eligibility and Intake staff completes a form verifying eligibility documents were collected, and an administrative assistant enters this data into ARIES.

N-MCM:

Clients seeking services need to express willingness to work on HIV disease management and support service goals such as attending scheduled primary medical care, lab, oral health, medical nutrition therapy, and support service appointments. Clients should agree to follow the goals in the non-medical case management individualized service plan. Clients who identify as African American or Hispanic will be referred to the Case Management Non-Medical MAI program for culturally and linguistically appropriate services, depending on the availability of space.

Eligibility and Intake staff will utilize a screening tool with outlined criteria to designate which case management program clients are assigned to. Thereafter, case managers assess the client acuity based on the two acuity scales required by the Austin TGA Case Management Standards of Care.

The client's score on each acuity scale determines the level of contact that will be provided. When the client's acuity score is one, two, or three for the Medical Case Management acuity scale and the client expresses willingness to participate in programmatic goals, he/she may be

assigned to a Behavioral Health Medical Case Manager (BHMCM) and a Registered Nurse Medical Case Manager (RN MCM) with special attention to clients with identified medication adherence difficulties and complex medical issues. When capacity is limited, clients with a score of one may have to wait for either the RN or the BHMCM. Clients who do not express a willingness to participate in this program's goals will be assigned to either regular Medical Case Management and/or Non Medical Case Management (N-MCM) if they score a one, two or three on the respective scale Case management supervisors or assigned case managers, based on professional judgment, may determine that a client's unique situation and needs qualify he/she for a higher level of service than indicated by the acuity score provided that the rationale is documented in the client's record. Clients are only assigned two medical case managers when there is capacity within each case manager position. Clients scoring a one, two, or three on the N-MCM acuity scale will be assigned to a non-medical case manager as capacity allows. Clients scoring a zero on either scale will not be assigned to that respective service.

N-MCM Target Population

The target population for AIDS Services of Austin's (ASA) Case Management Non-Medical Program is primarily low-income[21] people residing in the five-county area of the Austin Transitional Grant Area (TGA) and living with HIV disease. The following table compares the 2015 calendar year demographics of Case Management programs to the demographics of people living with HIV and AIDS in the Austin Transitional Grant Area (TGA).

Table 2

	ASA Clients	**Austin TGA PLWH/A**
Gender		
Male	77%	85%
Female	20%	15%
Transgender	3%	(unavailable)
Race/Ethnicity		
White	32%	46%
Black	41%	22%
Hispanic	25%	29%
Other	2%	3%
Age Group		
0 – 12	0%	0%
13 – 24	2%	4%
25 – 44	27%	44%
45 +	71%	52%

[21] ASA defines low-income as a household that is at or below 80% of the U.S. Department of Housing and Urban Development's Area Median Income guideline for Travis County.

ASA client geographic concentration aligns with areas of high prevalence of HIV/AIDS in the Austin TGA. ASA's ten most common zip codes for Case Management clients are all located in Travis County.

Table 3

ASA Top 10 Client ZIP Codes	Prevalence Range of HIV/AIDS*
78752	314-674/100,000
78741	675-1,199/100,000
78723	675-1,199/100,000
78753	314-674/100,000
78758	675-1,199/100,000
78744	675-1,199/100,000
78702	115-313/100,000
78704	314-674/100,000
78721	115-313/100,000
78724	314-674/100,000

**Source: Enhanced HIV Reporting: S. Arbona and S. Novello (Travis County)*

Austin TGA data suggest that 84 percent of clients have medical co-morbidities, while others report social and health-related co-factors that complicate medical and other service delivery for HIV.[22] Recent studies have shown that 67 to 96 percent of HIV positive individuals have co-morbidities.[23] Co-morbidities and conditions for the Case Management Non-Medical program's target population include STDs, substance abuse, mental health issues, commercial sex work, poverty, homelessness, domestic violence, Hepatitis B and C, heart disease, diabetes, and tuberculosis (TB).

II. Service Category Activities

Service activities linked to Budget Justification

ASA has been implementing a N-MCM program since 2008 and psychosocial case management since 1988. Given ASA's history of providing these programs in the Austin TGA, necessary mechanisms for implementation are already in place. Long-standing mechanisms include:

- A Board of Directors and strong organizational governance structure
- An experienced leadership team
- Trained and experienced staff (see *Staffing section*)
- A physical location near public transportation and well-known in the HIV field
- A programmatic structure offering a comprehensive continuum of care including HIV Prevention, Outreach Services, Case Management (medical and non-medical), Food

[22] ARIES database, provided by the City of Austin (Addendum 5 to Ryan White Part A RFA 2012-13)
[23] "Prevalence and Patient Awareness of Medical Comorbidities in an Urban AIDS Clinic," Weiss, Jeffery J., PhD, et al

Bank, Medical Nutrition Therapy, Oral Health Care, Health Insurance Assistance, special programs for women living with HIV and AIDS and legal services
- Strong community partnerships providing access to services not offered at ASA

Eligibility and Intake staff and Non-Medical Case Managers receive training on the Austin TGA Standards of Care for Non-Medical Case Management services and the use of acuity scales for both Non-Medical and Medical Case Management services. This staff also received training on the use of the Substance Abuse and Mental Illness Symptoms Screener (SAMISS) tool. Eligibility and Intake staff and Non-Medical Case Managers employed have completed the initial required courses on core competencies as listed in the Austin TGA Ryan White Part A Case Management Standards of Care (page 12). All Eligibility and Intake staff and Non-Medical Case Managers complete at least 12 hours annually of continuing education targeting the 20 core competencies outlined on pages 13 and 14 of the Austin TGA Ryan White Part A Case Management Standards of Care within six months of hire or start of the grant year. Any newly hired Eligibility and Intake staff will complete specific requirements within 30 days of hire.

Case Management Non-Medical is responsive to the immediate needs of low-income individuals living with HIV and includes the provision of culturally and linguistically appropriate advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. AIDS Services of Austin's (ASA) N-MCM program uses a client-centered, strengths-based model designed to address the specific needs of each client. N-MCM may involve the coordination and follow-up of medical treatments.

Key activities for Non-Medical Case Management include:

- Initial Screening of Service Needs
- Development of Initial Comprehensive Assessment
- Development of Comprehensive, Individualized Service Plan
- Coordination of Services Required to Implement the plan
- Client Monitoring to Assess the Efficacy of the Plan
- Comprehensive Reassessment
- Periodic Reevaluation and Adaptation of the Plan
- Coordination with Multidisciplinary Team
- Case Closure

vii. Screening of Service Needs:

- **Initial Screening and Client Intake:** Eligibility and Intake staff screens all new and returning clients to determine eligibility and need for case management services. A intake appointment will be scheduled within 10 working days of the initial contact with the client or designated agent requesting services. In the interim, clients who are eligible for Outreach are connected with Outreach staff and are to be connected with community resources. In certain circumstances, clients are provided an emergency intake. Screening must include the eligibility parameters already described in *Eligibility Criteria section*;

the presenting problem as indicated by the client and referral source; HIV disease stage and medical need; household size; and history of mental health, substance abuse, and/or domestic violence when indicated.

- **Client Intake Process:** Once eligibility screening is complete and the client is determined to qualify for case management, Eligibility and Intake staff gather information about the client level of functioning, willingness to participate in case management and service plan goals, the quality of support given by family and significant others, and public/private benefit eligibility. Additional documentation will include such items as client preferred language, literacy level, household members, emergency contacts, health care and social service providers, a signed consent to receive services, the client Bill of Rights, the Client Confidentiality Policy, HIPAA Policy and the ASA Client Grievance Policy and Procedure.

- **Emergency/Critical Referrals:** Intake and Eligibility staff is expected to make immediate referrals in the following situations: client is in acute need of psychiatric or medical care, has less than 10 days of prescribed medications left, indicates they could be a danger to themselves or others, is homeless, faces an impending eviction or utility termination, or indicates he/she has no food. A temporary service plan may be executed following completion of the initial screening based upon immediate needs or concerns.

- Eligibility Reassessment: Eligibility and Intake staff will reevaluate the five areas of eligibility as required in the Austin TGA Ryan White Part A HIV Case Management Standards. Every six months Non Medical Case Managers will inform clients that they are due for an eligibility update and will make an appointment for the client with the Eligibility and Intake Specialist. During this appointment the client's eligibility documents will be collected and stored in the client's paper file and documented electronically in the agency's electronic client database, Provide Enterprise®.

viii. Development of Initial Comprehensive Assessment:

Expanding upon the information gathered during the initial intake visit, case management staff completes an initial comprehensive assessment for all clients entering into Services. The initial assessment provides a broader base of knowledge needed to address complex, longer-standing psychosocial needs. Information obtained during the initial assessment, as well as ongoing reassessments conducted by assigned case managers, is used to develop a comprehensive, individualized service plan, which assists in the coordination of the continuum of care.

The Austin TGA HIV services program is a needs-based program which strives to provide the appropriate type and level of case management support to clients with the greatest level of need to help them access and maintain quality medical care and manage their disease effectively. As part of the comprehensive assessment, the non-medical case manager will review the acuity level score determined at intake and revise it as necessary given the more thorough information collected from the client and other

sources.

- **Client Assessment:** The non-medical case manager will begin the assessment and will complete it within 30 calendar days of intake date. This period of time allows the case manager to assess client health status over time and collect more in-depth information in order to address complex client medical, mental health and substance abuse needs.
    - **SAMISS Assessment:** Non-Medical Case Managers will perform the Substance Abuse and Mental Illness Symptoms Screener (SAMISS) during the assessment process per the Austin TGA Ryan White Part A Case Management Standards of Care. If the client screens positive on the SAMISS, staff will immediately refer clients to mental health (Waterloo Counseling Center or Austin Travis County Integral Care) or substance abuse (Austin Travis County Integral Care) services and will follows through on the referrals.

ix. Development of Comprehensive, Individualized Service Plan:

Service plans are a critical component of case management activities, as they guide both the client and the case manager with an approach that is proactive to addressing the client's needs. The case manager and the client use the intake screening/brief assessment and the Initial Comprehensive Assessment to collaboratively develop a service plan for the client based on need and client readiness. Client needs identified in the Assessment/ Reassessment are prioritized and translated into a service plan which defines specific goals, objectives, and activities to meet those needs. The client and the case manager actively work together to develop and implement the service plan.

Service plans are negotiated in person with clients to further encourage their active participation and self-empowerment. Both the client and the case manager sign off on the service plan to verify agreement and understanding. Service plans are living documents for planning and tracking the client goals, tasks, and outcomes for specified and identified needs. A copy is offered to the client to emphasize the client participation in partnership with the case manager. The service plan is updated when outcomes are achieved and revised/amended in response to changes in the client's life circumstances or goals. Tasks and referrals are updated as identified or completed, and not at set intervals. The individualized service plan must also be completed within 45 calendar days of the client's intake date.

- **Acuity Scale Assessment:** Staff will use two acuity scales as described in the Austin Transitional Grant Area (TGA) Ryan White Part A Case Management Standards of Care. One acuity scale is for Non-Medical Case Management and one is for Medical Case Management. The two scales are used to determine the appropriate type and level of services needed by the client. Staff rates the client situation according to14 parameters of life situation or functioning that have four scores assigned to them. Totaling the scores for each parameter results in a weighted acuity score that assigns the client to an acuity level of zero, one, two, or three. ASA's staff are trained and experienced at taking into account information collected from the client, significant others, and medical/support

service providers in order to determine appropriate individualized acuity scores for each client. Those at zero acuity are not eligible for case management services.

Table 5

Acuity Level	1	2	3
Minimum Contact with Case Manager	Every 3 months	Monthly	Two times a month

x. Coordination of Services Required to Implement the plan

Non-Medical Case Managers coordinate services required to implement service plans by referring clients to appropriate resources and ensuring resource linkage. Staff ensures linkage by educating clients about the eligibility criteria and process, assisting in completion of applications, advocating on the client's behalf, and following up on referrals to monitor client progress and address barriers, as needed. The Non-Medical Case Manager provides advice and assistance in obtaining medical, public benefits (e.g. Medicare, Medicaid), social, community, legal, financial, and other needed services.

Case managers assist clients in the completion of applications for commonly needed services, such as food stamps, taxi vouchers, housing through Project Transitions (an Austin-area nonprofit that provides hospice, housing and support to people living with HIV and AIDS), Housing Opportunities for People Living with AIDS, Section 8 and public housing, Meals on Wheels and More, Capital Area AIDS Legal Project (CAALP), Texas HIV Medication Program, and Capital Metro's Metro Access transportation program. Regular communication (per table below), either by telephone or in person, is maintained with clients to establish rapport, as well as to foster self-advocacy and increase self-sufficiency skills. Staff provides services in venues that are convenient to the client, which include telephone contact and office, clinic, hospital, and home visits.

Case managers provide referrals to clients as determined appropriate or necessary. Referrals are a mutual decision between the client and case manager in which the client agrees to accept a service referral from the case manager for services not currently being accessed. The case manager utilizes a referral tracking mechanism to monitor completion of all case management referrals to ensure the client follows up and accesses services. The case manager identifies and resolves any barriers clients may have in following through with their referrals service plan goals.

xi. Comprehensive Reassessment

The Non-Medical Case Managers will reassess the client health, mental health, and psychosocial functioning, note changes since the last assessment, and identify new needs. If client household size or income has changed, the case manger will screen for eligibility for public/private benefit programs. Noted below are the frequencies for the different acuity levels for the reevaluation of the comprehensive assessment that

includes acuity update and service plan revisions:

Table 6

	Acuity Levels 1 & 2	Acuity Level 3
Reevaluation of Comprehensive Assessment	Every 12 months	Every 6 months

- Reassessment includes noting barriers to meeting service plan objectives and evaluating the success of case management interventions. This is also a time to reevaluate the current level of case management services and the need for additional levels. The assessment will also include a review of service utilization such as kept primary medical and specialty care appointments, use of medial nutrition therapy services, and adherence to oral health care visits.

- The Non-Medical Case Managers will incorporate client input into the assessment as well as feedback from the primary medical care team, the other assigned case manager, and other support service professionals.

xii. Client Monitoring to Assess Plan Effectiveness and Plan Re-Evaluation/Revision

The Non-Medical Case Manager will closely monitor client follow through on service plan goals and reevaluate the effectiveness of the service plan as services continue. Based on the reassessment, as needed, the service plan goals and tasks will be revised with client input, and will include actions to address any service utilization issues noted.

- Reassessment and plan reevaluation/revision will occur in the frequencies noted below:

Table 7

	Acuity Levels 1 & 2	Acuity Level 3
Reevaluation of Service Plan and Revisions	Every 6 months	Every 3 months

xiii. Coordination with Multidisciplinary Team

Clients in N-MCM experiencing a repeating cycle of the same medical crisis or problem are assessed for enrollment into MCM services, either onsite or offsite, and assisted in attaining these services. The goal of N-MCM is to meet the immediate health and psychosocial needs of the client at their level of readiness in order to restore or sustain client stability, and to establish a supportive relationship that can lead to enrollment in MCM services, if needed. Likewise, clients in MCM may be referred to receive N-MCM services as well.

Once the service plan is developed and reviewed with the client, the Non-Medical Case Manager will coordinate services and provide the advocacy required for plan implementation by communication and multidisciplinary consultation on client goals

and needs with all of the appropriate members of the client's team, which can include:

- primary medical providers;
- Registered Nurse (RN) medical case manager;
- Social Work/Counselor medical case manager;
- community social worker;
- registered dietician;
- oral care health professional; and/or,
- other supportive service professionals when appropriate.

The Non-Medical Case Manager will advocate for the client to ensure timely and coordinated access to appropriate levels of medical care.

Service coordination will include sharing the individualized service plan and progress on plan goals with the assigned RN and Social Work/Counselor medical case managers when part of the team as well as accepting their input into the development and revision of the service plan. Tier 1 Non-Medical Case Manager will focus on coordination of services and client advocacy related to mental health, substance abuse, and psychosocial needs.

Service coordination and client advocacy will be provided whenever the client needs such interventions. These actions, in more complex situations, could occur several times weekly until the client stabilizes to weekly or monthly when clients have a stable health, mental health, and substance use status or are functioning more independently. When appropriate and available, N-MCM clients may work jointly with a Medical Case Manager on the achievement of service plan goals and objectives. Depending on whether the client was first assigned to N-MCM or Medical Case Management, their first assigned case manager will be their primary case manager.

xiv. Case Closure:

Clients who are no longer engaged in active case management services will be evaluated by the case manager for closure. Clients achieve graduation from the program when all service plan goals are successfully met, the client is able to independently resolve his/her needs, and both client and case manager agree that services are no longer needed. Other reasons for closure may include: referral to another case management program, client relocation outside of the counties of the Austin TGA, incarceration for greater than three months, client choice, ineligibility for services, client lost to care or not engaging; agency-initiated termination due to behavioral violations; or client death. Clients that are lost to care or not engaging in their care will be contacted through the Return to Care Collaborative, and reasonable attempts will be made to bring them back into care. (Please see *Section j. Linkage to Primary Medical Care* for further explanation.)

Case Managers will complete a closure summary documenting case closure and reason for closure. Clients are considered non-compliant with case management if they do not

respond to three attempts to contact them within 30 days via phone, e-mail, or written correspondence. The case manager will notify clients of closure through an in-person meeting, phone contact, or written correspondence. Clients will be provided with written documentation explaining closure and the process to be followed if services are needed in the future. Case managers will offer appropriate referrals to the client and obtain a signed client release(s) of health information for new providers to assist in transfers. Staff will conduct exit interviews with clients upon case closure or graduation from the program, if appropriate. In situations in which closure is involuntary, case managers will review the client situation with supervisors to secure approval for termination of services.
Location(s) of these service activities for Non-Medical Case Management Staff provides services in venues that are convenient to the client, which include telephone contact and office, clinic, hospital, nursing facility, and home visits.

III. Staffing

Leadership for the N-MCM program includes: Director of Access Services, Non-Medical Case Management Programs Manager, and Medical Case Management Programs Manager.

Executive Team Members: The Executive Director is the primary contact with the City of Austin Health and Human Services Department (AHHSD) HIV Resource Administration Unit and has final authority in negotiating and approving contracts. The Chief Programs Officer interacts with AHHSD on matters relating to programs and is authorized to enter into negotiations with AHHSD regarding program issues, grant reporting, and performance measures. The Chief Financial Officer interfaces with AHHSD HIV Resource Administration on grant billings. The Grants Manager ensures contract compliance.

Table 8 indicates key staffing for the Non-Medical Case Management program:

Table 8

Name/Position	Qualifications	Primary Work Assignment	% Time Allocated
Williams-Price/Director of Access Services		Supervises all Case Management, including MCM, and Outreach programs; manages service delivery and evaluation; reviews financial assistance; budgets and implements program modifications; coordinates QM activities and	6.63%

Name/Position	Qualifications	Primary Work Assignment	% Time Allocated
		develops policy and procedures.	
Rios/Non-Medical Programs Manager	Master Degree in Healthcare Administration; 9yrs of experience in human services field; 7 yrs of experience in non-profit management. 5yrs of experience in case management.	Supervises all Non-Medical Case Management Programs, up to 2 interns, approves and tracks financial requests, evaluates program outcomes and service delivery, completes grant reporting requirements, and coordinates and implements QM activities.	24.75%
Braglia/Medical Programs Manager	MSSW; 10.5 years at ASA; 11.5 yrs in social services; 11 years experience with substance abuse, mental health, and persons of color; 11+ yrs in HIV; and 11 yrs with LGBT community.	Supervises all Medical Case Management Programs, up to 2 interns, approves and tracks financial requests, evaluates program outcomes and service delivery, completes grant reporting requirements, and coordinates and implements QM activities	2.38%
Medina/Intake Coordinator	BSW; 1 year at ASA, including experience with mental health, low-income people, and people of color .	Performs eligibility and intake, makes referrals and provides information, performs quality assurance activities.	3.77%
Maposa/Non-Medical Case Manager	Masters in Business Administration, 5 years Certified Nursing Assistant, 2 Women Rising Project Coordinator , 1.5 year experience Patient Navigation Services and Women's Empowerment	Provides Non-Medical Case Management to assist clients with issues related to HIV/AIDS in accessing medical care and social services through advocacy, resource linkage, and supportive counseling.	69.34%
Cirlos/ Eligibility and Intake Specialist		Performs eligibility and intake, makes referrals and provides information, performs quality assurance activities.	14.96%
Vacant/ Eligibility and Intake Specialist		Performs eligibility and intake, makes referrals and provides information, performs quality assurance activities.	69.34%
Lindgren/Receptionist	HIV, Substance Use, Mental Health Experience as direct receptionist	Provides programmatic support to clients in the verification and updates of eligibility documents and handles fees related to client services	3.41%

- The supervisor to staff ratio is 0.338 to 1.61 FTE.

Table 9

Number of Volunteers	1 undergraduate/1 graduate from Texas State University (TSU)*
Number of Volunteer Hours	75/30**
Volunteer Responsibilities	ASA recruits social work interns each semester from The University of Texas and TSU. Interns provide case management services to a small caseload under the supervision of a licensed social worker. The graduate intern from TSU will work on Quality Management and Strategic Plan activities.

*All volunteer intern activities depend on availability of qualified interns placed at ASA.
**Number of hours dedicated to Non-Medical Case Management depends on how case load is split with Medical Case Management and assignment.

ASA will not be using subcontractors for this service category.

ASA makes efforts to hire staff that are reflective of the populations served and that speak Spanish. In addition, all staff members are provided ongoing cultural competency training. Please see *Cultural Competency* section for more details on ASA's training and organizational efforts around cultural competency.

IV. Client Access

Current—and potential—clients for Case Management Non-Medical can access services via several points of entry as outlined below:

- Potential clients are being located and identified through Ryan White, Part A Outreach Program Services. Outreach staff identifies individuals with unknown HIV status and those with known HIV positive status who are late to care or "out-of-care." *HRSA defines an individual as being out-of-care if there is no evidence of a client accessing any one of the following three components of HIV primary medical care during a defined 12-month time frame: viral load testing, CD4 count, or provision of anti-retroviral therapy.* However, the Ryan White Quality Management Workgroup has agreed that clients without these three components need intervention prior to one year. As a result, the outreach team also identifies individuals with HIV who have not received primary medical care for six months or longer.

    - **Area Hospitals and Emergency Rooms:** AIDS Services of Austin (ASA) Outreach team members are placed at area hospitals to train staff in referring to agency programs and to follow-up on referrals made by hospital staff. Outreach is called at least biweekly to link HIV positive individuals to medical care and support services such as Case Management Non-Medical . Hospitals identified include University Medical Center Brackenridge, and Seton Medical Center Austin of the Seton Family of Hospitals; and St David's Medical Center, St. David's North Austin Medical Center, and St. David's South

Austin Medical Center. Outreach workers visit these hospitals and emergency rooms at the frequency of contact and hours agreed upon with hospital staff.

- **Correctional Facilities:** At Travis County Correctional Complex (TCCC), Travis State Jail, and Del Valle Correctional Facility, ASA outreach team members identify at-risk for HIV or HIV positive individuals who are pre-release from incarceration or recently released from incarceration and link them into medical and supportive services. Outreach workers engage in a broad range of activities include working with correctional facility staff to refer HIV positive individuals.

  Outreach staff receiving service inquiry letters from HIV positive individuals due to be released encourages those individuals to contact the agency upon release. Once contacted, the outreach staff immediately begins the process of linking the individual to medical care and with Case Managers. In cases where a person who has been recently released comes to or phones the agency directly, staff is deployed to the site of preference as identified by the individual who is contacting the agency for services.

  - **CommUnity Care at David Power Clinic:** Several times monthly or sometimes on a weekly basis, Outreach staff links identified HIV positive individuals to primary medical care . Staff provides targeted individuals with a transition from outreach to case management services through building on the trust already established during outreach.

- **Community and Peer Referrals:** Due to the high quality of services provided by ASA, 14 percent of clients that receive case management intake assessments identify themselves and initiate contact for services as a result of referrals from family, friends, or peers who have received agency services. For the same reason, 24 percent of clients are referred to case management from local health care providers.

- **ASA Prevention Programs:** ASA offers a variety of HIV prevention and testing programs that reach over 7,500 individuals annually. Prevention programs include:
  - Mpowerment, a prevention program for young gay, bisexual, and questioning men;
  - Healthy Relationships, an evidence-based intervention focused on prevention with positives;
  - HIV testing;
  - Hepatitis C and syphilis testing for targeted populations;
  - Linkage to care and patient navigation;
  - Condom Distribution Network;
  - Testing, Linkage, and Care, a program that brings HIV testing to sites where high risk populations frequent; and,
  - CLEAR, a risk reduction counseling program.

  All of ASA's Prevention programs refer HIV positive individuals into Outreach services or case management services through eligibility and intake.

- **Other:** ASA receives referrals through the United Way's 211, a non-emergency human services access phone line. ASA also receives referrals through HIV service directories. Please see *Section k. Other Linkages, Collaboration, and Referrals* for further description of ASA's referral system.

Clients will begin access Case Management Non-Medical services when they call or walk into the agency or transfer by another program.As described in *Section e. Service Category Activities*, Eligibility and Intake staff completes service eligibility screening to determine appropriateness for the program. They conduct eligibility screenings and assessments Monday through Friday primarily during agency business hours (8:30 am to 5:30 pm) and outside business hours as necessary. Eligibility and Intake staff strives to schedule intake appointments within one week of initial contact and rarely allows for a wait time of more than two weeks. The Non-Medical Case Managers will contact clients referred into their services within two weeks of the referral, at a minimum, with exceptions noted.

Access Barriers and Reducing Barriers to Access
One of the most difficult barriers to service delivery is lack of basic needs, such as food, housing, and transportation, which interferes with the client focusing on linkage to access to medical case management, medical care and supportive services. Other barriers are described below:

Table 10

Barrier	Description of Reduction/Elimination of Barrier
Eligibility Documentation	9. Eligibility and Intake staff or case managers provide reasonable assistance to clients to obtain identifying documentation. 10. Documentation may be a challenge for undocumented Hispanics or homeless individuals – ASA staff is trained to assist them is accessing appropriate documentation.
Basic Needs*: *Food*	13. Client intake and case manager assessment for eligibility for ASA's Helping Hand Food Bank services; 14. Assisting clients with Food Stamp applications; 15. Assisting clients with accessing emergency food needs through referrals to area agencies and food programs.
Basic Needs*: *Housing and Homelessness*	9. Access to short-term and long-term housing assistance needs to stabilize clients through ASA HOPWA and Best Single Source Plus Programs. 10. Case Manager coordination and referral to: Housing service providers such as Project Transitions, Foundation Communities, area boarding homes, Austin area public housing and emergency shelters. .
Basic Needs*: *Transportation*	17. ASA main facility located on two major bus routes as well as located in a zip code area where a high number HIV infections are located (78752); 18. ASA Intake, Outreach, and Tier 2 Client/Patient Navigators

Barrier	Description of Reduction/Elimination of Barrier
	conduct home visits when necessary and work with clients who are unable to transport to office location; 19. ASA Intake (or Client/Patient Navigators) complete client applications for Special Transportation Services through Capital Metro; 20. Access to bus passes through the Basic Transportation Needs Fund
Health Literacy and Education	9. Assess client's health and language literacy; 10. Work with client through verbal communication and with health education materials tailored to client's level of understanding and language needs.
Unique Cultural & Linguistic Issues	13. Extensive training in cultural awareness and responsiveness related to communities of color, specifically African-American and Hispanic; 14. ASA has established working relationship with qualified interpreters to assist clients whose primary language is not adequately represented by a staff person; 15. Tier 2 staff build trust with undocumented Hispanic clients by explaining that this status will not affect eligibility for agency services.
Substance Abuse Treatment	13. Consumer information about possible side effects of illicit drugs and HIV medications; 14. Access to appropriate case manager(s) with substance abuse assessment experience; 15. Collaborate with CARE program and other related agencies to provide support and treatment services.
Mental Health Treatment	5. Collaboration with and referrals to mental health providers including Waterloo Counseling and CARE program at ATCIC.
Historical Mistrust of Medical and Social Service Providers	5. ASA case managers work with client through skills building to mitigate mistrust and to improve the client health literacy through education.
HIV Disease Stigma	13. Frequent and prompt contact with individuals in target populations to build trust while relying on 24 years of established history of trust with ASA as an HIV provider for African-American and Hispanic populations; 14. Client-centered approach, emphasizing client strengths, respect for client self-determination – this approach is particularly effective in African-American and Hispanic communities; 15. Referrals of HIV positive women of color to Women Rising Project to educate women in making healthcare decisions – 60 percent of the women served are African-American.

* Basic needs as a barrier is more likely to affect African-American and Hispanic communities due to disproportionate poverty levels among communities of color.

V. Service Linkage, Referral, and Collaboration

Linkage to Primary Medical Care

Service category's key activity is to link clients to HIV primary medical care, at ASA, this can be accomplished in two ways the Outreach program and/or the case management programs. The Non-Medical Case Managers interventions are essential for ongoing retention of clients in medical care.

Referral Mechanism:

- Many clients are first assisted with initial access and linkage to HIV primary medical care through Outreach team efforts. The goal of the Outreach team is to successfully link clients to primary medical care in three months or less, in accordance with the National HIV/AIDS Strategy. To open a dialog with individuals about initial access to medical care, outreach staff will initiate rapport by providing information about general HIV transmission, risk reduction, and the benefits of early medical intervention. Once the Outreach team links the client into medical care, as evidenced by successful attendance at the first medical appointment, and the client is enrolled in the appropriate case management program depending on the individual needs (i.e. N-MCM, Medical Case Management and PLUS Program). Once assigned to a case manager they then work with the client on strategies to maintain their medical care as part of their service plan.

- A client who contacts the agency directly and do not meet the eligibility requirements for the Outreach program is linked with Eligibility and Intake staff that assess the client's immediate needs for basic needs services and link them to community resources to stabilize their situation and refers them to primary medical care, if needed. A Non-Medical Case Manager may coordinate the clients medical care appointments and visits and assist them with any housing, identification documentation, or financial assistance needs.

Service Coordination and Integration of Resources

The Non-Medical Case Managers addresses crucial barriers to access to primary care by providing referrals for immediate basic needs such as transportation, food, and/or housing. Clients may be assisted through agency resources such as bus passes/taxi vouchers, one of several housing assistance programs, and/or the Food Bank program. In addition, they may be referred to community support services such as area food pantries, Capital Metro for transportation access, and churches for financial assistance with rent and/or utilities.

To address fear of medical providers, the medical care system, or fears related to limited English or health literacy proficiency, staff discusses with clients any resistance to medical care and may be accompanied to their intake medical care visit.Once the client has successfully kept the initial

intake appointment at David Powell Clinic[24], the Non-Medical Case Managers work with clients on continued follow-up that may include accompanying clients to subsequent doctor visits. Non-Medical Case Managers build upon the trust developed with Outreach staff and the developing trust with medical providers to coordinate care with David Powell Clinic staff by assisting in appointment scheduling /rescheduling and conferencing around continued barriers to care.

In addition to working with the David Powell Clinic, ASA has long-standing referral relationships with other HIV-related medical providers including the Blackstock Family Clinic (a SETON non-profit practice); Austin Infectious Disease Consultants (a private specialty care practice); Academic Physicians at Trinity; South Austin Medical Clinic; Jefferson Street Family Practice; and, Austin Regional Clinic-South, Far West, and Quarry Lake locations.

Projected Results

As indicated in the *Service Coordination and Integration of Resources* section, clients are referred to primary medical care services by different agency staff depending upon their place in the broad continuum of services offered at ASA. In most cases, Outreach staff tracks primary care referrals by accompanying clients to appointments. When they do not attend appointments with clients, the staff calls health care providers to verify kept appointments or verifies the visit through the ARIES database. Non-Medical Case Managers attend primary medical care appointments with clients or call agencies to track and verify successful referrals.

Clients are considered successfully linked to medical care upon completing an intake session with CommUnity Care at David Powell Clinic or other medical providers. The Non-Medical Case Managers report on retention in medical care as measured through the HRSA/HAB HIV Performance Measures: two or more medical visits in an HIV care setting in the measurement year. All staff will document client progress in progress notes and successful outcomes in the service provided feature of the Provide Enterprise® electronic client database (ASA's internal electronic database). Non-Medical Case Managers will complete a referral tracking form that includes date of referral and completion date and keep the form updated in the paper client file. The desired outcome results are linkage to and retention in primary medical care services.

ASA also participates in the Return to Care Collaborative with CommUnityCare at David Powell Clinic, Austin/Travis County Integral Care Program, Community Action, Waterloo Counseling, and the Wright House Wellness Center. Through this partnership, the collaborative partners seek to improve information sharing to determine the reasons why people have fallen out of care and to use this data to predict out-of-care trends. As participants in the collaborative effort, ASA and CommUnityCare at David Powell Clinic will monitor and share out-of-care information on a bi-monthly basis, when able, and work together to return clients to medical care. When out-of-care clients are identified, they will be referred to ASA's Outreach Program when they have not received HIV primary medical care for one year or more. This staff will facilitate their reentry into the Medical Case Management, as this is typically the level of case management required for

[24] Clients entering services through Outreach rarely have private insurance and for those that do, the Outreach team will ensure they make a follow-up appointment with their private medical provider.

clients contacted through the Return to Care Collaborative. Once the Medical Case Manager is assigned, they must contact the client within 10 days, although it is typically sooner.

Other Linkages, Collaboration, and Referral

Linkages and Collaborations

AIDS Services of Austin (ASA) has collaborative agreements, letters of support, and/or Memoranda of Understanding (MOU) in place with several agencies, mostly with respect to specific programs. The MOUs guide referrals between agencies and allow smooth transitions of clients for additional services. ASA maintains MOUs with Waterloo Counseling Center, Project Transitions, the Housing Authority of the City of Austin, Austin Energy, the CARE Program of Austin/Travis County Integral CARE, and the Communicable Disease Unit at Austin/Travis County Health and Human Services Department (A/TCHHSD). For MOUs that require annual renewal, ASA contacts the partner agency 30 days prior to expiration of these agreements.

ASA also has long-standing referral relationships with HIV-related social service providers, including the CARE Program at Austin/Travis County Integral Care for substance abuse counseling and treatment referral for individuals that are dually diagnosed; Project Transitions for transitional housing and hospice; South Austin Marketplace for transitional and long-term housing; the Customer Assistance Program (Austin Energy) for utilities payment assistance; Waterloo Counseling Center for mental health counseling; the Wright House Wellness Center for holistic/alternative health services; Salvation Army and the Austin Resource Center for the Homeless for emergency housing; the Social Security Administration for disability benefit applications and appeals; Del Valle Correctional Facility, Travis State Jail, and the University of Texas Medical Branch State Penitentiary for services to inmates upon their release; the Communicable Disease Unit at A/TCHHSD for HIV/ STI/TB screening; and SafePlace for domestic violence assistance.

Eligible clients are also referred to the broad continuum of ASA services: the Capital Area AIDS Legal Project (CAALP) for legal assistance; Medical Nutrition Therapy for nutritional assessment, counseling, and supplements; the Jack Sansing Dental clinic for oral health services; HOPWA for housing assistance; Comprehensive Risk Reduction Counseling Services for support for individuals to reduce the risk of HIV transmission; and the Health Insurance Program for premium, medication copayment and medication deductible financial assistance.

Referral Process and Follow Up

ASA staff assists clients with completing and submitting other agencies' referral forms, communicates with those agencies to clarify client eligibility, and advocates for client service delivery. For those clients who are case managed at ASA, staff ensures that referrals are followed through on in one of the following ways:

- performs follow up at the next client contact by asking the client about the referral and the results;
- accompanies the client to appointments;
- checks the ARIES database to ensure appointment was attended; or,

- calls the agency the client was referred to and confirms client attendance.

All staff document client progress regarding follow-through on referrals in the progress log feature of the Provide Enterprise® electronic client database (ASA's internal electronic database). Non-Medical Case Managers will complete a referral tracking form that includes date of referral and completion date and keep the form updated in the paper client file. The desired outcome results are linkage to and retention in support services.

Goals of Collaborative Activities, Integration of Resources, and Projected Results
The goal of collaborative activities is the provision of comprehensive services through the HIV provider community and other social service agencies using linkages and referrals. These activities ensure clients have access to all needed services that are not offered by ASA. In addition, they allow clients to overcome barriers to accessing and remaining in primary medical care and moving toward self-sufficiency in managing their HIV disease.

Integration of resources and services includes the dedication of ASA staff time toward the completion of other agency intake forms, assisting clients with the intake process, accompanying clients to support service appointments, reporting required data, and working with clients on mutual goals in service plans. These mutual goals may be related to support services that client receive from other agencies, such as financial assistance, substance abuse or mental health counseling, housing, etc.

The projected results of collaborative activities, integration of resources, linkages, and referrals are:

- Client achievement of housing stability
- Meeting food intake needs
- Mental health services access and stability
- Independent management of substance use issues
- Financial stability
- Decreased recidivism
- Personal safety and security

VI. Client Input and Involvement

Clients have several opportunities to offer input into the Case Management Non-Medical. Staff's rapport with the target community enables them to respond to client comments and needs on an ongoing basis. During these encounters, staff works with clients to offer input and identify needs and services they want to pursue.

Clients are surveyed using the standardized questionnaire developed by the Ryan White Quality Management Group to solicit feedback for improving case management services. The 2013 survey yielded positive feedback, with 90 percent of clients reporting that through the support of AIDS Services of Austin (ASA), their ability to manage their health has improved and 94 percent

reporting they are satisfied or very satisfied with case management services. Supervisors will use survey results and staff feedback semiannually to evaluate the effectiveness of referral systems, barriers to service, and other service delivery components. The team will then plan, as appropriate, for service modification, especially actions to remove barriers. No 2014 survey was completed, ASA did distribute surveys in 2015 and is awaiting final results.

Individuals with HIV who access Non-Medical Case Management services work closely with case managers to develop individualized service plans. Client input is integral to developing the service plan, which includes only those issues and needs the client chooses to address.

All agency clients may register concerns with supervisors and through the client grievance process. All clients are provided a copy of the client grievance policy and procedure upon entry into services and it is posted in English and Spanish in the agency reception area.

ASA routinely incorporates client feedback and suggestions into planning activities. In developing the agency's 2011-2014 Strategic Plan, ASA used interviews and focus groups with current clients to ensure their active participation in the strategic direction of the agency. ASA's Strategic Plan specifically defines "client satisfaction with programs and services" as a key measure of success in alignment with our strategy to "maintain and strengthen existing programs and services through quality improvement." The 2011-2014 Strategic Plan has been extended for one year so that ASA is able to fully analyze the impact of the Affordable Care Act. A suggestion box located in the client lobby is available for clients to submit anonymous feedback. The box is routinely monitored by the Eligibility Services Supervisor. Client feedback is given to appropriate staff for use in program improvements. The Quality Management Guidance Team reviews the feedback from the suggestion box quarterly to evaluate trends and making agency improvements.

VII. Cultural Competency

Service activities will be delivered so that cultural and language differences do not constitute a barrier to services in full compliance with the National Standards on Culturally and Linguistically Appropriate Services (CLAS) described at: http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15.

AIDS Services of Austin (ASA) is in compliance with all 15 CLAS Standards.

Table 10

CLAS Standards	ASA Compliance
76. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and	▪ Staff members are proficient in Spanish, culturally reflective of the Hispanic clientele and available to interpret daily ▪ Staff members are from diverse backgrounds including African-Americans and individuals that are immigrants to the USA.

CLAS Standards	ASA Compliance
practices, preferred languages, health literacy, and other communication needs.	▪ One staff member proficient in American Sign Language and others with basic skills ▪ Interpretation services in any language are offered to clients free of charge; interpreters culturally reflect clients ▪ Staff assigned to clients are reflective of clients' cultural background, as feasible ▪ Client materials are written at a fifth to eighth grade literacy level and in Spanish at third to fifth grade level ▪ Client materials are provided in Spanish and English ▪ A professional volunteer translates materials from English to Spanish ▪ Organization includes "diversity" as one of its core values
77. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.	▪ A Cultural Appropriateness Action Team with staff from varied levels and departments is tasked with ensuring CLAS and health equity are promoted ▪ The agency maintains a tracking mechanism to ensure CLAS compliance ▪ Agency policies are cognitive of cultural appropriateness and those that are applicable to clients are provided in English and Spanish at an appropriate literacy level ▪ Resources are allocated based on community need and assessment ensuring targeting of demographics most affected by the epidemic ▪ 2011-2015 board approved organizational strategic plan includes goals, objectives, and action steps prioritizing staff cultural awareness and competency trainings ▪ Executive Director serves on the Central Health *Health Equity Council* for HIV issues
78. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.	▪ Compliance with Equal Employment Opportunity Commission (EEOC) guidelines since inception ▪ Compliance with The Americans with Disabilities Act (ADA) since inception ▪ EEOC and ADA language reflected on all job postings ▪ Staff are fluent in Spanish, culturally reflective of the Hispanic clientele, and available to interpret daily ▪ Staff members are from diverse backgrounds including African-Americans, Latino, and individuals that are immigrants to the USA. Organizational staffing is reflective of the demographics of the HIV epidemic in the Austin TGA ▪ One staff member proficient in American Sign Language and others with basic skills ▪ Committed to promoting from within for job openings

CLAS Standards	ASA Compliance
	▪ Evaluation of the potential of current staff for leadership development in order to promote direct service staff ▪ Structured Action Teams provide leadership development opportunities for all staff members ▪ Candidates for positions where bi-lingual (Spanish) skills are preferred are offered a salary premium for demonstrating appropriate proficiency in the language ▪ Organization recruits diverse candidates by networking with higher education institutions of color and advertising and conducting outreach into appropriate publications in communities of color ▪ 2011-2015 board approved organizational strategic plan includes goals, objectives, and action steps prioritizing recruiting, hiring, and training diverse staff and recruiting board members from communities of color ▪ Board officers are demographically and culturally diverse ▪ Agency participation in multicultural career expos for staff recruitment
79. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.	▪ The agency's Cultural Appropriateness Action Team and Professional Development Action Team research and implement ongoing training ▪ Agency support of language skills development when resources are available ▪ Executive Director serves on the Central Health *Health Equity Council* for HIV issues
80. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.	▪ Staff are proficient in Spanish, culturally reflective of the Hispanic clientele, and available to interpret daily ▪ Staff are from diverse backgrounds including African-Americans, Latino, and individuals that are foreign-born ▪ One staff member proficient in American Sign Language and others with basic skills ▪ Interpretation services in any language are offered to clients free of charge; interpreters culturally reflect clients ▪ Client materials are written at a fifth to eighth grade literacy level and in Spanish at a third to fifth grade level ▪ Client materials are provided in Spanish and English ▪ A professional volunteer translates client materials from English to Spanish ▪ The agency uses an independently certified system to evaluate the language proficiency of staff ▪ Organization's central voice mail and Dental Clinic voice mail systems are recorded in Spanish ▪ Key program staff have recorded voicemails in Spanish

CLAS Standards	ASA Compliance
81. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.	▪ Interpretation policy offering services free of charge posted in all locations ▪ Reception and Intake and Eligibility staff trained to notify clients of their right to receive language assistance services free of charge ▪ Front desk and key staff voicemail messages are recorded in English and Spanish ▪ Interpretation services in any language are offered to clients free of charge; interpreters culturally reflect clients ▪ Client materials are provided in Spanish and English ▪ Reception staff have access to language cards to identify need for interpretation services
82. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.	▪ The agency uses an independently certified system to evaluate the language proficiency of staff ▪ Written policy offers interpretation at no cost to the client in order to prevent the use of family and friends as interpreters ▪ Staff is trained to inform clients of their right to interpretation services at no cost and that family and friends are not a preferred source for interpretation in order to protect client confidentiality ▪ The agency hires professional, certified trainers to assist in interpretation upon request
83. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.	▪ Client materials are provided in Spanish and English ▪ Client materials are written at a fifth to eighth grade literacy level and in Spanish at a third to fifth grade level ▪ Key client information/policies and grievance information is posted in English and Spanish in common areas and available in hard copy from reception desks ▪ Quality Management Guidance Team reviews and updates materials to increase understandability
84. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.	▪ ASA's 2011 – 2015 Strategic Plan identifies compliance with CLAS Standards as a priority: o "Strategy #3: Ensure culturally appropriate programs and services ▪ Agency programs and services meet Culturally and Linguistically Appropriate Services (CLAS) standards ▪ Collaborative partners recognize ASA for delivery of programs and services to reduce stigma and for innovative and collaborative relationships" o Strategic plan action step is to implement an

CLAS Standards	ASA Compliance
	Organizational Cultural Appropriateness Committee representative of diversity of staff and management to further formalize cultural appropriateness trainings and action steps
85. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.	▪ Self-assessment of CLAS-related activities conducted in 2007; results continue to be used to improve services ▪ Cultural Appropriateness Action Team to survey annually and report to staff and board of directors of outcomes from strategic planning goals/objectives related to cultural appropriateness work
86. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.	▪ Collection of data and documentation on each consumer's race, ethnicity, disabilities, spoken and written language, and literacy level; information entered into client paper file, Provide Enterprise® internal electronic database, and ARIES; information updated periodically ▪ Use of the Austin Transitional Grant Area HIV Planning Council's periodic consumer needs assessment ▪ Use of the Brazos Valley Council of Government's periodic consumer needs assessment ▪ Provision of HIV testing data to the Texas Department of State Health Services, (DSHS) and the Centers for Disease Control and Prevention, (CDC)
87. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.	▪ Collection of data and documentation on each consumer's race, ethnicity, disabilities, spoken and written language, and literacy level; information entered into client paper file, Provide Enterprise® internal electronic database, and ARIES; information updated periodically ▪ Annual review and assessment of HIV epidemiology profile of epidemic as prepared by Texas Department of State Health Services (TDSHS) and the Austin/Travis County Health and Human Services Department ▪ Use of the Austin Transitional Grant Area HIV Planning Council's and Brazos Valley Council of Government's periodic consumer needs assessment ▪ Annual report to staff and board of directors on Austin TGA HIV epidemic in comparison to organization's client demographic profile, staff demographics, and board demographics
88. Partner with the community to design, implement, and evaluate	▪ Collection and updating of data and documentation on each consumer's race, ethnicity, disabilities, spoken and written language, and literacy level; information entered

CLAS Standards	ASA Compliance
policies, practices, and services to ensure cultural and linguistic appropriateness.	into client paper file, Provide Enterprise® client electronic database, and ARIES. ▪ Provision of HIV testing data results are reported to the DSHS and CDC ▪ Involvement in community events targeted to people of color to build collaborative partnerships in a participatory environment ▪ Staff shares lessons learned at above events with management and leadership staff to expand collective knowledge of local cultural practices and beliefs ▪ Organization is a member of the advisory committee to the Latino Commission on AIDS to develop training institutes on providing culturally appropriate HIV services to the Latino community in 2012 ▪ Executive Director serves on the Central Health *Health Equity Council* for HIV issues
89. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.	▪ Client materials are provided in Spanish and English ▪ Client materials are written at a fifth to eighth grade literacy level and in Spanish at a third to fifth grade level ▪ Client grievance procedures are posted in English and Spanish in common areas throughout the organization ▪ Organization has a formal grievance procedure in place that is reviewed annually by staff
90. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.	▪ Strategic Plan dissemination to donors and posted on website ▪ Community Impact Report disseminated to donors, posted to website, and available in hard copy to public ▪ Responsiveness and pursuit of opportunities to participate in ethnic media

VIII. Quality Management

Use of Output and Outcome Data

Using monthly data, AIDS Services of Austin (ASA) tracks progress on the total number of unduplicated clients served, units of service delivered, and achievement of outcome goals through the reporting feature of the Provide Enterprise® electronic client database. On a monthly and quarterly basis, supervisors analyze the data to determine if outputs and outcomes, respectively, are within a 10 percent variance of the elapsed period of the grant cycle. If not, supervisors determine reasons that program goals are not being met and develop plans to address the situation including staff training, supervision, and monitoring staff adherence to the standards of care for the service category. Supervisors also note trends in performance measures with

emphasis on clients who do not meet outcome goals and develop appropriate quality management activities or document the reasons for such exceptions. Provide Enterprise® reports give aggregate data at the agency level that documents client trends in service utilization for use in planning for service delivery.

Supervisors will use reports from the ARIES client database to validate data on performance measures such as number of unduplicated clients served and units of service provided. With the client's signed permission to share client information in ARIES, supervisors will use ARIES reports to facilitate getting complete data on services accessed by clients, to document successful linkages to primary medical care and support services, and to compare, if needed, client service utilization data in order to avoid duplication of services. ARIES will also provide aggregate data at the community level that documents client trends in service utilization for use in planning for service delivery.

Supervisors will use the service-specific client satisfaction survey to obtain data using client input on satisfaction with services provided. Supervisors review survey results including qualitative data at the program area, Leadership Team, Quality Management Guidance Team, and the Program and Services Committee meetings. With input from these various teams, supervisors use suggestions from the survey to identify problems and/or concerns and implement quality improvement activities including service delivery changes when possible.

The resources and tools used to facilitate this process are staff time, the Provide Enterprise® database, ARIES database, and the client satisfaction survey.

Assurance of Compliance with Austin TGA Standards of Care

In accordance with Austin TGA Ryan White Part A HIV Case Management Standards, all Non Medical Case Management staff will complete training as outlined in the Standards.

All newly hired Non-Medical Case Managers funded by Ryan White Part A will complete the initial four required courses as listed on page 12 of the standards and a minimum of 12 hours of ongoing required continuing education aimed at the 20 core competencies listed on page 13 of the standards in grant year 2016-2017. Non-Medical Case Managers will annually complete 12 hours of ongoing continuing education in the 2016-2017 grant year.

Case Management supervisors are responsible for case manager compliance with training requirements including the Standards of Care and for ensuring that evidence of training completion is retained in the employee's personnel file.

Agency supervisors and managers ensure that direct service staff and supervisors are qualified individuals as evidenced by the documentation of degree(s), length of experience and type of experience in the staff personnel file.

To assure that services are delivered consistent with the Austin TGA Standards of Care, supervisors annually review a total of 20 percent of client files served during the grant cycle. Supervisors complete reviews quarterly on a portion of client files. The results of file reviews can be found in the paper and electronic file review tool. Within 15 working days of the file review, supervisors review with Non-Medical Case Managers any indicators that are not in compliance. Supervisors and staff develop plans of correction that require completion within ten working days and note reasons for exceptions. The evaluation of staff performance is linked to compliance with the standards of care and follow-up on plans of corrections from file reviews. During monthly supervision, Case Managers and their supervisor review any deficiencies in compliance with standards.

Quality Management Plan

Quality Management Guidance Team

The overall responsibility and leadership for ASA's Quality Management (QM) program lies with the Chief Programs Officer, who authorizes the Quality Management Guidance Team (QMGT) to plan, assess, measure, and implement performance improvements throughout the entire agency, while providing the necessary resources and support to fulfill these functions.

The membership of the QMGT reflects the diverse service areas within AIDS Services of Austin (ASA). The agency's quality team is comprised of the Chief Programs Officer and other members of ASA staff, ranging from upper management to direct service staff. Other ASA staff members, such as Program Supervisors and Coordinators, Case Managers, and Prevention Specialists are involved, when appropriate. Nominations for membership are decided upon by the QMGT. The QMGT meets quarterly every other month. Additional meetings may be called, as needed. Minutes of meetings are distributed directly to each member of the committee and to all necessary internal and external stakeholders. A written summary is routinely made available to staff.

The Quality Management Plan

The Quality Management Plan seeks to improve service performance through collecting and evaluating data, identifying service problems based on the collected data, using quality improvement processes to address service delivery issues, and following up to ensure improvements will be sustained. The agency plan is designed annually with target goals and service specific quality improvement activities. It calls for a review of service performance measures, an analysis of this data, and recommendations for service improvements. The plan indicates that the team will oversee an annual update and revision of program policies and procedures. At the end of each year, the plan is evaluated to determine the achievement of goals and the service specific activities and to make recommendations for further follow-up.

The following sections describe other components in the Quality Management Plan:

Activities to Collect Data

The Chief Programs Officer, the Director of Access Services, the Case Management Programs Manager, and the Eligibility Services Manager will collect data on the program's performance in

achieving service goals and meeting standards of care through results from the following sources: outcome and output measures, the agency client satisfaction survey, client file reviews, client/staff feedback, and client grievances. The client suggestion box is located in the agency main reception lobby to allow clients the opportunity to provide feedback at any time. The Eligibility Services Manager checks the box monthly and provides any feedback to the appropriate program manager and to the Quality Management Guidance team for appropriate action or response.

Supervisors review performance measures quarterly and report measures not meeting contract objectives to the Quality Management Guidance Team, along with suggestions on planned action steps.

Client satisfaction surveys are an important way to identify quality issues. The agency distributes the standardized survey, after approval by the HIV Resource Administration Unit, City of Austin Health and Human Services Department, at the Food Bank and Dental Clinic sites to collect data on all Ryan White Service Categories offered at ASA. Trained social work interns and volunteers administer the survey during a selected two week period. The survey data is tabulated by the Data Manager-System Support Technician at the HIV Resource Administration Unit, AHHSD.

File reviews are essential to the quality of client data. Supervisors review 100 percent of client intakes and 20 percent of files on clients served during the grant cycle to evaluate pertinent Case Management Non-Medical (Tier 1 and Tier 2) program activities and compliance with indicators for the standards of care. Client input from registered grievances is documented by program supervisors and reviewed at department staff meetings. Supervisors adhere to the agency's policy on client/patient grievances, which includes review by the Executive Director and/or the Board of Directors, if necessary.

Evaluation of Performance and Assuring Delivery of Quality Services
As data and input are received and problems are identified, the QMGT evaluate concerns and suggestions in order to assure the delivery of quality services.

The QMGT analyzes the output/outcome data and makes recommendations for improvement to program supervisors. When quality improvement activities around performance measures are designed and completed, the results are then sent to the team and reported in the annual evaluation of the Quality Management Plan.

Supervisors will evaluate survey results to identify trends for improvements and advocate for unmet client need. Supervisors will be careful to note any client feedback related to the cultural appropriateness of service delivery especially with respect to policies and procedures and case manager interventions. To guide decisions about quality improvement activities, survey results are discussed at the program level in department/program meetings and at QMGT meetings. The Programs and Services Committee of the Board of Directors also reviews survey results and gives guidance when appropriate.

Program supervisors utilize grievance input obtained from clients and managers at the different grievance levels to make appropriate service changes, when feasible. Supervisors will be careful to note any client feedback related to the cultural appropriateness of service delivery.

Suggested actions taken based on this data could include staff development training in an identified area such as cultural appropriateness in communication or interventions, development of organization tracking tools, identification of a different site for service delivery, additional interventions to reduce barriers, or design of client/patient forms to better capture data and service performance measures.

Identification of Quality Improvement Activities

At the beginning of the year, supervisors and the QMGT identify specific service quality improvement activities based on staff and client feedback and the data already discussed. Activities are written using SMART objectives in that they are specific, measureable, attainable, relevant and time-bound.

Quality improvement activities for the Case Management Non-Medical will include monitoring on case manager completion of the client eligibility documents every six months.

Addressing Identified Problems

Once a problem or an area that needs further assessment is identified, the team will use, when appropriate, the Plan-Do-Study-Act cycle (PDSA), a four-step model for carrying out change. This process will be used in identified quality improvement activities as detailed in the annual Quality Management Plan. The components are as follows:

1. Plan by recognizing an opportunity and planning a change.
2. Do by testing the change and carrying out a small-scale study.
3. Study by reviewing the test, analyzing the results/data and identifying what has been learned.
4. Act by taking action based on what you learned as a result of data analysis in the study step.

If the change does not work, the cycle will be repeated again with a different plan.

To address client file review results, supervisors will implement a plan of correction when deficiencies in delivering services or lack of compliance to standards have been identified. Supervisors will require plans of correction and timelines for correction. If meeting the standard is systemic rather than related to one or two staff, then supervisors will design and require staff training and report quality improvement activity results to the QMGT.

Follow Up

Case manager supervisors will follow up to ensure the effectiveness of improvement activities and the maintenance of improvement results. On identified quality improvement activities, supervisors follow up on a quarterly basis to ensure that these activities have been effective in

resolving the problem, that no new problems have developed, and that there is sustained improvement in identified areas.

For file review results, supervisors work with staff to develop plans of correction within 15 working days of the file review. Staff has ten working days to implement corrections. At the next quarterly file review supervisors monitor the maintenance of the previous quarter's improvements to ensure problems do not reoccur.

Monitoring and Standardized Tools

Tools used in monitoring and standardization include the file review tool and Provide Enterprise® reports with features to track reporting of performance measures, completion of assessments, service plans, as well as a feature to describe content of progress notes for easy tracking. The annual client satisfaction survey is a standardized tool that the Ryan White Quality Management workgroup evaluates and standardizes across HIV service providers.

Compliance with Ryan White Part A Program Monitoring Standards

v. Maintain client charts that include the required elements as detailed by the grantee, including:
    - Date of encounter
    - Type of encounter
    - Duration of encounter
    - Key activities, including benefits/entitlement counseling and referral services

N-MCM:

Non-Medical Case Managers will maintain client files that include the required ARIES data elements as listed in the 2009 ARIES Taxonomy and required activities such as initial assessment of service needs, the comprehensive individualized assessment and service plan, service coordination for plan implementations, ongoing monitoring to evaluate plan effectiveness, and the review and revision of the plan at least every six months.

Eligibility and Intake staff will include required eligibility documents, the intake form that collects required ARIES information and the initial client services agreement in the client paper file. The initial assessment of service need will be documented in the client electronic file. Non-Medical Case Managers will record coordination of required services for plan implementation, monitoring to assess the effectiveness of the service plan, plan and re-assessment in the progress notes of the client file. Staff will also include service coordination such as linkage to health care, support services, public and private benefit programs, coordination of primary and support service appointments, and comprehensive assessment components such as ongoing evaluation of client/significant other needs/ support system and interventions such as skill-building addressing barriers to support services, and advocacy necessary to implement the plan. Plan revisions are noted in the paper service plan that is signed by the client and kept in the client paper file.

Eligibility and Intake Staff and Non-Medical Case Managers provide benefits and entitlement counseling and referrals to clients for programs such as Texas HIV Medication Program (ADAP), State Pharmacy Assistance Program, Medicaid and/or Medicare Part D, City of Austin Medical Assistance Program, medication Patient Assistance Programs, Social Security, and Food Stamps, as appropriate. The case managers note such discussions in ongoing Progress Logs in the Provide Enterprise® client data base. Referrals are tracked on a tracking form kept in the client's paper file and reviewed at each encounter with the client until the referral is successfully followed up upon.

Non-Medical case managers will document type, date and a summary of the contact on the progress log function of the electronic client file. Frequency of contact is illustrated through the activity view feature that shows dates of each client contact. Duration of contact is measured in 15 minute increments and recorded in the service provided section of the electronic file. 15 minutes equals to one unit of service for or on behalf of the client.

An extract developed by Groupware Technologies, Inc, will bridge to the ARIES client database the required ARIES data on units of service provided. Client identifying information and other required data is entered directly into ARIES by ASA staff.

Statement of Work 2016
AIDS Service of Austin – Ryan White Part A

Service Category Name
Oral Health Care

Client Eligibility
Persons with HIV and AIDS who reside in the ten counties of the Austin Transitional Grant Area (TGA) (Travis, Williamson, Bastrop, Hayes, and Caldwell) and who are unable to otherwise access dental care are eligible for services at AIDS Services of Austin's (ASA) Jack Sansing Dental Clinic. The Eligibility and Intake Specialist, Patient Navigator, or Receptionist screens potential patients for eligibility by verifying that they are HIV positive and reside in the service area.

xxxi. **Documentation of HIV Status:** Staff obtain verification of HIV status through:
- a signed statement from the medical provider;
- a positive Western Blot laboratory result with the name of the client;
- a printed document from the ARIES database indicating verification of HIV status by another provider;
- HIV detectable viral load lab results; or,
- a hospital discharge summary or medical records from previous provider(s).

xxxii. **Proof of Identity:** Proof of identity includes: Texas driver's license, Texas State identification card, a passport, Military or Student identification card, Social Security card, birth certificate or other official document as listed on the Austin TGA Ryan White Client Eligibility Form

xxxiii. **Residency Verification:** In order to establish residency, clients can provide unexpired documents such as a Texas driver's license, Texas State or Tribal identification cards, Social Security award letter, rental/mortgage agreement, utility bill, or similar forms accepted by the Ryan White Part A Austin TGA.

The Eligibility and Intake Specialist, Patient Navigator, or Receptionist also screens patients to determine and verify income and charts where they fall on the Dental Clinic's Sliding Scale Fee Schedule of charges. Patients are asked to state their net income, and the number of people it supports. Their Sliding Fee Scale Schedule level of contribution is based on the patient's individual income.

i. **Income Verification: S**taff use the MAGI or Mock MAGI form for client income verification. Clients that have filed a tax return in the previous year complete the MAGI form and submit their tax transcript as income verification. Clients that did not submit a tax return or have had a change in income complete a Mock MAGI form and submit an IRS proof of non-filing and income verification document. Income verification documents include Social Security Award letter, Veterans/Public Assistance or Worker's Compensation benefits statements, wage payment stubs, signed zero income verification letter or other document listed in the Austin TGA Ryan White Part A Client Eligibility Form. There are some populations that are excluded from having to obtain tax transcripts or IRS proof of non-filing, these include: homeless, recently released from incarceration (3 months), undocumented, emancipated minors, and SSI and/or SSDI recipients.

ii. **Health Insurance Coverage:** Cards verifying coverage by private medical insurance, Medicare, Medicaid, Veteran's Health Benefits, and Indian Health services will be accepted. Signed no insurance attestation statements will also be accepted. Should a client receive City of Austin Medical Assistance Program (MAP), a copy of the card will be made and a attestation of no insurance will be signed.

Using the sliding scale patients' fee level is determined and noted on the outside of their dental chart. Their discount rate (100% - 0%) is entered into the dental clinic practice management and billing software. The program calculates the amount of the discount to be applied to individual patient accounts after all the fees for the procedures they received at any given visit are entered in their record.

After the intake visit, this information is reviewed and updated with a patient every six months, or at any time they indicate a change in their financial situation.

The Eligibility and Intake Specialist, Patient Navigator, or Receptionist also determines if patients have dental insurance; however, coverage is not an eligibility criterion. Patients with dental insurance are eligible for services, which are billed to the insurer first before patients are asked if they are able to make payment. No one is refused treatment and care due to inability to pay for services.

Dental Clinic staff use the Austin TGA Ryan White Part A Client Eligibility Form to review patients in the program for six months or more for determination of continued eligibility. At that time, patient residency, income, and health insurance are updated and new documentation

obtained, as indicated. **Patients are reassessed to determine continued eligibility at six (6) month intervals after the completion of the eligibility review again using the RWA Eligibility Form.**

All required eligibility and intake documents, as well as periodic updates, are stored in the patient's paper chart and documented electronically in the agency's electronic client database, Provide Enterprise®. Supporting documents are scanned and saved to a secure network folder by the Data Entry Specialist. Client identifying information is also entered into the ARIES client database.

At the intake appointment, patients are required to provide comprehensive medical and dental histories and to sign a medical release form authorizing release of medical information, including current CD4 count, viral load, medications, recent lab values and any other medical information that may impact the provision of oral health care. Eligible patients may contact the Dental Clinic directly for services and do not have to be receiving services from any other ASA provider to be eligible for oral health care. The Clinic also accepts referrals from other AIDS Service Organizations (ASOs), Community-Based Organizations (CBOs), hospital emergency rooms, and area primary care physicians.

The Patient Navigator at ASA's Jack Sansing Dental Clinic may recommend patients access case management or other support services at ASA. In this case, patients will be referred to ASA Eligibility and Intake where they will complete a comprehensive screening process to determine their level of need for services.

Target Population

AIDS Services of Austin's (ASA) Jack Sansing Dental Clinic is the sole provider of dental services exclusively for HIV positive persons in Central Texas. People with HIV and AIDS who reside in Travis and the four surrounding counties (Bastrop, Caldwell, Hays, Williamson,), and who cannot otherwise access dental care, are eligible for services (see *Client Eligibility* section). Ryan White Part A funds will be used to provide services for patients residing in the TGA.

The Clinic treats eligible patients of all genders, ages, ethnicities and, co-morbidities and targets traditionally underserved populations and those experiencing an increased incidence of HIV. This includes women, children, ethnic/racial minorities, injecting drug users, crack/cocaine users and other substance abusers, the homeless, men and women engaged in the sex industry, the recently released from incarceration, and men who have sex with men.

The demographics of clients served by the program should mirror the current population served by ASA's Jack Sansing Dental Clinic. The following table (Table 1) compares the 2015 calendar year demographics of ASA's Oral Health Care program to the demographics of people living with HIV and AIDS in the Austin TGA.

Table 1

	ASA Clients	Austin TGA PLWH/A
Gender		
Male	83%	85%
Female	16%	15%
Transgender	1%	(unavailable)
Race/Ethnicity		
White	44%	46%
Black	24%	22%
Hispanic	29%	29%
Other	3%	3%
Age Group		
0 – 12	1%	0%
13 – 24	2%	4%
25 – 34	11%	17%
35 – 44	17%	27%
45 – 54	36%	34%
55 and over	33%	18%

ASA client geographic concentration aligns with areas of high prevalence of HIV/AIDS in the Austin TGA. ASA's 10 most common zip codes for Oral Health Care patients are all located in Travis County.

Table 2

ASA Top 10 Client Zip Codes	Prevalence Range of HIV/AIDS
78741	314-674/100,000
78753	675-1,199/100,000
78758	314-674/100,000
78723	675-1,199/100,000
78704	314-674/100,000
78745	675-1,199/100,000
78744	115-313/100,000
78702	675-1,199/100,000
78660	675-1,199/100,000
78752	*data unavailable

Austin TGA data suggest that 84 percent of clients have medical comorbidities, while others report social and health-related contributing factors that complicate medical and other service delivery for HIV.[25] Recent studies have shown that 67 to 96 percent of HIV positive individuals

[25] ARIES database, provided by the City of Austin (Addendum 5 to Ryan White Part A RFA 2012-13)

have comorbidities.[26] Co-morbidities and conditions for the Oral Health program's target population include STDs, substance abuse, mental health issues, commercial sex work, poverty, homelessness, domestic violence, Hepatitis B and C, heart disease, diabetes, and tuberculosis (TB).

Service Category Activities

Service activities linked to Budget Justification

ASA's Dental Clinic began in 1991 as the HIV Dental Project, an independently funded and managed satellite project. Concerned local dentists and community leaders initiated the project in response to the need for dental services first identified by the Austin/Travis County HIV Commission in 1990. As part of ASA, in April 1992 the clinic was named the Jack Sansing Dental Clinic in honor of Jack Sansing, a local businessman, benefactor, and long-time volunteer of ASA. Mr. Sansing died of AIDS in January 1992. Dr. Chris Fabre, the Clinic's Founder, remained involved in the project for 19 years, as a testament to his commitment to the original vision of public health care delivered in a compassionate, self-empowering manner reminiscent of a private practice.

ASA's Dental Clinic continues to implement a successful plan of oral health care service delivery that provides routine and emergency dental care for HIV positive individuals. General dentistry service activities include:

- oral examination;
- treatment planning;
- oral surgery (general);
- oral pathology;
- root canal treatment (in some cases);
- periodontal therapy (non-surgical);
- restorative dentistry such as fillings and crowns;
- removable prosthodontics (both partial and full dentures);
- treatment of oral infections; and,
- emergent care to alleviate dental pain.

The Clinic also treats many of the oral lesions affecting HIV positive patients, which may require a biopsy, excision, and/or lesion destruction with chemical treatments, and palliative care. On a routine basis, common lesions such as oral candidiasis, human papillomavirus lesions, herpetic lesions, and aphthous ulcers are diagnosed and treated. Less common, but still prevalent, Kaposi's sarcoma and more rare malignancies are diagnosed and treated (or in some cases co-managed in a multi-specialty approach). In this category of less common, but prevalent conditions are cytomegalovirus lesions (CMV) and fungal infections. The Dental Clinic's Class D Pharmacy carries a limited number of medications to treat oral infections and/or alleviate

[26] "Prevalence and Patient Awareness of Medical Comorbidities in an Urban AIDS Clinic," Weiss, Jeffery J., PhD, et al

pain, so that the patient is assured immediate access to antibiotics and over the counter pain relief when necessary.

- ***Service Initiation***

Patients are typically referred to ASA's Jack Sansing Dental Clinic from AIDS Services Organizations, social service providers, CommUnity Care at David Powell Clinic, private medical practices, or local emergency rooms. In addition, clients self-refer to the Dental Clinic. The Eligibility and Intake Specialist, Patient Navigator, or Receptionist performs an initial screening either in-person or by telephone to determine eligibility for services. (See *Client Eligibility* for a complete description of the eligibility process.) After confirming eligibility, the Receptionist schedules an intake visit appointment and gives patients a reminder call two business days before their appointment. If patients are missing eligibility documentation or it is out of date, the patient is reminded to bring necessary paperwork with them to the appointment and to arrive 30 minutes early to complete the paperwork.

- ***First Intake Appointment (IT1)***

At the first appointment, patients meet with the Eligibility and Intake Specialist or the Patient Navigator and are given HIPAA and privacy and patient rights policies and are required to complete medical/dental history forms, provide information on income, and sign various consents (for treatment, follow-up contact, and for ARIES information release) and primary care provider releases (for lab results and current medication list), as well as MAGI or mock MAGI, CAP and other financial qualifying forms. If the patient presents with dental pain, the patient is seen by a Dentist during this visit to asses and immediately treat their pain.

- ***Second Intake Appointment (IT2) Develop Patient Treatment Plan***

Once the patient has all of their documentation in order, they will be seen for x-rays, comprehensive oral examination, initial diagnosis, treatment planning, and to schedule a follow-up appointment. During this visit, the Dentist reviews the digital x-ray images, closely interviews patients with regard to their medical and dental history, and conducts a comprehensive head, neck and oral examination. Usually the patient is presented with one or more treatment plan options by the dentist which are documented in the patient's chart. The individualized treatment plan may include, but is not limited to restorative treatment through fillings, crowns, extractions, regular prophylaxes and/or referral to specialty care for multiple tooth removal or endodontic treatment. Restoring function often results in dentures (full or partial).

- ***Implement Patient Treatment Plan***

At the end of the second intake visit, new patients are scheduled to return for their first treatment visit as noted in their treatment plan. At the end of subsequent visits, an appointment for the next step in the treatment plan is scheduled. For those being referred to a specialty care provider, a referral form is used that documents the problem area(s) using a tooth chart and records any additional information that is necessary for care of the patient being referred. The Dentist signs the referral form and copies are made and given to the patient. The phone number and directions are provided to the patient so that they may make the appointment at their convenience. Most patients prefer to make this specialty appointment themselves so they can

coordinate transportation. Upon request, the Receptionist will make the appointment on behalf of the patient.

- ***Provide Ongoing Routine Care***

At subsequent visits and at a minimum, yearly, patients are asked to renew any expired permissions, update contact and income information, and report any changes in health status or medications which may impact provision of oral health care. To ensure ongoing care, patients schedule their next appointment at the end of their current visit, as needed to complete their treatment plan. ASA's automated call system contacts the patient three days prior to their upcoming appointment to confirm attendance. If patients have not confirmed through the automated system by one day prior to their appointment, staff place a reminder call directly to the patient. Patients who fail to show for an appointment or cancel with very short notice twice in any six month period are notified that further failed appointments may result in suspension of clinic privileges for non-emergency dental treatment. These patients are flagged to be assisted by the Patient Navigator. The Patient Navigator links patients into Medical Case Management and other support services when appropriate. If a patient is not currently case-managed at ASA or another ASO and is identified as being in need of this service, the Patient Navigator refers them into the medical case management program in the county in which the patient resides, as appropriate.

- ***Maintain Patient Records and Files***

Two days prior to a patient's scheduled visit, staff pulls and reviews the patient's chart. Expired paperwork is noted on an Eligibility Tracking Form and new blank forms are inserted in the chart. Out of date eligibility documents are updated when the patient arrives for their scheduled appointment. The Receptionist or Patient Navigator offers patients assistance with completing the required documents and has the Eligibility and Intake Specialist or Patient Navigator assist patients with vision, literacy, comprehension, and/or language issues. The Eligibility and Intake Specialist or Patient Navigator completes the paperwork using an interview style to obtain the information needed to complete the documents. After completion, documents are put in the patient's and sent to the data entry specialist. Any patient consent forms completed in the operatory (e.g., consents for surgical extractions or biopsies) are placed in the chart while accompanying the patient to check-out.

- ***Review Documentation for Quality Assurance and Alter Program as Needed***

The Systems and Facilities Administrator runs quarterly missing data element reports using ARIES to determine patients who may have received a service but whose data file is incomplete. Dental clinic direct service staff comprised of the Receptionist and Eligibility and Intake Specialist review the list along with the Director of Dental Services to determine a timeline to complete a quality assurance review of the files/charts in question. Missing eligibility documents are obtained directly from patients. The date they are obtained is noted in the patient's chart. Patients who were found to have been provided a service with ineligible qualifications for Ryan White funding have their units charged to a private funder.

Frequency of these service activities

ASA's Jack Sansing Dental Clinic is open Monday – Thursday from 8:00 am to 5:00 pm and Friday from 8:00 am to noon. Patients are treated at a frequency consistent with their treatment plan. This includes a minimum of two cleanings annually. Emergency care is also provided as needed and practicable.
Location(s) of these service activities ASA's Jack Sansing Dental Clinic is located at 711 W. 38th St., Bldg E-4, Austin, TX 78705. The Dental Clinic can be accessed by Capital Metro bus routes 3, 9, and 803.

Staffing

The Chief Programs Officer has responsibility for overall program direction and supervises the Director of Dental Services. Lead and Staff Dentists, Dental Hygienists, Dental Assistants, Patient Navigator, Data Entry Specialist, Eligibility and Intake Specialist, and Receptionist all report to the Director of Dental Services.

The Executive Director is the primary contact with the City of Austin Health and Human Services Department (AHHSD) HIV Resource Administration Unit and has final authority in negotiating and approving contracts. The Chief Programs Officer interacts with AHHSD on matters relating to programs and is authorized to enter into negotiations with AHHSD regarding program issues, grant reporting, and performance measures. The Chief Financial Officer interfaces with AHHSD HIV Resource Administration on grant billings. The Grants Manager ensures contract compliance.

The Dental Clinic staff is comprised of both males and females and has staff that is bilingual in English and Spanish. Staff qualifications, primary work assignment, and percentage of time allocated to this service are reflected in the following chart:

Table 3

Name/Position	Qualifications	Primary Work Assignment	% Time Allocated
Campion/Chief Programs Officer	BS in Education; 24 years combined with ASA as staff and/or volunteer, 11 years with MHMR, serving consumers from diverse backgrounds; 3 years with DSHS/TCADA developing and implementing HIV/substance use prevention and early intervention programs statewide; 30 + years experience with HIV/AIDS.	Responsible for overall strategic direction and implementation of agency departmental programs and services. Ultimately has responsibility for the success of agency programs, adherence to all legal and regulatory compliance, and the successful integration and delivery of services.	0%

Name/Position	Qualifications	Primary Work Assignment	% Time Allocated
Vacant/Lead Dentist	Vacant	Provides patient care and input on dental staff supervision to Director, assists with developing clinical policy and staff procedures for the Jack Sansing Dental Clinic. Leads clinical quality assurance activities.	50.6%
Nelson/ Director of Dental Services	Bachelor of Applied Technology; AAS Registered Dental Hygienist; Lead Dental Hygienist - 10 years, Clinical dental hygiene practice, Privacy & HIPAA Compliance Officer, Radiation Safety Officer, marketing experience; HR Manager – 9 years with Walmart Stores, Inc. HIV Prevention Outreach Volunteer with ASA.	Supervises all staff. Oversees operations of Jack Sansing Dental Clinic including daily operations, scheduling, contract compliance, federal, state and local laws and regulations related to operations; HIPAA,OSHA, Privacy Compliance; data management and quality, and clinical care.	43.1%
Bradley/DDS Staff Dentist	Diplomate – American Board of Special Care Dentistry; graduate degree in Dentistry; DDS with current State license: DEA and DPS registration permits; 25 years clinical experience in general dentistry practice and academics. Specializes in treating medically, mentally & physically compromised pts; hospital dentistry; periodontal and oral surgery procedures.	Provides part time general dentistry with emphasis on oral surgical procedures on patients with acute anxiety disorder, mental illness, and cognitive impairment and/or with complex treatment plans under sedation.	0% (Supported by private funds)
Howell/DDS Staff Dentist	Graduate degree in Dentistry; DDS with current State license; DEA and DPS registration permits .More than 23 years experience in general dentistry, has worked at ASA's Dental Clinic since February 1995.	Provides direct patient care, including patient education. Participates in ongoing quality assurance activities.	0% (Supported by private funds)
KilKelly/DDS Staff Dentist	Graduate degree in Dentistry; DDS with current State license; DEA and DPS registration permits. Has experience in general dentistry and dental emergency care. Has worked at the Dental Clinic since 2013.	Provides direct patient care, including patient education. Participates in ongoing quality assurance activities.	11.6%
Hildebrant/RPH Dental Hygienist	38 + years' experience in dental hygiene; 7 years with the Dental Clinic. Well regarded by patients; provides prophylactic care and	Provides direct patient care, including patient education. Participates in ongoing quality assurance activities.	0% (Supported by private funds)

Name/Position	Qualifications	Primary Work Assignment	% Time Allocated
	education to people with HIV/AIDS.		
McFarlan/Lead Dental Assistant	Chair-side ancillary staff member providing assistance to staff dentists; 21 years with Clinic. X-ray certified and State Board of Dental Examiners approved. Bilingual in Spanish and English.	Provides dental assistance to staff dentists. Responsible for cleaning and maintaining all operatories, instruments, and equipment. Works with various suppliers to order, purchase and maintain dental supply stock. Participates in ongoing quality assurance activities.	61.5%
Guebarra/Dental Assistant	Chair-side ancillary staff member providing primary assistance to Director of Dentistry and staff dentists. Began working at the Dental Clinic in June 2008. Speaks conversational Spanish.	Provides dental assistance to staff dentists. Provides dental laboratory support maintains instruments and equipment, sanitizes, and equipment supplies in all operatories. Monitors dental supply stock and reports deficits. Participates in ongoing quality assurance activities.	61.5%
Vacant/Dental Assistant	Vacant	Provides dental assistance to staff dentists. Provides dental laboratory support maintains instruments and equipment, sanitizes, and equipment supplies in all operatories. Monitors dental supply stock and reports deficits. Participates in ongoing quality assurance activities.	0% (Supported by private funds)
Burton/Dental Hygienist	40 + years experience in dental hygiene; 22 years with the Dental Clinic. Highly regarded as an expert in providing prophylactic care and education to people with HIV/AIDS.	Provides direct patient care, including patient education. Participates in ongoing quality assurance activities.	47.1%
Aleman/Receptionist	Has 8 years customer service experience; Qualified Dental Assistant Certification from Austin Dental Assistant School	Coordinates daily Clinic operations. Schedules patient appointments, check patients in/out of the facility, receives payments, reconciles accounts, places reminder calls to patients, conducts all data entry, including ARIES and Provide© Enterprise	67.2%

Name/Position	Qualifications	Primary Work Assignment	% Time Allocated
		patient databases. Maintains security of patient records, correspondence and facility. Works with patients to inform and reinforce the benefits of ARIES data sharing. Participates in ongoing quality assurance activities.	
Miranda/Patient Navigator	20 years case management experience; 17 years HIV experience; 14 years crisis intervention experience; experience in group facilitation, chemical dependency; domestic violence, assessments, treatment plan development, incarcerated and recently released populations	Removes barriers to accessing oral health care: contacts patients at risk of falling out of care and schedules appointments for follow-up visit. Facilitates flow of patient care aimed at increasing patient retention. Makes referrals to AIDS Service Organizations for additional patient support. Position shared with ASA Medical Case Management to integrate services.	0% (Supported by private funds)
Vacant/Eligibility and Intake Specialist		Performs eligibility and intake, makes referrals and provides information, performs quality assurance activities, light bookkeeping (AP and AR).	80.1%
Vacant/Data Entry Specialist	Vacant	Entry of patient and service data into agency and state-mandated databases. Data quality control.	0% (Supported by private funds)

- The supervisor to staff ratio for RWC is 0.431 FTE to 3.80 FTE.

Table 4

Number of Volunteers	1
Number of Volunteer Hours	24
Volunteer Responsibilities	Jenna Miller, R.Ph is the pharmacist in charge of the Clinic Class D Pharmacy. *Please see description below.*

The Dental Clinic relies on the expertise of one professional key volunteer. Jenna Miller, R.Ph, is the Pharmacist-in-Charge for the Dental Clinic's Class D Pharmacy. Her volunteer time is donated to provide at a minimum, a monthly check of the pharmacy, to verify inventory, and to

prepackage medications according to the Clinic formulary. Ms. Miller also conducts an annual training for the designated pharmacy support staff of dentists and the hygienists. Annually, Ms. Miller provides more than 20 hours of volunteer staff assistance.

Table 5

Subcontractor	Placement in Primary Management Structure	Service Description
Seretti Dental Laboratory	Subcontractor Laboratory	Fabricates removable prosthetic appliances
Stern – Empire Dental Laboratory	Subcontractor Laboratory	Fabricates fixed crowns
Central Texas Oral Surgery Associates	Subcontractor Oral Surgeons	Performs difficult tooth extractions often with sedation for patients as indicated by referral.
Austin Oral & Maxillofacial Surgery Associates	Subcontractor Oral Surgeons	Performs difficult tooth extractions often with sedation for patients as indicated by referral.
Capital Oral & Maxillofacial Surgery	Subcontractor Oral Surgeons	Performs difficult tooth extractions often with sedation for patients as indicated by referral.
Austin Endodontics	Subcontractor Endodontists	Performs root canal treatment for patients as indicated by referral.

Client Access

Client Location and Identification

Referrals to the AIDS Services of Austin (ASA) Jack Sansing Dental Clinic come from ASA's case management programs, CommUnityCare at David Powell Clinic (DPC), a number of regional AIDS Services Organizations (ASOs)/Community Based Organizations (CBOs), private HIV physicians in the area, and local emergency rooms. In addition, a number of clients self-refer. With over 20 years of patient care history, the Dental Clinic is well-known in the community and receives a number of referrals by word of mouth. Patients are quick to tell other people they know in need of dental care, of the clinic. Any client receiving an HIV positive test result provided by the ASA Prevention Department receives information about the clinic's services. In addition to these methods, patients report they often find out about ASA's services through internet search engines.

Client Barriers

Barriers that patients must overcome include, but are not limited to, mental illness and substance abuse, memory problems and memory loss, dementia, fear, and transportation, which is most common. Transportation barriers can range from unreliable transportation, (expired tags and inspections, vehicles needing costly repairs, needing to borrow vehicle from family members or friends) to patients who live in areas where public transportation is not readily accessible to unreliable Special Transit Services who require lengthy drop-off and pick-up windows around (1.5 – 2 hours before and after) appointment times. When patients are identified as having barriers at the intake visit or because they are chronically missing appointments, the Patient Navigator works with willing patients one-on-one to reduce barriers to continuing dental care services. Through this individualized service, Dental Clinic staff is able to refer patients in need to ASA or an appropriate ASO. The ASO can then assist the patient to overcome barriers to care,

typically through Medical Case Management. Medical Case Managers help patients to overcome barriers by:

- Providing access to transportation through bus passes/taxi vouchers or transportation in the agency's vehicle;
- Providing referrals to mental health and substance abuse treatment and counseling;
- Accompanying clients to appointments to overcome their fear of treatment; and,
- Providing access to basic needs assistance such as food bank, housing, and emergency financial assistance to stabilize their situations.

Patients may have difficulty in coordinating and prioritizing multiple health care services. Some employers refuse to allow their staff time off for dental treatment, unless it is an emergency. Other barriers include the lack of communication (home telephone); lack of childcare; and language barriers, including hearing impairment. Where possible, appointments are coordinated with other services to minimize travel and/or facilitate access to transportation.

Many people in the target population have stigma associated with their oral health care or they fear dental care and equate this care with loss, infection and/or pain. Some targeted patients lack understanding about the importance of dental treatment, especially the move into routine preventative dental care rather than emergency care. Most new patients to the Dental Clinic have not previously accessed dental care and have a limited understanding of the concept of treatment by appointment. The Dental Clinic will work closely with patients and their other medical care providers to emphasize and reinforce the importance of dental care as a component of primary health care.

The Dental Clinic employs bilingual Spanish speaking staff to ensure clear communication with regard to treatment procedures and treatment outcomes for Spanish speaking patients. In order to facilitate easier communication with Spanish speaking patients, Dr. Kilkelly and Dr. Howell participated in a Conversational Spanish for Medical Professionals continuing education course from January 2014 to May 2014. Interpretation services are offered in the client's preferred language at no cost to the client if their preferred language is not Spanish or English or Spanish-speaking staff is not available. Hard of hearing and deaf interpreter services are offered to hearing-impaired patients and are retained when treating hearing-impaired patients. The Dental Clinic provides oral health education pamphlets in both English and Spanish. Several easy-to-understand oral instruction and information pamphlets using pictures for those of low English literacy have been developed to explain some of the dental services provided. Internet access enables the evaluation and download of patient education materials in a variety of languages for those patients whose first language is not English or Spanish.

Service Linkage, Referral, and Collaboration

Linkage to Primary Medical Care

Dental care is essential medical care, particularly for people with HIV and AIDS. Signs of the progression of HIV disease often manifest in the mouth, and good oral health is integral to good

nutrition and food assimilation. AIDS Services of Austin's (ASA) Jack Sansing Dental Clinic is one of only three dental clinics in the State of Texas aimed at serving the unique oral health care needs of people with HIV and was the second clinic to begin operation. The Dental Clinic began in response to individuals with HIV being turned away from other dental practitioners, and to the barriers to access and unavailability of the Federally Qualified Health Center (FQHC) clinic system for patients that were eligible. (Until late 2011, Medicare and Medicaid did not cover dental care for adults in Texas). Many patients are receiving regular dental care for the first time in their lives. The Dental Clinic's close working relationship with CommUnityCare at David Powell Clinic (DPC) and other medical practitioners specializing in HIV care has resulted in most patients considering dental care as part of their primary medical care.

There is a long history of collaboration between DPC and ASA's Jack Sansing Dental Clinic. Because DPC and the Dental Clinic were conceived to work in partnership and were original recipients of grants that allowed them to work as a unit, both clinics have seen much of the same patient population, and providers in both clinics have always worked together closely. In fact, both agencies continue to operate together as part of a larger core medical care collaborative funded by Ryan White Part C. At present, every new patient at the DPC receives a referral to the Dental Clinic as a part of the baseline intake visit, and any Dental Clinic patients who are not actively engaged in the care of a physician are referred the DPC for medical care. On a regular basis, patients with latent (undetected) medical conditions are referred to the DPC. The mechanism for this is usually in the form of a dentist-to-doctor phone call or encrypted email; however, referral forms are also faxed to the facility. Referrals happen both ways. New lesions or oral manifestations, once detected by a physician at the DPC are referred to the Dental Clinic for diagnosis and treatment. In some instances, a lesion requires both the dentist and physician for successful diagnosis and treatment. Many years of working together have made this process function well.

Dentists and physicians in the community refer patients with oral lesions for diagnosis and treatment. The Dental Clinic is widely recognized by a large portion of the dental and medical community as a center for excellence and specialization in regards to HIV oral medicine. The Dental Clinic founder, an expert in HIV oral pathology, is on call and available to consult in the area of HIV oral pathology including but not limited to seeing the patient at the Dental Clinic. The Dental Clinic is the recipient of national and local awards for its skill and professionalism. Awarding agencies include as the American Dental Association and the Raymond Todd Civic Leadership Forum.

The Dental Clinic is the only oral health care provider in the Central Texas region available specifically for persons with HIV and AIDS so duplication of services is not a major concern. To assure ongoing access to care, the Dental Clinic continues to work collaboratively with other AIDS Service Organizations (ASOs), accepting referrals from agencies offering case management and other services to persons living with HIV disease. Because it is well known to so many in the community (including those in emergency medicine, residency programs, and dentists in private practice), the Clinic is the site where newly infected patients are referred for

oral manifestations or for unmet dental needs. This first point of contact results in referral by Clinic staff to primary medical care and other services.

The Dental Clinic employs a system that ensures every patient (100 percent) who receives scheduled routine dental care is "in care," meaning that they are being seen regularly by a physician. During the initial intake visit (IT1), Clinic staff requires documented certification (found on a Physician's Consultation Form) from the patient's primary medical care provider. This information must be updated every six months. This measure is not meant to provide a barrier to care, but rather to ensure that the Dental Clinic has the patient's pertinent lab values and current medications, in order to provide appropriate care. Because this information is required for patients to have their dental work completed, it serves as an incentive for patients to be compliant with their medical visits. Patients who are not yet in care are not turned away from services; rather, the Dental Patient Navigator works with patients until they can be brought into care and the Physician's Consultation Medical Certification is received. Until the document is produced, patients may still receive palliative care for emergent issues until the situation is resolved.

Dental Clinic Subcontractor Referrals

The Dental Clinic makes referrals for patients needing more complex oral health care provided by dental specialists located in private practices throughout the region, as well as for other services. See *Staffing* section for a list of the Dental Clinic's specialty practice subcontractors. ASA uses subcontractors on a fee-for-service basis to provide needed services that either cannot be performed on site at the Dental Clinic or are in addition to those performed on-site. The Dental Clinic uses two dental laboratories (Seretti Dental and Stern - Empire) for the off-site fabrication of partial and full dentures and crowns. An oral impression of the work required, along with a written order from the Dentist, is sent to the fabricating lab. The returned product is checked against the order for accuracy, as is the subsequent bill, prior to payment.

Referrals are made to three subcontracting oral surgery practices for patients who require surgical extractions under premedication and sedation, those with complicated extractions or impacted teeth, and those who need multiple or whole-mouth extractions that would require multiple clinic visits and an extended period of time to accommodate the patient within the clinic's schedule. A written order from the Dentist for the work required is faxed to the oral surgeon or provided to the patient to make to their appointment. Any changes to the written order are discussed with and approved by the referring Dentist prior to any procedures performed, and changes are noted in the patient's chart. The subsequent bill is checked for accuracy against the written order prior to payment. The bill is firm documentation that the patient did follow through with the treatment referral at the specialist's office. Typically, a letter from the referral accompanies this bill and is included in the patient's chart.

Referrals are made to a subcontracting endodontic practice for some patients requiring specialty root canal treatment and care. A written diagnostic order for the procedure required is provided to the patient to take to their appointment. Any changes to the written order will be discussed with and approved by the referring Dentist prior to any procedure being performed, and are noted

in the patient's chart. The subsequent bill is checked for accuracy against the written order prior to payment and serves as verification that the patient did indeed receive the referred services.

Other Linkages, Collaboration, and Referral

Linkages and Collaborations

For services other than medical or dental, patients of AIDS Services of Austin's (ASA) Jack Sansing Dental Clinic are referred to their Case Manager or to the appropriate service provider. If a patient is not currently case-managed at ASA or another AIDS Services Organization and is need of this service, the Patient Navigator refers them into the medical case management program in the county in which the patient resides, as appropriate. Follow up is accomplished at the patient's next treatment visit when the staff inquires about their previous and upcoming medical appointments and is documented in the patient's chart.

ASA has collaborative agreements, letters of support, and/or Memoranda of Understanding (MOU) in place with several agencies, mostly with respect to specific service category programs. The MOU agreements guide referrals between agencies and allow for smooth transitions of clients for additional services. ASA maintains MOUs with Waterloo Counseling Center, Project Transitions, and the Housing Authority of the City of Austin, Austin Energy, the C.A.R.E. Program of Austin/Travis County Integral CARE, and the Communicable Disease Unit at Austin/Travis County Health and Human Services Department (A/TCHHSD). For MOUs that require annual renewal, ASA contacts the partner agency 30 days prior to expiration of these agreements.

ASA also has long-standing referral relationships with HIV-related social service providers, including the C.A.R.E. Program at Austin/Travis County Integral Care for substance abuse counseling and treatment referral for individuals that are dually diagnosed; Project Transitions for transitional housing and hospice care; South Austin Marketplace for transitional and long-term housing; the Customer Assistance Program (Austin Energy) for utilities payment assistance; Waterloo Counseling Center for mental health counseling; the Wright House Wellness Center for holistic/alternative health services; Salvation Army and the Austin Resource Center for the Homeless for emergency housing; the Social Security Administration for disability benefit applications and appeals; Del Valle Correctional Facility, Travis State Jail, and the University of Texas Medical Branch State Penitentiary for services to inmates upon their release; the Communicable Disease Unit at A/TCHHSD for HIV/ STI/TB screening; and SafePlace for domestic violence assistance.

Eligible clients are also referred to the broad continuum of ASA services: the Capital Area AIDS Legal Project (CAALP) for legal assistance; Medical Nutrition Therapy for nutritional assessment, counseling, and supplements; HOPWA for housing assistance; CLEAR and Healthy Relationships for support for individuals to reduce the risk of HIV transmission and to work on disclosure issues; and the Health Insurance Program for premium, medication copayment and medication deductible financial assistance.

Referral Process and Follow Up

ASA staff assists clients with completing and submitting other agencies' referral forms, communicates with those agencies to clarify client eligibility, and advocates for client service delivery. For those clients who are case managed at ASA, staff ensures that referrals are followed through on in one of the following ways:

- performs follow up at the next client contact by asking the client about the referral and the results;
- accompanies the client to appointments;
- checks the ARIES database to ensure appointment was attended; or,
- calls the agency the client was referred to and confirms client attendance.

All staff document client progress regarding follow-through on referrals in the progress log feature of the Provide Enterprise electronic client database (ASA's internal electronic database). ASA staff complete a referral tracking form that includes date of referral and completion date and keep the form updated in the paper client file. The desired outcome results are linkage to and retention in support services.

Non-medical case managers, medical case managers, and/or the Dental Clinic Patient Navigator work jointly to successfully refer clients to needed support services. Non-medical case managers assist with referrals to support services as well as complex linkages such as disability applications to Social Security, substance abuse/mental health treatment, and using clinical interventions to address client readiness for and resistance to change.

Goals of Collaborative Activities, Integration of Resources, and Projected Results

The goal of collaborative activities is the provision of comprehensive services through the HIV provider community and other social service agencies using linkages and referrals. These activities ensure clients have access to all needed services that are not offered by ASA. In addition, they allow clients to overcome barriers to accessing and remaining in primary medical care and moving toward self-sufficiency in managing their HIV disease.

Integration of resources and services includes the dedication of ASA staff time toward the completion of other agency intake forms, assisting clients with the intake process, accompanying clients to support service appointments, reporting required data, and working with clients on mutual goals in service plans. These mutual goals may be related to support services that client receive from other agencies, such as financial assistance, substance abuse or mental health counseling, housing, etc.

The projected results of collaborative activities, integration of resources, linkages, and referrals are:

- Client achievement of housing stability
- Meeting food intake needs
- Mental health services access and stability
- Independent management of substance use issues
- Financial stability

- Decreased recidivism
- Personal safety and security

Role of Patient Navigator

The goals of the Patient Navigator program at ASA's Jack Sansing Dental Clinic are threefold. The primary goal of this program is to aid those patients identified at being at the greatest risk of not following through with comprehensive treatment in the navigation of the healthcare system with a focus on both the patient's oral and systemic health. Through this work the second goal is focused on increasing the patient retention rate through behavioral changes and increasing the access and follow through of the patients by identifying probable barriers and connecting patients with services that may help remove those barriers. This includes ensuring patients have updated eligibility paperwork so that access to care is not interrupted. As a third goal, the Patient Navigator functions much as many nurses do in medical practices by acting as a liaison between the physicians and the dentists working on the patient's behalf to obtain relevant medical information having the ability to triage emergencies, answering simple patient questions, following up with patients who have had a complicated procedure, obtaining current and accurate medical records to ensure that all Dental Clinic patients are currently in physician care, and transcribing medical information from physicians.

The Dental Clinic Patient Navigator identifies patients in need of medical case management or other social service assistance and refers those patients to ASA's Intake and Eligibility staff team or another appropriate ASO offering case management. Staff track progress made with Navigation patients through the use of the Navigation log. The Patient Navigation Log is a tool for tracking and monitoring patients who have shown to be in need of assistance from the Patient Navigator because of problems with attendance, identified barriers, or are in need to return to care. Some patients already have case managers and some have been referred. This Log assists in tracking different points of interest of the patient, including the last seen, last missed, next visit, last contact date, who (if any) is the case manager. The goal of the log is to successfully pin point the patients, motivate and guide them in the right direction to fulfill their appointment/treatment plan obligations and allow them to successfully graduate from Navigation. All ASA case managers have access to this log and it is updated, at a minimum weekly with upcoming appointment and contact attempted/made, etc.

<u>Client Input and Involvement</u>

Patient input and involvement in oral health care services is an individualized and ongoing relationship that begins with the first visit to the Dental Clinic. The patient and Dental staff relationship focuses on patients' most pervasive dental needs prioritized into a treatment care plan to address those needs. The plan hinges on the provision of quality oral health care by Dental staff. Patient input and involvement starts with each treatment plan established with patients' input and agreement during the second intake appointment (IT2). At this appointment, the Dental staff discusses and reviews all available treatment options with the patient. Staff reviews different options as a dentist/patient team and develops a plan that suits the needs of each patient. The benefits of developing a treatment plan with patient input is the successful prevention of tooth decay through proper dental maintenance at home and from the Dental Clinic

hygiene department. Subsequent to the IT2 visit, should patients' have additional questions or concerns, staff offer another appointed visit to review the different treatment plan options. This level of patient involvement is successful for the majority of Dental Clinic patients.

While it rarely happens, sometimes the patient and dentist cannot agree on a treatment plan. In that case, the Dentist offers the patient another opinion from an alternate staff dentist. Dentists do not discuss their clinical opinions in advance of examining the patient but they do confer after the two individual plans are established. The patient then has two opinions to consider and staff is able to present the findings to the patient. Dental Clinic staff takes great care to inform and educate patients on available options at the Dental Clinic. Should patients disagree with both treatment plan options, patients are free to seek care at a private practice at their own expense. Patients leaving the Dental Clinic to seek care from private practice dentists may return to the Clinic at any time to reestablish themselves as patients; agreeing to develop and follow a new treatment plan with Clinic staff.

Annually, ASA participates in surveying clients who participate in services offered by the agency to gauge their overall satisfaction with services. The 2013 Client Satisfaction Survey was developed and standardized by the Austin TGA HIV Planning Council with input from members of the TGA Clinical Quality Management workgroup. Results of the survey administered to 187 dental patients yielded positive feedback, with 97 percent of patients reporting overall satisfaction with 'Dental Care' services. The Average Rating Analysis (Manor, 2011) of satisfaction with 'Dental Care' based on Likert items with one (1) indicating "Very Dissatisfied" or "Strongly Disagree" and five (5) indicating "Very Satisfied" or "Strongly Agree" rated Dental Care services at 4.8 on the five point Likert Scale. There was no survey completed in 2014. A 2015 survey was completed and ASA ASA is currently waiting for the results to be compiled by the HRAU.

Program supervisors use survey results and direct client/patient feedback taken from comment sections of the Standardized Survey to evaluate the effectiveness of referral systems, barriers to service, and other service delivery components. The dental team plans, as appropriate, for service modification and adjustments, especially actions to remove barriers to care.

Clients who receive services from ASA may provide confidential input at any time, through the agency's suggestion box located in the main facility reception area. All agency clients may register concerns with supervisors and through the comprehensive client grievance process. ASA's main email address serves as another gateway for clients/patients to provide program feedback, voice concerns and/or file a complaint. Authorized agency staff forwards such confidential email communication to the appropriate director and supervisor of the department the client has concerns about. All clients receive a copy of the client grievance policy and procedure upon entry into services. The policy is posted in all agency reception areas or high client traffic areas in English and Spanish. Agency staff will assist clients with the grievance process as requested by the client.

ASA routinely incorporates client feedback and suggestions into program planning activities. In developing the agency's 2011 – 2014 Strategic Plan, ASA used individual interviews and held focus groups with current clients to ensure their active participation in the strategic direction of the agency. ASA's Strategic Plan specifically defines "client satisfaction with programs and services" as a key measure of success in alignment with the agency strategy to "maintain and strengthen existing programs and services through quality improvement." The 2011-2014 Strategic Plan has been extended for one year so that ASA is able to fully analyze the impact of the Affordable Care Act. ASA also conducted a "town hall" type of meeting with clients in 2011 on changes in waiting room policy issues and on changes to Cap Metro's Special Transportation Services in order to ensure their opinions were articulated and their needs advocated for with the City of Austin.

Cultural Competency

Service activities will be delivered so that cultural and language differences do not constitute a barrier to services in full compliance with the National Standards on Culturally and Linguistically Appropriate Services (CLAS) described at: http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15.

AIDS Services of Austin (ASA) is in compliance with all 15 CLAS Standards.

Table 6

CLAS Standards	ASA Compliance
91. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.	▪ Staff members are proficient in Spanish, culturally reflective of the Hispanic clientele and available to interpret daily ▪ Staff members are from diverse backgrounds including African-Americans and individuals that are immigrants to the USA. ▪ One staff member proficient in American Sign Language and others with basic skills ▪ Interpretation services in any language are offered to clients free of charge; interpreters culturally reflect clients ▪ Staff assigned to clients are reflective of clients' cultural background, as feasible ▪ Client materials are written at a fifth to eighth grade literacy level and in Spanish at third to fifth grade level ▪ Client materials are provided in Spanish and English ▪ A professional volunteer translates materials from English to Spanish ▪ Organization includes "diversity" as one of its core values
92. Advance and sustain organizational governance and leadership that	▪ A Cultural Appropriateness Action Team with staff from varied levels and departments is tasked with ensuring CLAS and health equity are promoted

CLAS Standards	ASA Compliance
promotes CLAS and health equity through policy, practices, and allocated resources.	▪ The agency maintains a tracking mechanism to ensure CLAS compliance ▪ Agency policies are cognitive of cultural appropriateness and those that are applicable to clients are provided in English and Spanish at an appropriate literacy level ▪ Resources are allocated based on community need and assessment ensuring targeting of demographics most affected by the epidemic ▪ 2011-2015 board approved organizational strategic plan includes goals, objectives, and action steps prioritizing staff cultural awareness and competency trainings ▪ Executive Director serves on the Central Health *Health Equity Council* for HIV issues
93. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.	▪ Compliance with Equal Employment Opportunity Commission (EEOC) guidelines since inception ▪ Compliance with The Americans with Disabilities Act (ADA) since inception ▪ EEOC and ADA language reflected on all job postings ▪ Staff are fluent in Spanish, culturally reflective of the Hispanic clientele, and available to interpret daily ▪ Staff members are from diverse backgrounds including African-Americans, Latino, and individuals that are immigrants to the USA. Organizational staffing is reflective of the demographics of the HIV epidemic in the Austin TGA ▪ One staff member proficient in American Sign Language and others with basic skills ▪ Committed to promoting from within for job openings ▪ Evaluation of the potential of current staff for leadership development in order to promote direct service staff ▪ Structured Action Teams provide leadership development opportunities for all staff members ▪ Candidates for positions where bi-lingual (Spanish) skills are preferred are offered a salary premium for demonstrating appropriate proficiency in the language ▪ Organization recruits diverse candidates by networking with higher education institutions of color and advertising and conducting outreach into appropriate publications in communities of color ▪ 2011-2015 board approved organizational strategic plan includes goals, objectives, and action steps prioritizing recruiting, hiring, and training diverse staff and recruiting board members from communities of color

CLAS Standards	ASA Compliance
	▪ Board officers are demographically and culturally diverse ▪ Agency participation in multicultural career expos for staff recruitment
94. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.	▪ The agency's Cultural Appropriateness Action Team and Professional Development Action Team research and implement ongoing training ▪ Agency support of language skills development when resources are available ▪ Executive Director serves on the Central Health *Health Equity Council* for HIV issues
95. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.	▪ Staff are proficient in Spanish, culturally reflective of the Hispanic clientele, and available to interpret daily ▪ Staff are from diverse backgrounds including African-Americans, Latino, and individuals that are foreign-born ▪ One staff member proficient in American Sign Language and others with basic skills ▪ Interpretation services in any language are offered to clients free of charge; interpreters culturally reflect clients ▪ Client materials are written at a fifth to eighth grade literacy level and in Spanish at a third to fifth grade level ▪ Client materials are provided in Spanish and English ▪ A professional volunteer translates client materials from English to Spanish ▪ The agency uses an independently certified system to evaluate the language proficiency of staff ▪ Organization's central voice mail and Dental Clinic voice mail systems are recorded in Spanish ▪ Key program staff have recorded voicemails in Spanish
96. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.	▪ Interpretation policy offering services free of charge posted in all locations ▪ Reception and Intake and Eligibility staff trained to notify clients of their right to receive language assistance services free of charge ▪ Front desk and key staff voicemail messages are recorded in English and Spanish ▪ Interpretation services in any language are offered to clients free of charge; interpreters culturally reflect clients ▪ Client materials are provided in Spanish and English ▪ Reception staff have access to language cards to identify need for interpretation services
97. Ensure the competence of individuals providing language assistance,	▪ The agency uses an independently certified system to evaluate the language proficiency of staff ▪ Written policy offers interpretation at no cost to the client

CLAS Standards	ASA Compliance
recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.	in order to prevent the use of family and friends as interpreters ▪ Staff is trained to inform clients of their right to interpretation services at no cost and that family and friends are not a preferred source for interpretation in order to protect client confidentiality ▪ The agency hires professional, certified trainers to assist in interpretation upon request
98. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.	▪ Client materials are provided in Spanish and English ▪ Client materials are written at a fifth to eighth grade literacy level and in Spanish at a third to fifth grade level ▪ Key client information/policies and grievance information is posted in English and Spanish in common areas and available in hard copy from reception desks ▪ Quality Management Guidance Team reviews and updates materials to increase understandability
99. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.	▪ ASA's 2011 – 2015 Strategic Plan identifies compliance with CLAS Standards as a priority: o "Strategy #3: Ensure culturally appropriate programs and services ▪ Agency programs and services meet Culturally and Linguistically Appropriate Services (CLAS) standards ▪ Collaborative partners recognize ASA for delivery of programs and services to reduce stigma and for innovative and collaborative relationships" o Strategic plan action step is to implement an Organizational Cultural Appropriateness Committee representative of diversity of staff and management to further formalize cultural appropriateness trainings and action steps
100. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.	▪ Self-assessment of CLAS-related activities conducted in 2007; results continue to be used to improve services ▪ Cultural Appropriateness Action Team to survey annually and report to staff and board of directors of outcomes from strategic planning goals/objectives related to cultural appropriateness work
101. Collect and maintain accurate and reliable demographic data to	▪ Collection of data and documentation on each consumer's race, ethnicity, disabilities, spoken and written language, and literacy level; information entered into client paper file,

CLAS Standards	ASA Compliance
monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.	Provide Enterprise® internal electronic database, and ARIES; information updated periodically ▪ Use of the Austin Transitional Grant Area HIV Planning Council's periodic consumer needs assessment ▪ Use of the Brazos Valley Council of Government's periodic consumer needs assessment ▪ Provision of HIV testing data to the Texas Department of State Health Services, (DSHS) and the Centers for Disease Control and Prevention, (CDC)
102. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.	▪ Collection of data and documentation on each consumer's race, ethnicity, disabilities, spoken and written language, and literacy level; information entered into client paper file, Provide Enterprise® internal electronic database, and ARIES; information updated periodically ▪ Annual review and assessment of HIV epidemiology profile of epidemic as prepared by Texas Department of State Health Services (TDSHS) and the Austin/Travis County Health and Human Services Department ▪ Use of the Austin Transitional Grant Area HIV Planning Council's and Brazos Valley Council of Government's periodic consumer needs assessment ▪ Annual report to staff and board of directors on Austin TGA HIV epidemic in comparison to organization's client demographic profile, staff demographics, and board demographics
103. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.	▪ Collection and updating of data and documentation on each consumer's race, ethnicity, disabilities, spoken and written language, and literacy level; information entered into client paper file, Provide Enterprise® client electronic database, and ARIES. ▪ Provision of HIV testing data results are reported to the DSHS and CDC ▪ Involvement in community events targeted to people of color to build collaborative partnerships in a participatory environment ▪ Staff shares lessons learned at above events with management and leadership staff to expand collective knowledge of local cultural practices and beliefs ▪ Organization is a member of the advisory committee to the Latino Commission on AIDS to develop training institutes on providing culturally appropriate HIV services to the Latino community in 2012 ▪ Executive Director serves on the Central Health *Health*

CLAS Standards	ASA Compliance
	Equity Council for HIV issues
104. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.	▪ Client materials are provided in Spanish and English ▪ Client materials are written at a fifth to eighth grade literacy level and in Spanish at a third to fifth grade level ▪ Client grievance procedures are posted in English and Spanish in common areas throughout the organization ▪ Organization has a formal grievance procedure in place that is reviewed annually by staff
105. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.	▪ Strategic Plan dissemination to donors and posted on website ▪ Community Impact Report disseminated to donors, posted to website, and available in hard copy to public ▪ Responsiveness and pursuit of opportunities to participate in ethnic media

Quality Management

Use of Output and Outcome Data

Using monthly data, AIDS Services of Austin (ASA) tracks progress on the total number of unduplicated clients served, units of service delivered, and achievement of outcome goals through the reporting feature of the Provide Enterprise® electronic client database. On a monthly and quarterly basis, supervisors analyze the data to determine if outputs and outcomes, respectively, are within a 10 percent variance of the elapsed period of the grant cycle. If a variance occurs, supervisors determine reasons that program goals are above or below desired performance and develop plans to address the situation including staff training, supervision, and monitoring staff adherence to the standards of care for the service category. In Oral Health Care, variances are often due to the timing of treatment plans and the grant reporting cycle. Supervisors also note trends in performance measures with emphasis on clients who do not meet outcome goals and develop appropriate quality management activities or document the reasons for such exceptions. Provide Enterprise® reports give aggregate data at the agency level that documents client trends in service utilization for use in planning for service delivery.

Supervisors will use reports from the ARIES client database to validate data on performance measures such as number of unduplicated clients served and units of service provided. With the client's signed permission to share client information in ARIES, supervisors will use ARIES reports to facilitate getting complete data on services accessed by clients, to document successful linkages to primary medical care and other HIV provider services, and to compare, if needed, client service utilization data in order to avoid duplication of services. ARIES will also provide aggregate data at the community level that documents client trends in service utilization for use in planning for service delivery.

Supervisors will use the service-specific client satisfaction survey to obtain data using client input on satisfaction with services provided. Supervisors review survey results including qualitative data at program area, Leadership Team and Quality Management Guidance Team meetings. With input from these teams, supervisors use suggestions from the survey to identify problems and/or concerns and implement quality improvement activities including service delivery changes when possible.

Assurance of Compliance with Austin TGA Standards of Care

Dental Clinic staff has been trained on the following Standards of Care in the Austin TGA continuum of care for Oral Health:

Standard 1: Patients receive routine oral assessment and treatment. New patients are given a panoramic x-ray and seated in the operatory, where additional x-rays are taken. The Dentist reviews the x-rays; closely interviews patients with regard to their medical and dental history; and conducts a comprehensive head, neck, and oral examination. Findings are documented in patients' charts. Current patients receive written reminder cards through the mail about scheduling an annual exam. Patients who present at their appointments with oral pain receive an examination to locate the cause, and findings are charted. At the intake appointment, patients are given HIPAA and privacy and patient rights policies and required to complete medical/dental history forms, various consents (for treatment, contact, ARIES), and releases (lab results and medications). At subsequent visits, patients are asked to renew expired permissions, update contact information, and report on changes in health status or medications which may impact provision of dental care.

In compliance with this Standard of Care, ASA strives to reach 80 percent of clients receiving annual preventative care, and 60 percent receiving semi-annual preventative care. Of these patients, 95 percent will have a medical history taken during their initial appointment and update their medical histories at each complete and periodic exam. All activities will be consistent with JADA and the NY AIDS Institute of Oral Health Guidelines.

Standard 2: Case management support is available to patients who require assistance in scheduling, arranging for travel, or otherwise needing assistance to attend dental appointments. Patients who are case managed at ASA have the support of their medical or psychosocial case manager in scheduling, arranging transportation, or any other assistance required to successfully attend dental appointments. All patients who miss an appointment receive a telephone call from the Receptionist or Patient Navigator to determine barriers to care and to reschedule. If patients reveal, or if it becomes apparent to the Receptionist or Patient Navigator, that they have barriers to accessing dental services (transportation, fear of keeping the appointment, altered mental state, etc.), staff will refer patients to the appropriate ASO offering medical or psychosocial case management. Even if patients do not ask for assistance or reveal barriers, if a pattern of missed appointments develops, this also triggers a referral to the case

management system. Dental Clinic staff enters the contact and result into the patient's file and Provide®.

Standard 3: Patients receive education of maintenance of good oral health as part of the routine visit. ASA is currently in compliance with this standard. The Dental Clinic is one of only three HIV dental clinics in the state and began in response to individuals with HIV being turned away from their regular practitioners. Many patients are receiving regular dental care for the first time in their lives. The Dental Clinic maintains a close working relationship with CommunityCare at David Powell Clinic and other medical practitioners. This allows medical providers to help patients understand the importance of oral health maintenance, explain that signs of the progression of HIV disease often manifest in the mouth, and that good oral health is integral to good nutrition and food assimilation. Information is standard with JADA and the NY AIDS Institute of Oral Health Guidelines. The result for patients is better attention to the full range of medical health. During visits, all non-urgent patients receive education from Clinic staff about the importance of routine visits to maintain and manage overall health. Preliminary results of ASA's most recent annual agency satisfaction survey distributed in 2013 revealed that the Dental Clinic achieved high satisfaction rating. Of the 187 respondents to the oral health component of the survey, 97 percent were satisfied or very satisfied with the overall quality of dental services received. Using the bipolar scaling method of measuring either a positive or negative response to polling, where one represents strong disagreement and five represents strong agreement, the average sum of the responses was 4.8 on average using the Likert scale method.

Standard 4: Patients receive intervention when indicated: ASA is currently in compliance with this standard. New patients are given a panoramic x-ray and seated in the operatory, where additional x-rays are taken. The doctor reviews the x-rays; closely interviews patients with regard to their medical and dental history; and conducts a comprehensive head, neck, and oral examination. Findings are documented in patients' charts. Existing patients are given x-rays, as ordered by the doctor, and receive an oral exam. Findings are documented in the patient's chart. Prior to any invasive or surgical procedures, the dentist evaluates the patient's risk of bleeding, infection, or other complication, in accordance with JADA and the NY AIDS Institute of Oral Health Guidelines.

Standard 5: Treatment of oral opportunistic infection is coordinated with the patient's medical provider. ASA is currently in compliance with this standard. Because it is well known to so many in the community (including those in emergency medicine, residency programs, and dentists in private practice), the Clinic is where newly infected patients are referred for oral manifestations or for unmet dental needs. This first point of contact results in referral by Clinic staff to primary medical care and other services. The Clinic employs a system that ensures every patient who receives scheduled routine dental care is "in care," meaning that they are being seen regularly by a physician. During the initial intake visit, Clinic staff requires documented certification (found on a Physician's Consultation Form) from the patient's primary medical care provider. This information must be updated annually. This measure is not meant to provide a barrier to care, but rather to ensure that the Clinic has the patient's pertinent lab values and

current medications needed to provide appropriate care. Because this information is required for patients to have their dental work completed, it serves as an incentive for patients to be compliant with their medical visits. Patients who are not in care are not turned away; rather, staff will work with patients until they can be brought into care and the Physician's Consultation Certification is received. If this document cannot be produced, patients may only receive care for emergent issues.

Quality Management Plan

Quality Management Guidance Team

The overall responsibility and leadership for ASA's Quality Management (QM) program lies with Chief Programs Officer, who authorizes the Quality Management Guidance Team (QMGT) to plan, assess, measure, and implement performance improvements throughout the entire agency, while providing the necessary resources and support to fulfill these functions.

The membership of the QMGT reflects the diverse service areas within AIDS Services of Austin (ASA). The agency's quality team is comprised of the Chief Programs Officer, Board of Directors members, and other members of ASA staff, ranging from upper management to direct service staff. Other ASA staff members, such as Program Supervisors and Coordinators, Case Managers, and Prevention Specialists are involved, as appropriately indicated. The QMGT meets every other month. Additional meetings may be called, as needed. Minutes of meetings are distributed directly to each member of the committee and to all necessary internal and external stakeholders. A written summary is routinely made available to staff.

The Quality Management Plan

The Quality Management Plan seeks to improve service performance through collecting and evaluating data, identifying service problems based on the collected data, using quality improvement processes to address service delivery issues, and following up to ensure improvements will be sustained. The agency plan is designed annually with target goals and service specific quality improvement activities. It calls for a review of service performance measures, an analysis of this data, and recommendations for service improvements. The plan indicates that the team will oversee an annual update and revision of program policies and procedures. At the end of each year, the plan is evaluated to determine the achievement of goals and the service specific activities and to make recommendations for further follow-up.

The following sections describe other components in the Quality Management Plan:

Activities to Collect Data

The Chief Programs Officer and the Director of Dental Services will collect data on the program's performance in achieving service goals and meeting standards of care through results from the following sources: outcome and output measures, the agency client satisfaction survey, clinical chart audits, client/staff feedback, and client grievances.

Supervisors review performance measures quarterly and report measures not meeting contract objectives to the Quality Management Guidance Team, along with suggestions on planned action steps.

Client satisfaction surveys are an important way to identify quality issues. The agency distributes the standardized survey, after approval by the HIV Resource Administration Unit, City of Austin Health and Human Services Department, at the Food Bank and Dental Clinic sites to collect data on all Ryan White Service Categories offered at ASA. The survey data is tabulated by the Data Manager-System Support Technician at the HIV Resource Administration Unit, AHHSD.

Specific to Oral Health Care, the Lead Dentist will review a minimum of 120 patient files annually, (divided into 12 monthly audits), to evaluate pertinent clinical activities, completeness of treatment note documentation and compliance with the five standards of care for Oral Health Care services. The Lead Dentist may choose to conduct additional chart audits on patient's files where specific clinic providers, (dentists/dental hygienists), were identified with deficiencies during the initial chart audit for the month. Any deficiencies in service delivery or lack of compliance with the standards of care will require a plan of correction along with an implementation timeline. The Lead Dentist will work with clinical staff to develop plans of correction for improvement based on the results of file audits. Staff will implement changes immediately upon notification of necessary improvements. The Lead Dentist will meet with clinic staff to ensure continuous improvements regularly. The Director of Dental Services will oversee and assist with chart reviews.

Client input from registered grievances is documented by program supervisors and reviewed at department staff meetings. Supervisors adhere to the agency's policy on client/patient grievances, which includes review by the Executive Director and/or the Board of Directors, if necessary.

Evaluation of Performance and Assuring Delivery of Quality Services
As data and input are received and problems are identified, the QMGT evaluate concerns and suggestions in order to assure the delivery of quality services.

The QMGT analyzes the output/outcome data and makes recommendations for improvement to program supervisors. When quality improvement activities around performance measures are designed and completed, the results are then sent to the team and reported in the annual evaluation of the Quality Management Plan.

Supervisors will evaluate survey results to identify trends for improvements and advocate for unmet client need. To guide decisions about quality improvement activities, survey results are discussed at the program level in department/program meetings and at QMGT meetings. Board of Directors members that participate on the QMGT report to the full board, as appropriate.

Program supervisors utilize grievance input obtained from clients and managers at the different grievance levels to make appropriate service changes, when feasible.

Suggested actions taken based on this data could include staff development training in an identified area, development of organization tracking tools, identification of a different site for service delivery, additional interventions to reduce barriers, or design of client/patient forms to better capture data and service performance measures.

Identification of Quality Improvement Activities
At the beginning of the year, supervisors and the QMGT identify specific service quality improvement activities based on staff and client feedback and on data already mentioned. Activities are written using SMART objectives in that they are specific, measureable, attainable, relevant and time-bound.

For Oral Health Care, the Annual Quality Assurance Chart Audit Plan the primary source of identification for clinical quality improvement activities within Oral Health Care services. In order to evaluate data on a timelier basis, the audits will be divided into 12 monthly audits totaling 10 patient records each review period. A random sample will be drawn reflecting each clinical provider (dentist or hygienist) proportionate to his/her hourly contribution to the total clinical full time equivalency rate, using the Provide Enterprise® electronic client database. Each individual record will be reviewed for activity/documentation by any of the providers during the three months preceding the date of the audit.

Annually, the Director of Dental Services and the Lead Dentist determine clinical indicators, which measure effective oral health treatment and care for patients. The clinical indicators of quality care and service provision currently used are: the review and documentation of patient treatment plans; evidence of recorded patient vital signs; hard and soft tissue exams; initial and annual periodontal charting and diagnosis; patient progress with oral hygiene (including provision of oral hygiene instruction); and, appropriate, dated documentation of treatment services in the progress notes and treatment plan. ASA's Director of Dental Services and Lead Dentist will review and update these as appropriate in 2016.

Addressing Identified Problems
Once a problem or an area that needs further assessment is identified, the team will use, when appropriate, the Plan-Do-Study-Act cycle (PDSA), a four-step model for carrying out change. This process will be used in identified quality improvement activities as detailed in the annual Quality Management Plan. The components are as follows:

1. Plan by recognizing an opportunity and planning a change.
2. Do by testing the change and carrying out a small-scale study.
3. Study by reviewing the test, analyzing the results/data and identifying what has been learned.
4. Act by taking action based on what you learned as a result of data analysis in the study step.

If the change does not work, the cycle will be repeated again with a different plan.

To address patient chart audit results, the Lead Dentist and Director of Dental Services will implement a plan of correction when deficiencies in delivering services or lack of compliance to standards/clinical indicators that have been identified.

Follow-up

The Director of Dental Services and the Lead Dentist will follow up to ensure the effectiveness of improvement activities and the maintenance of improvement results. On identified quality improvement activities, the Director of Dental Services and the Lead Dentist follow up on a quarterly basis to ensure that these activities have been effective in resolving the problem, that no new problems have developed, and that there is sustained improvement in identified areas.

For file review results, supervisors work with staff to develop plans of correction within 15 working days of the file review. Staff has ten working days to implement corrections. At the next monthly file review supervisors monitor the maintenance of the previous month's improvements to ensure problems do not reoccur.

Monitoring and standardized tools

Tools used in monitoring and standardization include the file/chart audit review tool and Provide Enterprise® reports with features to track reporting of performance measures, completion of assessments, service plans, as well as a feature to describe content of progress notes for easy tracking. The annual client satisfaction survey is a standardized tool that the Ryan White Quality Management workgroup evaluates and standardizes across HIV service providers.

<u>Compliance with Ryan White Part A Program Monitoring Standards</u>

i. Maintain a dental chart for each client that is signed by the licensed provider and includes a treatment plan, services provided, and any referrals made

During the initial intake appointment (IT1) the patient fills out all of the necessary paperwork. This paperwork becomes a permanent part of the patient's chart. During the second intake appointment (IT2), x-rays are taken, a comprehensive exam is completed, and a treatment plan is developed. After each treatment appointment, the provider makes a note in the patient chart, signs that note, completes treatment on the treatment plan, and uses the Dental Clinic diagnostic code form called the "superbill" to make the Receptionist aware of the treatment that was completed during that appointment. Entries are made to both the scheduling system and Provide Enterprise® (ASA's internal electronic database) using the superbill form.

If the patient is in need of specialty care by way of referral, the Dentist fills out the necessary paperwork and the receptionist faxes that paperwork to the subcontractor/dental specialist indicated. Referrals are tracked primarily through Provide Enterprise® as well as the paper trail that remains in the patient chart. After the patient attends the appointment with the dental

specialist, the Dental Clinic receives a bill that serves as an indicator that the patient did, in fact, follow through with the treatment for which they were referred.

Annually, the Lead Dentist audits 120 unduplicated patient records from patients receiving treatment through the Dental Clinic. In order to evaluate data on a more timely/ongoing basis, the audits are divided into 12 monthly audits totaling 10 patient records per review. A random sample is drawn reflecting each clinical provider (dentist or hygienist) proportionate to his/her hourly contribution to total clinical FTEs. This review method captures patients at different points in their treatment plan goals. Using clinical indicators developed annually by the Director of Dental Services and Lead Dentist, quality assurance issues and trends are documented and then findings and plans of correction are reviewed with the Clinic staff. Retraining or additional training is identified and conducted with staff as appropriate. The chart audits aid clinicians with several areas of quality control and ensure continuous quality dental services are provided. Quality Management Clinical Indicators, the chart audit review tool and related procedures/processes are evaluated continuously by the Director of Dental Services, Lead Dentist, and the Chief Programs Officer. Processes may be modified including forms, frequency of chart reviews, the review period, and clinical indicators. Additional charts may also be selected for review as indicated by this ongoing program evaluation.

ii. Maintain, and provide to grantee on request, copies of professional licensure and certification

Proof of professional licensure of all clinicians is maintained in two locations: at ASA's main office in the secure personnel files of each employee and at the Dental Clinic facility. Original licenses and certifications are posted in plain view on a bulletin board at the Clinic, as required by licensing and credentialing authorities. Clinical providers are charged with providing proof of current licensure and registration annually, or as certifications are renewed, and forwarding such documentation to ASA's Human Resources (HR) department. State licensing authorities such as the Texas State Board of Dental Examiners (TSBDE) and the Drug Enforcement Agency (DEA) provide online database access to check and print current licensure and certifications. Clinical providers may provide a copy of their most recent license/certification or access one of the databases and forward a copy of the database results to HR.

Work Statement

Service Category Name

Outreach Services: MAI

Client Eligibility

AIDS Services of Austin's (ASA) Outreach Services program will serve African-American and Hispanic individuals who did not previously know their HIV status or who know their status but are not or have not been in medical care (out of care). HRSA defines an individual as "out-of-care" as not receiving one of the three components of HIV primary medical care during the previous 12 months.

To be eligible for the services, clients must be HIV positive, a resident of the five county area in the Austin Transitional Grant Area (Travis, Williamson, Bastrop, Hayes, Caldwell), and willing to work on linkage to HIV primary medical care.

Outreach staff determines eligibility by securing verification of HIV status and residency. Staff will secure proof of identity, income, and insurance status as required intake documents.

xxxiv. **Documentation of HIV Status:** Staff obtain verification of HIV status through:
- a signed statement from the medical provider;
- a positive Western Blot laboratory result with the name of the client;
- HIV detectable viral load lab results;
- a printed document from the ARIES database indicating verification of HIV status by another provider; or,
- a hospital discharge summary or medical records from previous provider(s).

For clients unaware of their HIV status, Outreach staff will refer them to testing sites to document their HIV status. For clients aware of their status but lacking documentation, Outreach staff will refer them to CommUnity Care at David Powell Clinic for HIV lab work at clinic intake appointments to be used as proof of HIV status, and/or secure HIV test and lab results, previous hospital records, or incarceration discharge medical documents. Staff document out-of-care status on the eligibility screening form and verify length of time clients are out of care through the medical records previously mentioned.

i. **Residency Verification:** In order to establish residency, clients can provide unexpired documents such as a Texas driver's license, Texas State or Tribal identification cards, Social Security award letter, rental/mortgage agreement, utility bill, or similar forms accepted by the Ryan White Part A Austin TGA.

Documentation of HIV status must be presented within 30 days, and residency documentation must be presented within 60 days. Clients may be granted conditional eligibility if they present with an urgent need and lack the necessary eligibility documentation. ASA will make reasonable efforts to assist clients in obtaining the necessary documentation.

i. **Proof of Identity:** Proof of identity includes: Texas driver's license, Texas State identification card, a passport, Military or Student identification card, Social Security card, birth certificate or other official document as listed on the Austin TGA Ryan White Client Eligibility Form

xxxv. **Income Verification:** Staff use the MAGI or Mock MAGI form for client income verification. Clients that have filed a tax return in the previous year complete the MAGI form and submit their tax transcript as income verification. Clients that did not submit a tax return or have had a change in income complete a Mock MAGI form and submit an IRS proof of non-filing and income verification document. Income verification documents include Social Security Award letter, Veterans/Public Assistance or Worker's Compensation benefits statements, wage payment stubs, signed zero income verification letter or other document listed in the Austin TGA Ryan White Part A Client Eligibility Form. There are some populations that are excluded from having to obtain tax transcripts or IRS proof of non-filing, these include: homeless, recently released from incarceration (3 months), undocumented, emancipated minors, and SSI and/or SSDI recipients.

xxxvi. **Health Insurance Coverage:** Cards verifying coverage by private medical insurance, Medicare, Medicaid, Veteran's Health Benefits, and Indian Health services will be accepted. Signed no insurance attestation statements will also be accepted. Should a client receive City of Austin Medical Assistance Program (MAP), a copy of the card will be made and a attestation of no insurance will be signed.

Eligibility and Intake Staff will use the Austin TGA Ryan White Part A Client Eligibility Form to reassess clients in the program every six months for determination of continued eligibility. At that time, client residency, income, and health insurance will be updated and/or new documentation obtained as indicated. Clients presenting with a change to income, residency or health insurance status within the six month review period will complete the Change in Circumstances: Eligibility Verification Addendum form. All required eligibility and intake documents, as well as periodic updates, are stored in the client's paper file and documented electronically in the agency's electronic client database, Provide Enterprise®. Client identifying information is also entered into the ARIES client database. Eligibility and Intake staff completes a form verifying eligibility documents were collected, and an administrative assistant enters this data into ARIES.

Target Population

AIDS Services of Austin's (ASA) Outreach Services: MAI program targets all at-risk African-Americans and Hispanics. The program focuses on men who have sex with men (MSM) and incarcerated individuals released within the past three years. HRSA defines individuals as being "out-of-care" if they are not receiving one of the three components of HIV primary medical care during the previous 12 months: viral load testing, CD4 count, or provision of anti-retroviral therapy.

In the 2015-2016 grant period, 84 clients were served through the Outreach program. ASA has been successful in reaching these populations with the Outreach Services: MAI program since the transition of Ryan White funding to MAI and Non-MAI.

Table 1

	ASA Outreach Services
Community	
MSM	62%
Heterosexual Males	38%
Race/Ethnicity	
White	38%
Black	30%
Hispanic	31%
Other	1%

Risk Factors	
History of Incarceration	50%
History of Substance Use	55%
Homelessness	13%

ASA client geographic concentration aligns with areas of high prevalence of HIV/AIDS in the Austin TGA. The following are the most common zip codes for clients in ASA's case management programs (Medical Case Management, Case Management Non-Medical Tier 1, and Case Management Non-Medical Tier 2). As many clients for case management programs enter services through the Outreach program, these zip codes are representative of clients that are served through Outreach. In addition, many clients enter the Outreach program from incarceration facilities and therefore do not have a permanent residence to report at the time they begin services. ASA's ten most common zip codes for case management clients are all located in Travis County.

Table 2

ASA Top 10 Client Zip Codes	Prevalence Range of HIV/AIDS*
78752	314-674/100,000
78741	675-1,199/100,000
78723	314-674/100,000
78753	675-1,199/100,000
78758	314-674/100,000
78744	675-1,199/100,000
78702	675-1,199/100,000
78704	115-313/100,000
78721	115-313/100,000
78724	314-674/100,000

While ASA will provide outreach to all at-risk African-American and Hispanic populations, the agency specifically targets these populations: 1) men who have sex with men (MSM) and 2) incarcerated individuals released within the past three years. Below, ASA further describes each target population:

- ***Men who Have Sex with Men (MSM)***: The target population is African-American and Hispanic MSM, focusing on, but not limited to, ages 18 to 56. The risk for the majority of AIDS cases reported annually in the Austin TGA is male-to-male sexual contact and this risk has been steadily increasing in the TGA. One proposed reason for this is the increase in risky sexual activities with anonymous or pseudo anonymous partners met over the internet. In 2009-2010, 68.4 percent of all new AIDS cases in the TGA were among MSM.[27] Among men of color living with HIV, MSM was the most common risk factor for African Americans

[27] Texas Department of State Health Services, 2011

(67.8 percent) and Hispanics (85.7 percent).[28]

In addition to male sex with men, 11 percent of MSM of color report heterosexual contact, six percent report sharing needles, and five percent report commercial sex work as their transmission modes. MSM of color most frequently received their diagnosis at a hospital or ER when presenting for other medical issues, followed by testing at a clinic (24 percent), a physical examination or doctor's visit (11 percent), or in jail/prison (8 percent).[29] Six percent of MSM of color have never received HIV medical care.[30]

- ***Incarcerated Individuals Released Within the Past Three Years:*** As the incarcerated and recently released from incarceration are populations disproportionately affected by HIV and AIDS, ASA will target African-American and Hispanic males and females who are recently released from incarceration focusing on, but not limited to, ages 20 to 56. Women represent 22 percent of this population.[31] Thirty-two (32) percent of this population is African-American and 24 percent is Hispanic.[32] This population is more likely to have a transmission mode of injecting drug use (IDU) than the general HIV-infected population in the Austin TGA. About 36 percent of individuals recently released from incarceration report IDU as a transmission mode.[33] Most (30 percent) recently released individuals learned of their HIV status when they went to a hospital or ER for some other medical issue, while 26 percent learned their HIV status in jail or prison.[34]

Austin Transitional Grant Area (TGA) data suggest that 84 percent of clients have medical co-morbidities, while others report social and health-related co-factors that complicate medical and other service delivery for HIV.[35] Co-morbidities and conditions for this population include Sexually Transmitted Infections (STIs), substance abuse, mental health issues, commercial sex work, poverty, homelessness, domestic violence, Hepatitis B and C, and tuberculosis (TB). Among those served by ASA's MAI Outreach services in 2014-15, 55 percent reported a history of substance abuse, 20 percent reported homelessness, and 50 percent reported recent incarceration. ASA staff estimate that about 30 percent of past outreach clients are co-infected with Hepatitis C, and 58 percent have mental health issues.

Service Category Activities

AIDS Services of Austin (ASA) has been implementing an Outreach Services program since 2003. ASA has been offering services under the Minority AIDS Initiative (MAI) since 2007. Given ASA's history of providing these programs in the Austin TGA, necessary mechanisms

[28] Texas eHARS, 2011
[29] Ibid, p. IV-34
[30] Ibid, p. IV-35
[31] Ibid, p. IV-37
[32] Ibid, p. IV-37
[33] Ibid, p. IV-37
[34] Ibid, p. IV-38
[35] ARIES database, provided by the City of Austin (Addendum 5 to Ryan White Part A RFA 2012-13)

for implementation are already in place. Long-standing mechanisms include:

- A Board of Directors and strong organizational governance structure
- An experienced leadership team
- Trained and experienced staff (see *Staffing section*)
- A physical location near public transportation, within high HIV incidence zip codes, and well-known in the HIV field
- A programmatic structure offering a comprehensive continuum of care including HIV Prevention, Outreach Services, Case Management (medical and non-medical), Food Bank, Medical Nutrition Therapy, Oral Health Care, Health Insurance Assistance, special programs for women living with HIV and AIDS, and legal services
- Strong community partnerships providing access to services not offered at ASA

Ryan White Part A Outreach activities are meant to link HIV positive African-American and Hispanic individuals (persons unaware of their HIV status, are out of medical care, or have not accessed medical care before) into medical care and services. These activities are transitional in nature and facilitate an HIV positive person's entry to the continuum of HIV care in the Austin TGA. Outreach activities provided through Ryan White Part A funds include:

i. ***Identification of (case finding) MSM and Pre-Release and Recently Released from Incarceration (released in the last three years)***

Outreach staff target the African-American and Hispanic individuals in the population identified by frequently conducting outreach or deploying outreach staff to sites outlined below. Case finding outreach sites/locations, frequency, target populations, and targeted zip codes include:

Austin Recovery 4201 S Congress Ave #202. 78745 Bi-monthly.
Austin Transitional Facility. 3154 E Hwy 71. Del Valle, TX 787617. Weekly.
Center on Recovery; Resource Fair. 3420 Executive Center Drive, Suite G100. 78331. Monthly.

Table 3

Outreach Sites/Locations	Frequency	Target Populations
Brackenridge Hospital, Seton Family of Hospitals, 78701	Weekly*	African-American and Hispanic men and women; African-American and Hispanic individuals recently released from incarceration, African-American and Hispanic MSM
St. David's Medical Center, 78705 St. David's North Medical Center, 78758 St. David's South Medical Center, 78741	Weekly*	African-American and Hispanic men and women; African-American and Hispanic individuals recently released from incarceration, African-American and Hispanic MSM
Seton Medical Center Austin, 78705	Weekly*	African-American and Hispanic men and women; African-American and Hispanic individuals recently released from incarceration, African-American and Hispanic MSM
Austin Resource Center for the Homeless (ARCH): 78701	Monthly*	African American, and Hispanic men and women; homeless; recently incarcerated; MSM

Salvation Army: 78701	Monthly*	African American, and Hispanic men and women; homeless; recently incarcerated; MSM	
Angel House Community Kitchen 78702	Monthly	African-American, Hispanic homeless men and women; recently incarcerated; MSM	
Texas Department of Criminal Justice Resource Fair, Travis State Jail, 78724	Monthly	African-American and Hispanic individuals recently released from incarceration; African American and Hispanic MSMs	
Del Valle Correctional Facility, Travis County, 78617	Weekly*	African-American and Hispanic men and women; African-American and Hispanic individuals recently released from incarceration; African-American and Hispanic MSM	
AIDS Services of Austin Prevention on-site testing, 78752	Weekly*	African-American and Hispanic men and women; African-American and Hispanic individuals recently released from incarceration, African-American and Hispanic MSM	
AIDS Services of Austin Prevention Testing – community outreach events, highest risk zip code areas, and venues frequented by at-risk populations	Monthly	African-American and Hispanic men and women; African-American and Hispanic individuals recently released from incarceration, African-American and Hispanic MSM	

*For all activity frequencies listed as weekly, exceptions will be for staff vacation and sick leave and conflicts with client HIV primary care and case management appointments. These sites will be evaluated annually with input from clients served and will likely be revised annually (or as needed).

The staff networks with social workers or other agency staff by meeting with them, explaining or reminding them about services available through ASA's Outreach Services, giving them professional and referral cards, and responding within 24 to 48 business hours to their referrals for HIV-positive individuals into outreach services.

For the other sites listed above, the staff assesses the best ways to reach the African-American and Hispanic population that is recently released from incarcerated and/or MSM and meets with outside agency representatives to determine the best days and times for deployment of Outreach staff to these agencies and for staff training. In cases where individuals recently released from incarceration directly call or visit the agency, an Outreach staff member is deployed to the individual's temporary or transitional living situation, when it is not possible to meet at a social service agency. In cases where a person who has recently tested positive for HIV is referred to Outreach, the staff member meets with the individual at a site of their preference to facilitate getting into medical services and treatment. Outreach staff are present onsite for ASA's weekly testing days or at ASA prevention community testing events to meet immediately with an individual testing positive or to schedule a follow up meeting.

a. MSM population:

ASA has increased the frequency of visits and contact with outside health care organizations such as area hospitals, including emergency rooms. The result is the creation of a stronger partnership in which referrals of eligible positives can be received. The agency utilizes the "Deployment of Case Managers" practice, a community level intervention that provides supportive services to an "outside" organization to address the needs of people with HIV who are currently clients of their programs. ASA places the Outreach Coordinator at area hospitals

to train staff in referring to agency programs and to follow up on referrals. By increasing the frequency of Outreach staff deployment to hospitals and emergency rooms, Outreach is called at least weekly to link HIV positive individuals to primary medical care and support services. Due to the disproportionate number of MSM affected by the HIV and AIDS epidemic, the program has identified many African-American and Hispanic MSM who are out-of-care through this outreach effort. Hospitals identified include University Medical Center Brackenridge, and Seton Medical Center Austin of the Seton Family of Hospitals; and St David's Medical Center, St. David's North Austin Medical Center, and St. David's South Austin Medical Center. Outreach workers visit these hospitals and emergency rooms weekly or at the frequency of contact and hours agreed upon with hospital staff.

b. Pre-Release and Recently Released From Incarceration (Released Within Three Years):

Again utilizing the "Deployment of Case Managers" practice, ASA employs outreach workers to identify and link African-Americans and Hispanics who are pre-release from incarceration and recently released from incarceration who are at-risk for HIV infection or are HIV positive and out-of-care. These Outreach workers regularly visit the Travis State Jail and Del Valle Correctional Facility. Outreach worker activities include working with agency staff to refer HIV positive individuals, delivering HIV risk reduction messages and educational brochures in Spanish and English to develop rapport with individuals for self-referrals or referrals of friends, encouraging HIV testing for those at risk of infection, making referrals for primary medical care and Case Management Non-Medical (Tier 2), and addressing barriers to services. Outreach workers visit Travis State Jail and Del Valle Correctional Facility at frequencies and hours agreed upon with outside agency staff.

The team provides referral cards and information about their services monthly at the Travis State Jail. Individuals attending the facility's monthly community services fair are those who are soon to be released from jail into the community, the pre-release incarcerated. Staff also visits the Travis County Correctional Complex (TCCC) weekly to provide information to their pre-release incarcerated population about HIV services in the community and how Outreach can assist them with linkage into medical care and support services. Outreach workers visit these facilities to establish trust with targeted individuals, so that clients will seek testing and/or call for services upon discharge/release. Outreach staff is culturally and linguistically reflective of these populations, allowing them to establish immediate report with the African-American and Hispanic pre-release incarcerated. In April 2010, ASA's former Outreach Coordinator was awarded the POWER Service Award by TCCC in recognition of his work with the Travis County inmates.

Traditionally, Outreach staff has received inquiry letters from those who are soon to be released concerning housing and HIV services in the Austin community. Outreach staff communicates with those individuals to encourage their contacting the agency upon their release. The team receives letters from incarcerated individuals and responds to them, at a minimum, on a monthly basis. Written communication is conducted in the preferred language of the client. In cases where a person who has been recently released comes to or phones the agency, staff is

deployed to the site of the individual's preference.

At least weekly, staff engages in a dialog with these targeted individuals about initial access to primary medical care by providing information about HIV transmission and risk reduction, the benefits of testing and early medical intervention, referrals for sexually transmitted infection (STI) screening and HIV testing, and the support and assistance offered by Outreach and Case Management Non-Medical (Tier 2). Staff also informs clients about resources for substance abuse treatment, mental health problems, food assistance, financial assistance, and housing. Staff addresses the main barriers to primary medical care, food, and housing, through linking clients to the appropriate resources.

i. Planning and Coordination of Outreach Activities

Outreach workers, in conjunction with ASA's Prevention Department and with consumer feedback, work with business owners and staff to determine ways to promote discussions between outreach workers and African-American and Hispanic consumers. The goal is to maximize referrals or self-referrals by organizational staff and consumers to Outreach and agency services. Outreach staff coordinates services with ASA's Prevention Department in order to identify further sites for outreach deployment to identify African-American and Hispanic MSMs for HIV testing and those who know their status but are not in care.

The following ASA Prevention Department activities have an outreach component as one of the core elements of Evidence-Based Interventions and require reporting on outreach performance measures:

- Mpowerment, a community-level intervention funded by Travis County and the Department of State Health Services (DSHS) targeting MSMs of all races and ethnicities from 18 to 29 years of age;
- Healthy Relationships, an evidence-based intervention focused on prevention with positives; and,
- Testing and Linkage to Care (TLC), an HIV testing program funded by DSHS, identifies MSM and MSM/IDUs of all races and ethnicities in recruitment activities at gay-friendly bars, bath houses, drug treatment and methadone clinics, local harm reduction programs, and social events that target these MSM and MSM/IDU communities.

Ryan White Part A Outreach workers partner with the Prevention Department on CTR activities where counselors refer individuals with preliminary positive results to Outreach staff to immediately begin linkage activities. CTR counselors make referrals for primary medical care and support services while Outreach staff regularly follows up with the client, addresses barriers to service linkage, and ensures successful linkage to primary medical care and support services.

HIV testing is provided through the ASA Prevention Department through CDC – and SAMHSA – funded CTR services and through Department of State Health Services (DSHS)-funded TLC HIV Testing at nontraditional locations and social events targeted at MSM and MSM/IDUs. The Outreach Coordinator and outreach workers are on site during weekly testing at the agency and at scheduled testing events to accept referrals immediately for those testing

positive, at which point, they begin linkage to both primary medical care and social support/case management services.

There is no duplication of services between the ASA Prevention Department and the Ryan White Part A Outreach team because the Ryan White team does not provide outreach at any location targeted by the Prevention team.

i. Referring and Linking Late to Care and Out-of-Care Individuals into HIV Primary Medical Care and Case Management Non-Medical (Tier 2) Services

The Outreach team begins working closely with clients upon initiation of contact. Focusing on initial basic needs assistance, the Outreach team refers clients to an array of community resources available. Clients with no means of access to transportation are provided with Capital Metro bus passes and assisted with applying for the Reduced Fare ID Card during the initial visit to allow the client the means to attend future scheduled appointments. The Outreach worker will then address any presenting housing needs of the client by assisting with them obtaining an identification card or driver's license as needed for applying for housing. As many clients entering services are without stable housing, the Outreach specialists work to secure immediate short-term housing through boarding homes such as South Austin Market Place. Clients are assisted with emergency financial assistance or with securing such assistance through churches or community resources.

After Outreach staff discusses the clients' immediate needs, they begin working with the out-of-care individual on initial access to primary medical care by sharing eligibility requirements and access information on medical providers, usually CommUnity Care at David Powell Clinic. They also respond to questions about the intake visit and any anxiety about accessing medical care. They also assure the clients that services will be culturally appropriate and offered in their preferred language or through an interpreter at no charge to the client. Staff schedules the medical initial intake appointment for clients referred to David Powell Clinic. Outreach staff provides support in attending the initial medical intake appointment with the client, providing transportation as needed. Clients with private health insurance coverage schedule their own appointments, as they usually function independently, and then inform the staff of the appointment date.

Once the client has made the initial intake appointment at David Powell Clinic, Outreach staff facilitates the client's referral to Case Management Non Medical (Tier 2) for continued follow-up that includes accompanying clients to their first and subsequent doctor visits and lab appointments. This initial coordination work between Outreach staff, medical providers, and case management staff is critical in order to keep the client engaged in their medical care and to maintain rapport with the client while being assessed for appropriate services. Tier 2 Client/Patient Navigators build upon the trust developed with Outreach staff and the developing trust with medical providers to coordinate care with David Powell Clinic staff by assisting in appointment scheduling/rescheduling and conferencing around continued barriers to care.

Once clients are successfully linked and retained in primary medical care and barriers to

accessing care have been appropriately addressed, clients complete the ASA Eligibility and Intake comprehensive screening process. This process facilitates their linkage to Case Management Non-Medical (Tier 1) and/or Medical Case Management. Tier 2 Client/Patient Navigators continue to work jointly with assigned case managers to successfully assist clients with access to needed support services after they are linked to Case Management Non-Medical (Tier 1) and/or Medical Case Management services. Eligibility and Intake staff provides culturally and linguistically appropriate screening and aims to assign clients to case managers that reflect their cultural background and speak their preferred language. If case managers that speak the preferred language of the client are not available, staff informs clients of their right to interpretation services at no cost to them. Clients are discouraged from using family and friends as interpreters.

An example of client access and linkage into both medical care and case management follows:

The Outreach Coordinator received a referral from ASA's Testing and Linkage to Care program during a Volunteer Healthcare Clinic. The client received an onsite intake into Outreach services, but was admitted to Seton Hospital shortly after due to severe HIV related complications that arose due to his late diagnosis. Upon his discharge and entry into Doug's House, the client completed the CommUnity Care at David Powell intake paperwork with the Outreach Coordinator, which expedited his linkage to medical care. The client was also connected with ASA's Medical Case Management Program. Through the collaborative effort of the Outreach Coordinator, the Medical Case Manager, and Doug's House social worker, the client successfully attended his medical appointments, resulting in his CD4 increasing from 17 in early 2012 to 270 in September. The client continues to improve medically and remains adherent to his HIV treatment, while also volunteering with ASA's food bank.

Frequency of these service activities

Outreach Sites/Locations	Frequency	Target Populations
Brackenridge Hospital, Seton Family of Hospitals, 78701	Weekly*	White, African American, and Hispanic men and women; individuals recently released from incarceration, MSM
St. David's Medical Center, 78705 St. David's North Medical Center, 78758 St. David's South Medical Center, 78741	Weekly*	White, African American, and Hispanic men and women; individuals recently released from incarceration, MSM
Seton Medical Center Austin, 78705	Weekly*	White, African American, and Hispanic men and women; individuals recently released from incarceration, MSM
Austin Resource Center for the Homeless (ARCH): 78701	Monthly*	African American, and Hispanic men and women; homeless; recently incarcerated
Salvation Army: 78701	Monthly*	African American, and Hispanic men and women; homeless; recently incarcerated
Angel House Community Kitchen 78702	Monthly	African-American, Hispanic homeless men and women; recently incarcerated
Texas Department of Criminal Justice	Monthly	White, African American, and Hispanic

Resource Fair, Travis State Jail, 78724		individuals recently released from incarceration; White, African American, and Hispanic MSM
Del Valle Correctional Facility, Travis County, 78617	Weekly*	White, African-American, Hispanic men and women; individuals recently released from incarceration, MSM
AIDS Services of Austin Prevention on-site testing, 78752	Weekly*	White, African-American, Hispanic men and women; individuals recently released from incarceration, MSM
AIDS Services of Austin Prevention Testing – community outreach events, highest risk zip code areas, and venues frequented by at-risk populations	Monthly	White, African-American, Hispanic men and women; individuals recently released from incarceration, MSM

Location(s) of these service activities

Staff provides services in venues that are convenient to the client, which include telephone contact and office, clinic, hospital, nursing facility, and home visits.

Staffing

Leadership for the Outreach Services: MAI program includes:

vi. **Director of Access Services:** The Director of Access Services provides direct supervision to the Non-Medical Programs Manager, the Medical Programs Manager, the Outreach Coordinator, the Intake Coordinator and the Health Insurance Specialist. She also responds to grant requirements and outcomes reporting; assists in the completion of grant proposals; participates in Housing Opportunities for People with AIDS ("HOPWA") and Quality Management meetings; and coordinates and implements quality management activities, including participating in the development of community-wide standards of care.

vii. **Outreach Coordinator:** The Outreach Coordinator position provides direct supervision to two part-time Outreach Specialists. He coordinates with collaborative partners, both internal and external; assigns clients as appropriate; tracks performance measures; and provides information on quality assurance activities. This staff member also conducts HIV classes at local jails and inpatient/outpatient recovery centers, as well as accompanies clients to initial HIV primary medical intake appointments.

viii. **Executive Team Members:** The Executive Director is the primary contact with the City of Austin Health and Human Services Department (AHHSD) HIV Resource Administration Unit and has final authority in negotiating and approving contracts. The Chief Programs Officer interacts with AHHSD on matters relating to programs and is authorized to enter into negotiations with AHHSD regarding program issues, grant reporting, and performance measures. The Chief Financial Officer interfaces with

AHHSD HIV Resource Administration on grant billings. The Grants Manager ensures contract compliance.

Table 4 indicates key staffing for the Outreach Services: MAI program:

Table 4

Name/Position	Qualifications	Primary Work Assignment	% Time Allocated
Price/Director of Access Services	Master in Public Health Policy and Management; 5 years of nonprofit management experience; 10 years of human services, grants management, program development, and fiscal management experience; 5 years of case management/social work supervisory experience	Supervises all Case Management, including MCM, and Outreach programs; manages service delivery and evaluation; reviews financial assistance; budgets and implements program modifications; coordinates QM activities and develops policy and procedures.	0.3%
Knox/ Outreach Program Coordinator	Master's in Adult Education; 1 year experience in social services and working with people of color, 1 year experience in HIV (including testing); 12 years experience in substance abuse; 7 years experience in grants and funding for human services	Coordinates outreach services, identifies service delivery sites, supervises and trains Outreach Specialists, completes grant requirements. Provides outreach to identify targeted HIV+ individuals; begins linkage to primary care, case management services; addresses immediate client needs.	34.8%
Belozerco/ Outreach Specialist/part-time	Bachelor's Degree in Biology and Public Health; Associate's Degree in Spanish; current pre-medical student. 7 years clinical experience working with at-risk and underserved populations in reproductive healthcare; 8 years spent facilitating safe-sex education for teens; 9 years of part-time and volunteer experience providing disease prevention education and serving as an advocate for incarcerated individuals.	Provides outreach to identify targeted HIV+ individuals; begins linkage to primary care, case management services; addresses immediate needs.	22.3%
Richardson/ Outreach Specialist/part-time	7.5 years of part-time experience with event planning for HIV+ women with Women Rising Project (WRP); 5 years serving on WRP advisory board; 5 years of experience	Provides outreach to identify targeted HIV+ individuals; begins linkage to primary care, case management services; addresses immediate needs.	0%

	with incarcerated populations, substance users, mental health problems, and people of color		
Rios/Non-Medical Programs Manager	Master Degree in Healthcare Administration; 9yrs of experience in human services field; 7 yrs of experience in non-profit management. 5yrs of experience in case management.	Supervises all Non-Medical Case Management Programs, up to 2 interns, approves and tracks financial requests, evaluates program outcomes and service delivery, completes grant reporting requirements, and coordinates and implements QM activities.	0.003%

The supervisor to staff ratio is 0.03 to 0.571 FTE.

The Outreach Program Coordinator is MSM. One Outreach Specialist is Hispanic and bilingual in Spanish and English. The other Outreach Specialist is African-American and has experience working with HIV positive women. ASA makes efforts to hire staff that are reflective of the populations served and that speak Spanish. In addition, all staff members are provided ongoing cultural competency training. Please see *Cultural Competency* section for more details on ASA's training and organizational efforts around cultural competency.

The agency is not currently using volunteers in outreach activities. No subcontractors will be used for this service category.

Client Access

Current—and potential—African-American and Hispanic clients for Medical Case Management and Case Management Non-Medical will be located and identified through Ryan White, Part A Outreach Program Services. Outreach staff identify individuals with unknown HIV status and those with known HIV positive status who are late to care or "out-of-care." *HRSA defines an individual as being out-of-care if there is no evidence of a client accessing any one of the following three components of HIV primary medical care during a defined 12-month time frame: viral load testing, CD4 count, or provision of anti-retroviral therapy.* However, the Ryan White Quality Management Workgroup has agreed that clients without these three components need intervention prior to one year. As a result, the outreach team also identifies individuals with HIV who have not received primary medical care for six months or longer.

One Outreach Specialist is Hispanic, fluent in Spanish, and has experience with African-American populations. The other Outreach Specialist is an African-American woman who has experience with Hispanic populations and women with HIV and AIDS. In 2014-2015, 86.2 percent of clients served in the Outreach MAI program were linked to ASA case management services through the Outreach interventions.

- **Area Hospitals and Emergency Rooms:** AIDS Services of Austin (ASA) Outreach team members are placed at area hospitals to train staff in referring to agency programs and to follow-up on referrals made by hospital staff. Outreach is called at least biweekly to link HIV positive individuals to medical care and support services such as Case Management Non-Medical . Hospitals identified include University Medical Center Brackenridge, and Seton Medical Center Austin of the Seton Family of Hospitals; and St David's Medical Center, St. David's North Austin Medical Center, and St. David's South Austin Medical Center. Outreach workers visit these hospitals and emergency rooms at the frequency of contact and hours agreed upon with hospital staff.

- **Correctional Facilities:** At Travis County Correctional Complex (TCCC), Travis State Jail, and Del Valle Correctional Facility, ASA outreach team members identify at-risk for HIV or HIV positive individuals who are pre-release from incarceration or recently released from incarceration and link them into medical and supportive services. Outreach workers engage in a broad range of activities include working with correctional facility staff to refer HIV positive individuals.

  Outreach staff receiving service inquiry letters from HIV positive individuals due to be released encourages those individuals to contact the agency upon release. Once contacted, the outreach staff immediately begins the process of linking the individual to medical care and with Case Managers. In cases where a person who has been recently released comes to or phones the agency directly, staff is deployed to the site of preference as identified by the individual who is contacting the agency for services.

  - **CommUnity Care at David Power Clinic:** Several times monthly or sometimes on a weekly basis, Outreach staff links identified HIV positive individuals to primary medical care . Staff provides targeted individuals with a transition from outreach to case management services through building on the trust already established during outreach.

- **Community and Peer Referrals:** Due to the high quality of services provided by ASA, 14 percent of clients that receive case management intake assessments identify themselves and initiate contact for services as a result of referrals from family, friends, or peers who have received agency services. For the same reason, 24 percent of clients are referred to case management from local health care providers.

- **ASA Prevention Programs:** ASA offers a variety of HIV prevention and testing programs that reach over 7,500 individuals annually. Prevention programs include:
  - Mpowerment, a prevention program for young gay, bisexual, and questioning men;
  - Healthy Relationships, an evidence-based intervention focused on prevention with positives;
  - HIV testing;
  - Hepatitis C and syphilis testing for targeted populations;
  - Linkage to care and patient navigation;
  - Condom Distribution Network;

- Testing, Linkage, and Care, a program that brings HIV testing to sites where high risk populations frequent; and,
- CLEAR, a risk reduction counseling program.

All of ASA's Prevention programs refer HIV positive individuals into Outreach services or case management services through eligibility and intake.

- **Other:** ASA also receives referrals through HIV service directories and private medical practices. Please see *Other Linkages, Collaboration, and Referrals* section for further description of ASA's referral system.

Access Barriers and Reducing Barriers to Access

One of the most difficult barriers to service delivery is lack of basic needs, such as food, housing, and transportation, which interferes with the client focusing on linkage to access to medical case management, medical care and supportive services. Other barriers are described below:

Table 6

Barrier	Description of Reduction/Elimination of Barrier
Eligibility Documentation	11. Eligibility and Intake staff or case managers provide reasonable assistance to clients to obtain identifying documentation. 12. Documentation may be a challenge for undocumented Hispanics or homeless individuals – ASA staff is trained to assist them is accessing appropriate documentation.
Basic Needs*: *Food*	16. Client intake and case manager assessment for eligibility for ASA's Helping Hand Food Bank services; 17. Assisting clients with Food Stamp applications; 18. Assisting clients with accessing emergency food needs through referrals to area agencies and food programs.
Basic Needs*: *Housing and Homelessness*	11. Access to short-term and long-term housing assistance needs to stabilize clients through ASA HOPWA and Best Single Source Plus Programs. 12. Case Manager coordination and referral to: Housing service providers such as Project Transitions, Foundation Communities, area boarding homes, Austin area public housing and emergency shelters. .
Basic Needs*: *Transportation*	21. ASA main facility located on two major bus routes as well as located in a zip code area where a high number HIV infections are located (78752); 22. ASA Intake, Outreach, and Tier 2 Client/Patient Navigators conduct home visits when necessary and work with clients who are unable to transport to office location; 23. ASA Intake (or Client/Patient Navigators) complete client applications for Special Transportation Services through

Barrier	Description of Reduction/Elimination of Barrier
	Capital Metro; 24. Access to bus passes through the Basic Transportation Needs Fund
Health Literacy and Education	11. Assess client's health and language literacy; 12. Work with client through verbal communication and with health education materials tailored to client's level of understanding and language needs.
Unique Cultural & Linguistic Issues	16. Extensive training in cultural awareness and responsiveness related to communities of color, specifically African-American and Hispanic; 17. ASA has established working relationship with qualified interpreters to assist clients whose primary language is not adequately represented by a staff person; 18. Tier 2 staff build trust with undocumented Hispanic clients by explaining that this status will not affect eligibility for agency services.
Substance Abuse Treatment	16. Consumer information about possible side effects of illicit drugs and HIV medications; 17. Access to appropriate case manager(s) with substance abuse assessment experience; 18. Collaborate with CARE program and other related agencies to provide support and treatment services.
Mental Health Treatment	6. Collaboration with and referrals to mental health providers including Waterloo Counseling and CARE program at ATCIC.
Historical Mistrust of Medical and Social Service Providers	6. ASA case managers work with client through skills building to mitigate mistrust and to improve the client health literacy through education.
HIV Disease Stigma	16. Frequent and prompt contact with individuals in target populations to build trust while relying on 24 years of established history of trust with ASA as an HIV provider for African-American and Hispanic populations; 17. Client-centered approach, emphasizing client strengths, respect for client self-determination – this approach is particularly effective in African-American and Hispanic communities; 18. Referrals of HIV positive women of color to Women Rising Project to educate women in making healthcare decisions – 60 percent of the women served are African-American.

* Basic needs as a barrier is more likely to affect African-American and Hispanic communities due to disproportionate poverty levels among communities of color.

Service Linkage, Referral, and Collaboration

Linkage to Primary Medical Care

Many clients are first assisted with initial access and linkage to HIV primary medical care through Outreach team efforts. The goal of the Outreach team is to successfully link clients to primary medical care in three months or less, in accordance with the National HIV/AIDS Strategy. To open a dialog with African-American and Hispanic individuals about initial access to medical care, Outreach staff will initiate rapport by providing information about general HIV transmission, risk reduction, and the benefits of early medical intervention.

Referral Mechanism:

After Outreach staff discusses the clients' immediate needs (see *Section k. Other Linkages, Collaboration, and Referral*), they begin working with the out-of-care individual on initial access by sharing eligibility requirements and access information on medical providers, usually CommUnity Care at David Powell Clinic. They also respond to questions about the intake visit and anxiety about accessing medical care. Outreach staff informs clients that services at David Powell Clinic will be offered in their preferred language and in a culturally appropriate manner. If David Powell Clinic staff that speaks their preferred language is not available, an interpreter will be provided at no cost to the client. Outreach staff makes the initial intake appointment for clients referred to David Powell Clinic and completes DPC intake paperwork to expedite the client's transition into primary medical care. Clients with private health insurance coverage schedule their own appointments, as they usually function independently, and then inform the staff of the appointment date.

Service Coordination and Integration of Resources

The Outreach staff addresses crucial barriers to access to primary care by providing referrals for immediate basic needs such as transportation, food, and/or housing in the clients preferred language or through an interpreter at no cost to the client. Clients may be assisted through agency resources such as bus passes/taxi vouchers, one of several housing assistance programs, and/or the Food Bank program. In addition, they may be referred to community support services such as area food pantries, Capital Metro for transportation access, and churches for financial assistance with rent and/or utilities.

To address fear of medical providers, the medical care system, or fears related to limited English or health literacy proficiency, staff discusses with clients any resistance to medical care and may be accompanied to their intake medical care visit.Once the client has successfully kept the initial intake appointment at David Powell Clinic[36], the Non-Medical Case Managers work with clients on continued follow-up that may include accompanying clients to subsequent doctor visits. Non-Medical Case Managers build upon the trust developed with Outreach staff and the developing trust with medical providers to coordinate care with David Powell Clinic staff by assisting in appointment scheduling /rescheduling and conferencing around continued barriers to care.

[36] Clients entering services through Outreach rarely have private insurance and for those that do, the Outreach team will ensure they make a follow-up appointment with their private medical provider.

In addition to working with the David Powell Clinic, ASA has long-standing referral relationships with other HIV-related medical providers including the Blackstock Family Clinic (a SETON non-profit practice); Austin Infectious Disease Consultants (a private specialty care practice); Academic Physicians at Trinity; South Austin Medical Clinic; Jefferson Street Family Practice; and, Austin Regional Clinic-South, Far West, and Quarry Lake locations.

Projected Results

As indicated in the *Service Coordination and Integration of Resources* section, clients are referred to primary medical care services by different agency staff depending upon their place in the broad continuum of services offered at ASA. In most cases, Outreach staff tracks primary care referrals by accompanying clients to appointments. When they do not attend appointments with clients, the staff calls health care providers to verify kept appointments or verifies the visit through the ARIES database. Non-Medical Case Managers attend primary medical care appointments with clients or call agencies to track and verify successful referrals.

Clients are considered successfully linked to medical care upon completing an intake session with CommUnity Care at David Powell Clinic or other medical providers. The Non-Medical Case Managers report on retention in medical care as measured through the HRSA/HAB HIV Performance Measures: two or more medical visits in an HIV care setting in the measurement year. All staff will document client progress in progress notes and successful outcomes in the service provided feature of the Provide Enterprise® electronic client database (ASA's internal electronic database). Non-Medical Case Managers will complete a referral tracking form that includes date of referral and completion date and keep the form updated in the paper client file. The desired outcome results are linkage to and retention in primary medical care services.

ASA also participates in the Return to Care Collaborative with CommUnityCare at David Powell Clinic, Austin/Travis County Integral Care Program, Community Action, Waterloo Counseling, and the Wright House Wellness Center. Through this partnership, the collaborative partners seek to improve information sharing to determine the reasons why people have fallen out of care and to use this data to predict out-of-care trends. As participants in the collaborative effort, ASA and CommUnityCare at David Powell Clinic will monitor and share out-of-care information on a bi-monthly basis, when able, and work together to return clients to medical care. When out-of-care clients are identified, they will be referred to ASA's Outreach Program when they have not received HIV primary medical care for one year or more. This staff will facilitate their reentry into the Medical Case Management, as this is typically the level of case management required for clients contacted through the Return to Care Collaborative. Once the Medical Case Manager is assigned, they must contact the client within 10 days, although it is typically sooner.

Other Linkages, Collaboration, and Referral

Linkages and Collaborations

AIDS Services of Austin (ASA) has collaborative agreements, letters of support, and/or Memoranda of Understanding (MOU) in place with several agencies, mostly with respect to

specific programs. The MOUs guide referrals between agencies and allow smooth transitions of clients for additional services. ASA maintains MOUs with Waterloo Counseling Center, Project Transitions, the Housing Authority of the City of Austin, Austin Energy, the CARE Program of Austin/Travis County Integral CARE, and the Communicable Disease Unit at Austin/Travis County Health and Human Services Department (A/TCHHSD). For MOUs that require annual renewal, ASA contacts the partner agency 30 days prior to expiration of these agreements.

ASA also has long-standing referral relationships with HIV-related social service providers, including the CARE Program at Austin/Travis County Integral Care for substance abuse counseling and treatment referral for individuals that are dually diagnosed; Project Transitions for transitional housing and hospice; South Austin Marketplace for transitional and long-term housing; the Customer Assistance Program (Austin Energy) for utilities payment assistance; Waterloo Counseling Center for mental health counseling; the Wright House Wellness Center for holistic/alternative health services; Salvation Army and the Austin Resource Center for the Homeless for emergency housing; the Social Security Administration for disability benefit applications and appeals; Del Valle Correctional Facility, Travis State Jail, and the University of Texas Medical Branch State Penitentiary for services to inmates upon their release; the Communicable Disease Unit at A/TCHHSD for HIV/ STI/TB screening; and SafePlace for domestic violence assistance.

Eligible clients are also referred to the broad continuum of ASA services: the Capital Area AIDS Legal Project (CAALP) for legal assistance; Medical Nutrition Therapy for nutritional assessment, counseling, and supplements; the Jack Sansing Dental clinic for oral health services; HOPWA for housing assistance; Comprehensive Risk Reduction Counseling Services for support for individuals to reduce the risk of HIV transmission; and the Health Insurance Program for premium, medication copayment and medication deductible financial assistance.

Referral Process and Follow Up

ASA staff assists clients with completing and submitting other agencies' referral forms, communicates with those agencies to clarify client eligibility, and advocates for client service delivery. For those clients who are case managed at ASA, staff ensures that referrals are followed through on in one of the following ways:

- performs follow up at the next client contact by asking the client about the referral and the results;
- accompanies the client to appointments;
- checks the ARIES database to ensure appointment was attended; or,
- calls the agency the client was referred to and confirms client attendance.

All staff document client progress regarding follow-through on referrals in the progress log feature of the Provide Enterprise® electronic client database (ASA's internal electronic database). Non-Medical Case Managers will complete a referral tracking form that includes date of referral and completion date and keep the form updated in the paper client file. The desired outcome results are linkage to and retention in support services.

Goals of Collaborative Activities, Integration of Resources, and Projected Results
The goal of collaborative activities is the provision of comprehensive services through the HIV provider community and other social service agencies using linkages and referrals. These activities ensure clients have access to all needed services that are not offered by ASA. In addition, they allow clients to overcome barriers to accessing and remaining in primary medical care and moving toward self-sufficiency in managing their HIV disease.

Integration of resources and services includes the dedication of ASA staff time toward the completion of other agency intake forms, assisting clients with the intake process, accompanying clients to support service appointments, reporting required data, and working with clients on mutual goals in service plans. These mutual goals may be related to support services that client receive from other agencies, such as financial assistance, substance abuse or mental health counseling, housing, etc.

The projected results of collaborative activities, integration of resources, linkages, and referrals are:

- Client achievement of housing stability
- Meeting food intake needs
- Mental health services access and stability
- Independent management of substance use issues
- Financial stability
- Decreased recidivism
- Personal safety and security

Client Input and Involvement

Clients have several opportunities to offer input into the Outreach Services: MAI program. Staff's rapport with the target community, cultural backgrounds, and language abilities enables them to respond to client comments and needs on an ongoing basis. During these encounters, staff works with clients to offer input and identify needs and services they want to pursue.

Staff surveys clients using the standardized questionnaire developed by the Ryan White Quality Management Group to solicit feedback for improving case management services. The survey is offered in both English and Spanish and interpretation services, at no cost to the client, are offered for clients whose preferred language is not offered in written format. The 2013 survey yielded positive feedback, with 90 percent of clients reporting that through the support of AIDS Services of Austin (ASA), their ability to manage their health has improved and 94 percent reporting they are satisfied or very satisfied with case management services. Supervisors will use survey results and staff feedback semiannually to evaluate the effectiveness of referral systems, barriers to service, and other service delivery components. The team will then plan, as appropriate, for service modification, especially actions to remove barriers. Although no 2014

survey was completed, ASA assisted with survey distribution in 2015 and is awaiting results from the administrative agent.

African-American and Hispanic individuals with HIV who access Outreach Services: MAI work closely with case managers to develop individualized culturally and linguistically appropriate service plans. Service plans are written in the client's preferred language and at an appropriate literacy level, depending on the need to the client. In addition, cultural beliefs such as alternative medicine practices are taken into account. Client input is integral to developing the service plan, which includes only those issues and needs the client chooses to address.

All agency clients may register concerns with supervisors and through the client grievance process. All clients are provided a copy of the client grievance policy and procedure upon entry into services and it is posted in English and Spanish in the agency reception area. The interpretation policy is also posted in the reception area, offering clients interpretation services free of charge so that they may file a grievance in their preferred language.

ASA routinely incorporates client feedback and suggestions into planning activities. In developing the agency's 2011 – 2014 Strategic Plan, ASA used interviews and focus groups with current clients to ensure their active participation in the strategic direction of the agency. ASA's Strategic Plan specifically defines "client satisfaction with programs and services" as a key measure of success in alignment with our strategy to "maintain and strengthen existing programs and services through quality improvement." The 2011-2014 Strategic Plan has been extended for one year so that ASA is able to fully analyze the impact of the Affordable Care Act. A suggestion box located in the client lobby is available for clients to submit anonymous feedback. The box is routinely monitored by the Eligibility Services Supervisor. Client feedback is given to appropriate staff for use in program improvements. The Quality Management Guidance Team reviews the feedback from the suggestion box quarterly to evaluate trends and making agency improvements.

Cultural Competency

Service activities will be delivered so that cultural and language differences do not constitute a barrier to services in full compliance with the National Standards on Culturally and Linguistically Appropriate Services (CLAS) described at: http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15.

AIDS Services of Austin (ASA) is in compliance with all 15 CLAS Standards.

Table 5

CLAS Standards	ASA Compliance
106. Provide effective, equitable, understandable, and respectful quality care and services that are	▪ Staff members are proficient in Spanish, culturally reflective of the Hispanic clientele and available to interpret daily ▪ Staff members are from diverse backgrounds including

CLAS Standards	ASA Compliance
responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.	African-Americans and individuals that are immigrants to the USA. ▪ One staff member proficient in American Sign Language and others with basic skills ▪ Interpretation services in any language are offered to clients free of charge; interpreters culturally reflect clients ▪ Staff assigned to clients are reflective of clients' cultural background, as feasible ▪ Client materials are written at a fifth to eighth grade literacy level and in Spanish at third to fifth grade level ▪ Client materials are provided in Spanish and English ▪ A professional volunteer translates materials from English to Spanish ▪ Organization includes "diversity" as one of its core values
107. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.	▪ A Cultural Appropriateness Action Team with staff from varied levels and departments is tasked with ensuring CLAS and health equity are promoted ▪ The agency maintains a tracking mechanism to ensure CLAS compliance ▪ Agency policies are cognitive of cultural appropriateness and those that are applicable to clients are provided in English and Spanish at an appropriate literacy level ▪ Resources are allocated based on community need and assessment ensuring targeting of demographics most affected by the epidemic ▪ 2011-2015 board approved organizational strategic plan includes goals, objectives, and action steps prioritizing staff cultural awareness and competency trainings ▪ Executive Director serves on the Central Health *Health Equity Council* for HIV issues
108. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.	▪ Compliance with Equal Employment Opportunity Commission (EEOC) guidelines since inception ▪ Compliance with The Americans with Disabilities Act (ADA) since inception ▪ EEOC and ADA language reflected on all job postings ▪ Staff are fluent in Spanish, culturally reflective of the Hispanic clientele, and available to interpret daily ▪ Staff members are from diverse backgrounds including African-Americans, Latino, and individuals that are immigrants to the USA. Organizational staffing is reflective of the demographics of the HIV epidemic in the Austin TGA ▪ One staff member proficient in American Sign Language

CLAS Standards	ASA Compliance
	and others with basic skills ▪ Committed to promoting from within for job openings ▪ Evaluation of the potential of current staff for leadership development in order to promote direct service staff ▪ Structured Action Teams provide leadership development opportunities for all staff members ▪ Candidates for positions where bi-lingual (Spanish) skills are preferred are offered a salary premium for demonstrating appropriate proficiency in the language ▪ Organization recruits diverse candidates by networking with higher education institutions of color and advertising and conducting outreach into appropriate publications in communities of color ▪ 2011-2015 board approved organizational strategic plan includes goals, objectives, and action steps prioritizing recruiting, hiring, and training diverse staff and recruiting board members from communities of color ▪ Board officers are demographically and culturally diverse ▪ Agency participation in multicultural career expos for staff recruitment
109. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.	▪ The agency's Cultural Appropriateness Action Team and Professional Development Action Team research and implement ongoing training ▪ Agency support of language skills development when resources are available ▪ Executive Director serves on the Central Health *Health Equity Council* for HIV issues
110. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.	▪ Staff are proficient in Spanish, culturally reflective of the Hispanic clientele, and available to interpret daily ▪ Staff are from diverse backgrounds including African-Americans, Latino, and individuals that are foreign-born ▪ One staff member proficient in American Sign Language and others with basic skills ▪ Interpretation services in any language are offered to clients free of charge; interpreters culturally reflect clients ▪ Client materials are written at a fifth to eighth grade literacy level and in Spanish at a third to fifth grade level ▪ Client materials are provided in Spanish and English ▪ A professional volunteer translates client materials from English to Spanish ▪ The agency uses an independently certified system to evaluate the language proficiency of staff ▪ Organization's central voice mail and Dental Clinic voice

CLAS Standards	ASA Compliance
	mail systems are recorded in Spanish ▪ Key program staff have recorded voicemails in Spanish
111. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.	▪ Interpretation policy offering services free of charge posted in all locations ▪ Reception and Intake and Eligibility staff trained to notify clients of their right to receive language assistance services free of charge ▪ Front desk and key staff voicemail messages are recorded in English and Spanish ▪ Interpretation services in any language are offered to clients free of charge; interpreters culturally reflect clients ▪ Client materials are provided in Spanish and English ▪ Reception staff have access to language cards to identify need for interpretation services
112. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.	▪ The agency uses an independently certified system to evaluate the language proficiency of staff ▪ Written policy offers interpretation at no cost to the client in order to prevent the use of family and friends as interpreters ▪ Staff is trained to inform clients of their right to interpretation services at no cost and that family and friends are not a preferred source for interpretation in order to protect client confidentiality ▪ The agency hires professional, certified trainers to assist in interpretation upon request
113. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.	▪ Client materials are provided in Spanish and English ▪ Client materials are written at a fifth to eighth grade literacy level and in Spanish at a third to fifth grade level ▪ Key client information/policies and grievance information is posted in English and Spanish in common areas and available in hard copy from reception desks ▪ Quality Management Guidance Team reviews and updates materials to increase understandability
114. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.	▪ ASA's 2011 – 2015 Strategic Plan identifies compliance with CLAS Standards as a priority: o "Strategy #3: Ensure culturally appropriate programs and services ▪ Agency programs and services meet Culturally and Linguistically Appropriate Services (CLAS) standards ▪ Collaborative partners recognize ASA for delivery of programs and services to reduce stigma and for innovative and collaborative

CLAS Standards	ASA Compliance
	relationships" o Strategic plan action step is to implement an Organizational Cultural Appropriateness Committee representative of diversity of staff and management to further formalize cultural appropriateness trainings and action steps
115. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.	▪ Self-assessment of CLAS-related activities conducted in 2007; results continue to be used to improve services ▪ Cultural Appropriateness Action Team to survey annually and report to staff and board of directors of outcomes from strategic planning goals/objectives related to cultural appropriateness work
116. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.	▪ Collection of data and documentation on each consumer's race, ethnicity, disabilities, spoken and written language, and literacy level; information entered into client paper file, Provide Enterprise® internal electronic database, and ARIES; information updated periodically ▪ Use of the Austin Transitional Grant Area HIV Planning Council's periodic consumer needs assessment ▪ Use of the Brazos Valley Council of Government's periodic consumer needs assessment ▪ Provision of HIV testing data to the Texas Department of State Health Services, (DSHS) and the Centers for Disease Control and Prevention, (CDC)
117. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.	▪ Collection of data and documentation on each consumer's race, ethnicity, disabilities, spoken and written language, and literacy level; information entered into client paper file, Provide Enterprise® internal electronic database, and ARIES; information updated periodically ▪ Annual review and assessment of HIV epidemiology profile of epidemic as prepared by Texas Department of State Health Services (TDSHS) and the Austin/Travis County Health and Human Services Department ▪ Use of the Austin Transitional Grant Area HIV Planning Council's and Brazos Valley Council of Government's periodic consumer needs assessment ▪ Annual report to staff and board of directors on Austin TGA HIV epidemic in comparison to organization's client demographic profile, staff demographics, and board demographics
118. Partner with the	▪ Collection and updating of data and documentation on

CLAS Standards	ASA Compliance
community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.	each consumer's race, ethnicity, disabilities, spoken and written language, and literacy level; information entered into client paper file, Provide Enterprise® client electronic database, and ARIES. ▪ Provision of HIV testing data results are reported to the DSHS and CDC ▪ Involvement in community events targeted to people of color to build collaborative partnerships in a participatory environment ▪ Staff shares lessons learned at above events with management and leadership staff to expand collective knowledge of local cultural practices and beliefs ▪ Organization is a member of the advisory committee to the Latino Commission on AIDS to develop training institutes on providing culturally appropriate HIV services to the Latino community in 2012 ▪ Executive Director serves on the Central Health *Health Equity Council* for HIV issues
119. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.	▪ Client materials are provided in Spanish and English ▪ Client materials are written at a fifth to eighth grade literacy level and in Spanish at a third to fifth grade level ▪ Client grievance procedures are posted in English and Spanish in common areas throughout the organization ▪ Organization has a formal grievance procedure in place that is reviewed annually by staff
120. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.	▪ Strategic Plan dissemination to donors and posted on website ▪ Community Impact Report disseminated to donors, posted to website, and available in hard copy to public ▪ Responsiveness and pursuit of opportunities to participate in ethnic media

Quality Management

Use of Output and Outcome Data

Using monthly data, AIDS Services of Austin (ASA) tracks progress on the total number of unduplicated clients served, units of service delivered, and achievement of outcome goals through the reporting feature of the Provide Enterprise® electronic client database. On a monthly and quarterly basis, supervisors analyze the data to determine if outputs and outcomes, respectively, are within a 10 percent variance of the elapsed period of the grant cycle. If not, supervisors determine reasons that program goals are not being met and develop plans to address the situation including staff training, supervision, and monitoring staff adherence to the standards

of care for the service category. Supervisors also note trends in performance measures with emphasis on clients who do not meet outcome goals and develop appropriate quality management activities or document the reasons for such exceptions. Provide Enterprise® reports give aggregate data at the agency level that documents client trends in service utilization for use in planning for service delivery.

Supervisors will use reports from the ARIES client database to validate data on performance measures such as number of unduplicated clients served and units of service provided. With the client's signed permission to share client information in ARIES, supervisors will use ARIES reports to facilitate getting complete data on services accessed by clients, to document successful linkages to primary medical care and support services, and to compare, if needed, client service utilization data in order to avoid duplication of services. ARIES will also provide aggregate data at the community level that documents client trends in service utilization for use in planning for service delivery.

Supervisors will use the service-specific client satisfaction survey to obtain data using client input on satisfaction with services provided. Supervisors review survey results including qualitative data at the program area, Leadership Team, Quality Management Guidance Team, and the Program and Services Committee meetings. With input from these various teams, supervisors use suggestions from the survey to identify problems and/or concerns and implement quality improvement activities including service delivery changes when possible.

The resources and tools used to facilitate this process are staff time, the Provide Enterprise® database, ARIES database, and the client satisfaction survey.

Assurance of Compliance with Austin TGA Standards of Care

Outreach services staff has been trained on the following Standards of Care in the Austin TGA Continuum of Care for Outreach Services:

Standard 1: Outreach workers shall establish contacts with HIV testing sites, hospitals, substance abuse centers, and other potential sources of HIV infected clients. The agency is in compliance with this standard when delivering outreach services. ASA created a referral card that is handed out to potential clients during outreach activities. Staff establishes contacts in locations throughout the TGA where persons at high risk of contracting HIV are proven to be, hospitals and emergency rooms, HIV testing sites, and other identified locations. The Outreach Worker identifies HIV positive clients and works with the Tier 2 Non-Medical Case Manager to link clients into medical care and refer them to other needed services. Outreach staff completes a weekly activity record that includes the date of outreach to specific sites. Evidence of compliance with the standard can be found in the folder that contains all completed Outreach Activity forms.

Standard 2: Staff is accessible by phone or pager during work hours. ASA is in compliance with this standard when delivering outreach services. The Outreach Worker's cell phone is

reimbursed on a monthly basis and is used to assist potential clients in accessing medical care and/or other social services. A policy and procedure indicates use of the cell phone for work purposes, and the supervisor will monitor compliance with the policy on a quarterly basis. Evidence of compliance with this standard will be found in the policy and procedures manual.

Standard 3: Intake process is flexible and responsive, accommodating disabilities and health conditions. The agency is in compliance with the standard and has a policy to address appropriate accommodation. The Outreach Worker identifies newly HIV positive clients and documents clients' intake appointments for primary medical care. The supervisor will review quarterly 20 percent of files on clients served in this grant cycle to ensure compliance with the standard. Evidence of compliance with this standard can be found in intake documentation and client files.

Standard 4: Program is competent at delivering services to culturally and linguistically diverse populations to be served. ASA is in compliance with this standard. The Outreach Program strives to employ staff members who are bilingual and culturally represent the targeted communities or who are competent at delivering services to diverse populations. The agency will make every effort to provide adequate bicultural training to staff to ensure competency in those areas. Evidence of compliance with the standard is reflected in certification of cultural competency training in personnel files.

Standard 5: Outreach workers bring new clients into medical care, link clients to case management and other needed services. The agency is in compliance with this standard when delivering outreach services. The Outreach Specialist refers and links all new clients willing to accept referrals to primary medical care, case management, and other needed services. A supervisor will review quarterly 20 percent of files on clients served during this grant cycle to ensure compliance with the standard.

Standard 6: Within the first six months of employment, outreach workers will complete at least ten hours of HIV disease, treatment, transmission, at least ten hours of psychosocial and at least eight hours of cultural competency training. The agency is in compliance with the standard when delivering outreach services. Documentation of completion of training is tracked on an internal agency form or training certificates and filed with the Human Resources Department and in personnel files. The current Out-of-Care Specialists have received more than the required amount of training in all areas required by the standard and will receive a minimum of 12 hours annually. Within the first six months of employment, future newly hired Outreach Workers will receive the required training. Currently department staff, within three months of employment, receive training in HIV and AIDS 101 (medical), safety issues, role of volunteers, first aid, universal precautions (medical), cultural competency, confidentiality issues (psychosocial), agency-specific information, community resources (psychosocial), observation of Case Manager visits (psychosocial), harm reduction (psychosocial), professional boundaries (psychosocial), and fire/emergency procedures.

Standard 7: A minimum of one year of documented HIV/AIDS or related experience is preferred. A degree in social sciences field may substitute for experience requirement. HIV positive status when revealed may substitute for one year of experience. As indicated in the chart in the "Staffing" section, the agency has been in compliance with this standard when delivering outreach services. Each staff has a more than one year of HIV experience. Evidence of this standard can be found in personnel files kept in the Human Resources Department.

Standard 8: There is a system in place to document staff work time. The agency is in compliance with the standard to capture hours and attendance when delivering outreach services. Outreach workers document contacts on the HIV Activity Report Form, which includes the date and location of outreach activities. The supervisor receives and reviews this report. In practice, the agency already requires documentation of timesheets and the sign-in/out sheet. Evidence of meeting this standard will be found on timesheets, sign-in/out sheets, and in the policy.

Quality Management Plan

Quality Management Guidance Team

The overall responsibility and leadership for ASA's Quality Management (QM) program lies with the Chief Programs Officer, who authorizes the Quality Management Guidance Team (QMGT) to plan, assess, measure, and implement performance improvements throughout the entire agency, while providing the necessary resources and support to fulfill these functions.

The membership of the QMGT reflects the diverse service areas within AIDS Services of Austin (ASA). The agency's quality team is comprised of the Chief Programs Officer and other members of ASA staff, ranging from upper management to direct service staff. Other ASA staff members, such as Program Supervisors and Coordinators, Case Managers, and Prevention Specialists are involved, as appropriately indicated. Nominations for membership are decided upon by the QMGT. The QMGT meets every other month. Additional meetings may be called, as needed. Minutes of meetings are distributed directly to each member of the committee and to all necessary internal and external stakeholders. A written summary is routinely made available to staff.

The Quality Management Plan

The Quality Management Plan seeks to improve service performance through collecting and evaluating data, identifying service problems based on the collected data, using quality improvement processes to address service delivery issues, and following up to ensure improvements will be sustained. The agency plan is designed annually with target goals and service specific quality improvement activities. It calls for a review of service performance measures, an analysis of this data, and recommendations for service improvements. The plan indicates that the team will oversee an annual update and revision of program policies and procedures. At the end of each year, the plan is evaluated to determine the achievement of goals and the service specific improvement activities and to make recommendations for further follow-up.

The following sections describe other components in the Quality Management Plan:

Activities to Collect Data
The Chief Programs Officer, the Director of Access Services, and the Eligibility Services Supervisor will collect data on the program's performance in achieving service goals and meeting standards of care through results from the following sources: outcome and output measures, the agency client satisfaction survey, client file reviews, client/staff feedback, and client grievances.

Supervisors review performance measures quarterly and report measures not meeting contract objectives to the Quality Management Guidance Team, along with suggestions on planned action steps.

Client satisfaction surveys are an important way to identify quality issues. The agency distributes the standardized survey, after approval by the HIV Resource Administration Unit, City of Austin Health and Human Services Department, at the Food Bank and Dental Clinic sites to collect data on all Ryan White Service Categories offered at ASA. Trained social work interns and volunteers administer the survey during a selected two week period. The survey data is tabulated by the Data Manager-System Support Technician at the HIV Resource Administration Unit, AHHSD.

File reviews are essential to the quality of client data. Supervisors review 20 percent of Outreach client files on clients during the grant cycle to evaluate pertinent Outreach activities and compliance with indicators for the standards of care.

Client input from registered grievances is documented by program supervisors and reviewed at department staff meetings. Supervisors adhere to the agency's policy on client/patient grievances, which includes review by the Executive Director and/or the Board of Directors, if necessary.

Evaluation of Performance and Assuring Delivery of Quality Services
As data and input are received and problems are identified, the QMGT evaluate concerns and suggestions in order to assure the delivery of quality services.

The QMGT analyzes the output/outcome data and makes recommendations for improvement to program supervisors. When quality improvement activities around performance measures are designed and completed, the results are then sent to the team and reported in the annual evaluation of the Quality Management Plan.

Supervisors will evaluate survey results to identify trends for improvements and advocate for unmet client need. Supervisors will be careful to note any client feedback related to the culturally appropriateness of service delivery especially with respect to policies and procedures and Outreach interventions with African-Americans and Hispanics. To guide decisions about quality improvement activities, survey results are discussed at the program level in department/program

meetings and at QMGT meetings. The Programs and Services Committee of the Board of Directors also reviews survey results and gives guidance when appropriate.

Program supervisors utilize grievance input obtained from clients and managers at the different grievance levels to make appropriate service changes, when feasible. Supervisors will be careful to note any client feedback related to the culturally appropriateness of service delivery for African-American and Hispanics.

Suggested actions taken based on this data could include staff development training in an identified area such as cultural appropriateness in communication or interventions with African-Americans and Hispanics, development of organization tracking tools, identification of a different site for service delivery, additional interventions to reduce barriers, or design of client/patient forms to better capture data and service performance measures.

Identification of Quality Improvement Activities
At the beginning of the year, supervisors and the QMGT identify specific service quality improvement activities based on staff and client feedback and the data already discussed. Activities are written using SMART objectives in that they are specific, measureable, attainable, relevant and time-bound.

Addressing Identified Problems
Once a problem or an area that needs further assessment is identified, the team will use, when appropriate, the Plan-Do-Study-Act cycle (PDSA), a four-step model for carrying out change. This process will be used in identified quality improvement activities as detailed in the annual Quality Management Plan. The components are as follows:

1. Plan by recognizing an opportunity and planning a change.
2. Do by testing the change and carrying out a small-scale study.
3. Study by reviewing the test, analyzing the results/data and identifying what has been learned.
4. Act by taking action based on what you learned as a result of data analysis in the study step.

If the change does not work, the cycle will be repeated again with a different plan.

To address client file review results, supervisors will implement a plan of correction when deficiencies in delivering services or lack of compliance to standards have been identified. Supervisors will require plans of correction and timelines for correction. If meeting the standard is systemic rather than related to one or two staff, then supervisors will design and require staff training and report quality improvement activity results to the QMGT.

Follow Up
The Outreach Program supervisors will follow up to ensure the effectiveness of improvement activities and the maintenance of improvement results. On identified quality improvement activities, supervisors follow up on a quarterly basis to ensure that these activities have been

effective in resolving the problem, that no new problems have developed, and that there is sustained improvement in identified areas.

For file review results, supervisors work with staff to develop plans of correction within 15 working days of the file review. Staff has ten working days to implement corrections. At the next quarterly file review supervisors monitor the maintenance of the previous quarter's improvements to ensure problems do not reoccur.

Monitoring and Standardized Tools
Tools used in monitoring and standardization include the file review tool and Provide Enterprise® reports with features to track reporting of performance measures, and to describe content of progress notes for easy tracking. The annual client satisfaction survey is a standardized tool that the Ryan White Quality Management workgroup evaluates and standardizes across HIV service providers.

Compliance with Ryan White Part A Program Monitoring Standards

vi. Document and be prepared to share with the grantee:
    - The design, implementation, target areas and populations, and outcomes of outreach activities, including the number of individuals reached, referred for testing, found to be positive, referred to care, and entering care
    - Data showing that all RFP and contract requirements are being met with regard to program design, targeting, activities, and use of funds

The Outreach Coordinator conducts outreach activities, including case findings, at the locations detailed in *Service Category Activities* section. The target areas and populations are also detailed in the chart in the same section. ASA targets areas that have been identified through local epidemiological data to be at disproportionate risk for HIV infection. The Outreach Coordinator tracks the number of encounters at each location using an Excel® spreadsheet. Additionally, HIV-positive clients that are identified through these activities, as well as referred from ASA's Prevention Department testing programs are tracked on a separate spreadsheet. The Outreach Coordinator provides this information monthly to the program supervisor, who compiles the data. Data is reported monthly to the A/TCHHSD HIV Resource Administration Unit. As ASA will not be utilizing outreach funds to refer targeted populations into testing, this information will not be tracked. Outcome data of clients referred to and entering into both HIV primary medical and case management will be entered into the electronic database Provide Enterprise®. Supervisors will use a reporting function to report quarterly on achieved outcomes.

vii. Provide financial and program data demonstrating that no outreach funds are being used
    - To pay for HIV counseling and testing
    - To support broad-scope awareness activities
    - To duplicate HIV prevention outreach efforts

Outreach activities are planned and delivered in coordination with ASA's Prevention Department. The Prevention Department conducts HIV counseling and testing and broad-scope awareness activities that are funded by the Centers for Disease Control and Prevention, the Substance Abuse and Mental Health Services Administration, the Texas Department of State Health Services, and Travis County. While the Outreach staff works in conjunction with the ASA Prevention Department, they do not duplicate their efforts.

Work Statement

Service Category Name

Outreach Services: Non-MAI

Client Eligibility

AIDS Services of Austin's (ASA) Outreach Services program will serve all persons who did not previously know their HIV status and HIV positive individuals who know their status but are not or have not been in medical care (out of care). HRSA defines an individual as "out-of-care" as not receiving one of the three components of HIV primary medical care during the previous 12 months.
To be eligible for the services, clients must be HIV positive, a resident of the five county area in the Austin Transitional Grant Area (Travis, Williamson, Bastrop, Hayes, Caldwell), and willing to work on linkage to HIV primary medical care.

Outreach staff determines eligibility by securing verification of HIV status and residency. Staff will secure proof of identity, income, and insurance status as required intake documents.

xxxvii. **Documentation of HIV Status:** Staff obtain verification of HIV status through:
- a signed statement from the medical provider;
- a positive Western Blot laboratory result with the name of the client;
- HIV detectable viral load lab results;
- a printed document from the ARIES database indicating verification of HIV status by another provider; or,
- a hospital discharge summary or medical records from previous provider(s).

For clients unaware of their HIV status, Outreach staff will refer them to testing sites to document their HIV status. For clients aware of their status but lacking documentation, Outreach staff will refer them to CommUnity Care at David Powell Clinic for HIV lab work at clinic intake appointments to be used as proof of HIV status, and/or secure HIV test and lab results, previous hospital records, or incarceration discharge medical documents. Staff document out-of-care status on the eligibility screening form and verify length of time clients are out of care through the medical records previously mentioned.

ii. **Residency Verification:** In order to establish residency, clients can provide unexpired documents such as a Texas driver's license, Texas State or Tribal identification cards, Social Security award letter, rental/mortgage agreement, utility bill, or similar forms accepted by the Ryan White Part A Austin TGA.

Documentation of HIV status must be presented within 30 days, and residency documentation must be presented within 60 days. Clients may be granted conditional eligibility if they present with an urgent need and lack the necessary eligibility documentation. ASA will make reasonable efforts to assist clients in obtaining the necessary documentation.

ii. **Proof of Identity:** Proof of identity includes: Texas driver's license, Texas State identification card, a passport, Military or Student identification card, Social Security card, birth certificate or other official document as listed on the Austin TGA Ryan White Client Eligibility Form

xxxviii. **Income Verification:** Staff use the MAGI or Mock MAGI form for client income verification. Clients that have filed a tax return in the previous year complete the MAGI form and submit their tax transcript as income verification. Clients that did not submit a tax return or have had a change in income complete a Mock MAGI form and submit an IRS proof of non-filing and income verification document. Income verification documents include Social Security Award letter, Veterans/Public Assistance or Worker's Compensation benefits statements, wage payment stubs, signed zero income verification letter or other document listed in the Austin TGA Ryan White Part A Client Eligibility Form. There are some populations that are excluded from having to obtain tax transcripts or IRS proof of non-filing, these include: homeless, recently released from incarceration (3 months), undocumented, emancipated minors, and SSI and/or SSDI recipients.

xxxix. **Health Insurance Coverage:** Cards verifying coverage by private medical insurance, Medicare, Medicaid, Veteran's Health Benefits, and Indian Health services will be accepted. Signed no insurance attestation statements will also be accepted. Should a client receive City of Austin Medical Assistance Program (MAP), a copy of the card will be made and a attestation of no insurance will be signed.

Eligibility and Intake Staff will use the Austin TGA Ryan White Part A Client Eligibility Form to reassess clients in the program every six months for determination of continued eligibility. At that time, client residency, income, and health insurance will be updated and/or new documentation obtained as indicated. Clients presenting with a change to income, residency or health insurance status within the six month review period will complete the Change in Circumstances: Eligibility Verification Addendum form. All required eligibility and intake documents, as well as periodic updates, are stored in the client's paper file and documented electronically in the agency's electronic client database, Provide Enterprise®. Client identifying information is also entered into the ARIES client database. Eligibility and Intake staff completes a form verifying eligibility documents were collected, and an administrative assistant enters this data into ARIES.

Target Population

AIDS Services of Austin (ASA) targets all at-risk populations with a focus on men who have sex with men (MSM); and incarcerated individuals released within the past three years. HRSA defines individuals as being "out-of-care" if they are not receiving one of the three components of HIV primary medical care during the previous 12 months: viral load testing, CD4 count, or provision of anti-retroviral therapy.

In the 2015-2016 grant period, 84 clients were served through the Outreach program. ASA has been successful in reaching these populations with the Outreach Services: MAI program since the transition of Ryan White funding to MAI and Non-MAI.

Table 1

	ASA Outreach Services
Community	
MSM	62%
Heterosexual Males	38%
Race/Ethnicity	
White	38%
Black	30%
Hispanic	31%
Other	1%
Risk Factors	
History of Incarceration	50%
History of Substance Use	55%
Homelessness	13%

ASA client geographic concentration aligns with areas of high prevalence of HIV/AIDS in the Austin TGA. The following are the most common zip codes for clients in ASA's case management programs (Medical Case Management, Case Management Non-Medical Tier 1, and Case Management Non-Medical Tier 2). As many clients for case management programs enter services through the Outreach program, these zip codes are representative of clients that are served through Outreach. In addition, many clients enter the Outreach program from incarceration facilities and therefore do not have a permanent residence to report at the time they begin services. ASA's ten most common zip codes for case management clients are all located in Travis County.

Table 2

ASA Top 10 Client Zip Codes	**Prevalence Range of HIV/AIDS***
78752	314-674/100,000
78741	675-1,199/100,000
78723	314-674/100,000
78753	675-1,199/100,000
78758	314-674/100,000
78744	675-1,199/100,000
78702	675-1,199/100,000
78704	115-313/100,000

78721	115-313/100,000
78724	314-674/100,000

While ASA will provide outreach to all at-risk populations, the agency specifically targets these populations: 1) men who have sex with men (MSM) and 2) incarcerated individuals released within the past three years. Below, ASA further describes each target population:

- ***Men who Have Sex with Men (MSM)***: The target population is MSM of all races and ethnicities, focusing on, but not limited to, ages 18 to 56. The risk for the majority of AIDS cases reported annually in the Austin TGA is male-to-male sexual contact and this risk has been steadily increasing in the TGA. One proposed reason for this is the increase in risky sexual activities with anonymous or pseudo anonymous partners met over the internet. In 2009-2010, 68.4 percent of all new AIDS cases in the TGA were among MSM.[37] Among men of color living with HIV, MSM was the most common risk factor for African Americans (67.8 percent) and Hispanics (85.7 percent).[38]

  White MSM are largely receiving HIV medical care, with 89 percent in-care and 11 percent out-of-care. In addition to MSM, 12 percent reported sharing needles as a transmission mode, and 10 percent reported heterosexual sex.[39] White MSM more frequently receive an HIV/AIDS diagnosis during a routine physical examination or doctor's visit rather than a hospital or emergency room. Nevertheless, six percent of White MSM have never received HIV medical care.[40] In addition to male sex with men, 11 percent of MSM of color report heterosexual contact, six percent report sharing needles, and five percent report commercial sex work as their transmission modes. MSM of color most frequently received their diagnosis at a hospital or ER when presenting for other medical issues, followed by testing at a clinic (24 percent), a physical examination or doctor's visit (11 percent), or in jail/prison (8 percent).[41] Similar to White MSM, six percent of MSM of color have never received HIV medical care.[42]

- ***Incarcerated Individuals Released Within the Past Three Years:*** As the incarcerated and recently released from incarceration are populations disproportionately affected by HIV and AIDS, ASA will target males and females of all ethnicities who are recently released from incarceration focusing on, but not limited to, ages 20 to 56. Women represent 22 percent of this population.[43] The racial and ethnic demographics of the recently released population include 38 percent White, 32 percent African-American, 24 percent Latino, and six percent other races/ethnicities.[44] This population is more likely to have a transmission mode of

[37] Texas Department of State Health Services, 2011
[38] Texas eHARS, 2011
[39] 2005 Austin Area Comprehensive HIV Needs Assessment, p. IV-53
[40] Ibid, p. IV-54
[41] Ibid, p. IV-34
[42] Ibid, p. IV-35
[43] Ibid, p. IV-37
[44] Ibid, p. IV-37

injecting drug use (IDU) than the general HIV-infected population in the Austin TGA. About 36 percent of individuals recently released from incarceration report IDU as a transmission mode. [45] Most (30 percent) recently released individuals learned of their HIV status when they went to a hospital or ER for some other medical issue, while 26 percent learned their HIV status in jail or prison.[46]

Austin Transitional Grant Area (TGA) data suggest that 84 percent of clients have medical co-morbidities, while others report social and health-related co-factors that complicate medical and other service delivery for HIV.[47] Co-morbidities and conditions for this population include Sexually Transmitted Infections (STIs), substance abuse, mental health issues, commercial sex work, poverty, homelessness, domestic violence, Hepatitis B and C, and tuberculosis (TB). Among those served by ASA's Non-MAI Outreach Services in 2014-15, 46 percent reported a history of substance abuse, 17 percent reported homelessness, and 37 percent reported recent incarceration. ASA staff estimate that about 30 percent of past outreach clients are co-infected with Hepatitis C, and 37 percent have mental health issues.

Service Category Activities

Service activities linked to Budget Justification

AIDS Services of Austin (ASA) has been implementing an Outreach Services program since 2003. ASA has been offering services under the Minority AIDS Initiative (MAI) since 2007. Given ASA's history of providing these programs in the Austin TGA, necessary mechanisms for implementation are already in place. Long-standing mechanisms include:

- A Board of Directors and strong organizational governance structure
- An experienced leadership team
- Trained and experienced staff (see *Staffing* section)
- A physical location near public transportation and well-known in the HIV field
- A programmatic structure offering a comprehensive continuum of care including HIV Prevention, Outreach Services, Case Management (medical and non-medical), Food Bank, Medical Nutrition Therapy, Oral Health Care, Health Insurance Assistance, special programs for women living with HIV and AIDS, and legal services
- Strong community partnerships providing access to services not offered at ASA

Ryan White Part A Outreach activities are meant to link HIV positive individuals (persons unaware of their HIV status, are out of medical care, or have not accessed medical care before) into medical care and services. These activities are transitional in nature and facilitate an HIV positive person's entry to the continuum of HIV care in the Austin TGA. Outreach activities provided through Ryan White Part A funds include:

[45] Ibid, p. IV-37
[46] Ibid, p. IV-38
[47] ARIES database, provided by the City of Austin (Addendum 5 to Ryan White Part A RFA 2012-13)

v. ***Identification of (case finding) MSM and Pre-Release and Recently Released from Incarceration (released in the last three years)***

Outreach staff target the population identified by frequently conducting outreach or deploying outreach staff to sites outlined below. Case finding outreach sites/locations, frequency, target populations, and targeted zip codes include:
Austin Recovery 4201 S Congress Ave #202. 78745 Bi-monthly.
Austin Transitional Facility. 3154 E Hwy 71. Del Valle, TX 787617. Weekly.
Center on Recovery; Resource Fair. 3420 Executive Center Drive, Suite G100. 78331. Monthly.

Table 3

Outreach Sites/Locations	Frequency	Target Populations
Brackenridge Hospital, Seton Family of Hospitals, 78701	Weekly*	White, African American, and Hispanic men and women; individuals recently released from incarceration, MSM
St. David's Medical Center, 78705 St. David's North Medical Center, 78758 St. David's South Medical Center, 78741	Weekly*	White, African American, and Hispanic men and women; individuals recently released from incarceration, MSM
Seton Medical Center Austin, 78705	Weekly*	White, African American, and Hispanic men and women; individuals recently released from incarceration, MSM
Austin Resource Center for the Homeless (ARCH): 78701	Monthly*	White, African American, and Hispanic men and women; homeless; recently incarcerated; MSM
Salvation Army: 78701	Monthly*	White, African American, and Hispanic men and women; homeless; recently incarcerated; MSM
Angel House Community Kitchen 78702	Monthly	White, African-American, Hispanic homeless men and women; recently incarcerate; MSMd
AIDS Services of Austin Prevention Testing – community outreach events, highest risk zip code areas, and venues frequented by at-risk populations	Monthly	White, African-American, Hispanic men and women; individuals recently released from incarceration, MSM

*For all activity frequencies listed as weekly, exceptions will be for staff vacation and sick leave and conflicts with client HIV primary care and case management appointments. These sites will be evaluated annually with input from clients served and will likely be revised annually (or as needed).

The staff networks with social workers or other agency staff by meeting with them, explaining or reminding them about services available through ASA's Outreach Services, giving them professional and referral cards, and responding within 24 to 48 business hours to their referrals for HIV-positive individuals into outreach services.

For the other sites listed above, the staff assesses the best ways to reach the recently released from incarceration and/or MSM population and meets with outside agency representatives to determine the best days and times for deployment of outreach staff to these agencies and for staff training. In cases where individuals recently released from incarceration directly call or visit the agency, an Outreach staff member is deployed to the individual's temporary or transitional living situation, when it is not possible to meet at a social service agency. In cases

where a person who has recently tested positive for HIV is referred to Outreach, the staff member meets with the individual at a site of their preference to facilitate getting into medical services and treatment. Outreach staff are present onsite for ASA's weekly testing days or at ASA prevention community testing events to meet immediately with an individual testing positive or to schedule a follow up meeting.

a. MSM population:

ASA has increased the frequency of visits and contact with outside health care organizations such as area hospitals, including emergency rooms. The result is the creation of a stronger partnership in which referrals of eligible positives can be received. The agency utilizes the "Deployment of Case Managers" practice, a community level intervention that provides supportive services to an "outside" organization to address the needs of people with HIV who are currently clients of their programs. ASA places the Outreach Coordinator at area hospitals to train staff in referring to agency programs and to follow up on referrals. By increasing the frequency of Outreach staff deployment to hospitals and emergency rooms, Outreach is called at least weekly to link HIV positive individuals to primary medical care and support services. Due to the disproportionate number of MSM affected by the HIV and AIDS epidemic, the program has identified many MSM who are out-of-care through this outreach effort. Hospitals identified include University Medical Center Brackenridge, and Seton Medical Center Austin of the Seton Family of Hospitals; and St David's Medical Center, St. David's North Austin Medical Center, and St. David's South Austin Medical Center. Outreach workers visit these hospitals and emergency rooms weekly or at the frequency of contact and hours agreed upon with hospital staff.

b. Pre-Release and Recently Released From Incarceration (Released Within Three Years):

Again utilizing the "Deployment of Case Managers" practice, ASA employs outreach workers to identify and link individuals who are pre-release from incarceration and recently released from incarceration who are at-risk for HIV infection or are HIV positive and out-of-care. These Outreach workers regularly visit the Travis State Jail and Del Valle Correctional Facility. Outreach worker activities include working with agency staff to refer HIV positive individuals, delivering HIV risk reduction messages and educational brochures to develop rapport with individuals for self-referrals or referrals of friends, encouraging HIV testing for those at risk of infection, making referrals for primary medical care and Case Management Non-Medical (Tier 2), and addressing barriers to services. Outreach workers visit Travis State Jail and Del Valle Correctional Facility at frequencies and hours agreed upon with outside agency staff.

The team provides referral cards and information about their services monthly at the Travis State Jail. Individuals attending the facility's monthly community services fair are those who are soon to be released from jail into the community, the pre-release incarcerated. Staff also visits the Travis County Correctional Complex (TCCC) weekly to provide information to their pre-release incarcerated population about HIV services in the community and how Outreach can assist them with linkage into medical care and support services. Outreach workers visit these facilities to establish trust with targeted individuals, so that clients will seek testing and/or call

for services upon discharge/release. In April 2010, ASA's former Outreach Coordinator was awarded the POWER Service Award by TCCC in recognition of his work with the Travis County inmates.

Traditionally, Outreach staff has received inquiry letters from those who are soon to be released concerning housing and HIV services in the Austin community. Outreach staff communicates with those individuals to encourage their contacting the agency upon their release. The team receives letters from incarcerated individuals and responds to them, at a minimum, on a monthly basis. In cases where a person who has been recently released comes to or phones the agency, staff is deployed to the site of the individual's preference.

At least weekly, staff engages in a dialog with these targeted individuals about initial access to primary medical care by providing information about HIV transmission and risk reduction, the benefits of testing and early medical intervention, referrals for sexually transmitted infection (STI) screening and HIV testing, and the support and assistance offered by Outreach and Case Management Non-Medical (Tier 2). Staff also informs clients about resources for substance abuse treatment, mental health problems, food assistance, financial assistance, and housing. Staff addresses the main barriers to primary medical care, food, and housing, through linking clients to the appropriate resources.

v. Planning and Coordination of Outreach Activities

Outreach workers, in conjunction with ASA's Prevention Department and with consumer feedback, work with business owners and staff to determine ways to promote discussions between outreach workers and consumers. The goal is to maximize referrals or self-referrals by organizational staff and consumers to outreach and agency services. Outreach staff coordinates services with ASA's Prevention Department in order to identify further sites for outreach deployment to identify MSMs for HIV testing and those who know their status but are not in care.

The following ASA Prevention Department activities have an outreach component as one of the core elements of Evidence-Based Interventions and require reporting on outreach performance measures:

- Mpowerment, a community-level intervention funded by Travis County and the Department of State Health Services (DSHS) targeting MSMs of all races and ethnicities from 18 to 29 years of age;
- Healthy Relationships, an evidence-based intervention focused on prevention with positives; and,
- Testing and Linkage to Care (TLC), an HIV testing program funded by DSHS, identifies MSM and MSM/IDUs of all races and ethnicities in recruitment activities at gay-friendly bars, bath houses, drug treatment and methadone clinics, local harm reduction programs, and social events that target these MSM and MSM/IDU communities.

Ryan White Part A Outreach workers partner with the Prevention Department on CTR activities where counselors refer individuals with preliminary positive results to Outreach staff to

immediately begin linkage activities. CTR counselors make referrals for primary medical care and support services while Outreach staff regularly follows up with the client, addresses barriers to service linkage, and ensures successful linkage to primary medical care and support services.

HIV testing is provided through the ASA Prevention Department through CDC– funded CTR services and through Department of State Health Services (DSHS)-funded TLC HIV Testing at nontraditional locations and social events targeted at MSM and MSM/IDUs. The Outreach Coordinator and outreach workers are on site during weekly testing at the agency and at scheduled testing events to accept referrals immediately for those testing positive, at which point, they begin linkage to both primary medical care and social support/case management services.

There is no duplication of services between the ASA Prevention Department and the Ryan White Part A Outreach team because the Ryan White team does not provide outreach at any location targeted by the Prevention team.

i. Referring and Linking Late to Care and Out-of-Care Individuals into HIV Primary Medical Care and Case Management Non-Medical (Tier 2) Services

The Outreach team begins working closely with clients upon initiation of contact. Focusing on initial basic needs assistance, the Outreach team refers clients to an array of community resources available. Clients with no means of access to transportation are provided with Capital Metro bus passes during the initial visit to allow the client the means to attend future scheduled appointments. The Outreach worker will then address any presenting housing needs of the client by assisting with them obtaining an identification card or driver's license as needed for applying for housing. As many clients entering services are without stable housing, the Outreach specialists work to secure immediate short-term housing through boarding homes such as South Austin Market Place. Clients are assisted with emergency financial assistance or with securing such assistance through churches or community resources.

After Outreach staff discusses the clients' immediate needs, they begin working with the out-of-care individual on initial access to primary medical care by sharing eligibility requirements and access information on medical providers, usually CommUnity Care at David Powell Clinic. They also respond to questions about the intake visit and any anxiety about accessing medical care. Staff schedules the medical initial intake appointment for clients referred to David Powell Clinic. Outreach staff provides support in attending the initial medical intake appointment with the client, providing transportation as needed. Clients with private health insurance coverage schedule their own appointments, as they usually function independently, and then inform the staff of the appointment date.

Once the client has made the initial intake appointment at David Powell Clinic, Outreach staff facilitates the client's referral to Case Management Non Medical (Tier 2) for continued follow-up that includes accompanying clients to their first and subsequent doctor visits and lab appointments. This initial coordination work between Outreach staff, medical providers, and case management staff is critical in order to keep the client engaged in their medical care and to

maintain rapport with the client while being assessed for appropriate services. Tier 2 Client/Patient Navigators build upon the trust developed with Outreach staff and the developing trust with medical providers to coordinate care with David Powell Clinic staff by assisting in appointment scheduling/rescheduling and conferencing around continued barriers to care.

Once clients are successfully linked and retained in primary medical care and barriers to accessing care have been appropriately addressed, clients complete the ASA Eligibility and Intake comprehensive screening process. This process facilitates their linkage to Case Management Non-Medical (Tier 1) and/or Medical Case Management. Tier 2 Client/Patient Navigators continue to work jointly with assigned case managers to successfully assist clients with access to needed support services after they are linked to Case Management Non-Medical (Tier 1) and/or Medical Case Management services.

An example of client access and linkage into both medical care and case management follows:

The Outreach Coordinator received a referral from ASA's Testing and Linkage to Care program during a Volunteer Healthcare Clinic. The client received an onsite intake into Outreach services, but was admitted to Seton Hospital shortly after due to severe HIV related complications that arose due to his late diagnosis. Upon his discharge and entry into Doug's House, the client completed the CommUnity Care at David Powell intake paperwork with the Outreach Coordinator, which expedited his linkage to medical care. The client was also connected with ASA's Medical Case Management Program. Through the collaborative effort of the Outreach Coordinator, the Medical Case Manager, and Doug's House social worker, the client successfully attended his medical appointments, resulting in his CD4 increasing from 17 in early 2012 to 270 in September. The client continues to improve medically and remains adherent to his HIV treatment, while also volunteering with ASA's food bank.

Frequency of these service activities

Outreach Sites/Locations	Frequency	Target Populations
Brackenridge Hospital, Seton Family of Hospitals, 78701	Weekly*	White, African American, and Hispanic men and women; individuals recently released from incarceration, MSM
St. David's Medical Center, 78705 St. David's North Medical Center, 78758 St. David's South Medical Center, 78741	Weekly*	White, African American, and Hispanic men and women; individuals recently released from incarceration, MSM
Seton Medical Center Austin, 78705	Weekly*	White, African American, and Hispanic men and women; individuals recently released from incarceration, MSM
Austin Resource Center for the Homeless (ARCH): 78701	Monthly*	White, African American, and Hispanic men and women; homeless; recently incarcerated; MSM
Salvation Army: 78701	Monthly*	White, African American, and Hispanic men and women; homeless; recently incarcerated;

		MSM
Angel House Community Kitchen 78702	Monthly	White, African-American, Hispanic homeless men and women; recently incarcerate; MSM
AIDS Services of Austin Prevention Testing – community outreach events, highest risk zip code areas, and venues frequented by at-risk populations	Monthly	White, African-American, Hispanic men and women; individuals recently released from incarceration, MSM

Location(s) of these service activities

Staff provides services in venues that are convenient to the client, which include telephone contact and office, clinic, hospital, nursing facility, and home visits.

Staffing

Leadership for the Outreach Services program includes:

ix. **Director of Access Services:** The Director of Access Services provides direct supervision to the Non-Medical Programs Manager, the Medical Programs Manager, the Outreach Coordinator, the Intake Coordinator and the Health Insurance Specialist. She also responds to grant requirements and outcomes reporting; assists in the completion of grant proposals; participates in Quality Management meetings; and coordinates and implements quality management activities, including participating in the development of community-wide standards of care.

x. **Outreach Coordinator:** The Outreach Coordinator position provides direct supervision to two part-time Outreach Specialists. He coordinates with collaborative partners, both internal and external; assigns clients as appropriate; tracks performance measures; and provides information on quality assurance activities. This staff member also conducts HIV classes at local jails, as well as accompanies clients to initial HIV primary medical intake appointments.

xi. **Executive Team Members:** The Executive Director is the primary contact with the City of Austin Health and Human Services Department (AHHSD) HIV Resource Administration Unit and has final authority in negotiating and approving contracts. The Chief Programs Officer interacts with AHHSD on matters relating to programs and is authorized to enter into negotiations with AHHSD regarding program issues, grant reporting, and performance measures. The Chief Financial Officer interfaces with AHHSD HIV Resource Administration on grant billings. The Grants Manager, ensures contract compliance.

Table 4 indicates key staffing for the Outreach Services program:

Table 4

Name/Position	Qualifications	Primary Work Assignment	% Time Allocated
Becnel/Director of Access Services	Licensed Master Social Worker (LMSW); 13.5 years at ASA and AIDS Resource Center in Louisiana; 14+ years experience with substance abuse; 14 + years experience	Supervises all Case Management, including MCM, and Outreach programs; manages service delivery and evaluation; reviews financial assistance; budgets and implements program modifications; coordinates QM activities and develops policy and procedures.	0.53%
Knox/ Outreach Program Coordinator	Master's in Adult Education; 1 year experience in social services and working with people of color, 1 year experience in HIV (including testing); 12 years experience in substance abuse; 7 years experience in grants and funding for human services	Coordinates outreach services, identifies service delivery sites, supervises and trains Outreach Specialists, completes grant requirements. Provides outreach to identify targeted HIV+ individuals; begins linkage to primary care, case management services; addresses immediate client needs.	65.2%
Belozerco/ Outreach Specialist/part-time	Associate's Degree in Spanish; current pre-medical student. 7years clinical experience working with at-risk and underserved populations in reproductive healthcare; 8 years spent facilitating safe-sex education for teens; 9 years of part-time and volunteer experience providing disease prevention education and serving as an advocate for incarcerated individuals.	Provides outreach to identify targeted HIV+ individuals; begins linkage to primary care, case management services; addresses immediate needs.	41.7%
Richardson/ Outreach Specialist/part-time	7.5 years of part-time experience with event planning for HIV+ women with Women Rising Project (WRP); 5 years serving on WRP advisory board; 5 years of experience with incarcerated populations, substance users, mental health problems, and people of color	Provides outreach to identify targeted HIV+ individuals; begins linkage to primary care, case management services; addresses immediate needs.	0.0%
Rios/Non-Medical Programs Manager	Master Degree in Healthcare Administration; 9yrs of experience in human services field; 7 yrs of experience in non-profit management. 5yrs of experience in case	Supervises all Non-Medical Case Management Programs, up to 2 interns, approves and tracks financial requests, evaluates program outcomes and service delivery, completes	0.01%

Name/Position	Qualifications	Primary Work Assignment	% Time Allocated
	management.	grant reporting requirements, and coordinates and implements QM activities.	

The supervisor to staff ratio is 0.0053 to 1.7 FTE.

The Outreach Program Coordinator is an MSM. One Outreach Specialist is a bilingual Hispanic. The other Outreach Specialist is African-American and has experience working with HIV positive women. ASA makes efforts to hire staff that are reflective of the populations served and that speak Spanish. In addition, all staff members are provided ongoing cultural competency training. Please see *Section g. Cultural Competency* for more details on ASA's training and organizational efforts around cultural competency.

The agency is not currently using volunteers in outreach activities. No subcontractors will be used for this service category.

Client Access

Current—and potential—clients for Medical Case Management and Case Management Non-Medical (Tier 1) will be located and identified through Ryan White, Part A Outreach Program Services. Outreach staff identify individuals with unknown HIV status and those with known HIV positive status who are late to care or "out-of-care." *HRSA defines an individual as being out-of-care if there is no evidence of a client accessing any one of the following three components of HIV primary medical care during a defined 12-month time frame: viral load testing, CD4 count, or provision of anti-retroviral therapy.* However, the Ryan White Quality Management Workgroup has agreed that clients without these three components need intervention prior to one year. As a result, the outreach team also identifies individuals with HIV who have not received primary medical care for six months or longer.

- **Area Hospitals and Emergency Rooms:** AIDS Services of Austin (ASA) Outreach team members are placed at area hospitals to train staff in referring to agency programs and to follow-up on referrals made by hospital staff. Outreach is called at least biweekly to link HIV positive individuals to medical care and support services such as Case Management Non-Medical . Hospitals identified include University Medical Center Brackenridge, and Seton Medical Center Austin of the Seton Family of Hospitals; and St David's Medical Center, St. David's North Austin Medical Center, and St. David's South Austin Medical Center. Outreach workers visit these hospitals and emergency rooms at the frequency of contact and hours agreed upon with hospital staff.

- **Correctional Facilities:** At Travis County Correctional Complex (TCCC), Travis State Jail, and Del Valle Correctional Facility, ASA outreach team members identify at-risk for

HIV or HIV positive individuals who are pre-release from incarceration or recently released from incarceration and link them into medical and supportive services. Outreach workers engage in a broad range of activities include working with correctional facility staff to refer HIV positive individuals.

Outreach staff receiving service inquiry letters from HIV positive individuals due to be released encourages those individuals to contact the agency upon release. Once contacted, the outreach staff immediately begins the process of linking the individual to medical care and with Case Managers. In cases where a person who has been recently released comes to or phones the agency directly, staff is deployed to the site of preference as identified by the individual who is contacting the agency for services.

- **CommUnity Care at David Power Clinic:** Several times monthly or sometimes on a weekly basis, Outreach staff links identified HIV positive individuals to primary medical care . Staff provides targeted individuals with a transition from outreach to case management services through building on the trust already established during outreach.

- **Community and Peer Referrals:** Due to the high quality of services provided by ASA, 14 percent of clients that receive case management intake assessments identify themselves and initiate contact for services as a result of referrals from family, friends, or peers who have received agency services. For the same reason, 24 percent of clients are referred to case management from local health care providers.

- **ASA Prevention Programs:** ASA offers a variety of HIV prevention and testing programs that reach over 7,500 individuals annually. Prevention programs include:
  - Mpowerment, a prevention program for young gay, bisexual, and questioning men;
  - Healthy Relationships, an evidence-based intervention focused on prevention with positives;
  - HIV testing;
  - Hepatitis C and syphilis testing for targeted populations;
  - Linkage to care and patient navigation;
  - Condom Distribution Network;
  - Testing, Linkage, and Care, a program that brings HIV testing to sites where high risk populations frequent; and,
  - CLEAR, a risk reduction counseling program.

All of ASA's Prevention programs refer HIV positive individuals into Outreach services or case management services through eligibility and intake.

- **Other:** ASA also receives referrals through HIV service directories and private medical practices. Please see *Section k. Other Linkages, Collaboration, and Referrals* for further description of ASA's referral system.

Access Barriers and Reducing Barriers to Access

One of the most difficult barriers to service delivery is lack of basic needs, such as food, housing, and transportation, which interferes with the client focusing on linkage to access to medical case management, medical care and supportive services. Other barriers are described below:

Table 6

Barrier	Description of Reduction/Elimination of Barrier
Eligibility Documentation	13. Eligibility and Intake staff or case managers provide reasonable assistance to clients to obtain identifying documentation. 14. Documentation may be a challenge for undocumented Hispanics or homeless individuals – ASA staff is trained to assist them is accessing appropriate documentation.
Basic Needs*: *Food*	19. Client intake and case manager assessment for eligibility for ASA's Helping Hand Food Bank services; 20. Assisting clients with Food Stamp applications; 21. Assisting clients with accessing emergency food needs through referrals to area agencies and food programs.
Basic Needs*: *Housing and Homelessness*	13. Access to short-term and long-term housing assistance needs to stabilize clients through ASA HOPWA and Best Single Source Plus Programs. 14. Case Manager coordination and referral to: Housing service providers such as Project Transitions, Foundation Communities, area boarding homes, Austin area public housing and emergency shelters. .
Basic Needs*: *Transportation*	25. ASA main facility located on two major bus routes as well as located in a zip code area where a high number HIV infections are located (78752); 26. ASA Intake, Outreach, and Tier 2 Client/Patient Navigators conduct home visits when necessary and work with clients who are unable to transport to office location; 27. ASA Intake (or Client/Patient Navigators) complete client applications for Special Transportation Services through Capital Metro; 28. Access to bus passes through the Basic Transportation Needs Fund
Health Literacy and Education	13. Assess client's health and language literacy; 14. Work with client through verbal communication and with health education materials tailored to client's level of understanding and language needs.
Unique Cultural & Linguistic Issues	19. Extensive training in cultural awareness and responsiveness related to communities of color, specifically African-American and Hispanic; 20. ASA has established working relationship with qualified

Barrier	Description of Reduction/Elimination of Barrier
	interpreters to assist clients whose primary language is not adequately represented by a staff person; 21. Tier 2 staff build trust with undocumented Hispanic clients by explaining that this status will not affect eligibility for agency services.
Substance Abuse Treatment	19. Consumer information about possible side effects of illicit drugs and HIV medications; 20. Access to appropriate case manager(s) with substance abuse assessment experience; 21. Collaborate with CARE program and other related agencies to provide support and treatment services.
Mental Health Treatment	7. Collaboration with and referrals to mental health providers including Waterloo Counseling and CARE program at ATCIC.
Historical Mistrust of Medical and Social Service Providers	7. ASA case managers work with client through skills building to mitigate mistrust and to improve the client health literacy through education.
HIV Disease Stigma	19. Frequent and prompt contact with individuals in target populations to build trust while relying on 24 years of established history of trust with ASA as an HIV provider for African-American and Hispanic populations; 20. Client-centered approach, emphasizing client strengths, respect for client self-determination – this approach is particularly effective in African-American and Hispanic communities; 21. Referrals of HIV positive women of color to Women Rising Project to educate women in making healthcare decisions – 60 percent of the women served are African-American.

* Basic needs as a barrier is more likely to affect African-American and Hispanic communities due to disproportionate poverty levels among communities of color.

Service Linkage, Referral, and Collaboration

Linkage to Primary Medical Care

Many clients are first assisted with initial access and linkage to HIV primary medical care through Outreach team efforts. The goal of the Outreach team is to successfully link clients to primary medical care in three months or less, in accordance with the National HIV/AIDS Strategy. To open a dialog with targeted individuals about initial access to medical care, Outreach staff will initiate rapport by providing information about general HIV transmission, risk reduction, and the benefits of early medical intervention.

Referral Mechanism:

After Outreach staff discusses the clients' immediate needs (see *Section k. Other Linkages, Collaboration, and Referral*), they begin working with the out-of-care individual on initial access by sharing eligibility requirements and access information on medical providers, usually CommUnity Care at David Powell Clinic. They also respond to questions about the intake visit and anxiety about accessing medical care. Outreach staff informs clients that services at David Powell Clinic will be offered in their preferred language and in a culturally appropriate manner. If David Powell Clinic staff that speaks their preferred language is not available, an interpreter will be provided at no cost to the client. Outreach staff makes the initial intake appointment for clients referred to David Powell Clinic and completes DPC intake paperwork to expedite the client's transition into primary medical care. Clients with private health insurance coverage schedule their own appointments, as they usually function independently, and then inform the staff of the appointment date.

Service Coordination and Integration of Resources

The Outreach staff addresses crucial barriers to access to primary care by providing referrals for immediate basic needs such as transportation, food, and/or housing. Clients may be assisted through agency resources such as bus passes/taxi vouchers, one of several housing assistance programs, and/or the Food Bank program. In addition, they may be referred to community support services such as area food pantries, Capital Metro for transportation access, and churches for financial assistance with rent and/or utilities.

To address fear of medical providers, the medical care system, or fears related to limited English or health literacy proficiency, staff discusses with clients any resistance to medical care and may be accompanied to their intake medical care visit.Once the client has successfully kept the initial intake appointment at David Powell Clinic[48], the Non-Medical Case Managers work with clients on continued follow-up that may include accompanying clients to subsequent doctor visits. Non-Medical Case Managers build upon the trust developed with Outreach staff and the developing trust with medical providers to coordinate care with David Powell Clinic staff by assisting in appointment scheduling /rescheduling and conferencing around continued barriers to care.

In addition to working with the David Powell Clinic, ASA has long-standing referral relationships with other HIV-related medical providers including the Blackstock Family Clinic (a SETON non-profit practice); Austin Infectious Disease Consultants (a private specialty care practice); Academic Physicians at Trinity; South Austin Medical Clinic; Jefferson Street Family Practice; and, Austin Regional Clinic-South, Far West, and Quarry Lake locations.

Projected Results

As indicated in the *Service Coordination and Integration of Resources* section, clients are referred to primary medical care services by different agency staff depending upon their place in the broad continuum of services offered at ASA. In most cases, Outreach staff tracks primary care referrals by accompanying clients to appointments. When they do not attend appointments

[48] Clients entering services through Outreach rarely have private insurance and for those that do, the Outreach team will ensure they make a follow-up appointment with their private medical provider.

with clients, the staff calls health care providers to verify kept appointments or verifies the visit through the ARIES database. Non-Medical Case Managers attend primary medical care appointments with clients or call agencies to track and verify successful referrals.

Clients are considered successfully linked to medical care upon completing an intake session with CommUnity Care at David Powell Clinic or other medical providers. The Non-Medical Case Managers report on retention in medical care as measured through the HRSA/HAB HIV Performance Measures: two or more medical visits in an HIV care setting in the measurement year. All staff will document client progress in progress notes and successful outcomes in the service provided feature of the Provide Enterprise® electronic client database (ASA's internal electronic database). Non-Medical Case Managers will complete a referral tracking form that includes date of referral and completion date and keep the form updated in the paper client file. The desired outcome results are linkage to and retention in primary medical care services.

ASA also participates in the Return to Care Collaborative with CommUnityCare at David Powell Clinic, Austin/Travis County Integral Care Program, Community Action, Waterloo Counseling, and the Wright House Wellness Center. Through this partnership, the collaborative partners seek to improve information sharing to determine the reasons why people have fallen out of care and to use this data to predict out-of-care trends. As participants in the collaborative effort, ASA and CommUnityCare at David Powell Clinic will monitor and share out-of-care information on a bi-monthly basis, when able, and work together to return clients to medical care. When out-of-care clients are identified, they will be referred to ASA's Outreach Program when they have not received HIV primary medical care for one year or more. This staff will facilitate their reentry into the Medical Case Management, as this is typically the level of case management required for clients contacted through the Return to Care Collaborative. Once the Medical Case Manager is assigned, they must contact the client within 10 days, although it is typically sooner.

Other Linkages, Collaboration, and Referral

Linkages and Collaborations

AIDS Services of Austin (ASA) has collaborative agreements, letters of support, and/or Memoranda of Understanding (MOU) in place with several agencies, mostly with respect to specific programs. The MOUs guide referrals between agencies and allow smooth transitions of clients for additional services. ASA maintains MOUs with Waterloo Counseling Center, Project Transitions, the Housing Authority of the City of Austin, Austin Energy, the CARE Program of Austin/Travis County Integral CARE, and the Communicable Disease Unit at Austin/Travis County Health and Human Services Department (A/TCHHSD). For MOUs that require annual renewal, ASA contacts the partner agency 30 days prior to expiration of these agreements.

ASA also has long-standing referral relationships with HIV-related social service providers, including the CARE Program at Austin/Travis County Integral Care for substance abuse counseling and treatment referral for individuals that are dually diagnosed; Project Transitions for transitional housing and hospice; South Austin Marketplace for transitional and long-term housing; the Customer Assistance Program (Austin Energy) for utilities payment assistance; Waterloo Counseling Center for mental health counseling; the Wright House Wellness Center for

holistic/alternative health services; Salvation Army and the Austin Resource Center for the Homeless for emergency housing; the Social Security Administration for disability benefit applications and appeals; Del Valle Correctional Facility, Travis State Jail, and the University of Texas Medical Branch State Penitentiary for services to inmates upon their release; the Communicable Disease Unit at A/TCHHSD for HIV/ STI/TB screening; and SafePlace for domestic violence assistance.

Eligible clients are also referred to the broad continuum of ASA services: the Capital Area AIDS Legal Project (CAALP) for legal assistance; Medical Nutrition Therapy for nutritional assessment, counseling, and supplements; the Jack Sansing Dental clinic for oral health services; HOPWA for housing assistance; Comprehensive Risk Reduction Counseling Services for support for individuals to reduce the risk of HIV transmission; and the Health Insurance Program for premium, medication copayment and medication deductible financial assistance.

Referral Process and Follow Up
ASA staff assists clients with completing and submitting other agencies' referral forms, communicates with those agencies to clarify client eligibility, and advocates for client service delivery. For those clients who are case managed at ASA, staff ensures that referrals are followed through on in one of the following ways:

- performs follow up at the next client contact by asking the client about the referral and the results;
- accompanies the client to appointments;
- checks the ARIES database to ensure appointment was attended; or,
- calls the agency the client was referred to and confirms client attendance.

All staff document client progress regarding follow-through on referrals in the progress log feature of the Provide Enterprise® electronic client database (ASA's internal electronic database). Non-Medical Case Managers will complete a referral tracking form that includes date of referral and completion date and keep the form updated in the paper client file. The desired outcome results are linkage to and retention in support services.

Goals of Collaborative Activities, Integration of Resources, and Projected Results
The goal of collaborative activities is the provision of comprehensive services through the HIV provider community and other social service agencies using linkages and referrals. These activities ensure clients have access to all needed services that are not offered by ASA. In addition, they allow clients to overcome barriers to accessing and remaining in primary medical care and moving toward self-sufficiency in managing their HIV disease.

Integration of resources and services includes the dedication of ASA staff time toward the completion of other agency intake forms, assisting clients with the intake process, accompanying clients to support service appointments, reporting required data, and working with clients on mutual goals in service plans. These mutual goals may be related to support services that client receive from other agencies, such as financial assistance, substance abuse or mental health counseling, housing, etc.

The projected results of collaborative activities, integration of resources, linkages, and referrals are:

- Client achievement of housing stability
- Meeting food intake needs
- Mental health services access and stability
- Independent management of substance use issues
- Financial stability
- Decreased recidivism
- Personal safety and security

Client Input and Involvement

Clients have several opportunities to offer input into the Outreach Services program. Staff's rapport with the target community enables them to respond to client comments and needs on an ongoing basis. During these encounters, staff works with clients to offer input and identify needs and services they want to pursue.

Staff surveys clients using the standardized questionnaire developed by the Ryan White Quality Management Group to solicit feedback for improving case management services. The 2013 survey yielded positive feedback, with 90 percent of clients reporting that through the support of AIDS Services of Austin (ASA), their ability to manage their health has improved and 94 percent reporting they are satisfied or very satisfied with case management services. Supervisors will use survey results and staff feedback semiannually to evaluate the effectiveness of referral systems, barriers to service, and other service delivery components. The team will then plan, as appropriate, for service modification, especially actions to remove barriers. Although no 2014 survey was completed, ASA anticipates a survey distribution in 2015 and is awaiting guidance from the administrative agent.

Individuals with HIV who access Outreach services work closely with case managers to develop individualized service plans. Client input is integral to developing the service plan, which includes only those issues and needs the client chooses to address.

All agency clients may register concerns with supervisors and through the client grievance process. All clients are provided a copy of the client grievance policy and procedure upon entry into services and it is posted in English and Spanish in the agency reception area.

ASA routinely incorporates client feedback and suggestions into planning activities. In developing the agency's 2011 – 2014 Strategic Plan, ASA used interviews and focus groups with current clients to ensure their active participation in the strategic direction of the agency. ASA's Strategic Plan specifically defines "client satisfaction with programs and services" as a key measure of success in alignment with our strategy to "maintain and strengthen existing programs

and services through quality improvement." The 2011-2014 Strategic Plan has been extended for one year so that ASA is able to fully analyze the impact of the Affordable Care Act.

The client suggestion box is located in the agency main reception lobby to allow clients the opportunity to provide feedback at any time. The Eligibility Services Manager checks the box monthly and provides any feedback to the appropriate program manager and to the Quality Management Guidance team for appropriate action or response.

Cultural Competency

Service activities will be delivered so that cultural and language differences do not constitute a barrier to services in full compliance with the National Standards on Culturally and Linguistically Appropriate Services (CLAS) described at: http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15.

AIDS Services of Austin (ASA) is in compliance with all 15 CLAS Standards.

Table 5

CLAS Standards	ASA Compliance
121. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.	▪ Staff members are proficient in Spanish, culturally reflective of the Hispanic clientele and available to interpret daily ▪ Staff members are from diverse backgrounds including African-Americans and individuals that are immigrants to the USA. ▪ One staff member proficient in American Sign Language and others with basic skills ▪ Interpretation services in any language are offered to clients free of charge; interpreters culturally reflect clients ▪ Staff assigned to clients are reflective of clients' cultural background, as feasible ▪ Client materials are written at a fifth to eighth grade literacy level and in Spanish at third to fifth grade level ▪ Client materials are provided in Spanish and English ▪ A professional volunteer translates materials from English to Spanish ▪ Organization includes "diversity" as one of its core values
122. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.	▪ A Cultural Appropriateness Action Team with staff from varied levels and departments is tasked with ensuring CLAS and health equity are promoted ▪ The agency maintains a tracking mechanism to ensure CLAS compliance ▪ Agency policies are cognitive of cultural appropriateness and those that are applicable to clients are provided in

CLAS Standards	ASA Compliance
	English and Spanish at an appropriate literacy level ▪ Resources are allocated based on community need and assessment ensuring targeting of demographics most affected by the epidemic ▪ 2011-2015 board approved organizational strategic plan includes goals, objectives, and action steps prioritizing staff cultural awareness and competency trainings ▪ Executive Director serves on the Central Health *Health Equity Council* for HIV issues
123. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.	▪ Compliance with Equal Employment Opportunity Commission (EEOC) guidelines since inception ▪ Compliance with The Americans with Disabilities Act (ADA) since inception ▪ EEOC and ADA language reflected on all job postings ▪ Staff are fluent in Spanish, culturally reflective of the Hispanic clientele, and available to interpret daily ▪ Staff members are from diverse backgrounds including African-Americans, Latino, and individuals that are immigrants to the USA. Organizational staffing is reflective of the demographics of the HIV epidemic in the Austin TGA ▪ One staff member proficient in American Sign Language and others with basic skills ▪ Committed to promoting from within for job openings ▪ Evaluation of the potential of current staff for leadership development in order to promote direct service staff ▪ Structured Action Teams provide leadership development opportunities for all staff members ▪ Candidates for positions where bi-lingual (Spanish) skills are preferred are offered a salary premium for demonstrating appropriate proficiency in the language ▪ Organization recruits diverse candidates by networking with higher education institutions of color and advertising and conducting outreach into appropriate publications in communities of color ▪ 2011-2015 board approved organizational strategic plan includes goals, objectives, and action steps prioritizing recruiting, hiring, and training diverse staff and recruiting board members from communities of color ▪ Board officers are demographically and culturally diverse ▪ Agency participation in multicultural career expos for staff recruitment
124. Educate and train	▪ The agency's Cultural Appropriateness Action Team and

CLAS Standards	ASA Compliance
governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.	Professional Development Action Team research and implement ongoing training ▪ Agency support of language skills development when resources are available ▪ Executive Director serves on the Central Health *Health Equity Council* for HIV issues
125. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.	▪ Staff are proficient in Spanish, culturally reflective of the Hispanic clientele, and available to interpret daily ▪ Staff are from diverse backgrounds including African-Americans, Latino, and individuals that are foreign-born ▪ One staff member proficient in American Sign Language and others with basic skills ▪ Interpretation services in any language are offered to clients free of charge; interpreters culturally reflect clients ▪ Client materials are written at a fifth to eighth grade literacy level and in Spanish at a third to fifth grade level ▪ Client materials are provided in Spanish and English ▪ A professional volunteer translates client materials from English to Spanish ▪ The agency uses an independently certified system to evaluate the language proficiency of staff ▪ Organization's central voice mail and Dental Clinic voice mail systems are recorded in Spanish ▪ Key program staff have recorded voicemails in Spanish
126. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.	▪ Interpretation policy offering services free of charge posted in all locations ▪ Reception and Intake and Eligibility staff trained to notify clients of their right to receive language assistance services free of charge ▪ Front desk and key staff voicemail messages are recorded in English and Spanish ▪ Interpretation services in any language are offered to clients free of charge; interpreters culturally reflect clients ▪ Client materials are provided in Spanish and English ▪ Reception staff have access to language cards to identify need for interpretation services
127. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be	▪ The agency uses an independently certified system to evaluate the language proficiency of staff ▪ Written policy offers interpretation at no cost to the client in order to prevent the use of family and friends as interpreters ▪ Staff is trained to inform clients of their right to interpretation services at no cost and that family and

CLAS Standards	ASA Compliance
avoided.	friends are not a preferred source for interpretation in order to protect client confidentiality ▪ The agency hires professional, certified trainers to assist in interpretation upon request
128. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.	▪ Client materials are provided in Spanish and English ▪ Client materials are written at a fifth to eighth grade literacy level and in Spanish at a third to fifth grade level ▪ Key client information/policies and grievance information is posted in English and Spanish in common areas and available in hard copy from reception desks ▪ Quality Management Guidance Team reviews and updates materials to increase understandability
129. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.	▪ ASA's 2011 – 2015 Strategic Plan identifies compliance with CLAS Standards as a priority: o "Strategy #3: Ensure culturally appropriate programs and services ▪ Agency programs and services meet Culturally and Linguistically Appropriate Services (CLAS) standards ▪ Collaborative partners recognize ASA for delivery of programs and services to reduce stigma and for innovative and collaborative relationships" o Strategic plan action step is to implement an Organizational Cultural Appropriateness Committee representative of diversity of staff and management to further formalize cultural appropriateness trainings and action steps
130. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.	▪ Self-assessment of CLAS-related activities conducted in 2007; results continue to be used to improve services ▪ Cultural Appropriateness Action Team to survey annually and report to staff and board of directors of outcomes from strategic planning goals/objectives related to cultural appropriateness work
131. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.	▪ Collection of data and documentation on each consumer's race, ethnicity, disabilities, spoken and written language, and literacy level; information entered into client paper file, Provide Enterprise® internal electronic database, and ARIES; information updated periodically ▪ Use of the Austin Transitional Grant Area HIV Planning Council's periodic consumer needs assessment

CLAS Standards	ASA Compliance
	▪ Use of the Brazos Valley Council of Government's periodic consumer needs assessment ▪ Provision of HIV testing data to the Texas Department of State Health Services, (DSHS) and the Centers for Disease Control and Prevention, (CDC)
132. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.	▪ Collection of data and documentation on each consumer's race, ethnicity, disabilities, spoken and written language, and literacy level; information entered into client paper file, Provide Enterprise® internal electronic database, and ARIES; information updated periodically ▪ Annual review and assessment of HIV epidemiology profile of epidemic as prepared by Texas Department of State Health Services (TDSHS) and the Austin/Travis County Health and Human Services Department ▪ Use of the Austin Transitional Grant Area HIV Planning Council's and Brazos Valley Council of Government's periodic consumer needs assessment ▪ Annual report to staff and board of directors on Austin TGA HIV epidemic in comparison to organization's client demographic profile, staff demographics, and board demographics
133. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.	▪ Collection and updating of data and documentation on each consumer's race, ethnicity, disabilities, spoken and written language, and literacy level; information entered into client paper file, Provide Enterprise® client electronic database, and ARIES. ▪ Provision of HIV testing data results are reported to the DSHS and CDC ▪ Involvement in community events targeted to people of color to build collaborative partnerships in a participatory environment ▪ Staff shares lessons learned at above events with management and leadership staff to expand collective knowledge of local cultural practices and beliefs ▪ Organization is a member of the advisory committee to the Latino Commission on AIDS to develop training institutes on providing culturally appropriate HIV services to the Latino community in 2012 ▪ Executive Director serves on the Central Health *Health Equity Council* for HIV issues
134. Create conflict and grievance resolution processes that are culturally	▪ Client materials are provided in Spanish and English ▪ Client materials are written at a fifth to eighth grade literacy level and in Spanish at a third to fifth grade level

CLAS Standards	ASA Compliance
and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.	▪ Client grievance procedures are posted in English and Spanish in common areas throughout the organization ▪ Organization has a formal grievance procedure in place that is reviewed annually by staff
135. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.	▪ Strategic Plan dissemination to donors and posted on website ▪ Community Impact Report disseminated to donors, posted to website, and available in hard copy to public ▪ Responsiveness and pursuit of opportunities to participate in ethnic media

Quality Management

Use of Output and Outcome Data

Using monthly data, AIDS Services of Austin (ASA) tracks progress on the total number of unduplicated clients served, units of service delivered, and achievement of outcome goals through the reporting feature of the Provide Enterprise® electronic client database. On a monthly and quarterly basis, supervisors analyze the data to determine if outputs and outcomes, respectively, are within a 10 percent variance of the elapsed period of the grant cycle. If not, supervisors determine reasons that program goals are not being met and develop plans to address the situation including staff training, supervision, and monitoring staff adherence to the standards of care for the service category. Supervisors also note trends in performance measures with emphasis on clients who do not meet outcome goals and develop appropriate quality management activities or document the reasons for such exceptions. Provide Enterprise® reports give aggregate data at the agency level that documents client trends in service utilization for use in planning for service delivery.

Supervisors will use reports from the ARIES client database to validate data on performance measures such as number of unduplicated clients served and units of service provided. With the client's signed permission to share client information in ARIES, supervisors will use ARIES reports to facilitate getting complete data on services accessed by clients, to document successful linkages to primary medical care and support services, and to compare, if needed, client service utilization data in order to avoid duplication of services. ARIES will also provide aggregate data at the community level that documents client trends in service utilization for use in planning for service delivery.

Supervisors will use the service-specific client satisfaction survey to obtain data using client input on satisfaction with services provided. Supervisors review survey results including qualitative data at the program area, Leadership Team, Quality Management Guidance Team, and the Programs and Services Committee meetings. With input from these various teams,

supervisors use suggestions from the survey to identify problems and/or concerns and implement quality improvement activities including service delivery changes when possible.

The resources and tools used to facilitate this process are staff time, the Provide Enterprise® database, ARIES database, and the client satisfaction survey.

Assurance of Compliance with Austin TGA Standards of Care

Outreach services staff has been trained on the following Standards of Care in the Austin TGA Continuum of Care for Outreach Services:

Standard 1: Outreach workers shall establish contacts with HIV testing sites, hospitals, substance abuse centers, and other potential sources of HIV infected clients. The agency is in compliance with this standard when delivering outreach services. ASA created a referral card that is handed out to potential clients during outreach activities. Staff establishes contacts in locations throughout the TGA where persons at high risk of contracting HIV are proven to be, hospitals and emergency rooms, HIV testing sites, and other identified locations. The Outreach Worker identifies HIV positive clients and works with the Tier 2 Non-Medical Case Manager to link clients into medical care and refer them to other needed services. Outreach staff completes a weekly activity record that includes the date of outreach to specific sites. Evidence of compliance with the standard can be found in the folder that contains all completed Outreach Activity forms.

Standard 2: Staff is accessible by phone or pager during work hours. ASA is in compliance with this standard when delivering outreach services. The Outreach Worker's cell phone is reimbursed on a monthly basis and is used to assist potential clients in accessing medical care and/or other social services. A policy and procedure indicates use of the cell phone for work purposes, and the supervisor will monitor compliance with the policy on a quarterly basis. Evidence of compliance with this standard will be found in the policy and procedures manual.

Standard 3: Intake process is flexible and responsive, accommodating disabilities and health conditions. The agency is in compliance with the standard and has a policy to address appropriate accommodation. The Outreach Worker identifies newly HIV positive clients and documents clients' intake appointments for primary medical care. The supervisor will review quarterly 20 percent of files on clients served in this grant cycle to ensure compliance with the standard. Evidence of compliance with this standard can be found in intake documentation and client files.

Standard 4: Program is competent at delivering services to culturally and linguistically diverse populations to be served. ASA is in compliance with this standard. The Outreach Program strives to employ staff members who are bilingual and culturally represent the targeted communities or who are competent at delivering services to diverse populations. The agency will make every effort to provide adequate bicultural training to staff to ensure competency in those

areas. Evidence of compliance with the standard is reflected in certification of cultural competency training in personnel files.

Standard 5: Outreach workers bring new clients into medical care, link clients to case management and other needed services. The agency is in compliance with this standard when delivering outreach services. The Outreach Specialist refers and links all new clients willing to accept referrals to primary medical care, case management, and other needed services. A supervisor will review quarterly 20 percent of files on clients served during this grant cycle to ensure compliance with the standard.

Standard 6: Within the first six months of employment, outreach workers will complete at least ten hours of HIV disease, treatment, transmission, at least ten hours of psychosocial and at least eight hours of cultural competency training. The agency is in compliance with the standard when delivering outreach services. Documentation of completion of training is tracked on an internal agency form or training certificates and filed with the Human Resources Department and in personnel files. The current Out-of-Care Specialists have received more than the required amount of training in all areas required by the standard and will receive a minimum of 12 hours annually. Within the first six months of employment, future newly hired Outreach Workers will receive the required training. Currently department staff, within three months of employment, receive training in HIV and AIDS 101 (medical), safety issues, role of volunteers, first aid, universal precautions (medical), cultural competency, confidentiality issues (psychosocial), agency-specific information, community resources (psychosocial), observation of Case Manager visits (psychosocial), harm reduction (psychosocial), professional boundaries (psychosocial), and fire/emergency procedures.

Standard 7: A minimum of one year of documented HIV/AIDS or related experience is preferred. A degree in social sciences field may substitute for experience requirement. HIV positive status when revealed may substitute for one year of experience. As indicated in the chart in the "Staffing" section, the agency has been in compliance with this standard when delivering outreach services. Each staff has a more than one year of HIV experience. Evidence of this standard can be found in personnel files kept in the Human Resources Department.

Standard 8: There is a system in place to document staff work time. The agency is in compliance with the standard to capture hours and attendance when delivering outreach services. Outreach workers document contacts on the HIV Activity Report Form, which includes the date and location of outreach activities. The supervisor receives and reviews this report. In practice, the agency already requires documentation of timesheets and the sign-in/out sheet. Evidence of meeting this standard will be found on timesheets, sign-in/out sheets, and in the policy.

Quality Management Plan

Quality Management Guidance Team

The overall responsibility and leadership for ASA's Quality Management (QM) program lies with the Chief Programs Officer, who authorizes the Quality Management Guidance Team

(QMGT) to plan, assess, measure, and implement performance improvements throughout the entire agency, while providing the necessary resources and support to fulfill these functions.

The membership of the QMGT reflects the diverse service areas within AIDS Services of Austin (ASA). The agency's quality team is comprised of Chief Programs Officer and other members of ASA staff, ranging from upper management to direct service staff. Other ASA staff members, such as Program Supervisors and Coordinators, Case Managers, and Prevention Specialists are involved, as appropriately indicated Nominations for membership are decided upon by the QMGT. The QMGT meets quarterly or at least four scheduled times per year. Additional meetings may be called, as needed. Minutes of meetings are distributed directly to each member of the committee and to all necessary internal and external stakeholders. A written summary is routinely made available to staff.

The Quality Management Plan
The Quality Management Plan seeks to improve service performance through collecting and evaluating data, identifying service problems based on the collected data, using quality improvement processes to address service delivery issues, and following up to ensure improvements will be sustained. The agency plan is designed annually with target goals and service specific quality improvement activities. It calls for a review of service performance measures, an analysis of this data, and recommendations for service improvements. The plan indicates that the team will oversee an annual update and revision of program policies and procedures. At the end of each year, the plan is evaluated to determine the achievement of goals and the service specific improvement activities and to make recommendations for further follow-up.

The following sections describe other components in the Quality Management Plan:

Activities to Collect Data
The Chief Programs Officer, the Director of Access Services, and the Eligibility Services Manager will collect data on the program's performance in achieving service goals and meeting standards of care through results from the following sources: outcome and output measures, the agency client satisfaction survey, client file reviews, client/staff feedback, and client grievances.

Supervisors review performance measures quarterly and report measures not meeting contract objectives to the Quality Management Guidance Team, along with suggestions on planned action steps.

Client satisfaction surveys are an important way to identify quality issues. The agency distributes the standardized survey, after approval by the HIV Resource Administration Unit, City of Austin Health and Human Services Department, at the Food Bank and Dental Clinic sites to collect data on all Ryan White Service Categories offered at ASA. Trained social work interns and volunteers administer the survey during a selected two week period. The survey data is tabulated by the Data Manager-System Support Technician at the HIV Resource Administration Unit, AHHSD.

File reviews are essential to the quality of client data. Supervisors review 20 percent of Outreach client files on clients during the grant cycle to evaluate pertinent Outreach activities and compliance with indicators for the standards of care.

Client input from registered grievances is documented by program supervisors and reviewed at department staff meetings. Supervisors adhere to the agency's policy on client/patient grievances, which includes review by the Executive Director and/or the Board of Directors, if necessary.

Evaluation of Performance and Assuring Delivery of Quality Services
As data and input are received and problems are identified, the QMGT evaluate concerns and suggestions in order to assure the delivery of quality services.

The QMGT analyzes the output/outcome data and makes recommendations for improvement to program supervisors. When quality improvement activities around performance measures are designed and completed, the results are then sent to the team and reported in the annual evaluation of the Quality Management Plan.

Supervisors will evaluate survey results to identify trends for improvements and advocate for unmet client need. Supervisors will be careful to note any client feedback related to the culturally appropriateness of service delivery especially with respect to policies and procedures and Outreach interventions with African-Americans and Hispanics. To guide decisions about quality improvement activities, survey results are discussed at the program level in department/program meetings and at QMGT meetings. The Programs and Services Committee of the Board of Directors also reviews survey results and gives guidance when appropriate.

Program supervisors utilize grievance input obtained from clients and managers at the different grievance levels to make appropriate service changes, when feasible. Supervisors will be careful to note any client feedback related to the culturally appropriateness of service delivery for African-American and Hispanics.

Suggested actions taken based on this data could include staff development training in an identified area such as cultural appropriateness in communication or interventions with African-Americans and Hispanics, development of organization tracking tools, identification of a different site for service delivery, additional interventions to reduce barriers, or design of client/patient forms to better capture data and service performance measures.

Identification of Quality Improvement Activities
At the beginning of the year, supervisors and the QMGT identify specific service quality improvement activities based on staff and client feedback and the data already discussed.

Activities are written using SMART objectives in that they are specific, measureable, attainable, relevant and time-bound.

Addressing Identified Problems
Once a problem or an area that needs further assessment is identified, the team will use, when appropriate, the Plan-Do-Study-Act cycle (PDSA), a four-step model for carrying out change. This process will be used in identified quality improvement activities as detailed in the annual Quality Management Plan. The components are as follows:

1. Plan by recognizing an opportunity and planning a change.
2. Do by testing the change and carrying out a small-scale study.
3. Study by reviewing the test, analyzing the results/data and identifying what has been learned.
4. Act by taking action based on what you learned as a result of data analysis in the study step.

If the change does not work, the cycle will be repeated again with a different plan.

To address client file review results, supervisors will implement a plan of correction when deficiencies in delivering services or lack of compliance to standards have been identified. Supervisors will require plans of correction and timelines for correction. If meeting the standard is systemic rather than related to one or two staff, then supervisors will design and require staff training and report quality improvement activity results to the QMGT.

Follow Up
The Outreach Program supervisors will follow up to ensure the effectiveness of improvement activities and the maintenance of improvement results. On identified quality improvement activities, supervisors follow up on a quarterly basis to ensure that these activities have been effective in resolving the problem, that no new problems have developed, and that there is sustained improvement in identified areas.

For file review results, supervisors work with staff to develop plans of correction within 15 working days of the file review. Staff has ten working days to implement corrections. At the next quarterly file review supervisors monitor the maintenance of the previous quarter's improvements to ensure problems do not reoccur.

Monitoring and Standardized Tools
Tools used in monitoring and standardization include the file review tool and Provide Enterprise® reports with features to track reporting of performance measures, and to describe content of progress notes for easy tracking. The annual client satisfaction survey is a standardized tool that the Ryan White Quality Management workgroup evaluates and standardizes across HIV service providers.

Compliance with Ryan White Part A Program Monitoring Standards

viii. Document and be prepared to share with the grantee:
- The design, implementation, target areas and populations, and outcomes of outreach activities, including the number of individuals reached, referred for testing, found to be positive, referred to care, and entering care
- Data showing that all RFP and contract requirements are being met with regard to program design, targeting, activities, and use of funds

The Outreach Coordinator conducts outreach activities, including case findings, at the locations detailed *Service Category Activities sections*. The target areas and populations are also detailed in the chart in the same section. ASA targets areas that have been identified through local epidemiological data to be at disproportionate risk for HIV infection. The Outreach Coordinator tracks the number of encounters at each location using an Excel® spreadsheet. Additionally, HIV-positive clients that are identified through these activities, as well as referred from ASA's Prevention Department testing programs are tracked on a separate spreadsheet. The Outreach Coordinator provides this information monthly to the program supervisor, who compiles the data. Data is reported monthly to the A/TCHHSD HIV Resource Administration Unit. As ASA will not be utilizing outreach funds to refer targeted populations into testing, this information will not be tracked. Outcome data of clients referred to and entering into both HIV primary medical and case management will be entered into the electronic database Provide Enterprise®. Supervisors will use a reporting function to report quarterly on achieved outcomes.

ix. Provide financial and program data demonstrating that no outreach funds are being used
- To pay for HIV counseling and testing
- To support broad-scope awareness activities
- To duplicate HIV prevention outreach efforts

Outreach activities are planned and delivered in coordination with ASA's Prevention Department. The Prevention Department conducts HIV counseling and testing and broad-scope awareness activities that are funded by the Centers for Disease Control and Prevention, the Substance Abuse and Mental Health Services Administration, the Texas Department of State Health Services, and Travis County. While the Outreach staff works in conjunction with the ASA Prevention Department, they do not duplicate their efforts.

ATTACHMENT B

PERFORMANCE MEASURES

Summary Page only

Service Category	Units of Service to be delivered with initial funding for 12-month term	Unduplicated Clients to be served with initial funding for 12-month term
Food Bank Services	1,045	138
Medical Nutrition Therapy	964	67
Case Management Non-Medical	1,504	21
Case Management Non-Medical - MAI	980	14
Oral Health Care	997	249
Outreach Services: MAI	80	15
Outreach Services	146	17
Health Insurance Premiums and Cost Sharing Assistance	142	25
Medical Case Management	1975	25
Medical Case Management- -MAI	1,352	22

2. Performance – Section I

a. Output Performance Measures

A. SERVICE CATEGORY: ***Food Bank Services***
Output Measure #1: *ASA will provide 1,045 food pantry/voucher visits without nutritional supplements provided between March 1, 2016 and February 28, 2017.*
How will the data be collected and compiled for this output measure (include description of resources and tools used)? The Food Bank Client Visit Log tracks the number of clients receiving services and the number of visits made each month. The Data Entry Specialist enters information from the log into the Provide® Enterprise ARIES databases for tracking and reporting purposes. Quantitative measures regarding Food Bank visits, medical care, and case management access are entered into Provide® Enterprise. A report of unduplicated clients with the numbers of visits and units of services are generated which the Food and Nutrition Manager checks against the service delivery Food Bank Log Book. Monthly reports are then run to generate the number of unduplicated clients that have received services and the units of service numbers for the month. This report is forwarded to the Associate Director of Direct Services for review by the 10th of the month following service delivery. Resources include the staff time of food bank staff and volunteers, the Data Entry Specialist, the Food and Nutrition Services Manager, the Associate Director of Direct Services, the Systems and Facilities Administrator, and the Chief Financial Officer.
Output Measure #2: *ASA will provide __0__ food pantry/voucher visits with nutritional supplements provided between March 1, 2013 and February 28, 2014.*
How will the data be collected and compiled for this output measure (include description of resources and tools used)? Not applicable.
Output Measure #3: *ASA will serve 138 unduplicated clients with food pantry/vouchers services without nutritional supplements between March 1, 2065 and February 28, 2017. .* *a) __**110**__ continuing clients served.*

*b) _**28**_ new clients served.*

How will the data be collected and compiled for this output measure (include a description of resources and tools used)?

The Food Bank Client Visit Log tracks the number of clients receiving services and the number of visits made each month. The Data Entry Specialist enters information from the log into the Provide® Enterprise and ARIES databases for tracking and reporting purposes. Quantitative measures regarding Food Bank visits, medical care, and case management access are entered into Provide® Enterprise. A report of unduplicated clients with the numbers of visits and units of services are generated which the Food and Nutrition Manager checks against the service delivery Food Bank Log Book. Monthly reports are then run to generate the number of unduplicated clients having received services and the units of service numbers for service period (month).

Resources include the staff time of food bank staff and volunteers, the Data Entry Specialist, the Food and Nutrition Services Manager, the Associate Director of Direct Services, the Systems and Facilities Administrator, and the Chief Financial Officer.

Output Measure #4: *ASA will serve _0_ unduplicated clients with food pantry/vouchers services with nutritional supplements between March 1, 2013 and February 28, 2014.*

c) _0_ continuing clients served.

d) _0_ new clients served.

How will the data be collected and compiled for this output measure (include a description of resources and tools used)?

Not applicable.

2. Performance (cont.) – Section II

a. Outcome Performance Measures

A. SERVICE CATEGORY: ***Food Bank Services***

Outcome Measure #1: *Percent of clients served receiving primary medical care services* **(Outcome target = 95%)**
Numerator: 131 = Number of clients served receiving primary medical care services
Denominator: 138 = Number of clients served

What data will be collected, analyzed, and reported in order to assess this outcome?

1. Number of clients served during Food Bank weeks of the grant period;
2. Client's name;
3. If the client has a doctor;
4. Date of last client visit to the doctor or a primary care facility; and
5. The name of the agency where the client is case managed.

How will the data be collected and compiled for this outcome measure (include description of resources and tools used)?

1. The Food Bank Log book will be used to collect raw data on the number of unduplicated clients served during service delivery.
2. Data for this outcome may be collected and reported through the ARIES database. In addition each case manager and the Eligibility and Intake staff collect in care verification every six months. ASA staff monitor clients to ensure that client's in care status is documented every six months. The community case managers are alerted if a client is not in care so that steps can be taken to get them back into care.

At what point(s) or times(s) in the service delivery sequence will the data be collected and evaluated? During Food Bank service deliver when the client receives the Food Bank menu; the client will be informed that eligibility information is due at their six month anniversary date. When client provides this information it will be collected along with the menu by FB staff at the time of service. FB staff will document this information in the client eligbility tracking data sheet. Data sheet is monitored quarterly to ensure quality assurance. Data is evaluated at the end of the grant year, prior to submitting the 12th monthly report; no later than 03/20/2017.

Total Undup. Clients Evaluated for Outcome Objective	Total Number of Undup. Clients Achieving Objective	% of Undup. Clients Achieving Outcome Objective	Reporting Dates
138	131	95%	03/15/2017

A. SERVICE CATEGORY: ***Food Bank Services***

Outcome Measure #2: *Percent of clients served receiving case management services (medical and non-medical)* **(Outcome target =95%)**
Numerator: _131_ = Number of clients served receiving case management services (medical and non-medical)
Denominator: _138_ = Number of clients served

What data will be collected, analyzed, and reported in order to assess this outcome?

ASA's Eligibility and Intake staff will collect information on clients enrolled in case management as one criteria used to determine eligibility for food bank services. Data collected will be entered into the Provide Enterprise® database.

How will the data be collected and compiled for this outcome measure (include description of resources and tools used)?
1. The Food Bank Log book will be used to collect raw data on the number of unduplicated clients served during service delivery
2. The Eligibility and Intake staff will ensure that interagency clients are receiving case management from an area AIDS Service Organization every six months. When a client is exited from case management services at any agency the case manager will inform Food Bank staff via email. Clients who are exited will be removed from the Food Bank log. Food Bank log is monitored quarterly to ensure quality assurance

At what point(s) or times(s) in the service delivery sequence will the data be collected and evaluated? Client level data will be collected during Intake and Eligibility screening, and/or when eligibility is re-determined at six month intervals. Data will be evaluated at the annually, end of the grant year, prior to reporting contract close-out activities; no later than 03/20/2017.

Total Undup. Clients Evaluated for Outcome Objective	Total Number of Undup. Clients Achieving Objective	% of Undup. Clients Achieving Outcome Objective	Reporting Dates
138	131	95%	03/15/2017

2. Performance – Section I

b. Output Performance Measures

A. SERVICE CATEGORY: ***Medical Nutrition Therapy***
Output Measure #1: *ASA will provide 2,235 units of service of Medical Nutrition Therapy between March 1, 2016 and February 28, 2017.* *a)* *__964____ units of therapy provided.* **b)** *__1,271___ units of supplements provided.*
How will the data be collected and compiled for this output measure (include description of resources and tools used)? The Dietitian tracks the number of clients receiving services, the service activities provided, and the number of visits made each month on the Nutrition Services Monthly Report Form. The Form collects data on the date of service, client name, case manager's name, supplements distributed, appointment time, educational literature distributed, BIA, therapy consult, initial assessment, follow-up visit, phone reminder completed, appointment no show, client level data entered into client database progress logs, and the total units associated with the unduplicated client. The Data Entry Specialist enters information taken from the form into the Provide® Enterprise and ARIES databases for tracking and reporting purposes. Quantitative measures regarding MNT visits, medical care, and case management access are entered into Provide® Enterprise. A report of unduplicated clients with the numbers of visits and units of services are generated which the Dietitian checks against the service delivery Nutrition Services Monthly Report Form. Monthly reports are then run to generate the number of unduplicated clients having received services and the units of service for the month. This report is forwarded to the Associate Director of Direct Services for review by the 10th of the month following service delivery. Resources used include the staff time of Eligibility and Intake staff, the Dietitian, the Data Entry Specialist, the Food and Nutrition Services Manager, the Associate Director of Direct Services, the Systems and Facilities Administrator, and the Chief Financial Officer.
Output Measure # 2: *ASA will serve __**67**__ unduplicated clients with Medical Nutrition Therapy between March 1, 2016 and February 28, 2017.* *e)* *__59___ continuing clients served.* *f)* *__8___ new clients served.*
How will the data be collected and compiled for this output measure (include a description of

resources and tools used)?

The Dietitian tracks the number of clients receiving services, the service activities provided, and the number of visits made each month on the Nutrition Services Monthly Report Form. The Forms collect data on the date of service, client name, case manager's name, supplements distributed, appointment time, educational literature distributed, BIA, therapy consult, initial assessment, follow-up visit, phone reminder completed, appointment no show, client level data entered into client database progress logs, and the total units associated with the unduplicated client.

The Data Entry Specialist enters information taken from the form into the Provide® Enterprise and ARIES databases for tracking and reporting purposes. Quantitative measures regarding MNT visits, medical care, and case management access are entered into Provide® Enterprise. A report of unduplicated clients with the numbers of visits and units of services are generated which the Dietitian checks against the Supplement and Counseling log books. Monthly reports are then run to generate the number of unduplicated clients having received services and the units of service for the month. This report is forwarded to the Associate Director of Direct Services for review by the 10th of the month following service delivery.

Resources used include the staff time of Eligibility and Intake staff, the Dietitian, the Data Entry Specialist, the Food and Nutrition Services Manager, the Associate Director of Direct Services, the Systems and Facilities Administrator, and the Chief Financial Officer.

2. Performance (cont.) – Section II

b. Outcome Performance Measures

A. SERVICE CATEGORY: *Medical Nutrition Therapy*

Outcome Measure #1: *Percent of clients receiving nutritional counseling services remaining in or accessing primary medical care* **(Outcome target=90%)**

Numerator: 60 = Number of clients who are receiving nutritional counseling services remaining in or accessing primary medical care
Denominator: 67 = Number of clients who are receiving nutritional counseling services

What data will be collected, analyzed, and reported in order to assess this outcome?
ASA case managers will work with clients to identify keeping medical visit appointments as a goal in their health service plans. Progress notes and service plans will reflect progress made in achievement of this goal and exceptions including reasons for not attaining goal. ASA case managers will collect information that documents clients kept medical visits in Provide Enterprise®.

A report of unduplicated clients who are receiving MNT services and remaining in or accessing primary medical care in comparison to the number of clients who are receiving MNT counseling therapy, will be generated by the Dietitian. The report will be forwarded to the Associate Director of Direct Services and Food and Nutrition Services Manager for review by the 10th of the month following service delivery for evaluation and assessment of progress made towards the goal.

For other ASOs, data for this outcome must be collected and reported through the ARIES database – ASA will not be reporting on clients who are case managed at other ASOs.

How will the data be collected and compiled for this outcome measure (include description of resources and tools used)?
The Provide Enterprise® client database will be used to collect and aggregate the data entered by ASA case managers. Reports, as described above, will be used to summarize the data.

Resources used will include staff time of the Dietitian, the Data Entry Specialist, the Food and Nutrition Services Manager, the Associate Director of Direct Services, the Systems and Facilities Administrator, and the Chief Financial Officer.

At what point(s) or times(s) in the service delivery sequence will the data be collected and evaluated?

Data will be collected at all points of service delivery from entry into the program until the client is closed to services. Aggregate data is evaluated at the end of the grant year, prior to submitting the 12th monthly report; no later than 03/15/2017.

Total Undup. Clients Evaluated for Outcome Objective	Total Number of Undup. Clients Achieving Objective	% of Undup. Clients Achieving Outcome Objective	Reporting Dates
60	67	90%	03/15/2017

A. SERVICE CATEGORY: ***Medical Nutrition Therapy***

Outcome Measure #2: *Percent of clients demonstrating improved nutritional status based on nutritional plan goals and nutritional assessment* **(Outcome target =90%)**

Numerator: 27 = Number of clients demonstrating improved nutritional status based on nutritional plan goals and nutritional assessment
Denominator: 30 = Number of clients who are receiving nutritional counseling services and have a client file review completed on improving nutritional plan goals.

What data will be collected, analyzed, and reported in order to assess this outcome?
20% of the clients at MNT Level Two services (receiving nutritional supplements) will have their files reviewed for improvement in nutritional plan goals.

ASA's Dietitian(s) will collect information concerning improved nutritional status based on previously completed nutritional assessment(s) on clients engaged in MNT Level Two Services and will be compared to their individual nutrition plan goals. Assessment results and progress will be documented in the client's individual chart file maintained in the MNT office. As a medical clinician, the Dietitian(s) will make the determination of whether or not improved nutritional status is met, or to what extent the client attained or made progress in this area. Dietitian(s) will report improved nutritional status to the Food and Nutrition Services Manager at regular intervals.

It should be noted that individual client nutritional status may change throughout the course of the grant year as client's health status fluctuates. It is conceivable that at some point in service delivery, nutritional goals were met, yet may not be sustained due to mitigating circumstances. The nutritional assessment (initial and follow-up) will help gauge success and reset goals, as appropriate.

How will the data be collected and compiled for this outcome measure (include description of resources and tools used)?
The nutritional assessment is completed at various times during clients' MNT Level Two services.

Usually, it is performed at the first visit, or the second if the client is not prepared for the in-depth assessment due to time constraints (60 – 90 minutes required); nutritional assessment is required in order to receive nutritional supplement therapy. Clients who have been taking supplements for six months or more will be considered for this outcome.

The Dietitian(s) will collect information on goal progress and attainment in the client's MNT chart file. Through quarterly file reviews of active continuing clients who have taken nutritional supplements for six (6) months or more, the Dietitian, or their designee will review charts for note of progress/attainment. While data will be collected through quarterly chart audits conducted on active clients taking nutritional supplements, this measure will be reported after the end of the grant year on the contract close out report. Nutritional assessments occur once a year, follow –ups every 3 months therefore ASA needs to collect data for the previous nine months to be able to accurately report the measure

Note: This is not an automated collection and reporting function at this time, however, ASA is working toward automating data collection and reporting within the grant year. Resources required to accomplish this task are a data collection and reporting feature in Provide® Enterprise and staff time to enter the data, run the reports, and spot check the data against the client file for validity.

Resources used will include staff time of the Dietitian, the Data Entry Specialist, the Food and Nutrition Services Manager, volunteers and interns, the Associate Director of Direct Services, the Systems and Facilities Administrator, and the Chief Financial Officer.

At what point(s) or times(s) in the service delivery sequence will the data be collected and evaluated?

Data is collected at all points of service delivery from entry into the program until the client is closed to services. Data is evaluated at the end of the grant year, prior to submitting the 12th monthly report; and no later than 03/15/2017.

Total Undup. Clients Evaluated for Outcome Objective	Total Number of Undup. Clients Achieving Objective	% of Undup. Clients Achieving Outcome Objective	Reporting Dates
30	27	90%	03/15/2017

2. Performance – Section I

c. Output Performance Measures

A. SERVICE CATEGORY: ***Case Management Non-Medical***
Output Measure #1: *ASA will provide 1504_ units of service of Case Management Non-Medical between March 1, 2016 and February 28, 2017.*
How will the data be collected and compiled for this output measure (include description of resources and tools used)? The Eligibility and Intake Staff and/or Non-Medical Case Manager collects data by entering units of service by unduplicated client in the "Services Provided" function of Provide Enterprise®. Using the Provide Enterprise® reporting function, the Non-Medical Programs Manager will generate a report on number of units received by clients. The Provide Enterprise® database contains the client file and includes the data fields necessary to export required information to the ARIES database for statistical analysis as required by AHHSD. The number of units will then be reported to the Chief Financial Officer who completes and submits the monthly grant reports to the AHHSD HIV Resource Administration Unit. Resources include the staff time of the Eligibility and Intake staff, Non-Medical Case Managers, the Non-Medical Programs Manager, the Director of Access Services, the Systems and Facilities Administrator, and the Chief Financial Officer.
Output Measure # 2: *ASA will serve 21_ unduplicated clients with Case Management Non-Medical between March 1, 2016 and February 28, 2017.* *g) 24 clients served will receive N-MCM.*
How will the data be collected and compiled for this output measure (include a description of resources and tools used)? The Eligibility and Intake Staff and/or Non-Medical Case Manager collects data by entering units of service by unduplicated client in the "Services Provided" function of Provide Enterprise®. Using the Provide Enterprise® reporting function, the Non-Medical Programs Manager will generate a report on number of units received by clients that indicates the total number of unduplicated clients receiving this

service. The Provide Enterprise® database contains the client file and includes the data fields necessary to export required information to the ARIES database for statistical analysis as required by AHHSD. The number of unduplicated clients will then be reported to the Chief Financial Officer who completes and submits the monthly grant reports to the AHHSD HIV Resource Administration Unit.

Resources include staff time of the Eligibility and Intake staff, Non-Medical Case Managers, the Non-Medical Programs Manager, the Director of Access Services, the Systems and Facilities Administrator and the Chief Financial Officer.

2. Performance (cont.) – Section II

c. Outcome Performance Measures

A. SERVICE CATEGORY: ***Case Management Non-Medical***
Outcome Measure #1: *Percent of HIV-infected non-medical case management clients who had a non-medical case management plan development and/or updated two or more times in the measurement year.* **(Outcome target =95%)** 20 = Number of HIV-infected non-medical case management clients who had a non-medical case management plan development and/or updated two or more times in the measurement year 21 = Number of HIV-infected non-medical case management clients served
What data will be collected, analyzed, and reported in order to assess this outcome? Non-Medical Case Managers will collect client information during the assessment and, based on this information, will evaluate client needs in order to establish health goals and objectives, with client input, for the individualized health service plan. Non-Medical Case Managers will develop an updated assessment and individualized service plan two or more times during the grant cycle.
How will the data be collected and compiled for this outcome measure (include description of resources and tools used)? Non-Medical Case Managers enter service plan goals into the Provide Enterprise® service plan template (electronic form) and then prints the plan for the client paper file. Clients sign a paper copy of the individualized service plan, which is included in the client paper file. The client is provided with a signed copy for his or her records. Non-Medical Case Managers will document in progress notes in the electronic client file, client self-report, and medical and social service providers reports that address the health service plan goals. Using a feature in Provide Enterprise®, case managers will report in the electronic file that the client has signed the service plan. Using another Provide Enterprise® reporting function, a report will be generated on the number of clients achieving the outcome and the total number of unduplicated clients receiving Case Management Non-Medical services. Once the percentage is determined from these reports, it will then be reported to the Chief Financial Officer or designee. The Provide Enterprise® database contains the client file and includes the data fields necessary to enter into or export required information to the ARIES® database for statistical analysis as required by AHHSD. Resources include the staff time of the Eligibility and Intake staff, Tier 1 Non-Medical Case Managers, the Non-Medical Programs Manager, the Director of Access Services, the Systems and Facilities Administrator and the Chief Financial Officer.

At what point(s) or times(s) in the service delivery sequence will the data be collected and evaluated?

Data will be collected by the Non-Medical Case Manager at the time of service delivery. Service plans are created and/or updated every six months for Acuity 1 and 2 clients and every three months for Acuity 3 clients. Managers evaluate and report on data based upon the Provide Enterprise® reporting function at the end of Quarters 2 and 4.

Total Undup. Clients Evaluated for Outcome Objective	Total Number of Undup. Clients Achieving Objective	% of Undup. Clients Achieving Outcome Objective	Reporting Dates
20	21	95%	Sept. 15, 2016 March 15, 2017

A. SERVICE CATEGORY: ***Case Management Non-Medical***

Outcome Measure #2: *Percent of HIV-infected non-medical case management clients who had two or more medical visits in an HIV care setting in the measurement year.* **(Outcome target =95%)**

20 = Number of HIV-infected non-medical case management clients who had two or more medical visits in an HIV care setting in the measurement year.

21 = Number of HIV-infected non-medical case management clients served

What data will be collected, analyzed, and reported in order to assess this outcome?

Non-Medical Case Managers will work with clients to identify maintaining HIV medical visit appointments as a goal in the service plan. Progress notes and service plans will reflect progress made in achievement of this goal and exceptions including reasons for not attaining goal. Non-Medical Case Managers will collect information that documents client kept medical visits in Provide Enterprise®.

How will the data be collected and compiled for this outcome measure (include description of resources and tools used)?

Non-Medical Case Managers will document client medical provider reports, medical visit billing information, and ARIES data fields (with client permission) that verify kept medical appointments by clients. Non-Medical Case Managers will document this medical information through a reporting function in Provide Enterprise®. Managers will use a different reporting function to generate the number of clients receiving Case Management Non-Medical and the number of unduplicated clients achieving the outcome. The Provide Enterprise® database contains the client file and includes the data fields necessary to enter

into or export required information to ARIES for statistical analysis as required by AHHSD.

Resources include the staff time of the intake staff, Non-Medical Case Managers, the Non-Medical Programs Manager, the Director of Access Services, the Systems and Facilities Administrator, and the Chief Financial Officer.

At what point(s) or times(s) in the service delivery sequence will the data be collected and evaluated?

Data is collected by the Non-Medical Case Manager at the individual frequency of client medical appointments. The Non-Medical Case Managers discusses client medical appointments at each encounter and documents client kept medical visits in Provide Enterprise®. Managers evaluate and report on data based upon the Provide Enterprise® reporting function at the end of Quarters 2 and 4.

Total Undup. Clients Evaluated for Outcome Objective	Total Number of Undup. Clients Achieving Objective	% of Undup. Clients Achieving Outcome Objective	Reporting Dates
20	21	95%	Sept. 15, 2016 March 15, 2017

2. Performance – Section I

d. Output Performance Measures

A. SERVICE CATEGORY: ***Case Management Non-Medical (Tier 1) - MAI***
Output Measure #1: *ASA will provide _980_ units of service of Case Management Non-Medical: MAI between March 1, 2016 and February 28, 2017.*
How will the data be collected and compiled for this output measure (include description of resources and tools used)? The Eligibility and Intake Staff and/or MAI Non-Medical Case Manager collects data by entering units of service by unduplicated client in the "Services Provided" function of Provide Enterprise®. Using the Provide Enterprise® reporting function, the Non-Medical Programs Manager will generate a report on number of units received by clients. The Provide Enterprise® database contains the client file and includes the data fields necessary to export required information to the ARIES database for statistical analysis as required by AHHSD. The number of units will then be reported to the Chief Financial Officer who completes and submits the monthly grant reports to the AHHSD HIV Resource Administration Unit. Resources include the staff time of the Eligibility and Intake staff, MAI Non-Medical Case Managers, the Non-Medical Programs Manager, the Director of Access Services, the Systems and Facilities Administrator, and the Chief Financial Officer.
Output Measure # 2: *ASA will serve _14_ unduplicated clients with Case Management Non-Medical MAI between March 1, 2016 and February 28, 2017.* *h) __14 clients served will receive services under the NMCM – MAI*
How will the data be collected and compiled for this output measure (include a description of resources and tools used)? The Eligibility and Intake Staff and/or MAI Non-Medical Case Manager collects data by entering units of service by unduplicated client in the "Services Provided" function of Provide Enterprise®. Using the

Provide Enterprise® reporting function, the Director of Access Services will generate a report on number of units received by clients that indicates the total number of unduplicated clients receiving this service. The Provide Enterprise® database contains the client file and includes the data fields necessary to export required information to the ARIES database for statistical analysis as required by AHHSD. The number of unduplicated clients will then be reported to the Chief Financial Officer who completes and submits the monthly grant reports to the AHHSD HIV Resource Administration Unit.

Resources include the staff time of the intake staff, MAI Non-Medical Case Managers, the Non-Medical Programs Manager, the Director of Access Services, the Systems and Facilities Administrator, and the Chief Financial Officer.

2. Performance (cont.) – Section II

d. Outcome Performance Measures

A. SERVICE CATEGORY: ***Case Management Non-Medical (Tier 1): MAI***
Outcome Measure #1: *Percent of HIV-infected African-American and Hispanic Tier 1 non-medical case management clients who had a non-medical case management plan developed and/or updated two or more times in the measurement year.* **(Outcome target =95%)** 13 = Number of HIV-infected non-medical case management African-American and Hispanic clients who had a non-medical case management plan development and/or updated two or more times in the measurement year 14 = Number of HIV-infected non-medical case management clients served
What data will be collected, analyzed, and reported in order to assess this outcome? MAI Non-Medical Case Managers will collect client information during the assessment and, based on this information, will evaluate client needs in order to establish health goals and objectives, with client input, for the individualized health service plan. MAI Non-Medical Case Managers will develop an updated assessment and individualized service plan two or more times during the grant cycle.
How will the data be collected and compiled for this outcome measure (include description of resources and tools used)? MAI Non-Medical Case Managers enter service plan goals into the Provide Enterprise® service plan template (electronic form) and then prints the plan for the client paper file. Clients sign a paper copy of the individualized service plan, which is included in the client paper file. The client is provided with a signed copy for his or her records. MAI Non-Medical Case Managers will document in progress notes in the electronic client file, client self-report, and medical and social service providers reports that address the health service plan goals. Using a feature in Provide Enterprise®, case managers will report in the electronic file that the client has signed the service plan. Using another Provide Enterprise® reporting function, a report will be generated on the number of clients achieving the outcome and the total number of unduplicated clients receiving Case Management Non-Medical: MAI. Once the percentage is determined from these reports, it will then be reported to the Chief Financial Officer or designee. The Provide Enterprise® database contains the client file and includes the data fields necessary to enter into or export required information to the ARIES® database for statistical analysis as required by AHHSD. Resources include the staff time of the intake staff, MAI Non-Medical Case Managers, the Non-Medical Programs Manager, the Director of Access Services, the Systems and Facilities Administrator, and the

Chief Financial Officer.

At what point(s) or times(s) in the service delivery sequence will the data be collected and evaluated?

Data will be collected by the Tier 1 MAI Non-Medical Case Manager at the time of service delivery. Service plans are created and/or updated every six months for Acuity 1 and 2 clients and every three months for Acuity 3 clients. Managers evaluate and report on data based upon the Provide Enterprise® reporting function at the end of Quarters 2 and 4.

Total Undup. Clients Evaluated for Outcome Objective	Total Number of Undup. Clients Achieving Objective	% of Undup. Clients Achieving Outcome Objective	Reporting Dates
13	14	95%	Sept. 15, 2016 March 15, 2017

A. SERVICE CATEGORY: ***Case Management Non-Medical (Tier 1): MAI***

Outcome Measure #2: *Percent of HIV-infected African-American and Hispanic Tier 1 non-medical case management clients who had two or more medical visits in an HIV care setting in the measurement year.* **(Outcome target =95%)**

13 = Number of HIV-infected African-American and Hispanic non-medical case management clients who had two or more medical visits in an HIV care setting in the measurement year.

14 = Number of HIV-infected African-American and Hispanic non-medical case management clients served

What data will be collected, analyzed, and reported in order to assess this outcome?

MAI Non-Medical Case Managers will work with clients to identify maintaining HIV medical visit appointments as a goal in the health service plan. Progress notes and service plans will reflect progress made in achievement of this goal and exceptions including reasons for not attaining goal. MAI Non-Medical Case Managers will collect information that documents client kept medical visits in Provide Enterprise®.

How will the data be collected and compiled for this outcome measure (include description of resources and tools used)?

MAI Non-Medical Case Managers will document client medical provider reports, medical visit billing

information, and ARIES data fields (with client permission) that verify kept medical appointments by clients. MAI Non-Medical Case Managers will document this medical information through a reporting function in Provide Enterprise®. Managers will use a different reporting function to generate the number of African-American and Hispanic clients receiving Case Management Non-Medical - MAI and the number of unduplicated African-American and Hispanic clients achieving the outcome. The Provide Enterprise® database contains the client file and includes the data fields necessary to enter into or export required information to ARIES® for statistical analysis as required by AHHSD.

Resources include the staff time of the intake staff, MAI Non-Medical Case Managers, the Non-Medical Programs Manager, the Director of Access Services, the Systems and Facilities Administrator, and the Chief Financial Officer.

At what point(s) or times(s) in the service delivery sequence will the data be collected and evaluated?

Data is collected by the MAI Non-Medical Case Manager at the individual frequency of client medical appointments. MAI Non-Medical Case Managers discuss client medical appointment at each encounter and document client kept medical visits in Provide Enterprise®. Managers evaluate and report on data based upon the Provide Enterprise® reporting function at the end of Quarters 2 and 4.

Total Undup. Clients Evaluated for Outcome Objective	Total Number of Undup. Clients Achieving Objective	% of Undup. Clients Achieving Outcome Objective	Reporting Dates
13	14	95%	Sept. 15, 2016 March 15, 2017

SECTION I: OUTPUT PERFORMANCE MEASURES

A. SERVICE CATEGORY: ***Oral Health Care***

Output Measure #1: *ASA will provide **997** units of service between March 1, 2016 and February 28, 2017.*

a) ***598*** *units of routine treatment service provided.*
b) ***349*** *units of prophylaxis treatment service provided.*
c) ***50*** *units of specialty care treatment service provided.*

How will the data be collected and compiled for this output measure (include description of resources and tools used)?

Routine, prophylaxis and specialty care treatment services provided will be noted by the Dentist or Dental Hygienist and documented on the record of procedures provided at each patient visit. Results will be entered into the Practice management software and Provide® Enterprise databases by the Dental staff.

Using a data reporting feature in Provide® Enterprise, an activity summary by program report will be generated each month by the Systems and Facilities Administrator. The report identifies the total number of units of routine, prophylaxis and specialty care treatment services provided during the reporting period.

Using a billing extract feature in Provide® Enterprise, services provided are exported for upload into individual client records in the ARIES database. ARIES Utilization by funding Source reports identify the number of units of routine, prophylaxis and specialty care treatment services provided each month during the reporting period and posted to the grant source.

The Practice management software database is a tool developed by a dentist specifically for dental facilities and is aimed at providing patient scheduling, insurance billing, and tracking of daily oral health care procedures. The Provide® Enterprise database contains the patient file and includes the data fields necessary to enter into or export required information to the ARIES (the AIDS Regional Information and

A. SERVICE CATEGORY: *Oral Health Care*

Evaluation System) database and for statistical analysis as required by DSHS and A/TCHHSD.

Output Measure # 2:
*ASA will provide Oral Health Care Services to **249** unduplicated patients between March 1, 2016 and February 28, 2017*

*d) **199** continuing clients will be served.*
e) ***50** new clients will be served.*

How will the data be collected and compiled for this output measure (include a description of resources and tools used)?

Routine, prophylaxis and specialty care treatment services provided will be noted by the Dentist or Dental Hygienist and documented on the record of procedures provided at each patient visit. Results will be entered into the Practice management software and Provide® Enterprise databases by the Dental staff.

Using a data reporting feature in Provide® Enterprise, an activity summary by program report will be generated each month by the Systems and Facilities Administrator. The report identifies the total number of unduplicated clients that received routine, prophylaxis and specialty care treatment services each month during the reporting period.

Using a billing extract feature in Provide® Enterprise, services provided are exported for upload into individual client records in the ARIES database.

ARIES Utilization by funding Source reports identify the total number of unduplicated clients that received routine, prophylaxis and specialty care treatment services provided each month during the reporting period. Using different date parameters the same ARIES reports identify the unduplicated number of new clients to receive services each month during the reporting period.

The number of continuing clients is determined by subtracting the number new clients from the number of total clients.

The Practice management software database is a practice management software product specifically for dental practices and is aimed at providing patient scheduling, insurance billing, and tracking of daily oral health care procedures. The Provide® Enterprise database contains the patient file and includes the data fields necessary to enter into or export required information to the ARIES (the AIDS Regional Information and Evaluation System) database and for statistical analysis as required by DSHS and A/TCHHSD.

A. SERVICE CATEGORY: ***Oral Health Care***

Outcome Measure #1: *Percentage of HIV-infected oral health patients who had a dental and medical health history (initial or updated) at least once in the measurement year* ***(Outcome target = 95%)***
Numerator = Number of HIV infected oral health patients who had a dental and medical health history (initial or updated) at least once in the measurement year
Denominator = Number of HIV infected oral health patients that received a clinical oral evaluation at least once in the measurement year
Patient Exclusions:

1. *Patients who had only an evaluation or treatment for a dental emergency in the measurement year*
2. *Patients who were <12 months old.*

What data will be collected, analyzed, and reported in order to assess this outcome?
Dental and Medical history (initial or updated), clinical oral evaluation, and evaluation or emergency treatment will be documented in the patient chart by the Dentist at each patient visit.

How will the data be collected and compiled for this outcome measure (include description of resources and tools used)?
Patient receipt of dental and medical history (initial or updated), clinical oral evaluation, and evaluation or emergency treatment will be noted by the Dentist and documented on the record of procedures provided at each patient visit. Results will be entered into the Practice management software and Provide® databases by the Dental staff.

Using the Provide® Enterprise data reporting feature the Systems and Facilities Administrator will generate separate reports every three months to determine:

a) the unduplicated clients that received a dental and medical history (initial or updated) during the reporting period, and
b) the unduplicated clients that received a clinical oral evaluation during the reporting period, and
c) the unduplicated clients that received an evaluation or treatment for a dental emergency only, during the reporting period.

Using an ARIES client demographic report, the Systems and Facilities Administrator will determine the unduplicated clients who were less than 12 months old.

All results of all four reports will be used to determine the number of patients to achieve the outcome.

The Program Director will analyze the reports for validity and the Systems and Facilities Administrator will complete the report and submit results every three months.

The Practice management software database is a tool developed by a dentist specifically for dental facilities and is aimed at providing patient scheduling, insurance billing, and tracking of daily oral health care procedures. The Provide® Enterprise database contains the patient file and includes the data fields

A. SERVICE CATEGORY: ***Oral Health Care***

necessary to enter into or export required information to the ARIES database and for statistical analysis as required by DSHS and A/TCHHSD.

At what point(s) or times(s) in the service delivery sequence will the data be collected and evaluated?
Data will be collected at each patient visit. Collected data will be evaluated every three months.

Total Undup. Clients Evaluated for Outcome Objective	Total Number of Undup. Clients Achieving Objective	% of Undup. Clients Achieving Outcome Objective	Reporting Dates
(249 minus the # of patient exclusions)	(249 minus the # of patient exclusions)*95%	95%	Jun. 15, 2016 Sep. 15, 2016 Dec. 15, 2016 Mar. 15, 2017

A. SERVICE CATEGORY: ***Oral Health Care***

Outcome Measure #2: *Percentage of HIV-infected oral health patients who had a dental treatment plan developed and/or updated at least once in the measurement year* ***(Outcome target = 90%)***

Numerator = Number of HIV infected oral health patients who had a dental treatment plan developed and/or updated at least once in the measurement year
Denominator = Number of HIV infected oral health patients that received a clinical oral evaluation at least once in the measurement year
Patient Exclusions:

1. *Patients who had only an evaluation or treatment for a dental emergency in the measurement year*
2. *Patients who were <12 months old.*

What data will be collected, analyzed, and reported in order to assess this outcome?

Dental Treatment plan developed or updated, clinical oral evaluation, and evaluation or emergency treatment will be documented in the patient chart by the Dentist at each patient visit.

How will the data be collected and compiled for this outcome measure (include description of resources and tools used)?

Patient receipt of the development or update of a dental treatment plan, clinical oral evaluation, and evaluation or emergency treatment will be noted by the Dentist and documented on the record of procedures provided at each patient visit. Results will be entered into the Practice management software and Provide® databases by the Dental staff.

Using the Provide® Enterprise data reporting feature the Systems and Facilities Administrator will generate separate reports every three months to determine:

a) the unduplicated clients that had a dental treatment plan developed or updated during the reporting period, and
b) the unduplicated clients that received a clinical oral evaluation during the reporting period, and
c) the unduplicated clients that received an evaluation or treatment for a dental emergency only during the reporting period.

Using an ARIES client demographic report, the Systems and Facilities Administrator will determine the

A. SERVICE CATEGORY: ***Oral Health Care***

unduplicated clients who were less than 12 months old.

All results of all four reports will be used to determine the number of patients to achieve the outcome.

The Program Director will analyze the reports for validity and the Systems and Facilities Administrator will complete the report and submit results every three months.

The Practice management software database is a tool developed by a dentist specifically for dental facilities and is aimed at providing patient scheduling, insurance billing, and tracking of daily oral health care procedures.
The Provide® Enterprise database contains the patient file and includes the data fields necessary to enter into or export required information to the ARIES database and for statistical analysis as required by DSHS and A/TCHHSD.

At what point(s) or times(s) in the service delivery sequence will the data be collected and evaluated?

Data will be collected at each patient visit. Collected data will be evaluated every three months.

Total Undup. Clients Evaluated for Outcome Objective	Total Number of Undup. Clients Achieving Objective	% of Undup. Clients Achieving Outcome Objective	Reporting Dates
(249 minus the # of patient exclusions)	(249 minus the # of patient exclusions)*90%	90%	Jun. 15, 2016 Sep. 15, 2016 Dec 15, 2016 Mar.15, 2017

A. SERVICE CATEGORY: ***Oral Health Care***

Outcome Measure #3: *Percentage of HIV-infected oral health patients who received oral health education at least once in the measurement year* ***(Outcome target = 95%)***
Numerator = Number of HIV infected oral health patients who received oral health education at least once in the measurement year
Denominator = Number of HIV infected oral health patients that received a clinical oral evaluation at least once in the measurement year
Patient Exclusions:

1. *Patients who had only an evaluation or treatment for a dental emergency in the measurement year*
2. *Patients who were <12 months old.*

What data will be collected, analyzed, and reported in order to assess this outcome?
Oral Health Education data will be documented in the patient chart by the Dental Hygienist at each patient visit. Clinical oral evaluation, and evaluation or emergency treatment will be documented in the patient chart by the Dentist at each patient visit.

How will the data be collected and compiled for this outcome measure (include description of resources and tools used)?
Patient receipt of Oral Health Education will be noted by the Dental Hygienist and documented on the record of procedures provided at each patient visit. Clinical oral evaluation, and evaluation or emergency treatment will be noted by the Dentist and documented on the record of procedures provided at each patient visit. Results will be entered into the Practice management software and Provide® databases by the Dental staff.

Using the Provide® Enterprise data reporting feature the Systems and Facilities Administrator will generate separate reports every three months to determine:

a) the unduplicated clients that received oral health education during the reporting period, and

A. SERVICE CATEGORY: ***Oral Health Care***

b) the unduplicated clients that received a clinical oral evaluation during the reporting period, and
c) the unduplicated clients that received an evaluation or treatment for a dental emergency only during the reporting period.

Using an ARIES client demographic report, the Systems and Facilities Administrator will determine the unduplicated clients who were less than 12 months old.

All results of all four reports will be used to determine the number of patients to achieve the outcome.

The Program Director will analyze the reports for validity and the Systems and Facilities Administrator will complete the report and submit results every three months.

The Practice management software database is a tool developed by a dentist specifically for dental facilities and is aimed at providing patient scheduling, insurance billing, and tracking of daily oral health care procedures.
The Provide® Enterprise database contains the patient file and includes the data fields necessary to enter into or export required information to the ARIES database and for statistical analysis as required by DSHS and A/TCHHSD.

At what point(s) or times(s) in the service delivery sequence will the data be collected and evaluated?
Data will be collected at each patient visit. Collected data will be evaluated every three months.

Total Undup. Clients Evaluated for Outcome Objective	Total Number of Undup. Clients Achieving Objective	% of Undup. Clients Achieving Outcome Objective	Reporting Dates
(249 minus the # of patient exclusions)	(249 minus the # of patient exclusions)*95%	95%	Jun. 15, 2016 Sep. 15, 2016 Dec 15, 2016 Mar. 15, 2017

A. SERVICE CATEGORY: ***Oral Health Care***

Outcome Measure #4: *Percentage of HIV-infected oral health patients who had a periodontal screen or examination at least once in the measurement year* ***(Outcome target = 80%)***
Numerator = Number of HIV infected oral health patients who had a periodontal screen or examination at least once in the measurement year
Denominator = Number of HIV infected oral health patients that received a clinical oral evaluation at least once in the measurement year
Patient Exclusions:

1. *Patients who had only an evaluation or treatment for a dental emergency in the measurement year*
2. *Edentulous patients (complete)*
3. *Patients who were <13 years*

What data will be collected, analyzed, and reported in order to assess this outcome?
Periodontal Screening or examination data will be documented in the patient chart by the Dental Hygienist at each patient visit. Clinical oral evaluation, patient edentualism (complete), and evaluation or emergency treatment will be documented in the patient chart by the Dentist at each patient visit.

How will the data be collected and compiled for this outcome measure (include description of resources and tools used)?
Patient receipt of Periodontal screening or examination will be noted by the Dental Hygienist and documented on the record of procedures provided at each patient visit. Clinical oral evaluation, patient

A. SERVICE CATEGORY: ***Oral Health Care***

edentualism, and evaluation or emergency treatment will be noted by the Dentist and documented on the record of procedures provided at each patient visit.
Results will be entered into the Practice management software and Provide® databases by the Dental staff.

Using the Provide® Enterprise data reporting feature the Systems and Facilities Administrator will generate separate reports every three months to determine:

a) the unduplicated clients that received periodontal screening or examination during the reporting period, and
b) the unduplicated clients that received a clinical oral evaluation during the reporting period, and
c) the unduplicated clients that received an evaluation or treatment for a dental emergency only during the reporting period, and
d) the unduplicated clients that are edentalist (complete) during the reporting period.

Using an ARIES client demographic report, the Systems and Facilities Administrator will determine the unduplicated clients aged 13 years or older.

All results of all five reports will be used to determine the number of patients to achieve the outcome.

The Program Director will analyze the reports for validity and the Systems and Facilities Administrator will complete the report and submit results every three months.

The Practice management software database is a tool developed by a dentist specifically for dental facilities and is aimed at providing patient scheduling, insurance billing, and tracking of daily oral health care procedures.
The Provide® Enterprise database contains the patient file and includes the data fields necessary to enter into or export required information to the ARIES database and for statistical analysis as required by DSHS and A/TCHHSD.

At what point(s) or times(s) in the service delivery sequence will the data be collected and evaluated?
Data will be collected at each patient visit. Collected data will be evaluated every three months.

Total Undup. Clients Evaluated for Outcome Objective	Total Number of Undup. Clients Achieving Objective	% of Undup. Clients Achieving Outcome Objective	Reporting Dates
(249 minus the # of patient exclusions)	(249 minus the # of patient exclusions)*80%	80%	Jun. 15, 2016 Sep. 15, 2016 Dec 15, 2016 Mar. 15, 2017

A. SERVICE CATEGORY: *Oral Health Care*
Outcome Measure #5: *Percentage of HIV-infected oral health patients with a Phase 1 treatment plan that is completed within 12 months of establishing a treatment plan* ***(Outcome target = 80%)*** Numerator = Number of HIV infected oral health patients that completed a Phase 1 treatment within 12 months of establishing a treatment plan Denominator = Number of HIV infected oral health patients with a Phase 1 treatment plan in the year prior to the measurement year *Patient Exclusions:* 1. *Patients who had only an evaluation or treatment for a dental emergency in the year prior to the measurement year*
What data will be collected, analyzed, and reported in order to assess this outcome? Phase 1 treatment completion data, treatment plan established, and evaluation or emergency treatment will be documented in the patient chart by the Dentist at each patient visit.

A. SERVICE CATEGORY: ***Oral Health Care***

How will the data be collected and compiled for this outcome measure (include description of resources and tools used)?
Completion of Phase I treatment, treatment plan established and evaluation or emergency treatment will be noted by the Dentist and documented on the record of procedures provided at each patient visit. Results will be entered into the Practice management software and Provide® databases by the Dental staff.

Using the Provide® Enterprise data reporting feature the Systems and Facilities Administrator will generate separate reports every three months to determine:

a) the unduplicated clients completed a Phase 1 treatment plan within 12 months of establishing a treatment plan during the reporting period, and
b) the unduplicated clients with a Phase 1 treatment plan in the year prior to the measurement year, and
c) the unduplicated clients that received an evaluation or treatment for a dental emergency only during the year prior to the measurement year.

All results of all three reports will be used to determine the number of patients to achieve the outcome.

The Program Director will analyze the reports for validity and the Systems and Facilities Administrator will complete the report and submit results every three months.

The Practice management software database is a tool developed by a dentist specifically for dental facilities and is aimed at providing patient scheduling, insurance billing, and tracking of daily oral health care procedures.
The Provide® Enterprise database contains the patient file and includes the data fields necessary to enter into or export required information to the ARIES database and for statistical analysis as required by DSHS and A/TCHHSD.

At what point(s) or times(s) in the service delivery sequence will the data be collected and evaluated?
Data will be collected at each patient visit. Collected data will be evaluated every three months.

Total Undup. Clients Evaluated for Outcome Objective	Total Number of Undup. Clients Achieving Objective	% of Undup. Clients Achieving Outcome Objective	Reporting Dates
(249 minus the # of patient exclusions)	(249 minus the # of patient exclusions)*80%	80%	Jun 15, 2016 Sep. 15, 2016 Dec. 15, 2016 Mar. 15, 2017

2. Performance – Section I

e. Output Performance Measures

A. SERVICE CATEGORY: *Outreach Services: MAI*
Output Measure #1: *ASA will provide _80*_ units of service between March 1, 2016 and February 28, 2017.* **One unit of service = 1 encounter in attempts to identify persons with unknown and known HIV disease.*
How will the data be collected and compiled for this output measure (include description of resources and tools used)? The Outreach Coordinator will enter units of service (encounters) on an Excel Spreadsheet. The monthly total is tallied and provided to the Director of Access Services. The number of units will then be reported to the Chief Financial Officer who completes and submits the monthly grant reports to the AHHSD HIV Resource Administration Unit. Resources include the time of the Outreach staff, the Director of Access Services, the Systems and Facilities Administrator, and the Chief Financial Officer.
Output Measure #2: *ASA will identify _3_ African-American and/or Hispanic persons with unknown HIV disease between March 1, 2016 and February 28, 2017.*
How will the data be collected and compiled for this output measure (include description of resources and tools used)? The Outreach Coordinator will enter unduplicated clients on an Excel Spreadsheet. The monthly total is tallied and provided to the Director of Access Services. The number of unduplicated clients will then be reported to the Chief Financial Officer who completes and submits the monthly grant reports to the AHHSD HIV Resource Administration Unit. Resources include the time of the Outreach staff, the Director of Access Services, the Systems and Facilities Administrator, and the Chief Financial Officer.
Output Measure #3: *ASA will identify _15_ African-American and/or Hispanic persons with known HIV disease between March 1, 2016 and February 28, 2017.*
How will the data be collected and compiled for this output measure (include a description of resources and tools used)? The Outreach Coordinator will enter unduplicated clients on an Excel Spreadsheet. The monthly total is tallied and provided to the Director of Access Services. The number of unduplicated clients will then be reported to the Chief Financial Officer who completes and submits the monthly grant reports to the AHHSD HIV Resource Administration Unit. Resources include the time of the Outreach staff, the Director of Access Services, the Systems and Facilities Administrator, and the Chief Financial Officer.

2. Performance (cont.) – Section II

e. Outcome Performance Measures

A. SERVICE CATEGORY: ***Outreach Services: MAI***
Outcome Measure #1: *Percent of African-American and/or Hispanics persons with unknown HIV disease status successfully referred into primary medical care services* **(Outcome target =95%)** 3 = Number of persons with unknown HIV disease status successfully referred into primary medical care services 3 = Number of persons with unknown HIV disease status identified **(Successful referral is defined as completion of intake appointment)**
What data will be collected, analyzed, and reported in order to assess this outcome? Outreach staff will collect data to include the number of clients who are linked to primary medical care as a result of services. Clients are considered successfully linked to primary medical care after clients have attended their initial intake appointment at CommUnity Care at David Powell Clinic.
How will the data be collected and compiled for this outcome measure (include description of resources and tools used)? Data will be collected by Outreach staff at the time of the initial HIV primary medical care intake appointment. The staff attends these appointments so has firsthand knowledge of client kept appointments. This staff person will document this medical information in progress notes in the client paper file. The Outreach Coordinator will use an Excel spreadsheet to track and report on the number of clients who attended the primary medical care intake appointment and the number of unduplicated clients served. Once the percentage is determined, it will then be reported to AHHSD HIV Resource Administration Unit. Resources include the time of the Outreach staff, the Director of Access Services,, the Systems and Facilities Administrator, and the Chief Financial Officer.
At what point(s) or times(s) in the service delivery sequence will the data be collected and evaluated? The data will be collected when the Outreach staff person has verified that the initial appointment for primary medical care is kept. The Outreach Coordinator will evaluate the data on a bi-annual basis.

Total Undup. Clients Evaluated for Outcome Objective	Total Number of Undup. Clients Achieving Objective	% of Undup. Clients Achieving Outcome Objective	Reporting Dates
3	3	95%	Sept. 15, 2016 March 15, 2016

A. SERVICE CATEGORY: ***Outreach Services: MAI***

Outcome Measure #2: *Percent of African-American and/or Hispanic persons with unknown HIV disease status successfully referred into case management and/or support services* **(Outcome target =95%)**
3 = Number of persons with unknown HIV disease status successfully referred into case management and/or support services
3 = Number of persons with unknown HIV disease status identified
(Successful referral is defined as completion of intake appointment)

What data will be collected, analyzed, and reported in order to assess this outcome?
Outreach staff will collect data to include the number of clients who are linked to case management and/or support services as a result of services. Clients are considered successfully linked to case management and/or support services after clients have attended their initial intake appointments.

How will the data be collected and compiled for this outcome measure (include description of resources and tools used)?
Data will be collected by Outreach staff at the time of the initial case management and/or support services intake appointment. The staff attends these appointments so has firsthand knowledge of client kept appointments. This staff person will document this information in progress notes in the client paper file. The Outreach Coordinator will use an Excel spreadsheet to track and report on the number of clients who attended the primary medical care intake appointment and the number of unduplicated clients served. Once the percentage is determined, it will then be reported to AHHSD HIV Resource Administration Unit.
Resources include the time of the Outreach staff, the Director of Access Services,, the Systems and Facilities Administrator, and the Chief Financial Officer.

At what point(s) or times(s) in the service delivery sequence will the data be collected and evaluated?
The data will be collected when the Outreach staff person has verified that the initial appointment for case management and/or support services is kept. The Outreach Coordinator will evaluate the data on a bi-annual basis.

Total Undup. Clients Evaluated for Outcome Objective	Total Number of Undup. Clients Achieving Objective	% of Undup. Clients Achieving Outcome Objective	Reporting Dates
3	3	95%	Sept. 15, 2016 March 15, 2017

A. SERVICE CATEGORY: ***Outreach Services: MAI***

Outcome Measure #3: *Percent of African-American and/or Hispanic persons with known HIV disease status successfully referred into primary medical care services* **(Outcome target =95%)**
14 = Number of persons with known HIV disease status successfully referred into primary medical care services
15 = Number of persons with known HIV disease status identified
(Successful referral is defined as completion of intake appointment)

What data will be collected, analyzed, and reported in order to assess this outcome?
Outreach staff will collect data to include the number of clients who are linked to primary medical care as a result of services. Clients are considered successfully linked to primary medical care after clients have attended their initial intake appointment at CommUnity Care at David Powell Clinic.

How will the data be collected and compiled for this outcome measure (include description of resources and tools used)?
Data will be collected by Outreach staff at the time of the initial HIV primary medical care intake appointment. The staff attends these appointments so has firsthand knowledge of client kept appointments. This staff person will document this medical information in progress notes in the client paper file. The Outreach Coordinator will use an Excel spreadsheet to track and report on the number of clients who attended the primary medical care intake appointment and the number of unduplicated clients served. Once the percentage is determined, it will then be reported to AHHSD HIV Resource Administration Unit.
Resources include the time of the Outreach staff, the Director of Access Services,, the Systems and Facilities Administrator, and the Chief Financial Officer.

At what point(s) or times(s) in the service delivery sequence will the data be collected and evaluated?
The data will be collected when the Outreach staff person has verified that the initial appointment for primary medical care is kept. The Outreach Coordinator will evaluate the data on a bi-annual basis.

Total Undup. Clients Evaluated for Outcome Objective	Total Number of Undup. Clients Achieving Objective	% of Undup. Clients Achieving Outcome Objective	Reporting Dates
14	15	95%	Sept. 15, 2016 March 15, 2017

A. SERVICE CATEGORY: ***Outreach Services: MAI***

Outcome Measure #7: *Percent of African-American and/or Hispanics persons with known HIV disease status successfully referred into case management and/or support services* **(Outcome target =95%)**
14 = Number of persons with known HIV disease status successfully referred into case management and/or support services
15 = Number of persons with known HIV disease status identified
(Successful referral is defined as completion of intake appointment)

What data will be collected, analyzed, and reported in order to assess this outcome?
Outreach staff will collect data to include the number of clients who are linked to case management and/or support services as a result of services. Clients are considered successfully linked to case management and/or support services after clients have attended their initial intake appointments.

How will the data be collected and compiled for this outcome measure (include description of resources and tools used)?
Data will be collected by Outreach staff at the time of the initial case management and/or support services intake appointment. The staff attends these appointments so has firsthand knowledge of client kept appointments. This staff person will document this information in progress notes in the client paper file. The Outreach Coordinator will use an Excel spreadsheet to track and report on the number of clients who attended the primary medical care intake appointment and the number of unduplicated clients served. Once the percentage is determined, it will then be reported to AHHSD HIV Resource Administration Unit.
Resources include the time of the Outreach staff, the Director of Access Services,, the Systems and Facilities Administrator, and the Chief Financial Officer.

At what point(s) or times(s) in the service delivery sequence will the data be collected and evaluated?
The data will be collected when the Outreach staff person has verified that the initial appointment for case management and/or support services is kept. The Outreach Coordinator will evaluate the data on a bi-annual basis.

Total Undup. Clients Evaluated for Outcome Objective	Total Number of Undup. Clients Achieving Objective	% of Undup. Clients Achieving Outcome Objective	Reporting Dates
14	15	95%	Sept. 15, 2016 March 15, 2017

2. Performance – Section I

f. Output Performance Measures

A. SERVICE CATEGORY: *Outreach Services*
Output Measure #1: *ASA will provide _146* units of service between March 1, 2016 and February 28, 2017.* **One unit of service = 1 encounter in attempts to identify persons with unknown and known HIV disease.*
How will the data be collected and compiled for this output measure (include description of resources and tools used)? The Outreach Coordinator will enter units of service (encounters) on an Excel Spreadsheet. The monthly total is tallied and provided to the Director of Access Services. The number of units will then be reported to the Chief Financial Officer who completes and submits the monthly grant reports to the AHHSD HIV Resource Administration Unit. Resources include the time of the Outreach staff, the Director of Access Services, the Systems and Facilities Administrator, and the Chief Financial Officer.
Output Measure #2: *ASA will identify _4_ persons with unknown HIV disease between March 1, 2016 and February 28, 2017.*
How will the data be collected and compiled for this output measure (include description of resources and tools used)? The Outreach Coordinator will enter unduplicated clients on an Excel Spreadsheet. The monthly total is tallied and provided to the Director of Access Services. The number of unduplicated clients will then be reported to the Chief Financial Officer who completes and submits the monthly grant reports to the AHHSD HIV Resource Administration Unit. Resources include the time of the Outreach staff, the Director of Access Services, the Systems and Facilities Administrator, and the Chief Financial Officer.
Output Measure #3: *ASA will identify _17_ persons with known HIV disease between March 1, 2016 and February 28, 2017.*
How will the data be collected and compiled for this output measure (include a description of resources and tools used)? The Outreach Coordinator will enter unduplicated clients on an Excel Spreadsheet. The monthly total is tallied and provided to the Director of Access Services. The number of unduplicated clients will then be reported to the Chief Financial Officer who completes and submits the monthly grant reports to the AHHSD HIV Resource Administration Unit. Resources include the time of the Outreach staff, the Director of Access Services, the Systems and Facilities Administrator, and the Chief Financial Officer.

2. Performance (cont.) – Section II

f. Outcome Performance Measures

A. SERVICE CATEGORY: *Outreach Services*
Outcome Measure #1: *Percent of persons with unknown HIV disease status successfully referred into primary medical care services* **(Outcome target =95%)** 4 = Number of persons with unknown HIV disease status successfully referred into primary medical care services 4 = Number of persons with unknown HIV disease status identified **(Successful referral is defined as completion of intake appointment)**
What data will be collected, analyzed, and reported in order to assess this outcome? Outreach staff will collect data to include the number of clients who are linked to primary medical care as a result of services. Clients are considered successfully linked to primary medical care after clients have attended their initial intake appointment at CommUnity Care at David Powell.
How will the data be collected and compiled for this outcome measure (include description of resources and tools used)? Data will be collected by Outreach staff at the time of the initial HIV primary medical care intake appointment. The staff attends these appointments so has firsthand knowledge of client kept appointments. This staff person will document this medical information in progress notes in the client paper file. The Outreach Coordinator will use an Excel spreadsheet to track and report on the number of clients who attended the primary medical care intake appointment and the number of unduplicated clients served. Once the percentage is determined, it will then be reported to AHHSD HIV Resource Administration Unit. Resources include the time of the Outreach staff, the Director of Access Services,, the Systems and Facilities Administrator, and the Chief Financial Officer.
At what point(s) or times(s) in the service delivery sequence will the data be collected and evaluated? The data will be collected when the Outreach staff person has verified that the initial appointment for primary medical care is kept. The Outreach Coordinator will evaluate the data on a bi-annual basis.

Total Undup. Clients Evaluated for Outcome Objective	Total Number of Undup. Clients Achieving Objective	% of Undup. Clients Achieving Outcome Objective	Reporting Dates
4	4	95%	Sept. 15, 2016 March 15, 2017

A. SERVICE CATEGORY: ***Outreach Services***

Outcome Measure #2: *Percent of persons with unknown HIV disease status successfully referred into case management and/or support services* **(Outcome target =95%)**
4 = Number of persons with unknown HIV disease status successfully referred into case management and/or support services
4 = Number of persons with unknown HIV disease status identified
(Successful referral is defined as completion of intake appointment)

What data will be collected, analyzed, and reported in order to assess this outcome?
Outreach staff will collect data to include the number of clients who are linked to case management and/or support services as a result of services. Clients are considered successfully linked to case management and/or support services after clients have attended their initial intake appointments.

How will the data be collected and compiled for this outcome measure (include description of resources and tools used)?
Data will be collected by Outreach staff at the time of the initial case management and/or support services intake appointment. The staff attends these appointments so has firsthand knowledge of client kept appointments. This staff person will document this information in progress notes in the client paper file. The Outreach Coordinator will use an Excel spreadsheet to track and report on the number of clients who attended the primary medical care intake appointment and the number of unduplicated clients served. Once the percentage is determined, it will then be reported to AHHSD HIV Resource Administration Unit.
Resources include the time of the Outreach staff, the Director of Access Services,, the Systems and Facilities Administrator, and the Chief Financial Officer.

At what point(s) or times(s) in the service delivery sequence will the data be collected and evaluated?
The data will be collected when the Outreach staff person has verified that the initial appointment for case management and/or support services is kept. The Outreach Coordinator will evaluate the data on a bi-annual basis.

Total Undup. Clients Evaluated for Outcome Objective	Total Number of Undup. Clients Achieving Objective	% of Undup. Clients Achieving Outcome Objective	Reporting Dates
4	4	95%	Sept. 15, 2016 March 15, 2017

A. SERVICE CATEGORY: ***Outreach Services***

Outcome Measure #3: *Percent of persons with known HIV disease status successfully referred into primary medical care services* **(Outcome target =95%)**
16 = Number of persons with known HIV disease status successfully referred into primary medical care services
17 = Number of persons with known HIV disease status identified
(Successful referral is defined as completion of intake appointment)

What data will be collected, analyzed, and reported in order to assess this outcome?
Outreach staff will collect data to include the number of clients who are linked to primary medical care as a result of services. Clients are considered successfully linked to primary medical care after clients have attended their initial intake appointment at CommUnity Care at David Powell.

How will the data be collected and compiled for this outcome measure (include description of resources and tools used)?
Data will be collected by Outreach staff at the time of the initial HIV primary medical care intake appointment. The staff attends these appointments so has firsthand knowledge of client kept appointments. This staff person will document this medical information in progress notes in the client paper file. The Outreach Coordinator will use an Excel spreadsheet to track and report on the number of clients who attended the primary medical care intake appointment and the number of unduplicated clients served. Once the percentage is determined, it will then be reported to AHHSD HIV Resource Administration Unit.
Resources include the time of the Outreach staff, the Director of Access Services,, the Systems and Facilities Administrator, and the Chief Financial Officer.

At what point(s) or times(s) in the service delivery sequence will the data be collected and evaluated?
The data will be collected when the Outreach staff person has verified that the initial appointment for primary medical care is kept. The Outreach Coordinator will evaluate the data on a quarterly basis.

Total Undup. Clients Evaluated for Outcome Objective	Total Number of Undup. Clients Achieving Objective	% of Undup. Clients Achieving Outcome Objective	Reporting Dates
16	17	95%	Sept. 15, 2016 March 15, 2017

A. SERVICE CATEGORY: ***Outreach Services***

Outcome Measure #4: *Percent of persons with known HIV disease status successfully referred into case management and/or support services* **(Outcome target =95%)**
16 = Number of persons with known HIV disease status successfully referred into case management and/or support services
17 = Number of persons with known HIV disease status identified
(Successful referral is defined as completion of intake appointment)

What data will be collected, analyzed, and reported in order to assess this outcome?
Outreach staff will collect data to include the number of clients who are linked to case management and/or support services as a result of services. Clients are considered successfully linked to case management and/or support services after clients have attended their initial intake appointments.

How will the data be collected and compiled for this outcome measure (include description of resources and tools used)?
Data will be collected by Outreach staff at the time of the initial HIV primary medical care intake appointment. The staff attends these appointments so has firsthand knowledge of client kept appointments. This staff person will document this medical information in progress notes in the client paper file. The Outreach Coordinator will use an Excel spreadsheet to track and report on the number of clients who attended the primary medical care intake appointment and the number of unduplicated clients served. Once the percentage is determined, it will then be reported to AHHSD HIV Resource Administration Unit.
Resources include the time of the Outreach staff, the Director of Access Services,, the Systems and Facilities Administrator, and the Chief Financial Officer.

At what point(s) or times(s) in the service delivery sequence will the data be collected and evaluated?
The data will be collected when the Outreach staff person has verified that the initial appointment for case management and/or support services is kept. The Outreach Coordinator will evaluate the data on a quarterly basis.

Total Undup. Clients Evaluated for Outcome Objective	Total Number of Undup. Clients Achieving Objective	% of Undup. Clients Achieving Outcome Objective	Reporting Dates
16	17	95%	Sept. 15, 2016 March 15, 2017

2. Performance – Section I

g. Output Performance Measures

A. SERVICE CATEGORY: ***Health Insurance Premiums and Cost Sharing Assistance***
Output Measure #1: *ASA will provide _142_ units of service of health insurance assistance between March 1, 2016 and February 28, 2017.*
How will the data be collected and compiled for this output measure (include description of resources and tools used)? The Accountant processes the approved request for HI assistance and gives the assistance checks to the Receptionist for client dispersal or mails them to clients. The Administrative Assistant, based on the check register, enters the units of service for health insurance assistance in the "Services Provided" function of Provide Enterprise®, the electronic client database. The data is then exported to the ARIES database as required by the HIV Resource Administration Unit at AHHSD. Using the ARIES report function, the Systems and Facilities Administrator then sends data on the number of units of service to the Chief Financial Officer who completes and submits the monthly grant reports to the AHHSD HIV Resource Administration Unit. Resources include the staff time dedicated for this activity and payment for the ARIES extract. Tools include the Provide Enterprise® database, the ARIES client database, and the agency check register.
Output Measure # 2: *ASA will provide _109_ units of service of premium payments between March 1, 2016 and February 28, 2017.*
How will the data be collected and compiled for this output measure (include a description of resources and tools used)? The Accountant processes the approved request for HI premium assistance and gives the assistance payments to the Receptionist for client dispersal or mails them to clients. The Administrative Assistant, based on the check register, enters the units of service for premium payments for each unduplicated client in the "Services Provided" function of Provide Enterprise®, the electronic client database. The data is then exported to the ARIES database as required by the HIV Resource Administration Unit at AHHSD. Using the ARIES report function, the Systems and Facilities Administrator then sends data on the number of units of service for premium payments to the Chief Financial Officer who completes and submits the monthly grant reports to the AHHSD HIV Resource Administration Unit. Resources include the staff time dedicated for this activity and payment for the ARIES extract. Tools include the Provide Enterprise® database, the ARIES client database, and the agency check register.
Output Measure # 4: *ASA will provide _75_ units of service of co-payments between March 1, 2016 and February 28, 2017.*
How will the data be collected and compiled for this output measure (include a description of resources and tools used)? The Accountant processes the approved request for HI co-payment assistance and gives the assistance payments to the Receptionist for client dispersal or mails them to clients. The Administrative Assistant, based on the check register, enters the units of service for co-payments per prescription for each

unduplicated client in the "Services Provided" function of Provide Enterprise®, the electronic client database. The data is then exported to the ARIES database as required by the HIV Resource Administration Unit at AHHSD. Using the ARIES report function, the Systems and Facilities Administrator then sends data on the number of units of service for co-payments to the Chief Financial Officer who completes and submits the monthly grant reports to the AHHSD HIV Resource Administration Unit.
Resources include the staff time dedicated for this activity and payment for the ARIES extract. Tools include the Provide Enterprise® database, the ARIES client database, and the agency check register.

Output Measure # 5: *ASA will provide _2_ units of service of deductible payments between March 1, 2016 and February 28, 2017.*

How will the data be collected and compiled for this output measure (include a description of resources and tools used)?
The Accountant processes the approved request for HI deductible assistance and gives the assistance payments to the Receptionist for client dispersal or mails them to clients. The Administrative Assistant, based on the check register, enters the units of service for deductible payments for each unduplicated client in the "Services Provided" function of Provide Enterprise®, the electronic client database. The data is then exported to the ARIES database as required by the HIV Resource Administration Unit at AHHSD. Using the ARIES report function, the Systems and Facilities Administrator then sends data on the number of units of service for deductible to the Chief Financial Officer who completes and submits the monthly grant reports to the AHHSD HIV Resource Administration Unit.
Resources include the staff time dedicated for this activity and payment for the ARIES extract. Tools include the Provide Enterprise® database, the ARIES client database, and the agency check register.

Output Measure # 6: *ASA will provide Health Insurance Premium and Cost Sharing Assistance to _25 unduplicated clients between March 1, 2016 and February 28, 2017*

f) _20_ continuing clients will be served.

g) *_5__ new clients will be served.*

How will the data be collected and compiled for this output measure (include a description of resources and tools used)?
The Administrative Assistant, based on the check register, enters the units of service for each unduplicated client in the "Services Provided" function of Provide Enterprise®, the electronic client database. The data on clients receiving services is then exported to the ARIES database as required by the HIV Resource Administration Unit at AHHSD. Using the ARIES report function, the Systems and Facilities Administrator then runs reports on the number of unduplicated clients served and uses a specially designed report to determine the number of continuing clients and the number of new clients served. She then gives the data to the Chief Financial Officer who completes and submits the monthly grant reports to the AHHSD HIV Resource Administration Unit.
Resources include the staff time dedicated for this activity and payment for the ARIES extract. Tools include the Provide Enterprise® database and the ARIES client database.

2. Performance (cont.) – Section II

g. Outcome Performance Measures

A. SERVICE CATEGORY: ***Health Insurance Premium and Cost Sharing Assistance***
Outcome Measure #1: *100 Percent of clients who receive this service will not use Ryan White HIV/AIDS Program funds to pay for primary medical care, with exceptions noted* **(Outcome target = 100%)**. **25** = Number of clients who receive this service not using Ryan White HIV/AIDS Program funds to pay for primary medical care **25**= Number of clients who receive this service
What data will be collected, analyzed, and reported in order to assess this outcome? The Health Insurance/Intake Specialist will collect data on clients utilizing this service who also receive primary medical care from CommUnity Care at David Powell Clinic.
How will the data be collected and compiled for this outcome measure (include description of resources and tools used)? Staff will inform clients receiving CommUnity Care at David Powell Clinic services and HI services that they are required to utilize private health benefits when accessing primary medical care and document responses on the Health Insurance Review Progress Log. The HI referral and intake form includes a statement that further confirms this requirement. The Health Insurance/Intake Specialist will complete a report in Provide Enterprise® that identifies clients receiving this service who access primary medical care at David Powell Clinic. A Manager or designee will contact the clinic to review client names as identified in the report and verify that the clinic is billing private health insurance benefits for clinic services accessed by these clients. The results of this verification process will be documented and the percentage of clients achieving this outcome will be determined. Once the percentage is determined from these reports, the Director of Access services will then document this percentage, the exceptions, and reasons for exceptions on the AHHSD Monthly Performance and Billing Report. The Chief Financial Officer then forwards the completed report to the appropriate Grants Coordinator at the HIV Resource Administration Unit, AHHSD. Resources include staff time dedicated to this activity and the funding for the Provide® Enterprise client database. Tools include the Provide Enterprise® database.
At what point(s) or times(s) in the service delivery sequence will the data be collected and evaluated? The data is collected annually and evaluated with David Powell staff.

Total Undup. Clients Evaluated for Outcome Objective	Total Number of Undup. Clients Achieving Objective	% of Undup. Clients Achieving Outcome Objective	Reporting Dates
25	25	100	March 15, 2017

A. SERVICE CATEGORY: ***Health Insurance Premium and Cost Sharing Assistance***

Outcome Measure #2: Percent of clients who receive this service will remain in primary medical care **(Outcome target = 90%)**.
23 = Number of clients who receive this service not using Ryan White HIV/AIDS Program funds to pay for primary medical care
25 = Number of clients who receive this service

What data will be collected, analyzed, and reported in order to assess this outcome?
The Health Insurance/Intake Specialist will collect data on clients utilizing this service who also receive primary medical care from CommUnity Care at David Powell Clinic.

How will the data be collected and compiled for this outcome measure (include description of resources and tools used)?
Staff will document client medical provider reports, medical visit billing information, and ARIES data fields (with client permission) that verify kept medical appointments by clients. Case managers will document this medical information through a reporting function in Provide Enterprise®. Managers will use a different reporting function to generate the number of clients receiving Health Insurance and the number of unduplicated clients achieving the outcome. The Provide Enterprise® database contains the client file and includes the data fields necessary to enter into or export required information to ARIES for statistical analysis as required by AHHSD.

At what point(s) or times(s) in the service delivery sequence will the data be collected and evaluated?
Data is collected by the case manager at the client's individualized frequency of medical appointments. Case Managers discuss client medical appointment at each encounter and document client kept medical visits in Provide Enterprise®. Managers evaluate and report on data based upon the Provide Enterprise® reporting function at the end of Quarter4.

Total Undup. Clients Evaluated for Outcome Objective	Total Number of Undup. Clients Achieving Objective	% of Undup. Clients Achieving Outcome Objective	Reporting Dates
25	23	90	March 15, 2017

2. Performance – Section 1

a. Output Performance Measures

A. SERVICE CATEGORY: Medical Case Management- Non-MAI
Output Measure #1: *ASA will provide _1975 units of service of Non-MAI medical case management between March 1, 2016 and February 28, 2017.*
How will the data be collected and compiled for this output measure (include description of resources and tools used)?The Intake Staff and/or Medical Case Manager collects data by entering units of service by unduplicated client in the "Services Provided" function of Provide Enterprise®. Using the Provide Enterprise® reporting function, the Director of Access Services will generate a report on number of units received by clients. The Provide Enterprise® database contains the client file and includes the data fields necessary to export required information to the ARIES database for statistical analysis as required by AHHSD. The number of unduplicated clients receiving these units will then be reported to the Chief Financial Officer who completes and submits the monthly grant reports to the AHHSD HIV Resource Administration Unit. Resources include the staff time of the intake staff, Medical Case Managers, the Director of Access Services, the Systems and Facilities Administrator and the Chief Financial Officer.
Output Measure # 2: *ASA will serve _25_ unduplicated clients with Non-MAI medical case management between March 1, 2016 and February 28, 2017.* *i) _15_ continuing clients served.* *j) _10_ new clients served.*
How will the data be collected and compiled for this output measure (include a description of resources and tools used)?The Intake Staff and/or Medical Case Manager collects data by entering units of service by unduplicated client in the "Services Provided" function of Provide Enterprise®. Using the Provide Enterprise® reporting function, the Medical Programs Manager will generate a report on number of units received by clients that indicates the total number of unduplicated clients receiving this service. The Provide Enterprise® database contains the client file and includes the data fields necessary to export required information to the ARIES database for statistical analysis as required by DSHS and AHHSD. The number of unduplicated clients will then be reported to the Chief Financial Officer who completes and submits the monthly grant reports to the AHHSD HIV Resource Administration Unit.Resources include the staff time of the intake staff, Medical Case Managers, the Medical Programs Manager, the Director of Access Services, the Systems and Facilities Administrator and the Chief Financial Officer.

2. Performance (cont.) – Section II

b. Outcome Performance Measures

A. SERVICE CATEGORY: Medical Case Management-
Outcome Measure #1: *Percentage of HIV-infected medical case management clients who had a medical case management care/service plan developed and/or updated two or more times in the measurement year* ***(Outcome Target=95%)****4 = Number of HIV-infected medical case management clients who had a medical case management care plan developed and/or updated two or more times in the measurement year* *25= Number of HIV-infected medical case management clients*
What data will be collected, analyzed, and reported in order to assess this outcome? Medical Case Managers will collect client information during the assessment. Based on this information, they, using client input, will evaluate client needs in order to establish health goals and objectives for the individualized care/service plan. Case managers will develop an updated assessment and individualized care/service plan two or more times during the grant cycle.
How will the data be collected and compiled for this outcome measure (include description of resources and tools used)? Medical Case Managers enter care/service plan goals into the Provide Enterprise® service plan template (electronic form) and then prints the plan for the client paper file. Clients sign a paper copy of the care/service plan, which is included in the client paper file. The client is provided with a signed copy for his or her records. Medical Case Managers will document in progress notes in the electronic client file, client self-report, and medical and social service providers reports that address the care/service plan goals. Using a feature in Provide Enterprise®, case managers will report in the electronic file that the client has signed the care/service plan. Using another Provide Enterprise® reporting function, a report will be generated on the number of clients achieving the outcome and the total number of unduplicated clients receiving case management services. Once the percentage is determined from these reports, it will then be reported to the Chief Financial Officer or designee. The Provide Enterprise® database contains the client file and includes the data fields necessary to enter into or export required information to the ARIES® database for statistical analysis as required by AHHSD.Resources include the staff time of the intake staff, Medical Case Managers, The Medical Programs Manager, the Director of Access Services, the Systems and Facilities Administrator and the Chief Financial Officer.
At what point(s) or times(s) in the service delivery sequence will the data be collected and evaluated?Data will be collected by the Medical Case Manager at the time of service delivery. Care/Service plans are created and/or updated every six months for Acuity 1 and 2 clients and every three months for Acuity 3 clients. Supervisors evaluate and report on data based upon the Provide Enterprise® reporting function at the end of Quarters 2 and 4.

Total Undup. Clients Evaluated for Outcome Objective	***Total Number of Undup. Clients Achieving Objective***	***% of Undup. Clients Achieving Outcome Objective***	***Reporting Dates***
25	24	95%	Sept. 20, 2016 March 20, 2017

A. SERVICE CATEGORY: Medical Case Management-

Outcome Measure #2: *Percentage of HIV-infected medical case management clients who had two or more medical visits in an HIV care setting in the measurement year* ***(Outcome Target=95%)***
24 = Number of HIV-infected medical case management clients who had two or more medical visits in an HIV care setting in the measurement year
25 = Number of HIV-infected medical case management clients

What data will be collected, analyzed, and reported in order to assess this outcome?
Medical Case Managers will work with clients to identify maintaining HIV medical visit appointments as a goal in the service plan. Progress notes and service plans will reflect progress made in achievement of this goal and exceptions including reasons for not attaining goal. Medical Case managers will collect information that documents client kept medical visits in Provide Enterprise®.

How will the data be collected and compiled for this outcome measure (include description of resources and tools used)?
Medical Case managers will document client medical provider reports, medical visit billing information, and ARIES data fields (with client permission) that verify kept medical appointments by clients. Case managers will document this medical information through a reporting function in Provide Enterprise®. Supervisors will use a different reporting function to generate the number of clients receiving medical case management and the number of unduplicated clients achieving the outcome. The Provide Enterprise® database contains the client file and includes the data fields necessary to enter into or export required information to ARIES® for statistical analysis as required by AHHSD.
Resources include the staff time of the intake staff, Medical Case Managers, the Medical Programs Manager, the Director of Access Services, the Systems and Facilities Administrator and the Chief Financial Officer.

At what point(s) or times(s) in the service delivery sequence will the data be collected and evaluated?
Data is collected by the Medical Case Manager at the client's individualized frequency of medical appointments. Medical Case Managers discuss client medical appointment at each encounter and document client kept medical visits in Provide Enterprise®. Supervisors evaluate and report on data based upon the Provide Enterprise® reporting function at the end of Quarters 2 and 4.

Total Undup. Clients Evaluated for Outcome Objective	***Total Number of Undup. Clients Achieving Objective***	***% of Undup. Clients Achieving Outcome Objective***	***Reporting Dates***
25	24	95%	Sept. 20, 2016 March 20, 2017

2. **Performance – Section 1**

3. Output Performance Measures

A. SERVICE CATEGORY: Medical Case Management- MAI
Output Measure #1: *ASA will provide _1352_ units of service of medical case management –MAI between March 1, 2016 and February 28, 2017.*
How will the data be collected and compiled for this output measure (include description of resources and tools used)? The Intake Staff and/or Medical Case Manager collects data by entering units of service by unduplicated client in the "Services Provided" function of Provide Enterprise®. Using the Provide Enterprise® reporting function, the will generate a report on number of units received by clients. The Provide Enterprise® database contains the client file and includes the data fields necessary to export required information to the ARIES database for statistical analysis as required by AHHSD. The number of unduplicated clients receiving these units will then be reported to the Chief Financial Officer who completes and submits the monthly grant reports to the AHHSD HIV Resource Administration Unit. Resources include the staff time of the intake staff, Medical Case Managers, the Medical Programs Manager, the Director of Access Services, the Systems and Facilities Administrator and the Chief Financial Officer.
Output Measure # 2: *ASA will serve _22_ unduplicated clients with medical case management - MAI between March 1, 2016 and February 28, 2017.* *k) 7 continuing clients served.* l) *_15_ new MAI clients served.*
How will the data be collected and compiled for this output measure (include a description of resources and tools used)? The Intake Staff and/or Medical Case Manager collects data by entering units of service by unduplicated client in the "Services Provided" function of Provide Enterprise®. Using the Provide Enterprise® reporting function, the will generate a report on number of units received by clients that indicates the total number of unduplicated clients receiving this service. The Provide Enterprise® database contains the client file and includes the data fields necessary to export required information to the ARIES database for statistical analysis as required by DSHS and AHHSD. The number of unduplicated clients will then be reported to the Chief Financial Officer who completes and submits the monthly grant reports to the AHHSD HIV Resource Administration Unit. Resources include the staff time of the intake staff, Medical Case Managers, the Medical Programs Manager, the Director of Access Services, the Systems and Facilities Administrator and the Chief Financial Officer.

2. Performance (cont.) – Section II

c. Outcome Performance Measures

A. SERVICE CATEGORY: Medical Case Management- - MAI
Outcome Measure #1: *Percentage of HIV-infected African-American and Hispanic medical case management clients who had a medical case management care/service plan developed and/or updated two or more times in the measurement year* ***(Outcome Target=95%)*** ***MAI*** *21 = Number of HIV-infected African-American and Hispanic medical case management clients who had a medical case management care/service plan developed and/or updated two or more times in the measurement year* *22 = Number of HIV-infected African-American and Hispanic medical case management clients*
What data will be collected, analyzed, and reported in order to assess this outcome? Medical Case Managers will collect client information during the assessment. Based on this information, they, using client input, will evaluate client needs in order to establish health goals and objectives for the individualized care/service plan. Case managers will develop an updated assessment and individualized care/service plan two or more times during the grant cycle.
How will the data be collected and compiled for this outcome measure (include description of resources and tools used)? Medical Case Managers enter care/service plan goals into the Provide Enterprise® service plan template (electronic form) and then prints the plan for the client paper file. Clients sign a paper copy of the care/service plan, which is included in the client paper file. The client is provided with a signed copy for his or her records. Medical Case Managers will document in progress notes in the electronic client file, client self-report, and medical and social service providers reports that address the care/service plan goals. Using a feature in Provide Enterprise®, case managers will report in the electronic file that the client has signed the care/service plan. Using another Provide Enterprise® reporting function, a report will be generated on the number of clients achieving the outcome and the total number of unduplicated clients receiving case management services. Once the percentage is determined from these reports, it will then be reported to the Chief Financial Officer or designee. The Provide Enterprise® database contains the client file and includes the data fields necessary to enter into or export required information to the ARIES® database for statistical analysis as required by AHHSD. Resources include the staff time of the intake staff, Medical Case Managers, the Medical Programs Manager, the Director of Access Services, the Systems and Facilities Administrator and the Chief Financial Officer.
At what point(s) or times(s) in the service delivery sequence will the data be collected and evaluated? Data will be collected by the Medical Case Manager at the time of service delivery. Care/Service plans are created and/or updated every six months for Acuity 1 and 2 clients and every three months for Acuity 3 clients. Supervisors evaluate and report on data based upon the Provide Enterprise® reporting function at the end of Quarters 2 and 4.

Total Undup. Clients Evaluated for Outcome Objective	*Total Number of Undup. Clients Achieving Objective*	*% of Undup. Clients Achieving Outcome Objective*	*Reporting Dates*
MAI 22	**MAI** 21	95%	Sept. 20, 2016 March 20, 2017

A. SERVICE CATEGORY: Medical Case Management- -MAI

Outcome Measure #2: *Percentage of HIV-infected African-American and Hispanic medical case management clients who had two or more medical visits in an HIV care setting in the measurement year* ***(Outcome Target=95%)***

MAI

22 = Number of HIV-infected African-American and Hispanic medical case management clients who had two or more medical visits in an HIV care setting in the measurement year

21 = Number of HIV-infected African-American and Hispanic medical case management clients

What data will be collected, analyzed, and reported in order to assess this outcome?

Medical Case Managers will work with clients to identify maintaining HIV medical visit appointments as a goal in the service plan. Progress notes and service plans will reflect progress made in achievement of this goal and exceptions including reasons for not attaining goal. Medical Case managers will collect information that documents client kept medical visits in Provide Enterprise®.

How will the data be collected and compiled for this outcome measure (include description of resources and tools used)?

Medical Case managers will document client medical provider reports, medical visit billing information, and ARIES data fields (with client permission) that verify kept medical appointments by clients. Medical case managers will document this medical information through a reporting function in Provide Enterprise®. Supervisors will use a different reporting function to generate the number of clients receiving medical case management and the number of unduplicated clients achieving the outcome. The Provide Enterprise® database contains the client file and includes the data fields necessary to enter into or export required information to ARIES® for statistical analysis as required by AHHSD.

Resources include the staff time of the intake staff, Medical Case Managers, the Medical Programs Manager, the Director of Access Services, the Systems and Facilities Administrator and the Chief Financial Officer.

At what point(s) or times(s) in the service delivery sequence will the data be collected and evaluated?

Data is collected by the Medical Case Manager at the client's individualized frequency of medical appointments. Medical Case Managers discuss client medical appointment at each encounter and document client kept medical visits in Provide Enterprise®. Supervisors evaluate and report on data based upon the Provide Enterprise® reporting function at the end of Quarters 2 and 4.

Total Undup. Clients Evaluated for Outcome Objective	*Total Number of Undup. Clients Achieving Objective*	*% of Undup. Clients Achieving Outcome Objective*	*Reporting Dates*
MAI 22	**MAI** 21	95%	Sept. 20, 2016 March 20, 2017

ATTACHMENT C

Amendment No. 11

BUDGET SUMMARY

Summary Page only

Service Category	Initial Funding for 12 month term Amendment No. 11
Food Bank Services	**$47,641**
Medical Nutrition Therapy	**$38,544**
Case Management Non-Medical	**$75,896**
Case Management Non-Medical - MAI	**$48,808**
Oral Health Care	**$261,843**
Outreach Services: MAI	**$30,408**
Outreach Services	**$39,154**
Health Insurance Premiums and Cost Sharing Assistance	**$106,297**
Medical Case Management	**$83,303**
Medical Case Management- -MAI	**$56,487**
TOTAL	**$788,381**

DIRECT SERVICES Line Item Budget

Yr./ Fund: **FY2016 Ryan White A (non MAI)**

Program: **Food Bank**

Agency: **AIDS Services of Austin**

City of Austin HIV Grant Agreements and Contracts

Cost Category & Description	FTE - Svc Categ	Annualized Salary	**Total Svc Annual Cost**	**RWA**		**Travis County**		**COA**		**General Fund**		Total DIRECT SERVICE Costs
OPERATING COSTS - PROGRAM DIRECT CLIENT SERVICES												
PROGRAM DIRECT - CLIENT SERVICES PERSONNEL	2.19		**93,410.36**	**22,483.36**	**0.96**	**16,434.50**	**0.70**	**10,702.24**	**0.45**	**3,192.00**	**0.07**	**52,812.10**
Casstevens, Programs Specialist	0.15	39,269.26	5,890.39	1,486.10	0.07	1,072.29	0.05	681.32	0.03	0.00		**$3,239.71**
Chavez, Associate Director of Direct Services	0.15	57,412.74	8,611.91	1,894.62	0.06	1,578.85	0.05	1,263.08	0.04	0.00	-	**$4,736.55**
Medina, Eligibility & Intake Specialist	0.17	35,394.39	6,017.05	1,518.06	0.08	1,095.34	0.06	695.97	0.04	0.00		**$3,309.38**
Searight, Food Bank Coordinator	0.75	34,904.06	26,178.05	6,604.54	0.34	4,765.46	0.25	3,027.93	0.16	0.00		**$14,397.93**
Vacant, Dietitian	0.20	58,004.82	11,600.96	2,926.84	0.09	2,111.84	0.07	1,341.85	0.04	0.00		**$6,380.53**
Simmons, Food and Nutrition Services Manager	0.77	45,600.00	35,112.00	8,053.19	0.32	5,810.72	0.23	3,692.09	0.15	3,192.00	0.07	**$20,748.00**
FRINGE Benefits			**24,227.49**	**5,852.41**		**4,272.50**		**2,775.75**		**771.75**		**$13,672.41**
Prgm.Combined - Soc. Sec./ Medicare taxes (FICA)		7.65%	7,145.89	1,719.98		1,257.24		818.72		244.19		**$4,040.13**
Prgm.Combined - Retirement system contributions		1500.00	1,830.00	454.43		333.42		218.65		0.00		**$1,006.50**

Prgm.Combined - Employee Insurance (health, life, etc.)	600.00	14,544.00	3,507.32		2,557.24		1,657.44		504.00		**$8,226.00**
Prgm.Combined - Worker's Compensation Insurance	.46%	429.69	103.42		75.60		49.23		14.68		**$242.94**
Prgm.Combined - State Unemployment Insurance (SUI)	1.41%	277.91	67.26		49.00		31.71		8.88		**$156.85**
TRAVEL - Direct Client services		**3,000.00**	**686.85**		**500.37**		**323.80**		**252.70**		**1,763.71**
Prgm. Direct - Local Travel		3,000.00	686.85	41.6%	500.37	30.3%	323.80	19.6%	252.70	8.4%	**$1,763.71**
EQUIPMENT - Direct Client services			**0.00**		**0.00**		**0.00**		**0.00**		**0.00**
SUPPLIES - Direct Client services		**1,600.00**	**244.80**		**176.63**		**112.23**		**629.39**		**1,163.05**
Prgm. Direct - Office Supplies		1,600.00	244.80	27.9%	176.63	20.1%	112.23	12.7%	629.39	39.3%	**$1,163.05**
CONTRACTUAL - Subcontracted Direct services		**0.00**	**0.00**		**0.00**		**0.00**		**0.00**		**0.00**
OTHER - Direct Client services		**136,315.94**	**13,609.49**		**9,553.50**		**5,743.43**		**82,197.61**		**111,104.03**
Prgm. Direct - Food for Clients		120,000.00	11,435.26	18.0%	8,317.58	13.0%	4,453.26	7.0%	74,400.00	62.0%	**$98,606.11**
Prgm. Direct - Hygiene		10,000.00	990.00	18.0%	376.88	13.0%	738.73	7.0%	6,200.00	62.0%	**$8,305.60**
Prgm. Direct - Training/ Contin. Educ. Conf./Seminars (Staff Devlp)		627.00	95.93	27.9%	69.22	20.1%	43.98	12.7%	246.64	39.3%	**$455.77**
Prgm. Direct - Staff/Vol Recognition		900.00	137.70	27.9%	99.36	20.1%	63.13	12.7%	354.03	39.3%	**$654.22**
Prgm. Direct - Equipment Repairs & Maintenance		1,250.00	191.25	27.9%	137.99	20.1%	87.68	12.7%	491.71	39.3%	**$908.63**
Prgm. Direct - Telephone Non Cell		874.38	200.19	41.6%	145.84	30.3%	94.37	19.6%	73.65	8.4%	**$514.05**
Prgm. Direct - Utilites		1,267.57	290.21	41.6%	211.42	30.3%	136.81	19.6%	106.77	8.4%	**$745.21**
Prgm. Direct - Cell phone		727.00	166.45	41.6%	121.26	30.3%	78.47	19.6%	61.24	8.4%	**$427.41**
Prgm. Direct - Licenses and Permits		420.00	64.26	27.9%	46.37	20.1%	29.46	12.7%	165.22	39.3%	**$305.30**
Prgm. Direct - Postage and delivery		150.00	22.95	27.9%	16.56	20.1%	10.52	12.7%	59.01	39.3%	**$109.04**

Prgm. Direct - Printing, copying, promotion and volunteer development		100.00	15.30	27.9%	11.04	20.1%	7.01	12.7%	39.34	39.3%	**$72.69**
SUBTOTAL- PROGRAM DIRECT COSTS		**258,553.79**	**42,876.90**		**30,937.50**		**19,657.44**		**87,043.46**		**180,515.30**

ADMINISTRATIVE Line Item Budget

Yr./ Fund: **FY2016 Ryan White A (non MAI)**

Program: **Food Bank**

Agency: **AIDS Services of Austin**

Cost Category & Description	FTE- Svc Admin	Salary	**Total Admin Costs for this Service**		**RWA**		**Travis County**		**City General Funds**		**ASA Unrestricted Funds**		**Total ADMIN Costs**
ADMINISTRATIVE LINE ITEMS		70.00	3.0%		0.96	1.2%	0.70	0.8%	0.45	0.5%	-	0.5%	0.030
ADMINISTRATIVE - PERSONNEL	**7.00**	**413,509.65**	**6,887.89**		**2,663.16**		**1,921.58**		**1,220.96**		**1,082.20**		**6,887.89**
Campion - Chief Programs Officer	1.00	91,200.00	1,519.13		587.36		423.81		269.28		238.68		1,519.13
White, Facilities and Systems	1.00	49,744.13	828.60		320.37		231.16		146.88		130.19		828.60
Vacant, Human Resources Manager	1.00	59,160.00	985.44		381.01		274.92		174.68		154.83		985.44
Garza, Chief Financial Officer	1.00	78,290.10	1,304.09		504.22		363.81		231.16		204.89		1,304.09
Vacant, Accountant	1.00	36,000.00	599.66		231.85		167.29		106.30		94.22		599.66
Oden, Accountant	1.00	42,368.76	705.74		272.87		196.89		125.10		110.88		705.74
Hayse, Grants Manager	1.00	56,746.67	945.24		365.47		263.70		167.55		148.51		945.24
FRINGE Benefits		**68,326.93**	**1,138.13**		**440.05**		**317.52**		**201.75**		**178.82**		**1,138.13**
Combined Admin. Staff - Soc. Sec./ Medicare taxes (FICA)	7.65%	31,633.49	526.92		203.73		147.00		93.40		82.79		526.92

Combined Admin. Staff - Retirement system contributions	$ 1,500	1,503.00	25.04		9.68		6.98		4.44		3.93		25.04
Combined Admin. Staff - Employee Insurance (health, life, etc.)	$ 600	32,400.00	539.69		208.67		150.56		95.67		84.79		539.69
Combined Admin. Staff - Worker's Compensation Insurance	0.46%	1,902.14	31.68		12.25		8.84		5.62		4.98		31.68
Combined Admin. Staff - State Unemployment Insurance (SUI)	1.41%	888.30	14.80		5.72		4.13		2.62		2.32		14.80
TRAVEL - Administrative Support													
EQUIPMENT - Administrative Support													
SUPPLIES - Administrative Support													
CONTRACTUAL - Subcontracted Admin. services													
OTHER - Administrative costs (list)		**257,888.00**	**4,295.68**		**1,660.89**		**1,198.41**		**761.46**		**674.92**		**4,295.68**
Admin. - General & Other Liability Insurance		47,055.00	783.80		303.05		218.66		138.94		123.15		783.80
Admin. - Telecommunications (Phone, Internet, etc.)		28,020.00	466.73		180.46		130.21		82.73		73.33		466.73
Admin. - Audit		44,480.00	740.91		286.47		206.70		131.33		116.41		740.91
Admin. - Computer Services (Other contract services)		58,904.00	981.17		379.36		273.73		173.92		154.16		981.17
Admin. - Repairs/Maintainence		29,420.00	490.05		189.48		136.71		86.87		77.00		490.05
Admin. - Facilities support (Utilities, etc.)		40,620.00	676.61		261.61		188.76		119.94		106.31		676.61
Admin. - Photocopier rental, Equip maint., etc. NOT directly serving clients		9,389.00	156.39		60.47		43.63		27.72		24.57		156.39
SUBTOTAL ADMINISTRATIVE COSTS		**739,724.59**	**12,321.70**		**4,764.10**		**3,437.50**		**2,184.16**		**1,935.94**		**12,321.70**

SUM OF DIRECT + ADMIN = TOTAL COST			-		**47,641.00**		**59,687.50**		**37,924.96**		**88,980.40**		**269,314.97**

BUDGET JUSTIFICATION	
AIDS Services of Austin	
Budget Period/Fund: FY2016 Ryan White Part A (not MAI)	
Service Category: Food Bank	
The agency total annual HIV services budget for this program will be funded as follows (add more rows as needed):	
Travis County $ 34,375 17.8%	
City of Austin $ 21,841.60 11.3%	
Agency Fundraising $ 88,979.39 46.1%	
Program Income $ 00,000 00.0%	
Ryan White Part A **$ 47,641** **24.7%**	
TOTAL - All Funding Sources **$ 192,837** **100%**	
DIRECT SERVICE Costs - LINE ITEMS NARRATIVE	**FY16 Funding**
PERSONNEL	
Casstevens, Programs Specialist	
0.0103 FTE x $39,269 annual salary	1,486
Provides direct support to Food Bank and Medical Nutrition Therapy through coordinating required eligibility documents for interagency clients.	

Chavez, Associate Director of Direct Services	$1,895
0.009 FTE x $57,413 annual salary	
Provides overall management and direction of all direct services programs. Develops program content and supervises program coordinators. Responsible for recruiting, training, and staff retention.	
Medina, Eligibility & Intake Specialist	$1,518
0.0133 FTE x $35,394 annual salary	
Performs eligibility and intake, makes referrals and provides information, performs quality assurance activities.	
Searight, Food Bank Coordinator	$6,605
0.258 FTE x $26,178 annual salary	
Delivers food bank services directly to clients; interviews, selects, and trains food bank volunteers; receives foodstuffs and dry goods from a variety of vendors and donors; and, assists with food bank daily operations; drives truck	
Vacant, Dietitian	$2,927
0.183 FTE x $58,005 annual salary	
Provides scheduled, walk-in, and referred Medical Nutritional Therapy, counseling and assessments for HIV+ persons; performs body composition analysis using BIA and assesses indicators of nutritional health change as reported by clients; instructs clients on appropriate diets for chronic diseases related to lifestyle assesses special nutritional needs of clients with advanced HIV disease and AIDS and recommends optimal nutritional supplementation, provides comprehensive nutrition analysis of foodstuffs annually and quality assurance of stock quarterly, provides individual nutrition education.	
Simmons, Food and Nutrition Services Manager	

0.2472 FTE x $4,600 annual salary	$8,053
Plans, coordinates, assesses, evaluates and manages daily operations of Food Bank and Medical Nutritional Therapy programs, supervises Dietitian, Food Bank Volunteer Coordinator and food bank volunteers, responsible for food acquisition, food and nutrition program quality assurance activities, checks data reports on performance activity and generates reports. Conducts quality assurance activities. Member of QMGT and Management Team	

Personnel Salaries Subtotal	**$22,483**
FRINGE BENEFITS	
FICA & Medicare Tax - Personnel Subtotal multiplied by 7.65% rate	$1,720
Retirement - 3% Match per employee salary for eligible and participating staff	$454
Medical Benefits - $600 per month per employee for eligible and participating staff	$3,507
Worker's Compensation Insurance: salaries x 0.46%	$103
State Unemployment Insurance: first $9,000 of salaries x 1.41%	$67
Fringe Benefits Subtotal	**$5,852**
TRAVEL	
Local Mileage: Reimbursement to Program Direct staff for use of their privately owned vehicles in the performance of program duties within service area. 463 miles/mo. x 12 months x $0.54/mile = $3,000 x 41.6%	$687

Travel Subtotal	**$687**
	FY16 Funding
EQUIPMENT	$0
Equipment with useable life over 1 year and cost of $5,000 or more per each unit	
Equipment Subtotal	**$0**
SUPPLIES	
Office supplies to support food bank program operations: $1,600 x 27.9%	$245
Supplies Subtotal	**$245**
CONTRACTUAL (must also submit completed Subcontractor Data Sheets)	
	$0
Contractual Subtotal	**$0**

OTHER	
Food for clients, including personal and household hygiene products: $120,000 x 18%	**$11,435**
Hygiene: $10,000 x 18%	**$990**
Staff Development: $225 x FTE	**$96**
Staff/Volunteer Recognition: $900 x 27.9%	**$138**
Equipment repair for food bank direct service equipment: $1,250 x 27.9%	**$191**
Telecommunications: $874 x 41.6%	**$200**
Utilities: $1,268 x 41.6%	**$290**
Cell Phones for staff safety: $29.99/month x FTE x 12 months	**$166**
Licenses and permits for food bank direct service operations: $420 x FTE	**$64**
Postage and Delivery: $150 x 27.9%	**$23**
Printing, Copying, Promotion, and Volunteer Development: $100 x 27.9%	**$15**
Other Subtotal	**$13,609**
TOTAL DIRECT SERVICES COSTS	**$42,877**
	FY16 Funding
ADMINISTRATIVE COSTS - LINE ITEMS NARRATIVE	
PERSONNEL	
Campion - Chief Programs Officer	**587.36**
0.012 FTE x $91,200 annual salary	
Duties include: Oversight of programs including output, outcome, and spending tracking; quality management and improvement; supervision of directors; budgeting; and compliance.	

Systems and Facilities Manager, Lynda White	**320.37**
0.012 FTE x $49,744 annual salary	
Duties include: Data management and improvement; facilities management; repairs and maintenance of facilities; quality control of data; maintenance of ARIES database and data.	
Human Resources Manager, Vacant	**381.01**
0.012 FTE x $59,160 annual salary	
Duties include: Organization HR issues, trainings, orientation, and organizational HR policies and procedures.	
Chief Financial Officer, Bill Garza	**504.22**
0.012 FTE x $78,290 annual salary	
Duties include: Oversees fiscal management of the organization.	
Accountant, Vacant	**231.85**
0.012 FTE x $36,000 annual salary	
Duties include: Financial services support for organization.	
Accountant. Wyatt Oden	**272.87**
0.012 FTE x $42,369 annual salary	
Duties include: Financial services support for organization.	
Grants Manager, Britt Hayse	**365.47**
0.012 FTE x $56,747 annual salary	
Duties include: Grant compliance responsibilities.	
Personnel Subtotal	**$2,663**

FRINGE BENEFITS	
FICA & Medicare Tax - Personnel Subtotal multiplied by 7.65% rate	**203.73**
Medical Benefits - $600 per month per employee for eligible and participating staff	**9.68**
Retirement - 3% Match per employee salary for eligible and participating staff	**208.67**
Worker's Compensation Insurance - .46% of employee salary	**12.25**
State Unemployment Insurance - 1.41% of first $9000 of employee salary	**5.72**
Fringe Benefits Subtotal	**$440**
SUPPLIES	
Supplies Subtotal	**$0**
OTHER	
General & Other Liability Insurance: $47,055 prorated by FTE	**303.05**
Telecommunications (phone, internet, etc): $28,020 prorated by FTE	**180.46**
Annual Audit: $44,480 prorated by FTE	**286.47**
Computer Services:$58,904 prorated by FTE	**379.36**
Repairs and Maintenance: $29,420 prorated by FTE	**189.48**
Facilities Support: $40,620 prorated by FTE	**261.61**
Photocopier Rental, Equipment Maintenance, etc (not directly serving clients): $9,389 prorated by FTE	**60.47**
Other Subtotal	**1,660.89**
TOTAL ADMINISTRATIVE COSTS	**$4,764**
TOTAL - DIRECT SERVICES and ADMINISTRATIVE COSTS BUDGET for FY 2014 Grant program	**$47,641**

DIRECT SERVICES Line Item Budget					Yr./ Fund:	**FY2016 Ryan White A (non MAI)**			
Program: **Medical Nutrition Therapy**					Agency:	**AIDS Services of Austin**			
City of Austin HIV Grant Agreements and Contracts									
Cost Category & Description	FTE - Svc Categ	Annualized Salary	**Total Svc Annual Cost**	**RWA**		**General Fund**		Total DIRECT SERVICE Costs	
OPERATING COSTS - PROGRAM DIRECT CLIENT SERVICES									
PROGRAM DIRECT - CLIENT SERVICES PERSONNEL			**46,726.21**	**25,699.42**	**0.86**	**0.00**		**25,699.42**	
Chavez, Associate Director of Direct Services	0.03	57,412.74	1,435.32	789.43	0.03	0.00	0%	**789.43**	
Simmons, Food and Nutrition Services Manager	0.23	45,600.00	10,488.00	5,768.40	0.23	0.00	0%	**5,768.40**	
Vacant, Dietitian	0.60	58,004.82	34,802.89	19,141.59	0.60	0.00	0%	**19,141.59**	
FRINGE Benefits			**7,304.42**	**5,550.32**		**0.00**		**$5,550.32**	
Prgm.Combined - Soc. Sec./ Medicare taxes (FICA)		7.65%	3,574.56	1,966.01		0.00		**$1,966.01**	
Prgm.Combined - Retirement system contributions		1,500	20.63	20.63		0.00		**$20.63**	
Prgm.Combined - Employee Insurance (health, life, etc.)		600	3,385.80	3,385.80		0.00		**$3,385.80**	
Prgm.Combined - Worker's Compensation Insurance		.46%	214.94	118.22		0.00		**$118.22**	
Prgm.Combined - State Unemployment Insurance (SUI)		1.41%	108.50	59.67		0.00		**$59.67**	
TRAVEL - Direct Client services			100.00	**55.00**		**0.00**		**$55.00**	
Prgm. Direct - Local Travel			100.00	55.00		0.00	0.0%	**$55.00**	
EQUIPMENT - Direct Client services			**0.00**	**0.00**		**0.00**		**$0.00**	
SUPPLIES - Direct Client services			1,000.00	**550.00**		**0.00**		**$550.00**	
Prgm. Direct - Office Supplies			1,000.00	550.00		0.00	0.0%	**$550.00**	
CONTRACTUAL - Subcontracted Direct services			0	**0.00**		**0.00**		**$0.00**	
OTHER - Direct Client services			18,854.15	**2,834.86**		**15,296.00**		**$18,130.86**	
Prgm. Direct - Nutritional Supplements			17,320.00	2,024.00		15,296.00	88.3%	**$17,320.00**	
Prgm. Direct - Educational Supplies for Clients			300.00	165.00		0.00	0.0%	**$165.00**	
Prgm. Direct - Training/ Contin. Educ. Conf./Seminars (Staff Devlp)		250.00	307.50	136.20		0.00	0.0%	**$136.20**	
Prgm. Direct - Staff/Vol Recognition			100.00	55.00		0.00	0.0%	**$55.00**	
Prgm. Direct - Cell phone			451.65	248.41		0.00	0.0%	**$248.41**	
Prgm. Direct - Licenses and Permits			125.00	68.75		0.00	0.0%	**$68.75**	
Prgm. Direct - Printing, copying, promotion and volunteer development			100.00	55.00		0.00	0.0%	**$55.00**	
Prgm. Direct - Subscriptions/Memberships			150.00	82.50		0.00	0.0%	**$82.50**	
SUBTOTAL- PROGRAM DIRECT COSTS			**73,984.78**	**34,689.60**		**15,296.00**		**49,985.60**	

CONTRACTUAL - Subcontracted Direct services			0	**0.00**		**0.00**		**$0.00**
OTHER - Direct Client services			18,854.15	**2,834.86**		**15,296.00**		**$18,130.86**
Prgm. Direct - Nutritional Supplements			17,320.00	2,024.00		15,296.00	88.3%	**$17,320.00**
Prgm. Direct - Educational Supplies for Clients			300.00	165.00		0.00	0.0%	**$165.00**
Prgm. Direct - Training/ Contin. Educ. Conf./Seminars (Staff Devlp)		250.00	307.50	136.20		0.00	0.0%	**$136.20**
Prgm. Direct - Staff/Vol Recognition			100.00	55.00		0.00	0.0%	**$55.00**
Prgm. Direct - Cell phone			451.65	248.41		0.00	0.0%	**$248.41**
Prgm. Direct - Licenses and Permits			125.00	68.75		0.00	0.0%	**$68.75**
Prgm. Direct - Printing, copying, promotion and volunteer development			100.00	55.00		0.00	0.0%	**$55.00**
Prgm. Direct - Subscriptions/Memberships			150.00	82.50		0.00	0.0%	**$82.50**
SUBTOTAL- PROGRAM DIRECT COSTS			**73,984.78**	**34,689.60**		**15,296.00**		**49,985.60**

ADMINISTRATIVE Line Item Budget | Yr./ Fund: **FY2016 Ryan White A (non MAI)**

Program: **Medical Nutrition Therapy** | Agency: **AIDS Services of Austin**

Cost Category & Description	FTE-Svc Admin	Salary	Total Admin Costs for this Service	RWA		ASA Unrestricted Funds		Total ADMIN Costs
ADMINISTRATIVE LINE ITEMS		70.00	1.2%	0.86	0.9%	-	0.3%	0.012
ADMINISTRATIVE - PERSONNEL	**7.00**	**413,509.65**	**5,050.73**	**2,154.63**		**1,133.22**		**3,287.85**
Campion - Chief Programs Officer	1.00	91,200.00	1,113.94	475.21		249.93		725.14
White, Facilities and Systems	1.00	49,744.13	607.59	259.20		136.32		395.52
Vacant, Human Resources Manager	1.00	59,160.00	722.60	308.26		162.13		470.39
Garza, Chief Financial Officer	1.00	78,290.10	956.26	407.94		214.55		622.49
Vacant, Accountant	1.00	36,000.00	439.71	187.58		98.66		286.24
Oden, Accountant	1.00	42,368.76	517.50	220.77		116.11		336.88
Hayse, Grants Manager	1.00	56,746.67	693.12	295.68		155.51		451.20
FRINGE Benefits		**68,326.93**	**834.56**	**356.02**		**187.25**		**543.27**
Combined Admin. Staff - Soc. Sec./ Medicare taxes (FICA)	7.65%	31,633.49	386.38	164.83		86.69		251.52
Combined Admin. Staff - Retirement system contributions	$1,500	1,503.00	18.36	7.83		4.12		11.95
Combined Admin. Staff - Employee Insurance (health, life, etc.)	$ 600	32,400.00	395.74	168.82		88.79		257.61
Combined Admin. Staff - Worker's Compensation Insurance	0.46%	1,902.14	23.23	9.91		5.21		15.12
Combined Admin. Staff - State Unemployment Insurance (SUI)	1.41%	888.30	10.85	4.63		2.43		7.06
TRAVEL - Administrative Support								

EQUIPMENT - Administrative Support							
SUPPLIES - Administrative Support							
CONTRACTUAL - Subcontracted Admin. services							
OTHER - Administrative costs (list)	**257,888.00**	**3,149.92**	**1,343.75**	**706.74**	**2,050.49**		
Admin. - General & Other Liability Insurance	47,055.00	574.74	245.18	128.95	374.14		
Admin. - Telecommunications (Phone, Internet, etc.)	28,020.00	342.24	146.00	76.79	222.79		
Admin. - Audit	44,480.00	543.29	231.77	121.90	353.66		
Admin. - Computer Services (Other contract services)	58,904.00	719.47	306.92	161.43	468.35		
Admin. - Repairs/Maintainence	29,420.00	359.34	153.30	80.63	233.92		
Admin. - Facilities support (Utilities, etc.)	40,620.00	496.14	211.65	111.32	322.97		
Admin. - Photocopier rental, Equip maint., etc. NOT directly serving clients	9,389.00	114.68	48.92	25.73	74.65		
SUBTOTAL ADMINISTRATIVE COSTS	**739,724.59**	**9,035.21**	**3,854.40**	**2,027.21**	**5,881.61**		
SUM OF DIRECT + ADMIN = TOTAL COST			**38,544.00**	**15,667.21**	**82,593.60**		

BUDGET JUSTIFICATION

AIDS Services of Austin

Budget Period/Fund: FY2016 Ryan White Part A (not MAI)

Service Category: Medical Nutrition Therapy

The agency total annual HIV services budget for this program will be funded as follows (add more rows as needed):

Agency Fundraising	$ 17,323.21	31.0%
Program Income	$ 00,000	00.0%
Ryan White Part A	**$ 38,544**	**69.0%**
TOTAL - All Funding Sources	**$ 55,867.21**	**100%**

DIRECT SERVICE Costs - LINE ITEMS NARRATIVE

PERSONNEL	**FY16 Funding**
Chavez, Associate Director of Direct Services	$789
0.006 FTE x $57,413 annual salary	
Provides overall management and direction of all direct services programs. Develops program content and supervise program coordinators. Responsible for recruiting, training, staff retention.	
Simmons, Food and Nutrition Services Manager	$5,768
0.0529 FTE x $45,600 annual salary	
Plans, assess, coordinates, evaluates, and manages daily operations of Food Bank and Medical Nutritional Therapy programs, supervises Dietitian, Volunteer Services Coordinator, and food bank volunteers, responsible for food acquisition, food and nutrition program quality assurance activities, oversees the input of performance activity data and generates reports, as needed. Member of QMGT and Management Team	
Vacant, Dietitian	$19,142
0.36 FTE x $56,005 annual salary	
Provides scheduled, walk-in, and referred Medical Nutritional Therapy, counseling and assessments for HIV+ persons; performs body composition analysis using BIA and assesses indicators of nutritional health change as reported by clients; instructs clients on appropriate diets for chronic diseases related to lifestyle assesses special nutritional needs of clients with advanced HIV disease and AIDS and recommends optimal nutritional supplementation, provides comprehensive nutrition analysis of foodstuffs annually and quality assurance of stock quarterly, provides individual nutrition education	
Personnel Salaries Subtotal	**$25,699**

FRINGE BENEFITS	
FICA & Medicare Tax - Personnel Subtotal multiplied by 7.65% rate	$1,966
Retirement - 3% Match per employee salary for eligible and participating staff	$21
Medical Benefits - $600 per month per employee for eligible and participating staff	$3,386
Worker's Compensation Insurance: salaries x 0.46%	$118
State Unemployment Insurance: first $9,000 of salaries x 1.41%	$60
Fringe Benefits Subtotal	**$5,550**
TRAVEL	
Local Mileage: Reimbursement to Program Direct staff for use of their privately owned vehicles in the performance of program duties within service area. 15 miles/mo. x 12 months x $0.54/mile = $100 x 55%	$55
Travel Subtotal	**$55**
	FY16 Funding
EQUIPMENT	0
Equipment with useable life over 1 year and cost of $5,000 or more per each unit	
Equipment Subtotal	**$0**
SUPPLIES	
Office supplies to support food bank program operations: $1,000/year x 55%	$550
Supplies Subtotal	**550**
CONTRACTUAL **(must also submit completed Subcontractor Data Sheets)**	
Contractual Subtotal	**$0**
OTHER	
Nutritional Supplements for clients: $17,320 x 11.7%	$2,024
Educational Supplies for Clients: $300 x 55%	$165
Staff Development: $225 x FTE	$136
Staff and Volunteer Recognition: $100 x 55%	$55
Cell Phones for staff safety: $29.99/month x FTE x 12 months	$248
Licenses and permits for food bank direct service operations: $420 x FTE	$69
Printing, Copying, Promotion and Volunteer Development: $100 x 55%	$55
Subscriptions and Memberships: $150 x 55%	$83
Other Subtotal	**$2,835**

TOTAL DIRECT SERVICES COSTS	**$34,690**
ADMINISTRATIVE COSTS - LINE ITEMS NARRATIVE	
PERSONNEL	**FY16 Funding**
Campion - Chief Programs Officer	475.21
0.009 FTE x $91,200 annual salary	
Duties include: Oversight of programs including output, outcome, and spending tracking; quality management and improvement; supervision of directors; budgeting; and compliance.	
Systems and Facilities Manager, Lynda White	259.20
0.009 FTE x $49,744 annual salary	
Duties include: Data management and improvement; facilities management; repairs and maintenance of facilities; quality control of data; maintenance of ARIES database and data.	
Human Resources Manager, Vacant	308.26
0.009 FTE x $59,160 annual salary	
Duties include: Organization HR issues, trainings, orientation, and organizational HR policies and procedures.	
Chief Financial Officer, Bill Garza	407.94
0.009 FTE x $78,290 annual salary	
Duties include: Oversees fiscal management of the organization.	
Accountant, Vacant	187.58
0.009 FTE x $36,000 annual salary	
Duties include: Financial services support for organization.	
Accountant. Wyatt Oden	220.77
0.009 FTE x $42,369 annual salary	
Duties include: Financial services support for organization.	
Grants Manager, Britt Hayse	295.68
0.009 FTE x $56,747 annual salary	
Duties include: Grant compliance responsibilities.	
Personnel Subtotal	**$2,155**

FRINGE BENEFITS	
FICA & Medicare Tax - Personnel Subtotal multiplied by 7.65% rate	164.83
Medical Benefits - $600 per month per employee for eligible and participating staff	7.83
Retirement - 3% Match per employee salary for eligible and participating staff	168.82
Worker's Compensation Insurance - .46% of employee salary	9.91
State Unemployment Insurance - 1.41% of first $9000 of employee salary	4.63
Fringe Benefits Subtotal	**$356**
SUPPLIES	
Supplies Subtotal	**$0**
OTHER	
General & Other Liability Insurance: $47,055 prorated by FTE	245.18
Telecommunications (phone, internet, etc): $28,020 prorated by FTE	146.00
Annual Audit: $44,480 prorated by FTE	231.77
Computer Services:$58,904 prorated by FTE	306.92
Repairs and Maintenance: $29,420 prorated by FTE	153.30
Facilities Support: $40,620 prorated by FTE	211.65
Photocopier Rental, Equipment Maintenance, etc (not directly serving clients): $9,389 prorated by FTE	48.92
Other Subtotal	**1,343.75**
TOTAL ADMINISTRATIVE COSTS	**$3,854**
TOTAL - DIRECT SERVICES and ADMINISTRATIVE COSTS BUDGET for FY 2014 Grant program	**$38,544**

DIRECT SERVICES Line Item Budget Yr./ Fund: **FY2016 Ryan White A Non-MAI**

Program: **Non-Medical Case Management** Agency: **AIDS Services of Austin**

City of Austin HIV Grant Agreements and Contracts *HHSD/ HRAU form rev. August 2014*

Cost Category & Description	FTE - Svc Categ			Annualized Salary	Total Svc Annual Cost	RWA T1 (Non-MAI)	100%	RWA T1 (MAI)	100%	City of Austin T1		Travis County		Other Funding Sources		Total DIRECT SERVICE Costs
PROGRAM DIRECT - CLIENT SERVICES																
PERSONNEL Staff Salaries	**9.60**				**205,321.36**	**49,062.11**	**2.25**	**21,691.57**	**0.99**	**59,552.89**	**2.82**	**69,716.96**	**3.29**	**5,297.83**	**0.25**	**205,321.36**
Williams-Price, Director of Access Services	0.38			68,226.67	14,071.75	6,635.20	0.18	2,933.59	0.08	2,110.47	0.06	2,392.49	0.06	-		14,071.75
Braglia, Medical Programs Manager	0.28			48,658.24	7,359.56	2,319.67	0.09	1,025.58	0.04	1,881.44	0.07	2,132.86	0.08	-		7,359.56
Rios M., Non-Medical Programs Manager	0.88			47,909.33	23,109.14	7,436.60	0.28	3,287.90	0.12	5,482.18	0.21	6,580.11	0.25	322.35	0.01	23,109.14
Medina, Intake Coordinator	0.68			36,899.39	13,800.37	1,125.82	0.06	497.75	0.02	5,707.08	0.28	6,469.72	0.32	-		13,800.37
Lindgren, Lead Receptionist	0.49			31,512.69	8,521.56	1,201.84	0.07	531.36	0.03	3,046.21	0.18	3,453.28	0.20	288.87	0.02	8,521.56
Cirlos, Eligibility & Intake Specialist	0.78			33,611.67	14,373.19	3,557.24	0.19	1,572.74	0.09	4,332.15	0.23	4,911.06	0.27	-		14,373.19
Maposa, Non-Medical Case Manager	1.00			37,123.41	20,417.88	14,158.19	0.69	6,259.69	0.31	-	0.00	-	0.00	-		20,417.88
Elzy, Non-Medical Case Manager	1.00			38,126.83	20,969.75	-	0.00	-	0.00	9,828.20	0.47	11,141.55	0.53	-		20,969.75
Vacant, Lead Non-Medical Case Manager	1.00			38,126.67	20,969.67	-	0.00	-	0.00	9,828.16	0.47	11,141.51	0.53	-		20,969.67
Jones, Non-Medical Case Manager	1.00			42,000.10	23,100.11	-	0.00	-	0.00	9,202.77	0.40	12,273.41	0.53	1,623.93	0.07	23,100.11
Kilgore, Non-Medical Case Manager	1.00			37,123.41	20,417.88	-	0.00	-	0.00	8,134.22	0.40	9,220.97	0.45	3,062.68	0.15	20,417.88
Vacant, Eligibility & Intake Specialist	1.00			33,110.00	18,210.50	12,627.55	0.69	5,582.95	0.31	-	0.00	-	0.00	-		18,210.50
Searight, Part-time Receptionist	0.13			35,620.69	2,448.92	-	0.00	-	0.00	1,147.77	0.06	1,301.15	0.07	-		2,448.92
FRINGE Benefits					**52,333.86**	**12,768.88**		**5,645.44**		**14,958.56**		**17,513.35**		**1,447.63**		**52,333.86**
Prgm.Combined - Soc. Sec./ Medicare taxes (FICA)			7.65%		15,707.08	3,753.25		1,659.41		4,555.80		5,333.35		405.28		15,707.08
Prgm.Combined - Retirement system contributions		year	$ 1,500.00		2,121.63	746.55		330.07		483.33		547.92		13.75		2,121.63
Prgm.Combined - Employee Insurance (health, life, etc.)		month	$600.00		32,890.56	7,886.36		3,486.76		9,448.76		11,081.84		986.83		32,890.56
Prgm.Combined - Worker's Compensation Insurance			0.46%		944.48	225.69		99.78		273.94		320.70		24.37		944.48
Prgm.Combined - State Unemployment Insurance (SUI)			1.41%		670.11	157.03		69.42		196.73		229.54		17.39		670.11
TRAVEL - Direct Client services					**1,980.00**	**463.97**		**205.13**		**581.27**		**678.24**		**51.39**		**1,980.00**
Prgm. Direct - Local Travel					1,980.00	463.97		205.13		581.27		678.24		51.39		1,980.00
EQUIPMENT - Direct Client services																
SUPPLIES - Direct Client services					**4,675.00**	**1,852.43**		**819.00**		**886.52**		**1,031.78**		**85.27**		4,675.00
Prgm. Direct - Educational supplies for clients					275.00	63.88		28.24		79.20		89.78		13.89		275.00
Prgm. Direct - Office Supplies					2,750.00	644.40		284.90		807.32		942.00		71.38		2,750.00
Prgm. Direct - Computer					1,650.00	1,144.15		505.85		-		-		-		1,650.00
CONTRACTUAL - Subcontracted Direct services																
OTHER - Direct Client services					**18,871.43**	**4,159.02**		**1,838.81**		**5,947.10**		**6,878.96**		**377.64**		**19,201.52**
Prgm. Direct - Vehicle Repair			By % Funding		110.00	25.55		11.30		31.68		35.91		5.56		110.00
Prgm. Direct - Contract Personnel					3,850.00	-		-		1,804.44		2,045.56		-		3,850.00
Prgm. Direct - Computer Services (inc. licenses)			420		2,075.42	503.69		222.69		596.97		698.35		53.72		2,075.42
Prgm. Direct - Conferences and Conventions			100		528.06	123.74		54.71		155.02		180.89		13.71		528.06
Prgm. Direct - Postage/Freight			By % Funding		275.00	64.44		28.49		80.73		94.20		7.14		275.00
Prgm. Direct - Staff Development and training			225		1,188.15	278.41		123.09		348.81		406.99		30.84		1,188.15
Prgm. Direct - Printing/copying			By % Funding		275.00	63.88		28.24		79.20		89.78		13.89		275.00
Prgm. Direct - Cell Phones			29.99		1,778.34	431.59		190.82		511.52		598.39		46.03		1,778.34
Prgm. Direct - Telecommunications (Phone, Internet, etc.)			240.00		2,276.36	533.41		235.83		668.28		779.76		59.08		2,276.36
Prgm. Direct - Interpreters					825.00	572.07		252.93		-		-		-		825.00
Prgm. Direct - Facilities support (Utilities, Repairs & Maintenance, etc.)				70,040.00	5,690.10	1,562.23		690.70		1,670.45		1,949.12		147.69		6,020.19
SUBTOTAL- PROGRAM DIRECT COSTS					**283,181.65**	**68,306.40**		**30,199.95**		**81,926.34**		**95,819.30**		**7,259.76**		**283,511.74**

Prgm. Direct - Staff Development and training		225		1,188.15		278.41		123.09		348.81		406.99		30.84		1,188.15
Prgm. Direct - Printing/copying		By % Funding		275.00		63.88		28.24		79.20		89.78		13.89		275.00
Prgm. Direct - Cell Phones		29.99		1,778.34		431.59		190.82		511.52		598.39		46.03		1,778.34
Prgm. Direct - Telecommunications (Phone, Internet, etc.)			28,020.00	2,276.36		533.41		235.83		668.28		779.76		59.08		2,276.36
Prgm. Direct - Interpreters				825.00		572.07		252.93		-		-		-		825.00
Prgm. Direct - Facilities support (Utilities, Repairs & Maintenance, etc.)			70,040.00	5,690.10		1,562.23		690.70		1,670.45		1,949.12		147.69		6,020.19
SUBTOTAL- PROGRAM DIRECT COSTS				**283,181.65**		**68,306.40**		**30,199.95**		**81,926.34**		**95,819.30**		**7,259.76**		**283,511.74**

ADMINISTRATIVE Line Item Budget Yr./ Fund: **FY2015 Ryan White A Non-MAI**

Program: **Non-Medical Case Management** Agency: **AIDS Services of Austin**

Cost Category & Description	FTE-Svc Admin	Salary	Total Admin Costs for this Service		RWA TIER 1 NonMAI		RWA TIER 1 MAI		City of Austin T1		Travis County		Other Funding Sources		ASA Unrestricted Funds		Total ADMIN Costs
ADMINISTRATIVE LINE ITEMS		65.00	14.18%		2.25	2.15%	0.99	0.95%	2.82	2.67%	3.29	3.30%	0.25	0.5%	-	4.65%	9.60
ADMINISTRATIVE - PERSONNEL	**7.00**	**413,509.65**	**32,257.57**		**4,890.99**		**2,162.43**		**6,063.58**		**7,503.82**		**1,063.31**		**10,573.43**		**32,257.57**
Campion - Chief Programs Officer	1.00	91,200.00	7,114.44		1,078.71		476.93		1,337.33		1,654.98		234.52		2,331.98		7,114.44
White, Facilities and Systems	1.00	49,744.13	3,880.50		588.37		260.13		729.43		902.69		127.91		1,271.96		3,880.50
Vacant, Human Resources Manager	1.00	59,160.00	4,615.03		699.74		309.37		867.50		1,073.56		152.13		1,512.72		4,615.03
Garza, Chief Financial Officer	1.00	78,290.10	6,107.35		926.01		409.41		1,148.02		1,420.70		201.32		2,001.88		6,107.35
Vacant, Accountant	1.00	36,000.00	2,808.33	0.08	425.81		188.26		527.89		653.28		92.57		920.52		2,808.33
Oden, Accountant	1.00	42,368.76	3,305.15		501.14		221.57		621.28		768.85		108.95		1,083.37		3,305.15
Hayse, Grants Manager	1.00	56,746.67	4,426.76		671.20		296.75		832.12		1,029.76		145.92		1,451.01		4,426.76
FRINGE Benefits		**67,565.53**	**5,330.13**		**808.17**		**357.31**		**1,001.93**		**1,239.91**		**175.70**		**1,747.12**		**5,330.13**
Combined Admin. Staff - Soc. Sec./ Medicare taxes (FICA)	7.65%	31,633.49	2,467.70		374.16		165.43		463.86		574.04		81.34		808.87		2,467.70
Combined Admin. Staff - Retirement system contributions	$1,500	1,503.00	117.25		17.78		7.86		22.04		27.27		3.86		38.43		117.25
Combined Admin. Staff - Employee Insurance (health, life, etc.)	$ 600	32,400.00	2,527.50		383.23		169.43		475.10		587.95		83.31		828.47		2,527.50
Combined Admin. Staff - Worker's Compensation Insurance	0.46%	1,902.14	148.38		22.50		9.95		27.89		34.52		4.89		48.64		148.38
Combined Admin. Staff - State Unemployment Insurance (SUI)	1.41%	126.90	69.30		10.51		4.65		13.03		16.12		2.28		22.71		69.30
TRAVEL - Administrative Support																	
EQUIPMENT - Administrative Support																	

SUPPLIES - Administrative Support														
CONTRACTUAL - Subcontracted Admin. services														
OTHER - Administrative costs (list)	**159,828.00**	**12,468.06**		**1,890.44**		**835.81**		**2,343.67**		**1,922.80**		**410.99**		**5,064.34**		**12,468.06**
Admin. - General & Other Liability Insurance	47,055.00	3,670.72		556.57		246.07		690.00		853.89		121.00		1,203.19		3,670.72
Admin. - Telecommunications (Phone, Internet, etc.)	0.00	0.00		-		-		-		-		-		-		-
Admin. - Audit	44,480.00	3,469.85		526.11		232.61		652.24		-		114.38		1,944.52		3,469.85
Admin. - Computer Services (Other contract services)	58,904.00	4,595.06		696.72		308.04		863.75		1,068.91		151.47		1,506.17		4,595.06
Admin. - Repairs/Maintainence	0.00	0.00		-		-		-		-		-		-		
Admin. - Facilities support (Utilities, etc.)	0.00	0.00		-		-		-		-		-		-		-
Admin. - Photocopier rental, Equip maint., etc. NOT directly serving clients	9,389.00	732.43		111.05		49.10		137.68		-		24.14		410.46		732.43
SUBTOTAL ADMINISTRATIVE COSTS	**640,903.19**	**50,055.75**		**7,589.60**		**3,355.55**		**9,409.18**		**10,666.54**		**1,650.00**		**17,384.89**		**50,055.75**
SUM OF DIRECT + ADMIN = TOTAL COST		**$333,237.40**		**$75,896.00**		**$33,555.50**		**$91,335.52**		**$106,485.83**		**$8,909.76**				

BUDGET JUSTIFICATION

AIDS Services of Austin

Budget Period/Fund: FY2016 Ryan White Part A (not MAI)

Service Category: Non-Medical Case Management

The agency total annual HIV services budget for this program will be funded as follows (add more rows as needed):

City Of Austin	$ 91,335.52	28.9%
Travis County	$ 106,485.83	33.7%
RWA MAI	$ 33,555.50	10.6%
Agency Fundraising	$ 8,909.76	2.8%
Ryan White Part A	**$ 75,896**	**24.0%**
TOTAL - All Funding Sources	**$ 316,182.61**	**100%**

DIRECT SERVICE Costs - LINE ITEMS NARRATIVE

PERSONNEL	**FY16 Funding**
Williams-Price, Director of Access Services	
0.0663 FTE x $68,227 annual salary	6,635.20
Supervises all Case Management, including MCM, Health Insurance, and Outreach programs; manages service delivery and evaluation; reviews financial assistance; budgets and implements program modifications; coordinates QM activities and develops policy and procedures.	
Braglia, Medical Programs Manager	
0.0238 FTE x $48,658 annual salary	2,319.67
Supervises all Medical Case Management Programs, up to 2 interns, approves and tracks financial requests, evaluates program outcomes and service delivery, completes grant reporting requirements, and coordinates and implements QM activities	
Rios M., Non-Medical Programs Manager	
0.2475 FTE x $47,909 annual salary	7,436.60
Supervises all Non-Medical Case Management Programs, up to 2 interns, approves and tracks financial requests, evaluates program outcomes and service delivery, completes grant reporting requirements, and coordinates and implements QM activities.	
Medina, Intake Coordinator	
0.0377 FTE x $36,899 annual salary	1,125.82
Performs eligibility and intake, makes referrals and provides information, performs quality assurance activities.	

Lindgren, Lead Receptionist	
0.0341 FTE x $31,513 annual salary	1,201.84
Provides programmatic support to clients in the verification and updates of eligibility documents and handles fees related to client services	
Cirlos, Eligibility & Intake Specialist	
0.1496 FTE x $33,612 annual salary	3,557.24
Performs eligibility and intake, makes referrals and provides information, performs quality assurance activities.	
Maposa, Non-Medical Case Manager	
0.6934 FTE x $37,123 annual salary	14,158.19
Provides Non-Medical Case Management to assist clients with issues related to HIV/AIDS in accessing medical care and social services through advocacy, resource linkage, and supportive counseling.	
Vacant, Eligibility & Intake Specialist	
0.6934 FTE x $33,110 annual salary	12,627.55
Performs eligibility and intake, makes referrals and provides information, performs quality assurance activities.	
Personnel Salaries Subtotal	**$49,062**
FRINGE BENEFITS	
FICA & Medicare Tax - Personnel Subtotal multiplied by 7.65% rate	3,753.25
Retirement - 3% Match per employee salary for eligible and participating staff	746.55
Medical Benefits - $600 per month per employee for eligible and participating staff	7,886.36
Worker's Compensation Insurance - .46% of employee salary	225.69
State Unemployment Insurance - 1.41% of first $9000 of employee salary	157.03
Fringe Benefits Subtotal	**$12,769**
TRAVEL	
Local Mileage: Reimbursement to Program Direct staff for use of their privately owned vehicles in the performance of program duties within service area. 306 miles/mo. x 12 months x $0.54/mile = $1,980 x 23%	463.97
Travel Subtotal	**$464**
	FY16 Funding
EQUIPMENT	0
Equipment with useable life over 1 year and cost of $5,000 or more per each unit	
Equipment Subtotal	**$0**

SUPPLIES	
Educational Supplies for direct client services: $275 x 23%	63.88
Office supplies to support non-medical case management program operations: $2,750 x 23%	644.40
Computer equipment for direct client services: 2 computers @ $1,500/each x partial award x 69%	1,144.15
Supplies Subtotal	**1,852.43**
CONTRACTUAL **(must also submit completed Subcontractor Data Sheets)**	
Contractual Subtotal	**$0**
OTHER	
Vehicle Repair: $110 x 23%	25.55
Computer Licenses: $420 x FTE	503.69
Conferences and Conventions: $40/year x FTE	123.74
Postage and Freight: $275 x 23%	64.44
Staff Development: $225/year x FTE	278.41
Printing and Copying: $275 x 23%	63.88
Cell Phones for staff safety: $29.99/month x FTE x 12 months	431.59
Tellecommunications: $28,020/year prorated by FTE	533.41
Interpretrers: $825 x 69%	572.07
Facilities Support: $70,040/year proprated by FTE	1,562.23
Other Subtotal	**4,159.02**
TOTAL DIRECT SERVICES COSTS	**$68,306**
ADMINISTRATIVE COSTS - LINE ITEMS NARRATIVE	
PERSONNEL	**FY16 Funding**
Campion - Chief Programs Officer	
0.0215 FTE x $91,200 annual salary	1,078.71
Duties include: Oversight of programs including output, outcome, and spending tracking; quality management and improvement; supervision of directors; budgeting; and compliance.	
Systems and Facilities Manager, Lynda White	
0.0215 FTE x $49,744 annual salary	588.37
Duties include: Data management and improvement; facilities management; repairs and maintenance of facilities; quality control of data; maintenance of ARIES database and data.	

Human Resources Manager, Vacant	
0.0215 FTE x $59,160 annual salary	699.74
Duties include: Organization HR issues, trainings, orientation, and organizational HR policies and procedures.	
Chief Financial Officer, Bill Garza	
0.0215 FTE x $78,290 annual salary	926.01
Duties include: Oversees fiscal management of the organization.	
Accountant, Vacant	
0.0215 FTE x $36,000 annual salary	425.81
Duties include: Financial services support for organization.	
Accountant. Wyatt Oden	
0.0215 FTE x $42,369 annual salary	501.14
Duties include: Financial services support for organization.	
Grants Manager, Britt Hayse	
0.0215 FTE x $56,747 annual salary	671.20
Duties include: Grant compliance responsibilities.	
Personnel Subtotal	**$4,891**
FRINGE BENEFITS	
FICA & Medicare Tax - Personnel Subtotal multiplied by 7.65% rate	374.16
Medical Benefits - $600 per month per employee for eligible and participating staff	17.78
Retirement - 3% Match per employee salary for eligible and participating staff	383.23
Worker's Compensation Insurance - .46% of employee salary	22.50
State Unemployment Insurance - 1.41% of first $9000 of employee salary	10.51
Fringe Benefits Subtotal	**$808**
SUPPLIES	
Supplies Subtotal	**$0**
OTHER	
General & Other Liability Insurance: $47,055 prorated by FTE	556.57
Telecommunications (phone, internet, etc): $28,020 prorated by FTE	-
Annual Audit: $44,480 prorated by FTE	526.11
Computer Services:$58,904 prorated by FTE	696.72
Repairs and Maintenance: $29,420 prorated by FTE	-
Facilities Support: $40,620 prorated by FTE	-
Photocopier Rental, Equipment Maintenance, etc (not directly serving clients): $9,389 prorated by FTE	111.05
Other Subtotal	**1,890.44**
TOTAL ADMINISTRATIVE COSTS	**$7,590**
TOTAL - DIRECT SERVICES and ADMINISTRATIVE COSTS BUDGET for FY 2014 Grant program	**$75,896**

DIRECT SERVICES Line Item Budget Yr./ Fund: **FY2016 Ryan White A MAI**

Program: **Non-Medical Case Management** Agency: **AIDS Services of Austin**

City of Austin HIV Grant Agreements and Contracts *HHSD/ HRAU form rev. August 2014*

Cost Category & Description	FTE - Svc Categ			Annualized Salary	**Total Svc Annual Cost**	**RWA (MAI)**	100%	**RWA (Non-MAI)**	100%	**City of Austin T1**		**Travis County**		**Other Funding Sources**		Total DIRECT SERVICE Costs
PROGRAM DIRECT - CLIENT SERVICES																
PERSONNEL Staff Salaries	**9.60**				**298,649.25**	**31,551.38**	**0.99**	**71,363.06**	**2.25**	**86,622.38**	**2.82**	**101,406.49**	**3.29**	**7,705.94**	**0.25**	**298,649.25**
Williams-Price, Director of Access Services	0.38			68,226.67	20,468.00	4,267.04	0.08	9,651.20	0.18	3,069.77	0.06	3,479.99	0.06	-		20,468.00
Braglia, Medical Programs Manager	0.28			48,658.24	10,704.81	1,491.76	0.04	3,374.07	0.09	2,736.64	0.07	3,102.34	0.08	-		10,704.81
Rios M., Non-Medical Programs Manager	0.88			47,909.33	33,613.30	4,782.41	0.12	10,816.87	0.28	7,974.09	0.21	9,571.06	0.25	468.87	0.01	33,613.30
Medina, Intake Coordinator	0.68			36,899.39	20,073.27	724.00	0.02	1,637.56	0.06	8,301.21	0.28	9,410.50	0.32	-		20,073.27
Lindgren, Lead Receptionist	0.49			31,512.69	12,394.99	772.89	0.03	1,748.13	0.07	4,430.85	0.18	5,022.95	0.20	420.17	0.02	12,394.99
Cirlos, Eligibility & Intake Specialist	0.78			33,611.67	20,906.46	2,287.63	0.09	5,174.16	0.19	6,301.31	0.23	7,143.36	0.27	-		20,906.46
Maposa, Non-Medical Case Manager	1.00			37,123.41	29,698.73	9,105.00	0.31	20,593.73	0.69	-	0.00	-	0.00	-		29,698.73
Elzy, Non-Medical Case Manager	1.00			38,126.83	30,501.46	-	0.00	-	0.00	14,295.57	0.47	16,205.89	0.53	-		30,501.46
Vacant, Lead Non-Medical Case Manager	1.00			38,126.67	30,501.33	-	0.00	-	0.00	14,295.51	0.47	16,205.83	0.53	-		30,501.33
Jones, Non-Medical Case Manager	1.00			42,000.10	33,600.16	-	0.00	-	0.00	13,385.84	0.40	17,852.24	0.53	2,362.09	0.07	33,600.16
Kilgore, Non-Medical Case Manager	1.00			37,123.41	29,698.73	-	0.00	-	0.00	11,831.60	0.40	13,412.33	0.45	4,454.81	0.15	29,698.73
Vacant, Eligibility & Intake Specialist	1.00			33,110.00	26,488.00	8,120.66	0.31	18,367.34	0.69	-	0.00	-	0.00	-		26,488.00
Searight, Part-time Receptionist	0.13			35,620.69	3,562.07	-	0.00	-	0.00	1,669.49	0.06	1,892.58	0.07	-		3,562.07
FRINGE Benefits					**76,121.97**	**8,211.55**		**18,572.92**		**21,757.90**		**25,473.97**		**2,105.64**		**76,121.97**
Prgm.Combined - Soc. Sec./ Medicare taxes (FICA)			7.65%		22,846.67	2,413.68		5,459.27		6,626.61		7,757.60		589.50		22,846.67
Prgm.Combined - Retirement system contributions		year	$ 1,500.00		3,086.00	480.10		1,085.90		703.03		796.97		20.00		3,086.00
Prgm.Combined - Employee Insurance (health, life, etc.)		month	$600.00		47,840.81	5,071.65		11,471.07		13,743.65		16,119.05		1,435.39		47,840.81
Prgm.Combined - Worker's Compensation Insurance			0.46%		1,373.79	145.14		328.27		398.46		466.47		35.45		1,373.79
Prgm.Combined - State Unemployment Insurance (SUI)			1.41%		974.71	100.98		228.40		286.15		333.88		25.30		974.71
TRAVEL - Direct Client services					**2,880.00**	**298.37**		**674.86**		**845.49**		**986.53**		**74.75**		**2,880.00**
Prgm. Direct - Local Travel					2,880.00	298.37		674.86		845.49		986.53		74.75		2,880.00
EQUIPMENT - Direct Client services																
SUPPLIES - Direct Client services					**6,800.00**	**1,191.28**		**2,694.44**		**1,289.49**		**1,500.78**		**124.02**		**6,800.00**
Prgm. Direct - Educational supplies for clients					400.00	41.08		92.92		115.20		130.59		20.20		400.00
Prgm. Direct - Office Supplies					4,000.00	414.41		937.30		1,174.29		1,370.18		103.82		4,000.00
Prgm. Direct - Computer					2,400.00	735.79		1,664.21		-		-		-		2,400.00
CONTRACTUAL - Subcontracted Direct services																

OTHER - Direct Client services			**27,449.35**		**2,674.63**		**6,049.48**		**8,650.33**		**10,005.76**		**549.29**		**27,929.49**
Prgm. Direct - Vehicle Repair	By % Funding		160.00		16.43		37.17		46.08		52.24		8.08		160.00
Prgm. Direct - Contract Personnel			5,600.00		-		-		2,624.63		2,975.37		-		5,600.00
Prgm. Direct - Computer Services (inc. licenses)	420		3,018.79		323.92		732.64		868.32		1,015.79		78.13		3,018.79
Prgm. Direct - Conferences and Conventions	100		768.09		79.58		179.98		225.49		263.11		19.94		768.09
Prgm. Direct - Postage/Freight	By % Funding		400.00		41.44		93.73		117.43		137.02		10.38		400.00
Prgm. Direct - Staff Development and training	225		1,728.21		179.05		404.96		507.35		591.99		44.86		1,728.21
Prgm. Direct - Printing/copying	By % Funding		400.00		41.08		92.92		115.20		130.59		20.20		400.00
Prgm. Direct - Cell Phones	29.99		2,586.68		277.55		627.76		744.03		870.39		66.95		2,586.68
Prgm. Direct - Telecommunications (Phone, Internet, etc.)		28,020.00	3,311.08		343.03		775.87		972.04		1,134.19		85.94		3,311.08
Prgm. Direct - Interpreters			1,200.00		367.89		832.11		-		-		-		1,200.00
Prgm. Direct - Facilities support (Utilities, Repairs & Maintenance, etc.)		70,040.00	8,276.51		1,004.66		2,272.34		2,429.75		2,835.08		214.82		8,756.64
SUBTOTAL- PROGRAM DIRECT COSTS			**411,900.58**		**43,927.20**		**99,354.76**		**119,165.59**		**139,373.52**		**10,559.64**		**412,380.71**

ADMINISTRATIVE Line Item Budget Yr./ Fund: **FY2016 Ryan White A MAI**

Program: **Non-Medical Case Management** Agency: **AIDS Services of Austin**

Cost Category & Description	FTE-Svc Admin	Salary	Total Admin Costs for this Service		RWA MAI		RWA NonMAI		City of Austin T1		Travis County		Other Funding Sources		ASA Unrestricted Funds		Total ADMIN Costs
ADMINISTRATIVE LINE ITEMS		65.00	14.18%		0.99	0.95%	2.25	2.15%	2.82	2.67%	3.29	3.30%	0.25	0.5%	-	4.65%	9.60
ADMINISTRATIVE - PERSONNEL	**7.00**	**413,509.65**	**46,920.09**		**3,145.35**		**7,114.16**		**8,819.76**		**10,914.65**		**1,546.64**		**15,379.53**		**46,920.09**
Campion - Chief Programs Officer	1.00	91,200.00	10,348.28		693.71		1,569.04		1,945.21		2,407.24		341.11		3,391.97		10,348.28
White, Facilities and Systems	1.00	49,744.13	5,644.36		378.38		855.82		1,060.99		1,313.00		186.06		1,850.12		5,644.36
Vacant, Human Resources Manager	1.00	59,160.00	6,712.76		450.00		1,017.81		1,261.83		1,561.54		221.27		2,200.32		6,712.76
Garza, Chief Financial Officer	1.00	78,290.10	8,883.42		595.51		1,346.93		1,669.85		2,066.48		292.83		2,911.82		8,883.42
Vacant, Accountant	1.00	36,000.00	4,084.85	0.11	273.83		619.36		767.84		950.23		134.65		1,338.94		4,084.85
Oden, Accountant	1.00	42,368.76	4,807.50		322.28		728.93		903.68		1,118.33		158.47		1,575.81		4,807.50
Hayse, Grants Manager	1.00	56,746.67	6,438.93		431.64		976.29		1,210.35		1,497.84		212.25		2,110.56		6,438.93
FRINGE Benefits		**67,565.53**	**7,752.92**		**519.73**		**1,175.52**		**1,457.35**		**1,803.50**		**255.56**		**2,541.26**		**7,752.92**
Combined Admin. Staff - Soc. Sec./ Medicare taxes (FICA)	7.65%	31,633.49	3,589.39		240.62		544.23		674.71		834.97		118.32		1,176.53		3,589.39
Combined Admin. Staff - Retirement system contributions	$1,500	1,503.00	170.54		11.43		25.86		32.06		39.67		5.62		55.90		170.54
Combined Admin. Staff - Employee Insurance (health, life, etc.)	$ 600	32,400.00	3,676.36		246.45		557.42		691.06		855.20		121.18		1,205.04		3,676.36
Combined Admin. Staff - Worker's Compensation Insurance	0.46%	1,902.14	215.83		14.47		32.73		40.57		50.21		7.11		70.75		215.83
Combined Admin. Staff - State Unemployment Insurance (SUI)	1.41%	126.90	100.79		6.76		15.28		18.95		23.45		3.32		33.04		100.79
TRAVEL - Administrative Support																	
EQUIPMENT - Administrative Support																	
SUPPLIES - Administrative Support																	
CONTRACTUAL - Subcontracted Admin. services																	
OTHER - Administrative costs (list)		**159,828.00**	**18,135.36**		**1,215.73**		**2,749.74**		**3,408.98**		**2,796.81**		**597.80**		**7,366.31**		**18,135.36**
Admin. - General & Other Liability Insurance		47,055.00	5,339.23		357.92		809.55		1,003.64		1,242.02		176.00		1,750.10		5,339.23
Admin. - Telecommunications (Phone, Internet, etc.)		0.00	0.00		-		-		-		-		-		-		-
Admin. - Audit		44,480.00	5,047.05		338.34		765.25		948.72		-		166.37		2,828.39		5,047.05
Admin. - Computer Services (Other contract services)		58,904.00	6,683.72		448.05		1,013.40		1,256.36		1,554.78		220.32		2,190.80		6,683.72
Admin. - Repairs/Maintainence		0.00	0.00		-		-		-		-		-		-		
Admin. - Facilities support (Utilities, etc.)		0.00	0.00		-		-		-		-		-		-		-
Admin. - Photocopier rental, Equip maint., etc. NOT directly serving clients		9,389.00	1,065.35		71.42		161.53		200.26		-		35.12		597.03		1,065.35
SUBTOTAL ADMINISTRATIVE COSTS		**640,903.19**	**72,808.37**		**4,880.80**		**11,039.42**		**13,686.08**		**15,514.96**		**2,400.00**		**25,287.11**		**72,808.37**
SUM OF DIRECT + ADMIN = TOTAL COST			**$484,708.95**		**$48,808.00**		**$110,394.18**		**$132,851.67**		**$154,888.48**		**$12,959.64**				

BUDGET JUSTIFICATION

AIDS Services of Austin

Budget Period/Fund: FY2016 Ryan White Part A (MAI)
Service Category: Non-Medical Case Management

The agency total annual HIV services budget for this program will be funded as follows (add more rows as needed):

City Of Austin	$ 132,851.67	28.9%
Travis County	$ 154,888.48	33.7%
RWA Non-MAI	$ 110,394.18	24.0%
Agency Fundraising	$ 12,959.64	2.8%
Ryan White Part A MAI	**$ 48,808.00**	**10.6%**
TOTAL - All Funding Sources	**$ 459,901.97**	**100%**

DIRECT SERVICE Costs - LINE ITEMS NARRATIVE

PERSONNEL	**FY16 Funding**
Williams-Price, Director of Access Services	
0.0293 FTE x $68,227 annual salary	4,267.04
Supervises all Case Management, including MCM, Health Insurance, and Outreach programs; manages service delivery and evaluation; reviews financial assistance; budgets and implements program modifications; coordinates QM activities and develops policy and procedures.	
Braglia, Medical Programs Manager	
0.0105 FTE x $48,658 annual salary	1,491.76
Supervises all Medical Case Management Programs, up to 2 interns, approves and tracks financial requests, evaluates program outcomes and service delivery, completes grant reporting requirements, and coordinates and implements QM activities	
Rios M., Non-Medical Programs Manager	
0.1094 FTE x $47,909 annual salary	4,782.41
Supervises all Non-Medical Case Management Programs, up to 2 interns, approves and tracks financial requests, evaluates program outcomes and service delivery, completes grant reporting requirements, and coordinates and implements QM activities.	
Medina, Intake Coordinator	
0.0167 FTE x $36,899 annual salary	724.00
Performs eligibility and intake, makes referrals and provides information, performs quality assurance activities.	
Lindgren, Lead Receptionist	
0.0151 FTE x $31,513 annual salary	772.89
Provides programmatic support to clients in the verification and updates of eligibility documents and handles fees related to client services	

Cirlos, Eligibility & Intake Specialist	
0.0661 FTE x $33,612 annual salary	2,287.63
Performs eligibility and intake, makes referrals and provides information, performs quality assurance activities.	
Maposa, Non-Medical Case Manager	
0.3066 FTE x $37,123 annual salary	9,105.00
Provides Non-Medical Case Management to assist clients with issues related to HIV/AIDS in accessing medical care and social services through advocacy, resource linkage, and supportive counseling.	
Vacant, Eligibility & Intake Specialist	
0.3066 FTE x $33,110 annual salary	8,120.66
Performs eligibility and intake, makes referrals and provides information, performs quality assurance activities.	
Personnel Salaries Subtotal	**$31,551**
FRINGE BENEFITS	
FICA & Medicare Tax - Personnel Subtotal multiplied by 7.65% rate	2,413.68
Retirement - 3% Match per employee salary for eligible and participating staff	480.10
Medical Benefits - $600 per month per employee for eligible and participating staff	5,071.65
Worker's Compensation Insurance - .46% of employee salary	145.14
State Unemployment Insurance - 1.41% of first $9000 of employee salary	100.98
Fringe Benefits Subtotal	**$8,212**
TRAVEL	
Local Mileage: Reimbursement to Program Direct staff for use of their privately owned vehicles in the performance of program duties within service area. 444 miles/mo. x 12 months x $0.54/mile = $2,880 x 10%	298.37
Travel Subtotal	**$298**
	FY16 Funding
EQUIPMENT	0
Equipment with useable life over 1 year and cost of $5,000 or more per each unit	
Equipment Subtotal	**$0**

SUPPLIES	
Educational Supplies for direct client services: $400 x 10%	41.08
Office supplies to support non-medical case management program operations: $4,000/year x 10%	414.41
Computer equipment for direct client services: 2 computers @ $1,500/each x partial award x 31%	735.79
Supplies Subtotal	**1,191.28**
CONTRACTUAL **(must also submit completed Subcontractor Data Sheets)**	
Contractual Subtotal	**$0**
OTHER	
Vehicle Repair: $160 x 10%	16.43
Computer Licenses: $420 x FTE	323.92
Conferences and Conventions: $40/year x FTE	79.58
Postage and Freight: $400 x 10%	41.44
Staff Development: $225/year x FTE	179.05
Printing and Copying: $400 x 10%	41.08
Cell Phones for staff safety: $29.99/month x FTE x 12 months	277.55
Tellecommunications: $28,020/year prorated by FTE	343.03
Interpretrers: $1,200 x 31%	367.89
Facilities Support: $70,040/year proprated by FTE	1,004.66
Other Subtotal	**$2,675**
TOTAL DIRECT SERVICES COSTS	**$43,927**
ADMINISTRATIVE COSTS - LINE ITEMS NARRATIVE	
PERSONNEL	**FY16 Funding**
Campion - Chief Programs Officer	
0.0095 FTE x $91,200 annual salary	693.71
Duties include: Oversight of programs including output, outcome, and spending tracking; quality management and improvement; supervision of directors; budgeting; and compliance.	
Systems and Facilities Manager, Lynda White	
0.0095 FTE x $49,744 annual salary	378.38
Duties include: Data management and improvement; facilities management; repairs and maintenance of facilities; quality control of data; maintenance of ARIES database and data.	

Human Resources Manager, Vacant	
0.0095 FTE x $59,160 annual salary	450.00
Duties include: Organization HR issues, trainings, orientation, and organizational HR policies and procedures.	
Chief Financial Officer, Bill Garza	
0.0095 FTE x $78,290 annual salary	595.51
Duties include: Oversees fiscal management of the organization.	
Accountant, Vacant	
0.0095 FTE x $36,000 annual salary	273.83
Duties include: Financial services support for organization.	
Accountant. Wyatt Oden	
0.0095 FTE x $42,369 annual salary	322.28
Duties include: Financial services support for organization.	
Grants Manager, Britt Hayse	
0.0095 FTE x $56,747 annual salary	431.64
Duties include: Grant compliance responsibilities.	
Personnel Subtotal	**$3,145**
FRINGE BENEFITS	
FICA & Medicare Tax - Personnel Subtotal multiplied by 7.65% rate	240.62
Medical Benefits - $600 per month per employee for eligible and participating staff	11.43
Retirement - 3% Match per employee salary for eligible and participating staff	246.45
Worker's Compensation Insurance - .46% of employee salary	14.47
State Unemployment Insurance - 1.41% of first $9000 of employee salary	6.76
Fringe Benefits Subtotal	**$520**
SUPPLIES	
Supplies Subtotal	**$0**
OTHER	
General & Other Liability Insurance: $47,055 prorated by FTE	357.92
Telecommunications (phone, internet, etc): $28,020 prorated by FTE	-
Annual Audit: $44,480 prorated by FTE	338.34

Computer Services:$58,904 prorated by FTE	448.05
Repairs and Maintenance: $29,420 prorated by FTE	-
Facilities Support: $40,620 prorated by FTE	-
Photocopier Rental, Equipment Maintenance, etc (not directly serving clients): $9,389 prorated by FTE	71.42
Other Subtotal	**1,215.73**
TOTAL ADMINISTRATIVE COSTS	**$4,881**
TOTAL - DIRECT SERVICES and ADMINISTRATIVE COSTS BUDGET for FY 2014 Grant program	**$48,808**

DIRECT SERVICES Line Item Budget Yr./ Fund: **FY2016 Ryan White PART A (non MAI)**

Program: **Oral Health** Agency: **AIDS Services of Austin**

City of Austin HIV Grant Agreements and Contracts

Cost Category & Description	FTE - Service Category		RWA		RWB		RWC		St. David's		Other Funding Sources		Total DIRECT SERVICE Costs
PROGRAM DIRECT CLIENT SERVICES				4.38		1.18		1.10		4.67			11.33
PERSONNEL Staff Salaries	**11.33**		**145,018.03**		**43,808.55**		**34,863.67**		**165,549.27**				**389,239.52**
Nelson, Director of Dental Services	1.00		15,423.24	0.43	5,544.86	0.15	4,094.74	0.11	10,741.22	0.30	-		35,804.06
Vacant, Lead Dentist	0.88		47,302.17	0.58	14,976.29	0.18	9,329.49	0.11	-	-	-		71,607.95
Bradley, Dentist, Specialist	0.05		-	-	-	-	-	-	4,076.66	0.05	-		4,076.66
Vacant, Dentist, Specialist	0.05		-	-	-	-	-	-	3,377.80	0.05	-		3,377.80
Howell, Dentist	0.40		-	-	-	-	-	-	28,114.09	0.40	-		28,114.09
Kilkelly, Dentist	0.88		9,116.44	0.13	3,277.48	0.05	2,420.34	0.04	45,476.31	0.66	-		60,290.57
Burton, Hygienist	0.88		21,959.95	0.54	7,894.89	0.19	5,830.19	0.14	-	-	-		35,685.03
Vacant, Hygienist	0.88		-	-	-	-	-	-	32,711.27	0.88	-		32,711.27
McFarlan, Lead Dental Assistant	1.00		14,040.96	0.62	5,047.91	0.22	3,727.76	0.16	-	-	-		22,816.63
Vacant, Dental Assistant	1.00		-	-	-	-	-	-	17,449.12	1.00	-		17,449.12
Guebara, Dental Assistant	1.00		12,181.73	0.62	4,379.49	0.22	3,234.15	0.16	-	-	-		19,795.37
Vacant, Eligibility/Intake Specialist	1.00		13,705.52	0.80	-	-	3,404.99	0.20	-	-	-		17,110.51
Aleman, Receptionist	1.00		11,288.02	0.67	2,687.62	0.16	2,822.01	0.17	-	-	-		16,797.66
Miranda, Patient Navigator	0.50		-	-	-	-	-	-	9,420.85	0.50	-		9,420.85
Vacant, Data Entry Specialist	0.83		-	-	-	-	-	-	14,181.94	0.83	-		14,181.94

FRINGE Benefits		**30,080.73**		**8,217.39**		**8,129.58**		**25,457.22**				**71,884.93**
Social Security / Medicare taxes (FICA)		11,093.88		3,351.35		2,667.07		12,664.52		-		29,776.82
Employee Insurance (health, life, etc.)		16,369.57		4,145.52		4,634.15		11,084.79		-		36,234.03
Retirement system contributions		1,644.82		436.69		591.34		621.15		-		3,294.00
Workers Compensation Insurance	0.46%	667.08		201.52		160.37		761.53		-		1,790.50
State Unemployment Insurance	1.41%	305.38		82.31		76.65		325.23		-		789.57
TRAVEL - Direct Client services		**816.54**		**290.10**		**0.00**		**895.76**		**514.21**		**2,516.62**
Local Travel & Mileage		91.68	16.7%	35.69	6.5%	-	0.0%	90.04	16.4%	331.60	60.4%	549.00
Travel Outside of Local Area		724.86	36.8%	254.42	12.9%	-		805.73	40.9%	182.62	9.3%	1,967.62
EQUIPMENT - Direct Client services		**0.00**		**0.00**		**0.00**		**0.00**				**0.00**
												0.00
SUPPLIES - Direct Client services		**16,181.13**		**2,794.96**		**9,343.99**		**5,176.85**		**18,471.45**		**51,968.38**
Dental Supplies		14,219.11	35.0%	2,031.30	5.0%	9,343.99	23.0%	3,250.08	0.08	11,375.29	28.0%	40,219.77
Infection Control		825.15	16.7%	321.17	6.5%	-	0.0%	810.32	0.16	2,984.37	60.4%	4,941.00
Dental Medications		458.42	16.7%	178.43	6.5%	-	0.0%	450.18	0.16	1,657.98	60.4%	2,745.00
Uniforms		82.51	16.7%	32.12	6.5%	-	0.0%	81.03	0.16	298.44	60.4%	494.10
Office Expense		45.84	16.7%	17.84	6.5%	-	0.0%	45.02	0.16	165.80	60.4%	274.50
Office Supplies		550.10	16.7%	214.11	6.5%	-	0.0%	540.22	16.4%	1,989.58	60.4%	3,294.00

CONTRACTUAL - Subcontracted Direct services											**0.00**
OTHER - Direct Client services	**43,562.27**		**7,454.45**		**32,385.16**		**61,549.72**		**75,128.22**		**220,079.82**
Contract Services	17,268.26	27.0%	2,726.25	5.0%	15,536.36	23.0%	21,740.42	33.0%	7,905.61	12.0%	**65,176.90**
Contract Personnel	1,037.61	27.0%	192.15	5.0%	883.89	23.0%	422.73	11.0%	1,306.62	34.0%	**3,843.00**
Dental Lab Services	16,332.76	35.0%	2,333.25	5.0%	10,732.96	23.0%	15,399.46	33.0%	5,599.80	12.0%	**50,398.24**
Conferences and Conventions	202.25	36.8%	70.99	12.9%	50.95	9.3%	224.81	40.9%	-	0.0%	**549.00**
Dues & Memberships	109.67	20.0%	42.69	7.8%	-	0.0%	-		396.65	72.2%	**549.00**
Equipment Repair	329.01	20.0%	128.06	7.8%	-	0.0%	-		1,189.94	72.2%	**1,647.00**
Liability Insurance - Dental	385.07	16.7%	149.88	6.5%	-	0.0%	378.15	0.164	1,392.70	60.4%	**2,305.80**
Licenses & Permits	91.68	16.7%	35.69	6.5%	-	0.0%	90.04	16.4%	331.60	60.4%	**549.00**
Postage & Freight	45.84	16.7%	17.84	6.5%	-	0.0%	45.02	0.164	165.80	60.4%	**274.50**
Printing & Copying	45.84	16.7%	17.84	6.5%	-	0.0%	45.02	16.4%	165.80	60.4%	**274.50**
Publications	22.92	16.7%	8.92	6.5%	-	0.0%	22.51	0.164	82.90	60.4%	**137.25**
Rent	5,437.07	10.0%	1,087.41	2.0%	4,349.66	8.0%	21,748.28	40.0%	38,490.48	40.0%	**71,112.90**
Staff & Volunteer Development	91.68	16.7%	35.69	6.5%	-	0.0%	90.04	0.164	331.60	60.4%	**549.00**
Staff & Volunteer Recruitment	91.68	16.7%	35.69	6.5%	-	0.0%	90.04	0.164	331.60	60.4%	**549.00**
Translation/Interpretation	164.50	20.0%	64.03	7.8%	-	0.0%	-	0.000	594.97	72.2%	**823.50**
Cell Phone	85.11	43.1%	22.60	11.4%	30.60	15.5%	59.27	30.0%	-		**197.57**
Computer Service (Dentrix/Eaglesoft)	180.43	16.7%	70.23	6.5%	-	0.0%	177.19	16.4%	652.58	60.4%	**1,080.43**
Telephone	674.61	8.0%	168.65	2.0%	337.31	4.0%	421.63	5.0%	6,830.44	81.0%	**8,432.65**

Utilities	546.30	8.0%	138.43	2.0%	264.92	4.0%	324.46	5.0%	5,256.24	81.0%	**6,530.35**
Repairs and Maintenance	397.04	8.0%	99.26	2.0%	198.52	4.0%	248.15	5.0%	4,020.00	81.0%	**4,962.96**
Staff/Volunteer Recognition	22.92	16.7%	8.92	6.5%	-	0.0%	22.51	0.164	82.90	60.4%	**137.25**
TOTAL PROGRAM DIRECT COSTS	235,658.70		62,565.46		84,722.40		258,628.83		94,113.88		**735,689.27**

ADMINISTRATIVE Line Item Budget Yr./ Fund: **FY2016 Ryan White PART A (non MAI)**

Program: **Oral Health** Agency: **AIDS Services of Austin**

Cost Category & Description	FTE-Svc Admin	Total Admin Costs for this Service	RWA		RWB		RWC		ST. David's		ASA Unrestricted Funds		Total ADMIN Costs
ADMINISTRATIVE LINE ITEMS		16.04%	4.81	6.45%	1.30	1.7%	-	0.0%	5.12	7.0%	-	0.9%	0.173
ADMINISTRATIVE - PERSONNEL	**7.00**	**36,408.75**	**14,637.15**		**3,886.04**		**-**		**15,874.93**		**2,010.63**		**36,408.75**
Campion - Chief Programs Officer	1.00	8,029.99	3,228.24		857.07		-		3,501.23		443.45		8,029.99
White, Facilities and Systems	1.00	4,379.88	1,760.81		467.48		-		1,909.71		241.87		4,379.88
Vacant, Human Resources Manager	1.00	5,208.93	2,094.11		555.97		-		2,271.19		287.66		5,208.93
Garza, Chief Financial Officer	1.00	6,893.30	2,771.26		735.75		-		3,005.61		380.67		6,893.30
Vacant, Accountant	1.00	3,169.73	1,274.31		338.32		-		1,382.07		175.04		3,169.73
Oden, Accountant	1.00	3,730.49	1,499.74		398.17		-		1,626.57		206.01		3,730.49
Hayse, Grants Manager	1.00	4,996.44	2,008.68		533.29		-		2,178.54		275.92		4,996.44
FRINGE Benefits		**6,016.06**	**2,418.59**		**642.12**		**-**		**2,623.12**		**332.23**		**6,016.06**
Combined Admin. Staff - Soc. Sec./ Medicare taxes (FICA)	7.65%	2,785.27	1,119.74		297.28		-		1,214.43		153.81		2,785.27
Combined Admin. Staff - Retirement system contributions	$1,500	132.34	53.20		14.12		-		57.70		7.31		132.34
Combined Admin. Staff - Employee Insurance (health, life, etc.)	$ 600	2,852.76	1,146.87		304.49		-		1,243.86		157.54		2,852.76
Combined Admin. Staff - Worker's Compensation Insurance	0.46%	167.48	67.33		17.88		-		73.02		9.25		167.48
Combined Admin. Staff - State Unemployment Insurance (SUI)	1.41%	78.21	31.44		8.35		-		34.10		4.32		78.21

TRAVEL - Administrative Support														
EQUIPMENT - Administrative Support														
SUPPLIES - Administrative Support														
CONTRACTUAL - Subcontracted Admin. services														
OTHER - Administrative costs (list)		**22,706.55**		**9,128.56**		**2,423.56**		**-**		**9,900.50**		**1,253.94**		**22,706.55**
Admin. - General & Other Liability Insurance		4,143.10		1,665.62		442.21		-		1,806.47		228.80		4,143.10
Admin. - Telecommunications (Phone, Internet, etc.)		2,467.11		991.83		263.32		-		1,075.71		136.24		2,467.11
Admin. - Audit		3,916.38		1,574.47		418.01		-		1,707.62		216.28		3,916.38
Admin. - Computer Services (Other contract services)		5,186.39		2,085.05		553.56		-		2,261.37		286.41		5,186.39
Admin. - Repairs/Maintainence		2,590.38		1,041.39		276.48		-		1,129.45		143.05		2,590.38
Admin. - Facilities support (Utilities, etc.)		3,576.51		1,437.84		381.74		-		1,559.43		197.51		3,576.51
Admin. - Photocopier rental, Equip maint., etc. NOT directly serving clients		826.68		332.35		88.24		-		360.45		45.65		826.68
SUBTOTAL ADMINISTRATIVE COSTS		**65,131.36**		**26,184.30**		**6,951.72**		**-**		**28,398.55**		**3,596.80**		**65,131.36**
SUM OF DIRECT + ADMIN = TOTAL COST				**$261,843.00**		**$69,517.17**		**$84,722.40**		**$287,027.38**		**$97,710.68**		

BUDGET JUSTIFICATION

AIDS Services of Austin

Budget Period/Fund: FY2016 Ryan White Part A

Service Category: Oral Health

The agency total annual HIV services budget for this program will be funded as follows (add more rows as needed):

Ryan White Part B	$ 65,517.17	8.7%
Ryan White Part C	$ 84,722.40	10.6%
St. David's Foundation	$ 287,027.38	35.8%
Agency Fundraising	$ 97,710.68	12.2%
Ryan White Part A	**$ 261,843**	**32.7%**
TOTAL - All Funding Sources	**$ 800,820.63**	**100%**

DIRECT SERVICE Costs - LINE ITEMS NARRATIVE

PERSONNEL	**FY16 Funding**
Nelson, Director of Dental Services	
0.43 FTE x $65,000 annual salary	15,423.24
Supervises all staff. Oversees operations of Jack Sansing Dental Clinic including daily operations, scheduling, contract compliance, federal, state and local laws and regulations related to operations; HIPAA,OSHA, Privacy Compliance; data management and quality, and clinical care.	
Vacant, Lead Dentist	
0.5104 FTE x $130,000 annual salary	47,302.17
Provides patient care and input on dental staff supervision to Director, leads assists with Clinical Team including developing clinical policy and staff procedures for the Jack Sansing Dental Clinic. Leads clinical quality assurance activities.	
Kilkelly, Dentist	
0.1144 FTE x $109,819 annual salary	9,116.44
Provides direct patient care, including patient education. Participates in ongoing quality assurance activities.	
Burton, Hygienist	
0.4752 FTE x $65,000 annual salary	21,959.95
Provides direct patient care, including patient education. Participates in ongoing quality assurance activities.	

McFarlan, Lead Dental Assistant	
0.62 FTE x $41,560 annual salary	14,040.96
Provides dental assistance to staff dentists. Responsible for cleaning and maintaining all operatories, instruments, and equipment. Works with various suppliers to order, purchase and maintain dental supply stock. Participates in ongoing quality assurance activities.	
Guebara, Dental Assistant	
0.62 FTE x $36,057 annual salary	12,181.73
Provides dental assistance to staff dentists. Provides dental laboratory support maintains instruments and equipment, sanitizes, and equipment supplies in all operatories. Monitors dental supply stock and reports deficits. Participates in ongoing quality assurance activities.	
Vacant, Eligibility/Intake Specialist	
0.80 FTE x $31,667 annual salary	13,705.52
Performs eligibility and intake, makes referrals and provides information, performs quality assurance activities, light bookkeeping (AP and AR).	
Aleman, Receptionist	
0.67 FTE x $30,597 annual salary	11,288.02
Coordinates daily Clinic operations. Schedules patient appointments, check patients in/out of the facility, receives payments, reconciles accounts, places reminder calls to patients, conducts all data entry, including ARIES and Provide© Enterprise patient databases. Maintains security of patient records, correspondence and facility. Works with patients to inform and reinforce the benefits of ARIES data sharing. Participates in ongoing quality assurance activities.	
Personnel Salaries Subtotal	**$145,018**
FRINGE BENEFITS	
FICA & Medicare Tax - Personnel Subtotal multiplied by 7.65% rate	11,093.88
Medical Benefits - $600 per month per employee for eligible and participating staff	16,369.57
Retirement - 3% Match per employee salary for eligible and participating staff	1,644.82
Worker's Compensation Insurance - .46% of employee salary	667.08
State Unemployment Insurance - 1.41% of first $9000 of employee salary	305.38
Fringe Benefits Subtotal	**$30,081**
TRAVEL	
Local Mileage: Reimbursement to Program Direct staff for use of their privately owned vehicles in the performance of program duties within service area. 85 miles/mo. x 12 months x $0.54/mile = $549 x 16.7%	91.68
Travel Outside Local Area: Lodging, per diem, travel, etc for Texas Dental Assoc Conference	724.86
Travel Subtotal	**$817**

EQUIPMENT	
Equipment with useable life over 1 year and cost of $5,000 or more per each unit	
Dental Equipment for patient services: TBD	$0
Equipment Subtotal	**$0**
SUPPLIES	
Dental supplies: Filling materials, sedative bases, cavity varnishes, antibiotics, antifungals, analgesics: $40,219.77 x 35%	14,219.11
Infection Control: $4,941 x 16.7%	825.15
Dental Medications: OTC pain relief, topical and fluoride rinses: $2,745 x 16.7%	458.42
Uniforms for staff: $494.10 x 16.7%	82.51
Office Expense: $274.50 x 16.7%	45.84
Office supplies to support oral health program operations: $3,294 x 16.7%	550.10
Supplies Subtotal	**$16,181**
CONTRACTUAL **(must also submit completed Subcontractor Data Sheets)**	
Contractual Subtotal	**$0**
OTHER	
Dental Contracted services: Referrals to private practice oral surgeons for complex procedures, oral pathology lab expenses, and endodontic (root canal) treatment $65,177 x	17,268.26
Contract Personnel: To support administration of oral health care services: $3,843 x 27%	1,037.61
Dental Laboratory services: Services for laboratory fabrication of full and partial dentures, fixed crowns, and other related laboratory procedures $50,398 x 35%	16,332.76
Conferences and Conventions: $549 x 36.8%	202.25
Dues and Memberships: $549 x 20%	109.67
Equipment repair for clinic direct service equipment: $1,647 x 20%	329.01
Liability Insurance for dental professionals: $2,306 x 16.7%	385.07
Licenses and permits for clinic direct service operations: $549 x 16.7%	91.68
Postage and Freight: $274.50 x 16.7%	45.84
Printing and Copying: $274.50 x 16.7%	45.84
Publications: $137.25 x 16.7%	22.92
Rent: $71,113 x 10%	5,437.07
Staff and Volunteer Development: $549 x 16.7%	91.68
Staff and Volunteer Recruitment: $549 x 16.7%	91.68
Translation and Interpretation: $823.50 x 20%	164.50

Cell Phone: $29.99/month x FTE of eligible staff	85.11
Computer Database for direct client services (Dentrix/Eaglesoft): $1,080.43 x 16.7%	180.43
Telephone: $8,433 x 8.0%	674.61
Utilities: $6,530 x 8.0%	546.30
Repairs and Maintenance: $4,963 x 8.0%	397.04
Staff and Volunteer Recognition: $137 x 16.7%	22.92
Other Subtotal	**$43,562**
TOTAL DIRECT SERVICES COSTS	**$235,659**
ADMINISTRATIVE COSTS - LINE ITEMS NARRATIVE	
PERSONNEL	**FY16 Funding**
Campion - Chief Programs Officer	
0.0645 FTE x $91,200 annual salary	3,228.24
Duties include: Oversight of programs including output, outcome, and spending tracking; quality management and improvement; supervision of directors; budgeting; and compliance.	
Systems and Facilities Manager, Lynda White	
0.0645 FTE x $49,744 annual salary	1,760.81
Duties include: Data management and improvement; facilities management; repairs and maintenance of facilities; quality control of data; maintenance of ARIES database and data.	
Human Resources Manager, Vacant	
0.0645 FTE x $59,160 annual salary	2,094.11
Duties include: Organization HR issues, trainings, orientation, and organizational HR policies and procedures.	
Chief Financial Officer, Bill Garza	
0.0645 FTE x $78,290 annual salary	2,771.26
Duties include: Oversees fiscal management of the organization.	

Accountant, Vacant	
0.0645 FTE x $36,000 annual salary	1,274.31
Duties include: Financial services support for organization.	
Accountant. Wyatt Oden	
0.0645 FTE x $42,369 annual salary	1,499.74
Duties include: Financial services support for organization.	
Grants Manager, Britt Hayse	
0.0645 FTE x $56,747 annual salary	2,008.68
Duties include: Grant compliance responsibilities.	
Personnel Subtotal	**$14,637**
FRINGE BENEFITS	
FICA & Medicare Tax - Personnel Subtotal multiplied by 7.65% rate	1,119.74
Medical Benefits - $600 per month per employee for eligible and participating staff	1,146.87
Retirement - 3% Match per employee salary for eligible and participating staff	53.20
Worker's Compensation Insurance - .46% of employee salary	67.33
State Unemployment Insurance - 1.41% of first $9000 of employee salary	31.44
Fringe Benefits Subtotal	**$2,419**
SUPPLIES	
Supplies Subtotal	**$0**
OTHER	
General & Other Liability Insurance: $47,055 prorated by FTE	1,665.62
Telecommunications (phone, internet, etc): $28,020 prorated by FTE	991.83
Annual Audit: $44,480 prorated by FTE	1,574.47
Computer Services:$58,904 prorated by FTE	2,085.05
Repairs and Maintenance: $29,420 prorated by FTE	1,041.39
Facilities Support: $40,620 prorated by FTE	1,437.84
Photocopier Rental, Equipment Maintenance, etc (not directly serving clients): $9,389 prorated by FTE	332.35
Other Subtotal	**$9,129**

TOTAL ADMINISTRATIVE COSTS	**$26,184**
TOTAL - DIRECT SERVICES and ADMINISTRATIVE COSTS BUDGET for FY 2016 Grant program	**$261,843**

DIRECT SERVICES Line Item Budget			Yr./ Fund:	FY2016 Ryan White Part A MAI						
Program: Outreach			Agency:	AIDS Services of Austin						
City of Austin HIV Grant Agreements and Contracts								HHSD/ HRAU form rev. August 2014		
Cost Category & Description	FTE - Svc Categ	Total Svc Annual Cost		Outeach MAI		Outreach Non-MAI		ASA General Fund		Total DIRECT SERVICE Costs
PROGRAM DIRECT CLIENT SERVICES					FTE		FTE		FTE	
PROGRAM DIRECT - CLIENT SERVICES PER	**2.25**	**79,323.30**		**19,504.43**	**0.66**	**25,114.33**	**1.24**	**9,280.35**	**0.35**	**53,899.11**
Williams-Price, Director of Access Services	0.09	6,140.40		1,709.88	0.03	2,201.68	0.06	-		3,911.56
Rios M., Non-Medical Programs Manager	0.01	479.09		133.41	0.00	171.78	0.01	-		305.19
Belozerco, Outreach Specialist	0.80	24,534.02		6,831.84	0.28	8,796.82	0.52	-		15,628.66
Knox, Outreach Coordinator	1.00	38,889.44		10,829.30	0.35	13,944.05	0.65	-		24,773.35
Richardson, Outreach Specialist	0.35	9,280.35		-	-	-	0.00	9,280.35	0.35	9,280.35
FRINGE Benefits		**15,899.38**		**5,662.17**		**7,290.73**		**801.78**		**$13,754.68**
Prgm.Combined - Soc. Sec./ Medicare taxes (FICA)		6,068.23		1,492.09		1,921.25		709.95		4,123.28
Prgm.Combined - Retirement system contributions		0.00		-		-		-		-
Prgm.Combined - Employee Insurance (health, life, etc.)		9,180.73		4,013.22		5,167.51		-		9,180.73
Prgm.Combined - Worker's Compensation Insurance		364.89		89.72		115.53		42.69		247.94
Prgm.Combined - State Unemployment Insurance (SUI)		285.53		67.14		86.45		49.14		202.73
TRAVEL - Direct Client services		**1,273.83**		**556.27**		**717.57**		-		**1,273.83**
Prgm. Direct - Local Travel		2,000.00		556.27	**27.8%**	717.57		-		1,273.83
EQUIPMENT - Direct Client services		**0.00**		-		-		-		-
SUPPLIES - Direct Client services		**1,500.00**		**417.20**		**538.18**		-		**955.37**
Prgm. Direct - Educational supplies for clients		1,000.00		278.13	**27.8%**	358.78				636.92
Prgm. Direct - Office Supplies		500.00		139.07	**27.8%**	179.39				318.46

CONTRACTUAL - Subcontracted Direct services									
OTHER - Direct Client services	**4,598.48**		**1,227.14**		**1,577.80**		-		**2,804.93**
Prgm. Direct - Conferences & Conventions	337.50		-	**0.0%**	247.50				$247.50
Prgm. Direct - Computer Services (inc. licenses)	945.00		222.21	**23.5%**	286.13				$508.34
Prgm. Direct - Cell phones	809.73		190.41	**23.5%**	245.17				$435.58
Prgm. Direct - Interpreters	100.00		27.81	**27.8%**	35.88				$63.69
Prgm. Direct - Telephone	750.00		208.85	**27.8%**	268.92				$477.76
Prgm. Direct - Facilities costs (Utilities, Repairs & Maintenance)	750.00		284.56	**37.9%**	197.41				$481.97
Prgm. Direct - Postage/Freight	150.00		41.72	**27.8%**	53.82		-		$95.54
Prgm. Direct - Staff Development and training	506.25		182.04	**36.0%**	153.28				$335.33
Prgm. Direct - Printing/copying	250.00		69.53	**27.8%**	89.70		-		$159.23
SUBTOTAL- PROGRAM DIRECT COSTS	**102,594.99**		**27,367.20**		**35,238.60**		**10,082.13**		**72,687.93**

ADMINISTRATIVE Line Item Budget | Yr./ Fund: **FY2016 Ryan White Part A MAI**

Program: **Outreach** | Agency: **AIDS Services of Austin**

Cost Category & Description	FTE-Svc Admin	Salary	Total Admin Costs for this Service		RWA MAI		RWA NonMAI		ASA Unrestricted Funds		Total ADMIN Costs
ADMINISTRATIVE LINE ITEMS		70.00	2.7%		0.66	0.5%	1.24	1.0%	-	1.2%	0.027
ADMINISTRATIVE - PERSONNEL	**7.00**	**413,509.65**	**8,979.07**		**1,699.82**		**3,183.60**		**4,095.64**		**8,979.07**
Campion - Chief Programs Officer	1.00	91,200.00	1,980.34		374.90		702.15		903.30		1,980.34
White, Facilities and Systems	1.00	49,744.13	1,080.16		204.48		382.98		492.69		1,080.16
Vacant, Human Resources Manager	1.00	59,160.00	1,284.62		243.19		455.47		585.96		1,284.62
Garza, Chief Financial Officer	1.00	78,290.10	1,700.01		321.83		602.75		775.43		1,700.01
Vacant, Accountant	1.00	36,000.00	781.71		147.99		277.16		356.56		781.71
Oden, Accountant	1.00	42,368.76	920.01		174.17		326.20		419.64		920.01
Hayse, Grants Manager	1.00	56,746.67	1,232.21		233.27		436.89		562.05		1,232.21
FRINGE Benefits		**68,326.93**	**1,483.67**		**280.87**		**526.05**		**676.75**		**1,483.67**
Combined Admin. Staff - Soc. Sec./ Medicare taxes (FICA)	7.65%	31,633.49	686.90		130.04		243.55		313.32		686.90
Combined Admin. Staff - Retirement system contributions	$1,500	1,503.00	32.64		6.18		11.57		14.89		32.64
Combined Admin. Staff - Employee Insurance (health, life, etc.)	$ 600	32,400.00	703.54		133.19		249.45		320.91		703.54
Combined Admin. Staff - Worker's Compensation Insurance	0.46%	1,902.14	41.30		7.82		14.64		18.84		41.30
Combined Admin. Staff - State Unemployment Insurance (SUI)	1.41%	888.30	19.29		3.65		6.84		8.80		19.29
TRAVEL - Administrative Support											
EQUIPMENT - Administrative Support											
SUPPLIES - Administrative Support											

CONTRACTUAL - Subcontracted Admin. services								
OTHER - Administrative costs (list)	**257,888.00**	**5,599.85**	**1,060.11**	**1,985.48**	**2,554.27**	**5,599.85**
Admin. - General & Other Liability Insurance	47,055.00	1,021.77	193.43	362.28	466.06	1,021.77
Admin. - Telecommunications (Phone, Internet, etc.)	28,020.00	608.43	115.18	215.73	277.53	608.43
Admin. - Audit	44,480.00	965.85	182.84	342.45	440.56	965.85
Admin. - Computer Services (Other contract services)	58,904.00	1,279.06	242.14	453.50	583.42	1,279.06
Admin. - Repairs/Maintainence	29,420.00	638.83	120.94	226.50	291.39	638.83
Admin. - Facilities support (Utilities, etc.)	40,620.00	882.03	166.98	312.73	402.32	882.03
Admin. - Photocopier rental, Equip maint., etc. NOT directly serving clients	9,389.00	203.88	38.60	72.29	92.99	203.88
SUBTOTAL ADMINISTRATIVE COSTS	**739,724.59**	**16,062.59**	**3,040.80**	**5,695.13**	**7,326.66**	**16,062.59**
SUM OF DIRECT + ADMIN = TOTAL COST			**30,408.00**	**40,933.73**	**17,408.79**	**88,750.52**

BUDGET JUSTIFICATION

AIDS Services of Austin

Budget Period/Fund: FY2016 Ryan White A (not MAI)

Service Category: Outreach

The agency total annual HIV services budget for this program will be funded as follows (add more rows as needed):

Ryan White Part A Non-MAI	$ 40,933.73	46.1%
Agency Fundraising	$ 17,408.79	19.6%
Ryan White Part A (MAI)	**$ 30,408**	**34.3%**
TOTAL - All Funding Sources	**$ 88,750.52**	**100%**

DIRECT SERVICE Costs - LINE ITEMS NARRATIVE

PERSONNEL	**FY16 Funding**
Williams-Price, Director of Access Services	
0.0028 FTE x $68,227 annual salary	1,709.88
Supervises all Case Management, including MCM, Health Insurance, and Outreach programs; manages service delivery and evaluation; reviews financial assistance; budgets and implements program modifications; coordinates QM activities and develops policy and procedures.	
Rios M., Non-Medical Programs Manager	
0.00003 FTE x $47,909 annual salary	133.41
Supervises all Non-Medical Case Management Programs, up to 2 interns, approves and tracks financial requests, evaluates program outcomes and service delivery, completes grant reporting requirements, and coordinates and implements QM activities.	
Belozerco, Outreach Specialist	
0.2228 FTE x $30,668 annual salary	6,831.84
Provides outreach to identify targeted HIV+ individuals; begins linkage to primary care, case management services; addresses immediate needs.	
Knox, Outreach Coordinator	
0.3481 FTE x $38,889 annual salary	10,829.30
Coordinates outreach services, identifies service delivery sites, supervises and trains Outreach Specialists, completes grant requirements. Provides outreach to identify targeted HIV+ individuals; begins linkage to primary care, case management services; addresses immediate client needs.	
Richardson, Outreach Specialist	
0.00 FTE x $26,515 annual salary	-
Provides outreach to identify targeted HIV+ individuals; begins linkage to primary care, case management services; addresses immediate needs.	

Personnel Salaries Subtotal	**$19,504**
FRINGE BENEFITS	
FICA & Medicare Tax - Personnel Subtotal multiplied by 7.65% rate	1,492.09
Retirement - 3% Match per employee salary for eligible and participating staff	-
Medical Benefits - $600 per month per employee for eligible and participating staff	4,013.22
Worker's Compensation Insurance - .46% of employee salary	89.72
State Unemployment Insurance - 1.41% of first $9000 of employee salary	67.14
Fringe Benefits Subtotal	**$5,662**
TRAVEL	
Local Mileage: Reimbursement to Program Direct staff for use of their privately owned vehicles in the performance of program duties within service area. 309 miles/mo. x 12 months x $0.54/mile = $2,000 x 27.8%	556.27
Travel Subtotal	**$556**
	FY16 Funding
EQUIPMENT	$0
Equipment with useable life over 1 year and cost of $5,000 or more per each unit	
Equipment Subtotal	**$0**
SUPPLIES	
Educational Supplies for direct client services: $1,000 x 27.8%	278.13
Office supplies to support outreach program operations: $500 x 27.8%	139.07
Supplies Subtotal	**417.20**
CONTRACTUAL **(must also submit completed Subcontractor Data Sheets)**	
Contractual Subtotal	**$0**
OTHER	
Computer Services: $420 x FTE	222.21
Cell Phones for staff safety: $29.99/month x FTE x 12 months	190.41
Interpreters: $100 x 27.8%	27.81
Telecommunications: $75 x 27.8%	208.85
Facilities Support: $750 x 37.9%	284.56

Postage and Freight: $150 x 27.8%	41.72
Staff Development/Conferneces and Conventions: $225 x FTE	182.04
Printing and Copying: $250 x 27.8%	69.53
Other Subtotal	**1,227.14**
TOTAL DIRECT SERVICES COSTS	**$27,367**
ADMINISTRATIVE COSTS - LINE ITEMS NARRATIVE	
PERSONNEL	**FY16 Funding**
Campion - Chief Programs Officer	374.90
0.005 FTE x $91,200 annual salary	
Duties include: Oversight of programs including output, outcome, and spending tracking; quality management and improvement; supervision of directors; budgeting; and compliance.	
Systems and Facilities Manager, Lynda White	204.48
0.005 FTE x $49,744 annual salary	
Duties include: Data management and improvement; facilities management; repairs and maintenance of facilities; quality control of data; maintenance of ARIES database and data.	
Human Resources Manager, Vacant	243.19
0.005 FTE x $59,160 annual salary	
Duties include: Organization HR issues, trainings, orientation, and organizational HR policies and procedures.	
Chief Financial Officer, Bill Garza	321.83
0.005 FTE x $78,290 annual salary	
Duties include: Oversees fiscal management of the organization.	
Accountant, Vacant	147.99
0.005 FTE x $36,000 annual salary	
Duties include: Financial services support for organization.	
Accountant. Wyatt Oden	174.17
0.005 FTE x $42,369 annual salary	
Duties include: Financial services support for organization.	

Grants Manager, Britt Hayse	233.27
0.005 FTE x $56,747 annual salary	
Duties include: Grant compliance responsibilities.	
Personnel Subtotal	**$1,700**
FRINGE BENEFITS	
FICA & Medicare Tax - Personnel Subtotal multiplied by 7.65% rate	130.04
Medical Benefits - $600 per month per employee for eligible and participating staff	6.18
Retirement - 3% Match per employee salary for eligible and participating staff	133.19
Worker's Compensation Insurance - .46% of employee salary	7.82
State Unemployment Insurance - 1.41% of first $9000 of employee salary	3.65
Fringe Benefits Subtotal	**$281**
SUPPLIES	
Supplies Subtotal	**$0**
OTHER	
General & Other Liability Insurance: $47,055 prorated by FTE	193.43
Telecommunications (phone, internet, etc): $28,020 prorated by FTE	115.18
Annual Audit: $44,480 prorated by FTE	182.84
Computer Services:$58,904 prorated by FTE	242.14
Repairs and Maintenance: $29,420 prorated by FTE	120.94
Facilities Support: $40,620 prorated by FTE	166.98
Photocopier Rental, Equipment Maintenance, etc (not directly serving clients): $9,389 prorated by FTE	38.60
Other Subtotal	**1,060.11**
TOTAL ADMINISTRATIVE COSTS	**$3,041**
TOTAL - DIRECT SERVICES and ADMINISTRATIVE COSTS BUDGET for FY 2014 Grant program	**$30,408**

DIRECT SERVICES Line Item Budget						Yr./ Fund:	FY2016 Ryan White Part A (not MAI)						
Program: Outreach						Agency:	AIDS Services of Austin						
City of Austin HIV Grant Agreements and Contracts												*HHSD/ HRAU form rev. August 2014*	
Cost Category & Description	FTE - Svc Categ		Annualized Salary	**Total Svc Annual Cost**		**Outreach Non-MAI**		**Outeach MAI**		**ASA General Fund**		Total DIRECT SERVICE Costs
PROGRAM DIRECT CLIENT SERVICES							FTE		FTE		FTE	
PROGRAM DIRECT - CLIENT SERVICES PER	**2.25**		212,208.24	**43,627.81**		**25,114.33**	**1.24**	**13,409.30**	**0.66**	**5,104.19**	**0.35**	**43,627.81**
Williams-Price, Director of Access Services	0.09		68,226.67	3,377.22		2,201.68	0.06	1,175.54	0.03	0.00		3,377.22
Rios M., Non-Medical Programs Manager	0.01		47,909.33	263.50		171.78	0.01	91.72	0.00	0.00		263.50
Belozerco, Outreach Specialist	0.80		30,667.52	13,493.71		8,796.82	0.52	4,696.89	0.28	0.00		13,493.71
Knox, Outreach Coordinator	1.00		38,889.44	21,389.19		13,944.05	0.65	7,445.15	0.35	0.00		21,389.19
Richardson, Outreach Specialist	0.35		26,515.29	5,104.19		0.00	0.00	0.00	-	5,104.19	0.35	5,104.19
FRINGE Benefits				**11,621.85**		**7,290.73**		**3,892.74**		**438.38**		**$11,621.85**
Prgm.Combined - Soc. Sec./ Medicare taxes (FICA)		7.65%		3,337.53		1,921.25		1,025.81		390.47		3,337.53
Prgm.Combined - Retirement system contributions		1,500.00		0.00		0.00		0.00		0.00		-
Prgm.Combined - Employee Insurance (health, life, etc.)		$ 600.00		7,926.60		5,167.51		2,759.09		0.00		7,926.60
Prgm.Combined - Worker's Compensation Insurance		0.46%		200.69		115.53		61.68		23.48		200.69
Prgm.Combined - State Unemployment Insurance (SUI)		1.41%		157.04		86.45		46.16		24.43		157.04
TRAVEL - Direct Client services				**1,100.00**		**717.57**		**382.43**		-		**1,100.00**
Prgm. Direct - Local Travel				1,100.00		717.57	**65.2%**	382.43		0.00		1,100.00
EQUIPMENT - Direct Client services				**0.00**		-		-		-		-
SUPPLIES - Direct Client services				**825.00**		**538.18**		**286.82**		-		**825.00**
Prgm. Direct - Educational supplies for clients				550.00		358.78		191.22		0.00		550.00
Prgm. Direct - Office Supplies				275.00		179.39		95.61		0.00		275.00
CONTRACTUAL - Subcontracted Direct services												

OTHER - Direct Client services		**2,529.16**		**1,577.80**		**843.66**		**150.13**		**2,421.45**
Prgm. Direct - Conferences & Conventions	$ 150	185.63		247.50		0.00		0.00		$247.50
Prgm. Direct - Computer Services (inc. licenses)		519.75		286.13		152.77		80.85		$438.90
Prgm. Direct - Cell phones		445.35		245.17		130.90		69.28		$376.07
Prgm. Direct - Interpreters		55.00		35.88		19.12		0.00		$55.00
Prgm. Direct - Telephone		412.50		268.92		143.58		0.00		$412.50
Prgm. Direct - Facilities costs (Utilities, Repairs & Maintenance)		412.50		197.41		195.63		0.00		$393.04
Prgm. Direct - Postage/Freight		82.50		53.82		28.68		0.00		$82.50
Prgm. Direct - Staff Development and training	225	278.44		153.28		125.15		0.00		$278.44
Prgm. Direct - Printing/copying		137.50		89.70		47.80		0.00		$137.50
SUBTOTAL- PROGRAM DIRECT COSTS		**59,703.83**		**35,238.60**		**18,814.95**		**5,692.70**		**59,596.12**

ADMINISTRATIVE Line Item Budget Yr./ Fund: **FY2016 Ryan White Part A (not MAI)**

Program: **Outreach** Agency: **AIDS Services of Austin**

Cost Category & Description	FTE-Svc Admin	Salary	Total Admin Costs for this Service		RWA NonMAI		RWA MAI		ASA Unrestricted Funds		Total ADMIN Costs
ADMINISTRATIVE LINE ITEMS		70.00	2.7%		1.24	1.0%	0.66	0.5%	-	1.2%	0.027
ADMINISTRATIVE - PERSONNEL	**7.00**	**413,509.65**	**6,173.11**		**2,188.73**		**1,168.63**		**2,815.75**		**6,173.11**
Campion - Chief Programs Officer	1.00	91,200.00	1,361.49		482.73		257.74		621.02		1,361.49
White, Facilities and Systems	1.00	49,744.13	742.61		263.30		140.58		338.73		742.61
Vacant, Human Resources Manager	1.00	59,160.00	883.17		313.14		167.19		402.84		883.17
Garza, Chief Financial Officer	1.00	78,290.10	1,168.76		414.39		221.26		533.11		1,168.76
Vacant, Accountant	1.00	36,000.00	537.43		190.55		101.74		245.14		537.43
Oden, Accountant	1.00	42,368.76	632.51		224.26		119.74		288.51		632.51
Hayse, Grants Manager	1.00	56,746.67	847.15		300.36		160.37		386.41		847.15
FRINGE Benefits		**68,326.93**	**1,020.02**		**361.66**		**193.10**		**465.27**		**1,020.02**
Combined Admin. Staff - Soc. Sec./ Medicare taxes (FICA)	7.65%	31,633.49	472.24		167.44		89.40		215.41		472.24
Combined Admin. Staff - Retirement system contributions	$1,500	1,503.00	22.44		7.96		4.25		10.23		22.44
Combined Admin. Staff - Employee Insurance (health, life, etc.)	$ 600	32,400.00	483.69		171.49		91.57		220.62		483.69
Combined Admin. Staff - Worker's Compensation Insurance	0.46%	1,902.14	28.40		10.07		5.38		12.95		28.40
Combined Admin. Staff - State Unemployment Insurance (SUI)	1.41%	888.30	13.26		4.70		2.51		6.05		13.26
TRAVEL - Administrative Support											
EQUIPMENT - Administrative Support											
SUPPLIES - Administrative Support											
CONTRACTUAL - Subcontracted Admin. services											

OTHER - Administrative costs (list)	**257,888.00**	**3,849.90**		**1,365.01**		**728.82**		**1,756.06**	**3,849.90**
Admin. - General & Other Liability Insurance	47,055.00	702.46		249.06		132.98		320.42	702.46
Admin. - Telecommunications (Phone, Internet, etc.)	28,020.00	418.30		148.31		79.19		190.80	418.30
Admin. - Audit	44,480.00	664.02		235.43		125.71		302.88	664.02
Admin. - Computer Services (Other contract services)	58,904.00	879.35		311.78		166.47		401.10	879.35
Admin. - Repairs/Maintainence	29,420.00	439.20		155.72		83.14		200.33	439.20
Admin. - Facilities support (Utilities, etc.)	40,620.00	606.40		215.00		114.80		276.60	606.40
Admin. - Photocopier rental, Equip maint., etc. NOT directly serving clients	9,389.00	140.16		49.70		26.53		63.93	140.16
SUBTOTAL ADMINISTRATIVE COSTS	**739,724.59**	**11,043.03**		**3,915.40**		**2,090.55**		**5,037.08**	**11,043.03**
SUM OF DIRECT + ADMIN = TOTAL COST				**$39,154.00**		**$20,905.50**		**$10,729.78**	**$70,639.15**

BUDGET JUSTIFICATION

AIDS Services of Austin

Budget Period/Fund: FY2016 Ryan White A (not MAI)

Service Category: Outreach

The agency total annual HIV services budget for this program will be funded as follows (add more rows as needed):

Ryan White Part A (MAI)	$ 20,905.50	29.5%
Agency Fundraising	$ 10,729.78	15.2%
Ryan White Part A	**$ 39,154.00**	**55.3%**
TOTAL - All Funding Sources	**$ 70,789.28**	**100%**

DIRECT SERVICE Costs - LINE ITEMS NARRATIVE

PERSONNEL	**FY16 Funding**
Williams-Price, Director of Access Services	
0.0053 FTE x $68,227 annual salary	2,201.68
Supervises all Case Management, including MCM, Health Insurance, and Outreach programs; manages service delivery and evaluation; reviews financial assistance; budgets and implements program modifications; coordinates QM activities and develops policy and procedures.	
Rios M., Non-Medical Programs Manager	
0.0001 FTE x $47,909 annual salary	171.78
Supervises all Non-Medical Case Management Programs, up to 2 interns, approves and tracks financial requests, evaluates program outcomes and service delivery, completes grant reporting requirements, and coordinates and implements QM activities.	
Belozerco, Outreach Specialist	
0.4172 FTE x $30,668 annual salary	8,796.82
Provides outreach to identify targeted HIV+ individuals; begins linkage to primary care, case management services; addresses immediate needs.	
Knox, Outreach Coordinator	
0.6519 FTE x $38,889 annual salary	13,944.05
Coordinates outreach services, identifies service delivery sites, supervises and trains Outreach Specialists, completes grant requirements. Provides outreach to identify targeted HIV+ individuals; begins linkage to primary care, case management services; addresses immediate client needs.	

Richardson, Outreach Specialist	
0.00 FTE x $26,515 annual salary	$0
Provides outreach to identify targeted HIV+ individuals; begins linkage to primary care, case management services; addresses immediate needs.	
Personnel Salaries Subtotal	**$25,114**
FRINGE BENEFITS	
FICA & Medicare Tax - Personnel Subtotal multiplied by 7.65% rate	1,921.25
Retirement - 3% Match per employee salary for eligible and participating staff	-
Medical Benefits - $600 per month per employee for eligible and participating staff	5,167.51
Worker's Compensation Insurance - .46% of employee salary	115.53
State Unemployment Insurance - 1.41% of first $9000 of employee salary	86.45
Fringe Benefits Subtotal	**$7,291**
TRAVEL	
Local Mileage: Reimbursement to Program Direct staff for use of their privately owned vehicles in the performance of program duties within service area. 170 miles/mo. x 12 months x $0.54/mile = $1,100 x 65.2%	717.57
Travel Subtotal	**$718**
	FY16 Funding
EQUIPMENT	$0
Equipment with useable life over 1 year and cost of $5,000 or more per each unit	
Equipment Subtotal	**$0**
SUPPLIES	
Educational Supplies for direct client services: $550 x 65.2%	358.78
Office supplies to support outreach program operations: $275 x 65.2%	179.39
Supplies Subtotal	**538.18**
CONTRACTUAL **(must also submit completed Subcontractor Data Sheets)**	
Contractual Subtotal	**$0**

OTHER	
Conferences and Conventions: $150/staff	$248
Computer Services: $420 x FTE	$286
Cell Phones for staff safety: $29.99/month x FTE x 12 months	$245
Interpreters: $55 x 65.2%	$36
Telecommunications: $412 x 65.2%	$269
Facilities Support: $412 x 65.2%	$197
Postage and Freight: $82.50 x 65.2%	$54
Staff Development/Conferneces and Conventions: $225 x FTE	$153
Printing and Copying: $137.50 x 65.2%	$90
Other Subtotal	**$1,578**
TOTAL DIRECT SERVICES COSTS	**$35,239**
ADMINISTRATIVE COSTS - LINE ITEMS NARRATIVE	
PERSONNEL	**FY16 Funding**
Campion - Chief Programs Officer	482.73
0.01 FTE x $91,200 annual salary	
Duties include: Oversight of programs including output, outcome, and spending tracking; quality management and improvement; supervision of directors; budgeting; and compliance.	
Systems and Facilities Manager, Lynda White	263.30
0.01 FTE x $49,744 annual salary	
Duties include: Data management and improvement; facilities management; repairs and maintenance of facilities; quality control of data; maintenance of ARIES database and data.	
Human Resources Manager, Vacant	313.14
0.01 FTE x $59,160 annual salary	
Duties include: Organization HR issues, trainings, orientation, and organizational HR policies and procedures.	
Chief Financial Officer, Bill Garza	414.39
0.01 FTE x $78,290 annual salary	
Duties include: Oversees fiscal management of the organization.	

Accountant, Vacant	190.55
0.01 FTE x $36,000 annual salary	
Duties include: Financial services support for organization.	
Accountant. Wyatt Oden	224.26
0.01 FTE x $42,369 annual salary	
Duties include: Financial services support for organization.	
Grants Manager, Britt Hayse	300.36
0.01 FTE x $56,747 annual salary	
Duties include: Grant compliance responsibilities.	
Personnel Subtotal	**$2,189**
FRINGE BENEFITS	
FICA & Medicare Tax - Personnel Subtotal multiplied by 7.65% rate	167.44
Medical Benefits - $600 per month per employee for eligible and participating staff	7.96
Retirement - 3% Match per employee salary for eligible and participating staff	171.49
Worker's Compensation Insurance - .46% of employee salary	10.07
State Unemployment Insurance - 1.41% of first $9000 of employee salary	4.70
Fringe Benefits Subtotal	**$362**
SUPPLIES	
Supplies Subtotal	**$0**
OTHER	
General & Other Liability Insurance: $47,055 prorated by FTE	249.06
Telecommunications (phone, internet, etc): $28,020 prorated by FTE	148.31
Annual Audit: $44,480 prorated by FTE	235.43
Computer Services:$58,904 prorated by FTE	311.78
Repairs and Maintenance: $29,420 prorated by FTE	155.72
Facilities Support: $40,620 prorated by FTE	215.00
Photocopier Rental, Equipment Maintenance, etc (not directly serving clients): $9,389 prorated by FTE	49.70
Other Subtotal	**$1,365**
TOTAL ADMINISTRATIVE COSTS	**$3,915**
TOTAL - DIRECT SERVICES and ADMINISTRATIVE COSTS BUDGET for FY 2014 Grant program	**$39,154**

DIRECT SERVICES Line Item Budget			Yr./ Fund:	FY2016 Ryan White A (non MAI)						
Program: Health Insurance			Agency:	AIDS Services of Austin						
City of Austin HIV Grant Agreements and Contracts										*HHSD/ HRAU form rev. August 2014*
Cost Category & Description	FTE - Svc Category	Annualized Salary	**Total Service Annual Cost**	**PART A** Direct Service Costs		**RWB and Supplemental** Direct Service Costs		**SS** Direct Service Costs		Total DIRECT SERVICE Costs
PROGRAM DIRECT CLIENT SERVICES										
PERSONNEL Staff Salaries	**2.43**	**275,661.36**	**53,483.03**	**28,066.99**	**1.28**	**16,430.18**	**0.75**	**8,985.86**	**0.41**	**53,483.03**
Williams-Price, Director of Access Services	0.29	68,226.67	10,882.15	5,710.77	0.15	3,343.04	0.09	1,828.35	0.05	10,882.15
Braglia, Medical Programs Manager	0.02	48,658.24	535.24	280.89	0.01	164.43	0.01	89.93	0.00	535.24
Rios M., Non-Medical Programs Manager	0.02	47,909.33	527.00	276.56	0.01	161.90	0.01	88.54	0.00	527.00
Gentle, Health Insurance Coordinator	1.00	37,484.53	20,616.49	10,819.19	0.52	6,333.46	0.31	3,463.85	0.17	20,616.49
Casstevens, Programs Specialist	0.10	39,269.26	2,159.81	1,133.43	0.05	663.50	0.03	362.88	0.02	2,159.81
Vacant, Health Insurance Specialist	1.00	34,113.33	18,762.33	9,846.16	0.52	5,763.86	0.31	3,152.32	0.17	18,762.33
FRINGE Benefits			**12,717.48**	**6,673.92**		**3,906.85**		**2,136.71**		**12,717.48**
Social Security / Medicare taxes (FICA)		7.65%	4,091.45	2,147.12		1,256.91		687.42		4,091.45
Employee Insurance (health, life, etc.)		$ 600	8,111.40	4,256.73		2,491.85		1,362.82		8,111.40
Retirement system contributions (75% Participation at 3%)		$ 1,500.00	99.00	51.95		30.41		16.63		99.00
Prgm.Combined - Worker's Compensation Insurance		0.46%	246.02	129.11		75.58		41.33		246.02
Prgm.Combined - State Unemployment Insurance (SUI)		1.41%	169.60	89.00		52.10		28.50		169.60
TRAVEL - Direct Client services			**275.00**	**144.32**		**84.48**		**46.20**		**275.00**
Local Travel & Mileage			275.00	144.32		84.48		46.20		275.00
EQUIPMENT - Direct Client services			**0.00**	**0.00**		**0.00**		**0.00**		**0.00**
SUPPLIES - Direct Client services			**550.00**	**288.63**		**168.96**		**92.41**		**550.00**
Office Supplies			550.00	288.63		168.96		92.41		550.00
CONTRACTUAL - Subcontracted Direct services			**0.00**	**0.00**		**0.00**		**0.00**		**0.00**
OTHER - Direct Client services			**115,273.23**	**60,493.44**		**35,412.34**		**19,367.44**		**115,273.23**
Insurance Assistance			111,218.73	58,365.71		34,166.79		18,686.23		111,218.73
Bank Fees			275.00	144.32		84.48		46.20		275.00
Licenses & Permits			561.33	294.58		172.44		94.31		561.33
Cell Phones			461.19	242.02		141.68		77.49		461.19
Telephone - Non-Cell		28,020.00	576.13	302.35		176.99		96.80		576.13
Facilties Support (Utilities, Repairs & Maintenance, etc.)		70,040.00	1,440.13	755.76		442.41		241.96		1,440.13
Staff & Volunteer Development		225.00	300.71	157.81		92.38		50.52		300.71
Printing/Copying			275.00	144.32		84.48		46.20		275.00
Postage & Freight			165.00	86.59		50.69		27.72		165.00
TOTAL PROGRAM DIRECT COSTS			182,298.74	95,667.30		56,002.81		30,628.62		182,298.74

Facilties Support (Utilities, Repairs & Maintenance, etc.)		70,040.00	1,440.13		755.76		442.41		241.96		1,440.13
Staff & Volunteer Development		225.00	300.71		157.81		92.38		50.52		300.71
Printing/Copying			275.00		144.32		84.48		46.20		275.00
Postage & Freight			165.00		86.59		50.69		27.72		165.00
TOTAL PROGRAM DIRECT COSTS			182,298.74		95,667.30		56,002.81		30,628.62		182,298.74

ADMINISTRATIVE Line Item Budget Yr./ Fund: **FY2016 Ryan White A (non MA**

Program: **Health Insurance** Agency: **AIDS Services of Austin**

Cost Category & Description	FTE-Svc Admin	Salary	Total Admin Costs for this Service		PART A ADMIN Costs		RWB ADMIN Costs		SS ADMIN Costs		Total ADMIN Costs
ADMINISTRATIVE LINE ITEMS		70.00	3.5%		1.28	2.6%	0.75	1.5%	0.41	0.8%	0.035
ADMINISTRATIVE - PERSONNEL	**7.00**	**413,509.65**	**11,322.88**		**5,942.05**		**3,478.43**		**1,902.39**		**11,322.88**
Campion - Chief Programs Officer	1.00	91,200.00	2,497.27		1,310.53		767.17		419.58		2,497.27
White, Facilities and Systems	1.00	49,744.13	1,362.11		714.81		418.45		228.85		1,362.11
Vacant, Human Resources Manager	1.00	59,160.00	1,619.94		850.12		497.65		272.17		1,619.94
Garza, Chief Financial Officer	1.00	78,290.10	2,143.77		1,125.01		658.57		360.18		2,143.77
Vacant, Accountant	1.00	36,000.00	985.77		517.31		302.83		165.62		985.77
Oden, Accountant	1.00	42,368.76	1,160.16		608.83		356.40		194.92		1,160.16
Hayse, Grants Manager	1.00	56,746.67	1,553.86		815.44		477.35		261.07		1,553.86

FRINGE Benefits		**68,326.93**	**1,870.95**		**981.84**		**574.76**		**314.35**		**1,870.95**
Combined Admin. Staff - Soc. Sec./ Medicare taxes (FICA)	7.65%	31,633.49	866.20		454.57		266.10		145.53		866.20
Combined Admin. Staff - Retirement system contributions	$1,500	1,503.00	41.16		21.60		12.64		6.91		41.16
Combined Admin. Staff - Employee Insurance (health, life, etc.)	$ 600	32,400.00	887.19		465.58		272.55		149.06		887.19
Combined Admin. Staff - Worker's Compensation Insurance	0.46%	1,902.14	52.09		27.33		16.00		8.75		52.09
Combined Admin. Staff - State Unemployment Insurance (SUI)	1.41%	888.30	24.32		12.76		7.47		4.09		24.32
TRAVEL - Administrative Support											
EQUIPMENT - Administrative Support											
SUPPLIES - Administrative Support											
CONTRACTUAL - Subcontracted Admin. services											
OTHER - Administrative costs (list)		**257,888.00**	**7,061.59**		**3,705.80**		**2,169.34**		**1,186.44**		**7,061.59**
Admin. - General & Other Liability Insurance		47,055.00	1,288.48		676.17		395.82		216.48		1,288.48
Admin. - Telecommunications (Phone, Internet, etc.)		28,020.00	767.25		402.64		235.70		128.91		767.25
Admin. - Audit		44,480.00	1,217.97		639.17		374.16		204.63		1,217.97
Admin. - Computer Services (Other contract services)		58,904.00	1,612.93		846.44		495.50		270.99		1,612.93
Admin. - Repairs/Maintainence		29,420.00	805.59		422.76		247.48		135.35		805.59
Admin. - Facilities support (Utilities, etc.)		40,620.00	1,112.27		583.70		341.69		186.88		1,112.27
Admin. - Photocopier rental, Equip maint., etc. NOT directly serving clients		9,389.00	257.09		134.92		78.98		43.20		257.09
SUBTOTAL ADMINISTRATIVE COSTS		739,724.59	20,255.42		10,629.70		6,222.54		3,403.18		20,255.42
SUM OF DIRECT + ADMIN = TOTAL COST			202,554.15		106,297.00		62,225.35		34,031.80		202,554.15

BUDGET JUSTIFICATION

AIDS Services of Austin

Budget Period/Fund: FY2016 Ryan White Part A (not MAI)

Service Category: Health Insurance

The agency total annual HIV services budget for this program will be funded as follows (add more rows as needed):

Ryan White Part B and Supp	$ 62,225.32	30.7%
State Services	$ 34,031.80	16.8%
Program Income	$ 00,000	00.0%
Ryan White Part A	**$ 106,297**	**52.5%**
TOTAL - All Funding Sources	**$ 202,554.15**	**100%**

DIRECT SERVICE Costs - LINE ITEMS NARRATIVE

PERSONNEL	**FY16 Funding**
Williams-Price, Director of Access Services	$5,711
0.0435 FTE x $68,227 annual salary	
Supervises all Case Management, including MCM, Health Insurance, and Outreach programs; manages service delivery and evaluation; reviews financial assistance; budgets and implements program modifications; coordinates QM activities and develops policy and procedures.	
Braglia, Medical Programs Manager	$281
0.0002 FTE x $48,658 annual salary	
Supervises all Medical Case Management Programs, up to 2 interns, approves and tracks financial requests, evaluates program outcomes and service delivery, completes grant reporting requirements, and coordinates and implements QM activities	
Rios M., Non-Medical Programs Manager	$277
0.0002 FTE x $47,909 annual salary	
Supervises all Non-Medical Case Management Programs, up to 2 interns, approves and tracks financial requests, evaluates program outcomes and service delivery, completes grant reporting requirements, and coordinates and implements QM activities.	
Gentle, Health Insurance Coordinator	$10,819
0.52 FTE x $37,485 annual salary	
Supervises Health Insurance Specialist. Coordinates, approves and tracks HI assistance requests, performs intake and six month reviews, makes referrals and provides information, performs quality assurance activities, and completes HI activities, such as data entry of required ARIES fields and reports performance measures	

Casstevens, Programs Specialist	$1,133
0.005 FTE x $39,269 annual salary	
Support direct service delivery by preparing and distributing checks for client assistance. Support program staff and clients with periodic reporting and analysis.	
Vacant, Health Insurance Specialist	
0.52 FTE x $34,113 annual salary	$9,846
Performs eligibility and intake and six month reviews, makes referrals and provides information, performs quality assurance activities, case manages low need clients, and completes HI activities, such as data entry of required ARIES fields and reports performance measures	
Personnel Salaries Subtotal	**$28,067**
FRINGE BENEFITS	
FICA & Medicare Tax - Personnel Subtotal multiplied by 7.65% rate	$2,147
Medical Benefits - $600 per month per employee for eligible and participating staff	$4,257
Retirement - 3% Match per employee salary for eligible and participating staff	$52
Worker's Compensation Insurance: salaries x 0.46%	$129
State Unemployment Insurance: first $9,000 of salaries x 1.41%	$89
Fringe Benefits Subtotal	**$6,674**
TRAVEL	
Local Mileage: Reimbursement to Program Direct staff for use of their privately owned vehicles in the performance of program duties within service area. 42 miles/mo. x 12 months x $0.54/mile = $275 x 52.5%	$144
Travel Subtotal	**$144**
(Direct Services - continued from previous page)	
	FY16 Funding
EQUIPMENT	$0
Equipment with useable life over 1 year and cost of $5,000 or more per each unit	
Equipment Subtotal	**$0**
SUPPLIES	
Office supplies to support non-medical case management program operations: $550/year x 52.5%	$289
Supplies Subtotal	**$289**

CONTRACTUAL **(must also submit completed Subcontractor Data Sheets)**	
Contractual Subtotal	**$0**
OTHER	
Health Insurance Assistance - financial assistance with Private Health Insurance, Medicare Supplemental, and Medicare-Part D premiums; Private Health Insurance, Medicare-Part D, and Texas High-Risk Pool Insurance co-payments; office co-payments; and Private Health Insurance and Texas High-Risk Pool Insurance medication deductibles.	$58,366
Bank Fees: $275 x 52.5%	$144
Licenses and Permits: $420 x FTE	$295
Cell Phones for staff safety: $29.99/month x FTE x 12 months	$242
Telephone: $28,020 x prorated by FTE	$302
Facilities Support: $70,040 x prorated by FTE	$756
Staff and Volunteer Development: $225 per FTE	$158
Printing and Copying: $275, x 52.5%	$144
Postage and Freight: $165 x 52.5%	$87
Other Subtotal	**$60,493**
TOTAL DIRECT SERVICES COSTS	**$95,667**
ADMINISTRATIVE COSTS - LINE ITEMS NARRATIVE	
PERSONNEL	**FY16 Funding**
Campion - Chief Programs Officer	1,310.53
0.026 FTE x $91,200 annual salary	
Duties include: Oversight of programs including output, outcome, and spending tracking; quality management and improvement; supervision of directors; budgeting; and compliance.	
Systems and Facilities Manager, Lynda White	714.81
0.026 FTE x $49,744 annual salary	
Duties include: Data management and improvement; facilities management; repairs and maintenance of facilities; quality control of data; maintenance of ARIES database and data.	
Human Resources Manager, Vacant	850.12
0.026 FTE x $59,160 annual salary	
Duties include: Organization HR issues, trainings, orientation, and organizational HR policies and procedures.	

Chief Financial Officer, Bill Garza	1,125.01
0.026 FTE x $78,290 annual salary	
Duties include: Oversees fiscal management of the organization.	
Accountant, Vacant	517.31
0.026 FTE x $36,000 annual salary	
Duties include: Financial services support for organization.	
Accountant. Wyatt Oden	608.83
0.026 FTE x $42,369 annual salary	
Duties include: Financial services support for organization.	
Grants Manager, Britt Hayse	815.44
0.026 FTE x $56,747 annual salary	
Duties include: Grant compliance responsibilities.	
Personnel Subtotal	**$5,942**
FRINGE BENEFITS	
FICA & Medicare Tax - Personnel Subtotal multiplied by 7.65% rate	454.57
Medical Benefits - $600 per month per employee for eligible and participating staff	21.60
Retirement - 3% Match per employee salary for eligible and participating staff	465.58
Worker's Compensation Insurance - .46% of employee salary	27.33
State Unemployment Insurance - 1.41% of first $9000 of employee salary	12.76
Fringe Benefits Subtotal	**$982**
SUPPLIES	
Supplies Subtotal	**$0**
OTHER	
General & Other Liability Insurance: $47,055 prorated by FTE	676.17
Telecommunications (phone, internet, etc): $28,020 prorated by FTE	402.64
Annual Audit: $44,480 prorated by FTE	639.17
Computer Services:$58,904 prorated by FTE	846.44
Repairs and Maintenance: $29,420 prorated by FTE	422.76
Facilities Support: $40,620 prorated by FTE	583.70
Photocopier Rental, Equipment Maintenance, etc (not directly serving clients): $9,389 prorated by FTE	134.92
Other Subtotal	**3,705.80**

TOTAL ADMINISTRATIVE COSTS	**$10,630**
TOTAL - DIRECT SERVICES and ADMINISTRATIVE COSTS BUDGET for FY 2014 Grant program	**$106,297**

DIRECT SERVICES Line Item Budget					Yr./ Fund:	FY2016 Ryan White A Non-MAI				
Program: Medical Case Management					Agency:	AIDS Services of Austin				
City of Austin HIV Grant Agreements and Contracts										*HHSD/ HRAU form rev. August 2014*
Cost Category & Description	FTE - Svc Categ	**Total Svc Annual Cost**		**RWA MCM (Non-MAI)**		**RWA MCM (MAI)**		**Other Funding Sources**		Total DIRECT SERVICE Costs
PROGRAM DIRECT - CLIENT SERVICES										
PERSONNEL Staff Salaries	**6.91**	**175,044.54**		**58,909.67**	**1.96**	**27,462.95**	**0.91**	**88,671.93**	**4.03**	**175,044.54**
Williams-Price, Director of Access Services	0.20	7,317.31		3,071.20	0.08	1,431.76	0.04	2,814.35	0.08	7,317.31
Braglia, Medical Programs Manager	0.67	17,930.56		6,388.48	0.24	2,978.23	0.11	8,563.85	0.32	17,930.56
Rios M., Non-Medical Programs Manager	0.09	2,450.56		1,437.75	0.05	670.26	0.03	342.55	0.01	2,450.56
Medina, Intake Coordinator	0.15	3,044.20		1,107.34	0.05	516.23	0.03	1,420.63	0.07	3,044.20
Lindgren, Lead Receptionist	0.08	1,299.90		768.37	0.04	358.21	0.02	173.32	0.01	1,299.90
Cirlos, Eligibility & Intake Specialist	0.22	4,113.23		2,238.01	0.12	1,043.33	0.06	831.89	0.05	4,113.23
Slaughter, Lead Medical Case Manager	1.00	22,123.24		-	0.00	-	0.00	22,123.24	1.00	22,123.24
Simmons, D., Medical Case Manager	1.00	20,544.89		-	0.00	-	0.00	20,544.89	1.00	20,544.89
Rios, A., Medical Case Manager	1.00	22,293.38		-	0.00	-	0.00	22,293.38	1.00	22,293.38
Flores, Behavioral Health Medical Case Manager	1.00	24,353.68		16,610.21	0.68	7,743.47	0.32	-	0.00	24,353.68
Martin, Nurse Medical Case Manager	1.00	40,009.76		27,288.30	0.68	12,721.46	0.32	-	0.00	40,009.76
Miranda, Patient Navigator	0.50	9,563.84		-	0.00	-	0.00	9,563.84	0.50	9,563.84

FRINGE Benefits	**43,957.76**		**13,749.29**		**6,349.21**		**23,859.26**		**43,957.76**
Prgm.Combined - Soc. Sec./ Medicare taxes (FICA)	13,390.91		4,506.59		2,100.92		6,783.40		13,390.91
Prgm.Combined - Retirement system contributions	2,800.88		1,403.90		654.48		742.50		2,800.88
Prgm.Combined - Employee Insurance (health, life, etc.)	26,478.80		7,431.08		3,403.74		15,643.98		26,478.80
Prgm.Combined - Worker's Compensation Insurance	805.20		270.98		126.33		407.89		805.20
Prgm.Combined - State Unemployment Insurance (SUI)	481.97		136.74		63.75		281.48		481.97
TRAVEL - Direct Client services	**1,265.00**		**137.50**		**137.50**		**990.00**		**1,265.00**
Prgm. Direct - Local Travel	1,265.00		137.50		137.50		990.00		1,265.00
EQUIPMENT - Direct Client services									
SUPPLIES - Direct Client services	**1,375.00**		**242.20**		**100.17**		**1,032.63**		**1,375.00**
Prgm. Direct - Educational supplies for clients	275.00		92.00		42.89		140.12		275.00
Prgm. Direct - Office Supplies	1,100.00		150.21		57.28		892.51		1,100.00
CONTRACTUAL - Subcontracted Direct services									
OTHER - Direct Client services	**6,694.19**		**1,934.04**		**901.63**		**3,858.52**		**6,694.19**
Prgm. Direct - Vehicle Repair	55.00		18.40		8.58		28.02		55.00
Prgm. Direct - Computer Services (inc. licenses)	1,577.85		442.33		206.21		929.31		1,577.85
Prgm. Direct - Conferences and Conventions	379.80		107.75		50.23		221.82		379.80
Prgm. Direct - Postage/Freight	275.00		78.02		36.37		160.61		275.00
Prgm. Direct - Staff Development and training	854.56		242.45		113.03		499.08		854.56
Prgm. Direct - Printing/copying	275.00		78.02		36.37		160.61		275.00
Prgm. Direct - Cell Phones	1,351.99		379.01		176.69		796.29		1,351.99
Prgm. Direct - Telecommunications (Phone, Internet, etc.)	550.00		156.04		72.74		321.21		550.00
Prgm. Direct - Interpreters	825.00		275.99		128.66		420.35		825.00
Prgm. Direct - Facilities support (Utilities, Repairs & Maintenance, etc.)	550.00		156.04		72.74		321.21		550.00
SUBTOTAL- PROGRAM DIRECT COSTS	**228,336.49**		**74,972.70**		**34,951.45**		**118,412.34**		**228,336.49**

ADMINISTRATIVE Line Item Budget								Yr./ Fund:	FY2016 Ryan White A Non-MAI			
Program: Medical Case Management								Agency:	AIDS Services of Austin			

Cost Category & Description	FTE-Svc Admin	Salary	Total Admin Costs for this Service	RWA NonMAI		RWA MAI		Other Funding Sources		ASA Unrestricted Funds		Total ADMIN Costs
ADMINISTRATIVE LINE ITEMS		65.00	9.87%	1.96	2.05%	0.91	0.95%	4.03	3.12%	-	3.74%	0.10
ADMINISTRATIVE - PERSONNEL	**7.00**	**413,509.65**	**22,436.00**	**4,656.68**		**2,170.89**		**7,092.56**		**8,515.86**		**22,436.00**
Campion - Chief Programs Officer	1.00	91,200.00	4,948.28	1,027.04		478.79		1,564.27		1,878.18		4,948.28
White, Facilities and Systems	1.00	49,744.13	2,698.99	560.19		261.15		853.22		1,024.44		2,698.99
Vacant, Human Resources Manager	1.00	59,160.00	3,209.87	666.22		310.59		1,014.72		1,218.35		3,209.87
Garza, Chief Financial Officer	1.00	78,290.10	4,247.83	881.65		411.02		1,342.84		1,612.32		4,247.83
Vacant, Accountant	1.00	36,000.00	1,953.27	405.41		189.00		617.48		741.39		1,953.27
Oden, Accountant	1.00	42,368.76	2,298.82	477.13		222.43		726.71		872.55		2,298.82
Hayse, Grants Manager	1.00	56,746.67	3,078.93	639.04		297.92		973.33		1,168.65		3,078.93
FRINGE Benefits		**68,326.93**	**3,707.25**	**769.45**		**358.71**		**1,171.95**		**1,407.13**		**3,707.25**
Combined Admin. Staff - Soc. Sec./ Medicare taxes (FICA)	7.65%	31,633.49	1,716.35	356.24		166.07		542.58		651.46		1,716.35
Combined Admin. Staff - Retirement system contributions	$1,500	1,503.00	81.55	16.93		7.89		25.78		30.95		81.55
Combined Admin. Staff - Employee Insurance (health, life, etc.)	$ 600	32,400.00	1,757.94	364.87		170.10		555.73		667.25		1,757.94
Combined Admin. Staff - Worker's Compensation Insurance	0.46%	1,902.14	103.21	21.42		9.99		32.63		39.17		103.21
Combined Admin. Staff - State Unemployment Insurance (SUI)	1.41%	888.30	48.20	10.00		4.66		15.24		18.29		48.20
TRAVEL - Administrative Support												
EQUIPMENT - Administrative Support												

SUPPLIES - Administrative Support											
CONTRACTUAL - Subcontracted Admin. services											
OTHER - Administrative costs (list)	**257,888.00**	**13,992.36**	**2,904.17**		**1,353.89**		**4,423.32**		**5,310.97**		**13,992.36**
Admin. - General & Other Liability Insurance	47,055.00	2,553.09	529.90		247.03		807.09		969.06		2,553.09
Admin. - Telecommunications (Phone, Internet, etc.)	28,020.00	1,520.30	315.54		147.10		480.60		577.05		1,520.30
Admin. - Audit	44,480.00	2,413.37	500.90		233.52		762.93		916.03		2,413.37
Admin. - Computer Services (Other contract services)	58,904.00	3,195.98	663.34		309.24		1,010.33		1,213.08		3,195.98
Admin. - Repairs/Maintainence	29,420.00	1,596.26	331.31		154.45		504.62		605.88		1,596.26
Admin. - Facilities support (Utilities, etc.)	40,620.00	2,203.94	457.44		213.25		696.72		836.53		2,203.94
Admin. - Photocopier rental, Equip maint., etc. NOT directly serving clients	9,389.00	509.42	105.73		49.29		161.04		193.36		509.42
SUBTOTAL ADMINISTRATIVE COSTS	**739,724.59**	**40,135.61**	**8,330.30**		**3,883.50**		**12,687.84**		**15,233.97**		**40,135.61**
SUM OF DIRECT + ADMIN = TOTAL COST			**$83,303.00**		**$38,834.95**		**$131,100.18**				

BUDGET JUSTIFICATION

AIDS Services of Austin

Budget Period/Fund: FY2016 Ryan White Part A (not MAI)

Service Category: Medical Case Management

The agency total annual HIV services budget for this program will be funded as follows (add more rows as needed):

RWA MAI	$ 38,834.95	15.2%
Agency Fundraising	$ 133,646.31	52.2%
Ryan White Part A	**$ 83,303**	**32.6%**
TOTAL - All Funding Sources	**$ 255,784.25**	**100%**

DIRECT SERVICE Costs - LINE ITEMS NARRATIVE

PERSONNEL	**FY16 Funding**
Williams-Price, Director of Access Services	
0.016 FTE x $68,227 annual salary	3,071.20
Supervises all Case Management, including MCM, Health Insurance, and Outreach programs; manages service delivery and evaluation; reviews financial assistance; budgets and implements program modifications; coordinates QM activities and develops policy and procedures.	
Braglia, Medical Programs Manager	
0.1599 FTE x $48,658 annual salary	6,388.48
Supervises all Medical Case Management Programs, up to 2 interns, approves and tracks financial requests, evaluates program outcomes and service delivery, completes grant reporting requirements, and coordinates and implements QM activities	
Rios M., Non-Medical Programs Manager	
0.0051 FTE x $47,909 annual salary	1,437.75
Supervises all Non-Medical Case Management Programs, up to 2 interns, approves and tracks financial requests, evaluates program outcomes and service delivery, completes grant reporting requirements, and coordinates and implements QM activities.	
Medina, Intake Coordinator	
0.0082 FTE x $36,899 annual salary	1,107.34
Performs eligibility and intake, makes referrals and provides information, performs quality assurance activities.	

Lindgren, Lead Receptionist	
0.0033 FTE x $31,513 annual salary	768.37
Provides programmatic support to clients in the verification and updates of eligibility documents and handles fees related to client services	
Cirlos, Eligibility & Intake Specialist	
0.0269 FTE x $33,612 annual salary	2,238.01
Performs eligibility and intake, makes referrals and provides information, performs quality assurance activities.	
Flores, Behavioral Health Medical Case Manager	
0.682 FTE x $44,279 annual salary	16,610.21
Perform in-depth client assessment to determine level of need for medical and psychosocial support services, make referrals to additional levels of care/social services as appropriate, work in an interdisciplinary clinical team for client care, develop and assist client in achieving client service plan goals, provide client education, assess and address client barriers to achieving treatment adherence including mental health concerns, reassess and reevaluate client needs periodically.	
Martin, Nurse Medical Case Manager	
0.682 FTE x $72,745 annual salary	27,288.30
Perform initial comprehensive medical assessment, make referrals to additional levels of care/social services as appropriate, work in an interdisciplinary clinical team for client care, develop and assist client in achieving nursing care service plan goals, provide client education, reassess and reevaluate client needs periodically.	
Personnel Salaries Subtotal	**58,909.67**
FRINGE BENEFITS	
FICA & Medicare Tax - Personnel Subtotal multiplied by 7.65% rate	4,506.59
Retirement - 3% Match per employee salary for eligible and participating staff	1,403.90
Medical Benefits - $600 per month per employee for eligible and participating staff	7,431.08
Worker's Compensation Insurance - .46% of employee salary	270.98
State Unemployment Insurance - 1.41% of first $9000 of employee salary	136.74
Fringe Benefits Subtotal	**$13,749**
TRAVEL	
Local Mileage: Reimbursement to Program Direct staff for use of their privately owned vehicles in the performance of program duties within service area. 195 miles/mo. x 12 months x $0.54/mile = $1,265 x 11%	137.50
Travel Subtotal	**$138**
	FY16 Funding
EQUIPMENT	0
Equipment with useable life over 1 year and cost of $5,000 or more per each unit	
Equipment Subtotal	**$0**

SUPPLIES	
Educational Supplies for direct client services: $275 x 33%	92.00
Office supplies to support non-medical case management program operations: $1,100 x 14%	150.21
Supplies Subtotal	**242.20**
CONTRACTUAL **(must also submit completed Subcontractor Data Sheets)**	
Contractual Subtotal	**$0**
OTHER	
Vehicle Repair: $55 x 33%	18.40
Computer Licenses: $420 x FTE	442.33
Conferences and Conventions: $40/year x FTE	107.75
Postage and Freight: $275 x 28%	78.02
Staff Development: $225/year x FTE	242.45
Printing and Copying: $275 x 28%	78.02
Cell Phones for staff safety: $29.99/month x FTE x 12 months	379.01
Tellecommunications: $550 x 28%	156.04
Interpretrers: $825 x 33%	275.99
Facilities Support: $550 x 28%	156.04
Other Subtotal	**$1,934**
TOTAL DIRECT SERVICES COSTS	**$74,973**
ADMINISTRATIVE COSTS - LINE ITEMS NARRATIVE	
PERSONNEL	**FY16 Funding**
Campion - Chief Programs Officer	
0.0205 FTE x $91,200 annual salary	1,027.04
Duties include: Oversight of programs including output, outcome, and spending tracking; quality management and improvement; supervision of directors; budgeting; and compliance.	
Systems and Facilities Manager, Lynda White	
0.0205 FTE x $49,744 annual salary	560.19
Duties include: Data management and improvement; facilities management; repairs and maintenance of facilities; quality control of data; maintenance of ARIES database and data.	

Human Resources Manager, Vacant	
0.0205 FTE x $59,160 annual salary	666.22
Duties include: Organization HR issues, trainings, orientation, and organizational HR policies and procedures.	
Chief Financial Officer, Bill Garza	
0.0205 FTE x $78,290 annual salary	881.65
Duties include: Oversees fiscal management of the organization.	
Accountant, Vacant	
0.0205 FTE x $36,000 annual salary	405.41
Duties include: Financial services support for organization.	
Accountant. Wyatt Oden	
0.0205 FTE x $42,369 annual salary	477.13
Duties include: Financial services support for organization.	
Grants Manager, Britt Hayse	
0.0205 FTE x $56,747 annual salary	639.04
Duties include: Grant compliance responsibilities.	
Personnel Subtotal	**$4,657**
FRINGE BENEFITS	
FICA & Medicare Tax - Personnel Subtotal multiplied by 7.65% rate	356.24
Medical Benefits - $600 per month per employee for eligible and participating staff	16.93
Retirement - 3% Match per employee salary for eligible and participating staff	364.87
Worker's Compensation Insurance - .46% of employee salary	21.42
State Unemployment Insurance - 1.41% of first $9000 of employee salary	10.00
Fringe Benefits Subtotal	**$769**
SUPPLIES	
Supplies Subtotal	**$0**

Human Resources Manager, Vacant	
0.0205 FTE x $59,160 annual salary	666.22
Duties include: Organization HR issues, trainings, orientation, and organizational HR policies and procedures.	
Chief Financial Officer, Bill Garza	
0.0205 FTE x $78,290 annual salary	881.65
Duties include: Oversees fiscal management of the organization.	
Accountant, Vacant	
0.0205 FTE x $36,000 annual salary	405.41
Duties include: Financial services support for organization.	
Accountant. Wyatt Oden	
0.0205 FTE x $42,369 annual salary	477.13
Duties include: Financial services support for organization.	
Grants Manager, Britt Hayse	
0.0205 FTE x $56,747 annual salary	639.04
Duties include: Grant compliance responsibilities.	
Personnel Subtotal	**$4,657**
FRINGE BENEFITS	
FICA & Medicare Tax - Personnel Subtotal multiplied by 7.65% rate	356.24
Medical Benefits - $600 per month per employee for eligible and participating staff	16.93
Retirement - 3% Match per employee salary for eligible and participating staff	364.87
Worker's Compensation Insurance - .46% of employee salary	21.42
State Unemployment Insurance - 1.41% of first $9000 of employee salary	10.00
Fringe Benefits Subtotal	**$769**
SUPPLIES	
Supplies Subtotal	**$0**

OTHER	
General & Other Liability Insurance: $47,055 prorated by FTE	529.90
Telecommunications (phone, internet, etc): $28,020 prorated by FTE	315.54
Annual Audit: $44,480 prorated by FTE	500.90
Computer Services:$58,904 prorated by FTE	663.34
Repairs and Maintenance: $29,420 prorated by FTE	331.31
Facilities Support: $40,620 prorated by FTE	457.44
Photocopier Rental, Equipment Maintenance, etc (not directly serving clients): $9,389 prorated by FTE	105.73
Other Subtotal	**2,904.17**
TOTAL ADMINISTRATIVE COSTS	**$8,330**
TOTAL - DIRECT SERVICES and ADMINISTRATIVE COSTS BUDGET for FY 2014 Grant program	**$83,303**

DIRECT SERVICES Line Item Budget					Yr./ Fund:	FY2016 Ryan White A MAI				
Program: Medical Case Management					Agency:	AIDS Services of Austin				
City of Austin HIV Grant Agreements and Contracts										*HHSD/ HRAU form rev. August 2014*
Cost Category & Description	FTE - Svc Categ	**Total Svc Annual Cost**		**RWA MCM (MAI)**		**RWA MCM (Non-MAI)**		**Other Funding Sources**		Total DIRECT SERVICE Costs
PROGRAM DIRECT - CLIENT SERVICES										
PERSONNEL Staff Salaries	**6.91**	**254,610.24**		**39,946.10**	**0.91**	**85,686.79**	**1.96**	**128,977.35**	**4.03**	**254,610.24**
Williams-Price, Director of Access Services	0.20	10,643.36		2,082.55	0.04	4,467.21	0.08	4,093.60	0.08	10,643.36
Braglia, Medical Programs Manager	0.67	26,080.82		4,331.97	0.11	9,292.34	0.24	12,456.51	0.32	26,080.82
Rios M., Non-Medical Programs Manager	0.09	3,564.45		974.92	0.03	2,091.27	0.05	498.26	0.01	3,564.45
Medina, Intake Coordinator	0.15	4,427.93		750.88	0.03	1,610.68	0.05	2,066.37	0.07	4,427.93
Lindgren, Lead Receptionist	0.08	1,890.76		521.03	0.02	1,117.63	0.04	252.10	0.01	1,890.76
Cirlos, Eligibility & Intake Specialist	0.22	5,982.88		1,517.57	0.06	3,255.28	0.12	1,210.02	0.05	5,982.88
Slaughter, Lead Medical Case Manager	1.00	32,179.25		-	0.00	-	0.00	32,179.25	1.00	32,179.25
Simmons, D., Medical Case Manager	1.00	29,883.47		-	0.00	-	0.00	29,883.47	1.00	29,883.47
Rios, A., Medical Case Manager	1.00	32,426.73		-	0.00	-	0.00	32,426.73	1.00	32,426.73
Flores, Behavioral Health Medical Case Manager	1.00	35,423.54		11,263.23	0.32	24,160.31	0.68	-	0.00	35,423.54
Martin, Nurse Medical Case Manager	1.00	58,196.01		18,503.94	0.32	39,692.07	0.68	-	0.00	58,196.01
Miranda, Patient Navigator	0.50	13,911.04		-	0.00	-	0.00	13,911.04	0.50	13,911.04
FRINGE Benefits		**63,938.38**		**8,935.03**		**20,298.97**		**34,704.37**		**63,938.38**
Prgm.Combined - Soc. Sec./ Medicare taxes (FICA)		19,477.68		3,055.88		6,555.04		9,866.77		19,477.68
Prgm.Combined - Retirement system contributions		4,074.00		951.97		2,042.03		1,080.00		4,074.00
Prgm.Combined - Employee Insurance (health, life, etc.)		38,514.44		4,650.71		11,108.85		22,754.88		38,514.44
Prgm.Combined - Worker's Compensation Insurance		1,171.21		183.75		394.16		593.30		1,171.21
Prgm.Combined - State Unemployment Insurance (SUI)		701.05		92.72		198.89		409.43		701.05

Prgm.Combined - Employee Insurance (health, life, etc.)	38,514.44		4,650.71		11,108.85		22,754.88		38,514.44
Prgm.Combined - Worker's Compensation Insurance	1,171.21		183.75		394.16		593.30		1,171.21
Prgm.Combined - State Unemployment Insurance (SUI)	701.05		92.72		198.89		409.43		701.05
TRAVEL - Direct Client services	**1,840.00**		**200.00**		**200.00**		**1,440.00**		**1,840.00**
Prgm. Direct - Local Travel	1,840.00		200.00		200.00		1,440.00		1,840.00
EQUIPMENT - Direct Client services									
SUPPLIES - Direct Client services	**2,000.00**		**217.13**		**280.86**		**1,502.01**		**2,000.00**
Prgm. Direct - Educational supplies for clients	400.00		133.81		62.38		203.81		400.00
Prgm. Direct - Office Supplies	1,600.00		83.32		218.48		1,298.20		1,600.00
CONTRACTUAL - Subcontracted Direct services									
OTHER - Direct Client services	**9,737.01**		**1,540.03**		**2,584.58**		**5,612.39**		**9,737.01**
Prgm. Direct - Vehicle Repair	80.00		26.76		12.48		40.76		80.00
Prgm. Direct - Computer Services (inc. licenses)	2,295.05		299.94		643.38		1,351.73		2,295.05
Prgm. Direct - Conferences and Conventions	552.44		73.07		156.73		322.64		552.44
Prgm. Direct - Postage/Freight	400.00		52.90		113.48		233.61		400.00
Prgm. Direct - Staff Development and training	1,242.99		164.40		352.65		725.94		1,242.99
Prgm. Direct - Printing/copying	400.00		52.90		113.48		233.61		400.00
Prgm. Direct - Cell Phones	1,966.53		257.00		551.29		1,158.24		1,966.53
Prgm. Direct - Telecommunications (Phone, Internet, etc.)	800.00		105.81	0.13	226.97		467.22		800.00
Prgm. Direct - Interpreters	1,200.00		401.43	0.33	187.14		611.42		1,200.00
Prgm. Direct - Facilities support (Utilities, Repairs & Maintenance, etc.)	800.00		105.81	0.13	226.97		467.22		800.00
SUBTOTAL- PROGRAM DIRECT COSTS	**332,125.62**		**50,838.30**		**109,051.20**		**172,236.12**		**332,125.62**

ADMINISTRATIVE Line Item Budget Yr./ Fund: **FY2016 Ryan White A MAI**

Program: **Medical Case Management** Agency: **AIDS Services of Austin**

Cost Category & Description	FTE-Svc Admin	Total Admin Costs for this Service	RWA MAI		RWA NonMAI		Other Funding Sources		ASA Unrestricted Funds		Total ADMIN Costs
ADMINISTRATIVE LINE ITEMS		9.87%	0.91	0.95%	1.96	2.05%	4.03	3.12%	-	3.74%	0.10
ADMINISTRATIVE - PERSONNEL	**7.00**	**32,634.18**	**3,157.66**		**6,773.35**		**10,316.46**		**12,386.71**		**32,634.18**
Campion - Chief Programs Officer	1.00	7,197.50	696.43		1,493.87		2,275.31		2,731.90		7,197.50
White, Facilities and Systems	1.00	3,925.81	379.86		814.82		1,241.04		1,490.09		3,925.81
Vacant, Human Resources Manager	1.00	4,668.91	451.76		969.05		1,475.95		1,772.14		4,668.91
Garza, Chief Financial Officer	1.00	6,178.65	597.84		1,282.40		1,953.22		2,345.19		6,178.65
Vacant, Accountant	1.00	2,841.12	274.90		589.69		898.15		1,078.38		2,841.12
Oden, Accountant	1.00	3,343.74	323.54		694.01		1,057.04		1,269.16		3,343.74
Hayse, Grants Manager	1.00	4,478.45	433.33		929.52		1,415.75		1,699.85		4,478.45
FRINGE Benefits		**5,392.36**	**521.76**		**1,119.21**		**1,704.66**		**2,046.74**		**5,392.36**
Combined Admin. Staff - Soc. Sec./ Medicare taxes (FICA)	7.65%	2,496.51	241.56		518.16		789.21		947.58		2,496.51
Combined Admin. Staff - Retirement system contributions	$1,500	118.62	11.48		24.62		37.50		45.02		118.62
Combined Admin. Staff - Employee Insurance (health, life, etc.)	$ 600	2,557.01	247.41		530.72		808.33		970.54		2,557.01
Combined Admin. Staff - Worker's Compensation Insurance	0.46%	150.12	14.53		31.16		47.46		56.98		150.12
Combined Admin. Staff - State Unemployment Insurance (SUI)	1.41%	70.10	6.78		14.55		22.16		26.61		70.10
TRAVEL - Administrative Support											
EQUIPMENT - Administrative Support											
SUPPLIES - Administrative Support											
CONTRACTUAL - Subcontracted Admin. services											
OTHER - Administrative costs (list)		**20,352.52**	**1,969.28**		**4,224.24**		**6,433.93**		**7,725.05**		**20,352.50**
Admin. - General & Other Liability Insurance		3,713.58	359.32		770.77		1,173.95		1,409.54		3,713.58
Admin. - Telecommunications (Phone, Internet, etc.)		2,211.34	213.97		458.97		699.06		839.34		2,211.34
Admin. - Audit		3,510.36	339.66		728.59		1,109.71		1,332.40		3,510.36
Admin. - Computer Services (Other contract services)		4,648.70	449.81		964.86		1,469.57		1,764.47		4,648.70
Admin. - Repairs/Maintainence		2,321.83	224.66		481.90		733.99		881.28		2,321.83
Admin. - Facilities support (Utilities, etc.)		3,205.73	310.18		665.36		1,013.41		1,216.78		3,205.73
Admin. - Photocopier rental, Equip maint., etc. NOT directly serving clients		740.98	71.68		153.79		234.24		281.25		740.96
SUBTOTAL ADMINISTRATIVE COSTS		**58,379.06**	**5,648.70**		**12,116.80**		**18,455.04**		**22,158.50**		**58,379.04**
SUM OF DIRECT + ADMIN = TOTAL COST		**$390,504.69**	**$56,487.00**		**$121,168.00**		**$190,691.16**		**$22,158.50**		**$390,504.67**

BUDGET JUSTIFICATION

AIDS Services of Austin

Budget Period/Fund: FY2016 Ryan White Part A (MAI)
Service Category: Medical Case Management

The agency total annual HIV services budget for this program will be funded as follows (add more rows as needed):

RWA Non-MAI	$ 121,168	32.6%
Agency Fundraising	$ 194,394.63	52.2%
Ryan White Part A MAI	**$ 56,487**	**15.2%**
TOTAL - All Funding Sources	**$ 372,049.63**	**100%**

DIRECT SERVICE Costs - LINE ITEMS NARRATIVE

PERSONNEL	**FY16 Funding**
Williams-Price, Director of Access Services	
0.0074 FTE x $68,227 annual salary	2,082.55
Supervises all Case Management, including MCM, Health Insurance, and Outreach programs; manages service delivery and evaluation; reviews financial assistance; budgets and implements program modifications; coordinates QM activities and develops policy and procedures.	
Braglia, Medical Programs Manager	
0.0746 FTE x $48,658 annual salary	4,331.97
Supervises all Medical Case Management Programs, up to 2 interns, approves and tracks financial requests, evaluates program outcomes and service delivery, completes grant reporting requirements, and coordinates and implements QM activities	
Rios M., Non-Medical Programs Manager	
0.0024 FTE x $47,909 annual salary	974.92
Supervises all Non-Medical Case Management Programs, up to 2 interns, approves and tracks financial requests, evaluates program outcomes and service delivery, completes grant reporting requirements, and coordinates and implements QM activities.	
Medina, Intake Coordinator	
0.0038 FTE x $36,899 annual salary	750.88
Performs eligibility and intake, makes referrals and provides information, performs quality assurance activities.	
Lindgren, Lead Receptionist	
0.0016 FTE x $31,513 annual salary	521.03
Provides programmatic support to clients in the verification and updates of eligibility documents and handles fees related to client services	
Cirlos, Eligibility & Intake Specialist	
0.0126 FTE x $33,612 annual salary	1,517.57
Performs eligibility and intake, makes referrals and provides information, performs quality assurance activities.	
Flores, Behavioral Health Medical Case Manager	
0.318 FTE x $44,279 annual salary	11,263.23
Perform in-depth client assessment to determine level of need for medical and psychosocial support services, make referrals to additional levels of care/social services as appropriate, work in an interdisciplinary clinical team for client care, develop and assist client in achieving client service plan goals, provide client education, assess and address client barriers to achieving treatment adherence including mental health concerns, reassess and reevaluate client needs periodically.	

Flores, Behavioral Health Medical Case Manager	
0.318 FTE x $44,279 annual salary	11,263.23
Perform in-depth client assessment to determine level of need for medical and psychosocial support services, make referrals to additional levels of care/social services as appropriate, work in an interdisciplinary clinical team for client care, develop and assist client in achieving client service plan goals, provide client education, assess and address client barriers to achieving treatment adherence including mental health concerns, reassess and reevaluate client needs periodically.	
Martin, Nurse Medical Case Manager	
0.318 FTE x $72,745 annual salary	18,503.94
Perform initial comprehensive medical assessment, make referrals to additional levels of care/social services as appropriate, work in an interdisciplinary clinical team for client care, develop and assist client in achieving nursing care service plan goals, provide client education, reassess and reevaluate client needs periodically.	
Personnel Salaries Subtotal	**39,946.10**
FRINGE BENEFITS	
FICA & Medicare Tax - Personnel Subtotal multiplied by 7.65% rate	3,055.88
Retirement - 3% Match per employee salary for eligible and participating staff	951.97
Medical Benefits - $600 per month per employee for eligible and participating staff	4,650.71
Worker's Compensation Insurance - .46% of employee salary	183.75
State Unemployment Insurance - 1.41% of first $9000 of employee salary	92.72
Fringe Benefits Subtotal	**$8,935**
TRAVEL	
Local Mileage: Reimbursement to Program Direct staff for use of their privately owned vehicles in the performance of program duties within service area. 284 miles/mo. x 12 months x $0.54/mile = $1,840 x 11%	200.00
Travel Subtotal	**$200**
	FY16 Funding
EQUIPMENT	0
Equipment with useable life over 1 year and cost of $5,000 or more per each unit	
Equipment Subtotal	**$0**
SUPPLIES	
Educational Supplies for direct client services: $400 x 33%	133.81
Office supplies to support medical case management program operations: $1,600 x 5%	83.32
Supplies Subtotal	**217.13**
CONTRACTUAL **(must also submit completed Subcontractor Data Sheets)**	
Contractual Subtotal	**$0**

OTHER	
Vehicle Repair: $80 x 33%	26.76
Computer Licenses: $420 x FTE	299.94
Conferences and Conventions: $40/year x FTE	73.07
Postage and Freight: $400 x 13%	52.90
Staff Development: $225/year x FTE	164.40
Printing and Copying: $400 x 13%	52.90
Cell Phones for staff safety: $29.99/month x FTE x 12 months	257.00
Tellecommunications: $800 x 13%	105.81
Interpretrers: $1,200 x 33%	401.43
Facilities Support: $800 x 13%	105.81
Other Subtotal	**1,540.03**
TOTAL DIRECT SERVICES COSTS	**$50,838**
ADMINISTRATIVE COSTS - LINE ITEMS NARRATIVE	
PERSONNEL	**FY16 Funding**
Campion - Chief Programs Officer	
0.0095 FTE x $91,200 annual salary	696.43
Duties include: Oversight of programs including output, outcome, and spending tracking; quality management and improvement; supervision of directors; budgeting; and compliance.	
Systems and Facilities Manager, Lynda White	
0.0095 FTE x $49,744 annual salary	379.86
Duties include: Data management and improvement; facilities management; repairs and maintenance of facilities; quality control of data; maintenance of ARIES database and data.	
Human Resources Manager, Vacant	
0.0095 FTE x $59,160 annual salary	451.76
Duties include: Organization HR issues, trainings, orientation, and organizational HR policies and procedures.	
Chief Financial Officer, Bill Garza	
0.0095 FTE x $78,290 annual salary	597.84
Duties include: Oversees fiscal management of the organization.	

Accountant, Vacant	
0.0095 FTE x $36,000 annual salary	274.90
Duties include: Financial services support for organization.	
Accountant. Wyatt Oden	
0.0095 FTE x $42,369 annual salary	323.54
Duties include: Financial services support for organization.	
Grants Manager, Britt Hayse	
0.0095 FTE x $56,747 annual salary	433.33
Duties include: Grant compliance responsibilities.	
Personnel Subtotal	**$3,158**
FRINGE BENEFITS	
FICA & Medicare Tax - Personnel Subtotal multiplied by 7.65% rate	241.56
Medical Benefits - $600 per month per employee for eligible and participating staff	11.48
Retirement - 3% Match per employee salary for eligible and participating staff	247.41
Worker's Compensation Insurance - .46% of employee salary	14.53
State Unemployment Insurance - 1.41% of first $9000 of employee salary	6.78
Fringe Benefits Subtotal	**$522**
SUPPLIES	
Supplies Subtotal	**$0**
OTHER	
General & Other Liability Insurance: $47,055 prorated by FTE	359.32
Telecommunications (phone, internet, etc): $28,020 prorated by FTE	213.97
Annual Audit: $44,480 prorated by FTE	339.66
Computer Services:$58,904 prorated by FTE	449.81
Repairs and Maintenance: $29,420 prorated by FTE	224.66
Facilities Support: $40,620 prorated by FTE	310.18
Photocopier Rental, Equipment Maintenance, etc (not directly serving clients): $9,389 prorated by FTE	71.68
Other Subtotal	**1,969.28**
TOTAL ADMINISTRATIVE COSTS	**$5,649**
TOTAL - DIRECT SERVICES and ADMINISTRATIVE COSTS BUDGET for FY 2014 Grant program	**$56,487**

ATTACHMENT D

PERFORMANCE and FINANCIAL REPORT DELIVERY SCHEDULE

Partial list of required reports with due dates on next page

Current reporting forms and assistance are available from
HIV Resources Administration Unit/ Austin Health and Human Services Dept.

REQUIRED PERFORMANCE and FINANCIAL REPORTS

Delivery Schedule and Due Dates
for FY 2016 Ryan White Part A/MAI Grant Agreements and Contracts

Partial list of required forms and reports, to be submitted no later than the indicated due dates:

Reporting Requirements	Due Dates
ARIES Monthly Data Report and **ARIES YTD Data Report** (for each sub/service category: Actual Units delivered and Unduplicated Clients served for the billed month, and also cumulative Year-to-Date totals. **For MAI program – breakdown by target group is also required**)	Ongoing ARIES data input is required. Two ARIES Data Reports are due monthly, no later than the 15th of each month for the previous month, uploaded into CIODM (Community Information Online Data Management) system
Monthly Performance Report and **Monthly Financial Summary spreadsheets**, including Program Income and Administrative Expenditures	Due no later than the 15th of each month for the previous month, uploaded **complete MS Excel spreadsheet sets** into CIODM system
(As applicable for each month where expenditures or performance are not within expected range): **Monthly Expenditure and Performance Variance Report** by HIV Service Category (submitted in **MS Word** format)	For each service category that meets criteria (instructions on form), a separate form is due no later than the 15th of each month, **uploaded as MS Word formatted file** into CIODM system
Contractor Detail for Monthly Expenditures Report (general ledger/financial system transactions documentation)	Submit contract actual monthly & YTD expenditures report generated from the Contractor's financial management system. Due no later than the 15th of each month for the previous month, uploaded into CIODM system
Ryan White Program Services Report (RSR) for calendar year 2016 submitted online into HRSA's EHB system, or as directed	March 2017, or as directed by City – for period January through December 2016
Administrative and Fiscal Review (AFR) Annual Update for existing provider agencies	May 31, 2016 or as directed by City.

submitted in CIODM or as directed	
Final Term Period Closeout Report for March 1, 2016 – February 28, 2017	April 14, 2017
Annual Financial Report with independent auditor's Management Letter and related items	No later than 160 calendar days after close of provider agency's fiscal year