Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? *EIIHA: Early Identification of Individuals with HIV/AIDS seeks to identify the status-unaware and link them into care *Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months *Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. *Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, protect, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. *Motion approved by QI 03/15/22*
Part 1: Services offered by Ryan White Part A, Part B, and State Services in the Houston EMA/HSDA as of 03-15-22							
Ambulatory/Outpatient Primary Medical Care (incl. Vision):							
CBO, Adult – Part A, Including LPAP, MCM, EFA-Pharmacy, Outreach & Service Linkage (Includes OB/GYN) *See below for Public Clinic, Rural, Pediatric, Vision* ***Workgroup #1*** ***Motion:*** *(Kelly/Boyle) Votes: Y=9; N=0; Abstentions= Aloysius, Castillo, de la Cruz, Leisher, Kelly, Miertschin,*	✔ Yes ___No	☒ EIIHA ☒ Unmet Need ☒ Continuum of Care EIIHA: The purpose of the HRSA EIIHA initiative is to identify the status-*unaware* and facilitate their entry into Primary Care Unmet Need: Facilitating entry/reentry into Primary Care reduces unmet need. Additionally, a criterion for met need is evidence of an ART prescription, and clients cannot access LPAP until they are	Epi (2019): An estimated 6,825 people in the EMA are living with HIV and unaware of their status. The current estimate of unmet need in the EMA is 7,187, or 25% of all PLWH. Current # of living HIV cases in EMA: 30,149 Need (2020): Rank w/in funded services: *Primary Care: #1* *LPAP/EFA: #2* *Case Management: #3* *Outreach: #14* Service Utilization (2021):	Primary Care: Medicaid, Medicare, RW Part D, and private providers, including federal health insurance marketplace participants LPAP: ADAP, State Pharmacy Assistance Program, Medicaid, Medicare Part D, RW Health Insurance Assistance, the public clinic's pharmacy program, private sector Patient Assistance Programs, and private	Justify the use of funds: This service category: - Is a HRSA-defined Core Medical Service - Is ranked as the #1 service need by PLWH; and use has increased - Adheres to a medical home model and is bundled with LPAP, Medical Case Management, and Service Linkage - Results in desirable health outcomes for clients who access the service - Referring and linking the	Can we make this service more efficient? No Can we bundle this service? Currently bundled with: EFA, LPAP, Medical Case Management, Outreach and Service Linkage Has a recent capacity issue been identified? No Does this service assist special populations to access primary care?	**05/03/22 – the QI committee approved the HTBMN wg recommendation** **Wg Motion 1:** Update the justification chart, keep the service definition and the financial eligibility the same for PriCare=300%, EFA=500%, MCM/SLW/ Outreach=none and increase the financial eligibility for LPAP non-

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Robinson		enrolled in Primary Care. <u>Continuum of Care</u>: Primary Care, MCM, and LPAP support maintenance/retention in care and viral suppression for PLWH.	# clients served: *Primary Care: 9,397 (slight increase v. 2020)* *LPAP: 6,034 (8.54% increase v. 2020)* *Medical Case Mgmt: 5,263 (3.9% decrease v. 2020)* *EFA-Pharmacy: 2,654 (93% increase v. 2020)* *Outreach: 1,119 (27.6% increase v. 2020)* *Non-Medical Case Mgmt, or Service Linkage: 7,581 (8.9% decrease v. 2020)* <u>Outcomes (FY2020)</u>: *Primary Care/LPAP:* 79% of Primary Care clients and 78% of LPAP clients were virally suppressed;	pharmacy benefit programs, including federal health insurance marketplace participants <u>Medical Case Management:</u> RW Part C and D <u>Service Linkage:</u> RW Part C and D, HOPWA, and a grant from a private foundation <u>EHE Funding</u>: RWGA received $1,794,295 in HRSA funding for Year 1 implementation of EHE activities. Houston Health Department (HHD) has received funding under PS19-1906 for Accelerating State and Local HIV Planning	status-unaware to Primary Care is the goal of the national and local EIIHA initiative - Referring and linking the out-of-care to Primary Care is the goal of reducing unmet need - Facilitates national, state, and local goals related to continuous HIV care, reducing unmet need, and viral load suppression - Addresses specific activities from Strategy #3 of the Comprehensive Plan and addresses certain Special Populations named in the Plan		HIV meds to the same as HIV meds=500%.

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			Medical Case Mgmt: 50% of clients were in continuous HIV care following MCM; 68% of clients who received MCM were virally suppressed; *Outreach:* 34% of clients accessed HIV care w/in 3 mos.; 45% were virally suppressed w/in 12 mos.; *Non-Medical Case Mgmt, or Service Linkage:* 49% of clients were in continuous HIV care following Service Linkage Pops. with difficulty accessing needed services: *Primary Care*: HL, 18-24, 25-49, Rural, OOC, MSM	to End the HIV Epidemic. Several Houston area FQHCs received a combined total of $1,067,555 from HRSA's Ending the HIV Epidemic-Primary Care HIV Prevention (PCHP) Grant. Covered under QHP? ✔ Yes ___No	Is this a duplicative service or activity? - This service is funded locally by other public and private sources for (1) specific Special Populations (e.g., WICY), (2) those meeting income, disability, and/or age-related eligibility criteria, and (3) those with private sector health insurance.		

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			LPAP/EFA: Females (sex at birth), HL, 25-49, Homeless, MSM, Rural *Outreach*: Males (sex at birth), White, 18 – 24, Homeless, MSM, RR, Transgender *Case Management:* Other/multiracial, Black/AA, 18-24, OOC, Transgender, RR, Homeless				

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Public Clinic, Adult – Part A, Including LPAP, MCM, EFA-Pharmacy, Outreach & Service Linkage (Includes OB/GYN) *See below for Rural, Pediatric, Vision* ***Workgroup #1*** ***Motion:*** *(Kelly/Boyle) Votes: Y=9; N=0; Abstentions= Aloysius, Castillo, de la Cruz, Leisher, Kelly, Miertschin, Robinson*	✔ Yes ___No	☒ EIIHA ☒ Unmet Need ☒ Continuum of Care EIIHA: The purpose of the HRSA EIIHA initiative is to identify the status-*unaware* and facilitate their entry into Primary Care Unmet Need: Facilitating entry/reentry into Primary Care reduces unmet need. Additionally, a criterion for met need is evidence of an ART prescription, and clients cannot access LPAP until they are enrolled in Primary Care. Continuum of Care: Primary Care, MCM, and LPAP support maintenance/retention in care	Epi (2019): An estimated 6,825 people in the EMA are living with HIV and unaware of their status. The current estimate of unmet need in the EMA is 7,187, or 25% of all PLWH. Current # of living HIV cases in EMA: 30,149 Need (2020): Rank w/in funded services: *Primary Care: #1* *LPAP/EFA: #2* *Case Management: #3* *Outreach: #14* Service Utilization (2021): # clients served: *Primary Care: 9,397 (slight increase v. 2020)* *LPAP: 6,034*	Primary Care: Medicaid, Medicare, RW Part D, and private providers, including federal health insurance marketplace participants LPAP: ADAP, State Pharmacy Assistance Program, Medicaid, Medicare Part D, RW Health Insurance Assistance, the public clinic's pharmacy program, private sector Patient Assistance Programs, and private pharmacy benefit programs, including federal health insurance marketplace participants	Justify the use of funds: This service category: - Is a HRSA-defined Core Medical Service - Is ranked as the #1 service need by PLWH; and use has increased - Adheres to a medical home model and is bundled with LPAP, Medical Case Management, and Service Linkage - Results in desirable health outcomes for clients who access the service - Referring and linking the status-unaware to Primary Care is the goal of the national and local EIIHA initiative	Can we make this service more efficient? No Can we bundle this service? Currently bundled with: EFA, LPAP, Medical Case Management, Outreach and Service Linkage Has a recent capacity issue been identified? No Does this service assist special populations to access primary care?	**05/03/22 – the QI committee approved the HTBMN wg recommendation** **Wg Motion 1:** Update the justification chart, keep the service definition and the financial eligibility the same for PriCare=300%, EFA=500%, MCM/SLW/ Outreach=none and increase the financial eligibility for LPAP non-HIV meds to the same as HIV meds=500%.

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		and viral suppression for PLWH.	*(8.54% increase v. 2020) Medical Case Mgmt: 5,263 (3.9% decrease v. 2020) EFA-Pharmacy: 2,654 (93% increase v. 2020) Outreach: 1,119 (27.6% increase v. 2020) Non-Medical Case Mgmt, or Service Linkage: 7,581 (8.9% decrease v. 2020)* Outcomes (FY2020): *Primary Care/LPAP:* 79% of Primary Care clients and 78% of LPAP clients were virally suppressed; *Medical Case Mgmt:* 50% of clients were in continuous HIV care following MCM; 68% of clients who received	Medical Case Management: RW Part C and D Service Linkage: RW Part C and D, HOPWA, and a grant from a private foundation EHE Funding: RWGA received $1,794,295 in HRSA funding for Year 1 implementation of EHE activities. Houston Health Department (HHD) has received funding under PS19-1906 for Accelerating State and Local HIV Planning to End the HIV Epidemic. Several Houston area FQHCs received a combined total of $1,067,555 from	- Referring and linking the out-of-care to Primary Care is the goal of reducing unmet need - Facilitates national, state, and local goals related to continuous HIV care, reducing unmet need, and viral load suppression - Addresses specific activities from Strategy #3 of the Comprehensive Plan and addresses certain Special Populations named in the Plan Is this a duplicative service or activity? - This service is funded locally by other public and		

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Rural, Adult – Part A, Including LPAP, MCM, EFA-Pharmacy, Outreach & Service Linkage (Includes OB/GYN) *See below for Pediatric, Vision* ***Workgroup #1*** ***Motion:** (Kelly/Boyle)* *Votes: Y=9; N=0;* *Abstentions= Aloysius, Castillo, de la Cruz, Leisher, Kelly, Miertschin, Robinson*	✔ Yes ___No	☒ EIIHA ☒ Unmet Need ☒ Continuum of Care EIIHA: The purpose of the HRSA EIIHA initiative is to identify the status-*unaware* and facilitate their entry into Primary Care Unmet Need: Facilitating entry/reentry into Primary Care reduces unmet need. Additionally, a criterion for met need is evidence of an ART prescription, and clients cannot access LPAP until they are enrolled in Primary Care. Continuum of Care: Primary Care, MCM, and LPAP support maintenance/retention in care	Epi (2019): An estimated 6,825 people in the EMA are living with HIV and unaware of their status. The current estimate of unmet need in the EMA is 7,187, or 25% of all PLWH. Current # of living HIV cases in EMA: 30,149 Need (2020): Rank w/in funded services: *Primary Care: #1* *LPAP/EFA: #2* *Case Management: #3* *Outreach: #14* Service Utilization (2021): # clients served: *Primary Care: 9,397 (slight increase v. 2020)* *LPAP: 6,034*	Primary Care: Medicaid, Medicare, RW Part D, and private providers, including federal health insurance marketplace participants LPAP: ADAP, State Pharmacy Assistance Program, Medicaid, Medicare Part D, RW Health Insurance Assistance, the public clinic's pharmacy program, private sector Patient Assistance Programs, and private pharmacy benefit programs, including federal health insurance marketplace participants	Justify the use of funds: This service category: - Is a HRSA-defined Core Medical Service - Is ranked as the #1 service need by PLWH; and use has increased - Adheres to a medical home model and is bundled with LPAP, Medical Case Management, and Service Linkage - Results in desirable health outcomes for clients who access the service - Referring and linking the status-unaware to Primary Care is the goal of the national and local EIIHA initiative	Can we make this service more efficient? No Can we bundle this service? Currently bundled with: EFA, LPAP, Medical Case Management, Outreach and Service Linkage Has a recent capacity issue been identified? No Does this service assist special populations to access primary care?	**05/03/22 – the QI committee approved the HTBMN wg recommendation** **Wg Motion 1:** Update the justification chart, keep the service definition and the financial eligibility the same for PriCare=300%, EFA=500%, MCM/SLW/ Outreach=none and increase the financial eligibility for LPAP non-HIV meds to the same as HIV meds=500%.

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Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, protect, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. *Motion approved by QI 03/15/22*
		and viral suppression for PLWH.	*(8.54% increase v. 2020)* *Medical Case Mgmt: 5,263 (3.9% decrease v. 2020)* *EFA-Pharmacy: 2,654 (93% increase v. 2020)* *Outreach: 1,119 (27.6% increase v. 2020)* *Non-Medical Case Mgmt, or Service Linkage: 7,581 (8.9% decrease v. 2020)* Outcomes (FY2020): *Primary Care/LPAP:* 79% of Primary Care clients and 78% of LPAP clients were virally suppressed; *Medical Case Mgmt:* 50% of clients were in continuous HIV care following MCM; 68% of clients who received	Medical Case Management: RW Part C and D Service Linkage: RW Part C and D, HOPWA, and a grant from a private foundation EHE Funding: RWGA received $1,794,295 in HRSA funding for Year 1 implementation of EHE activities. Houston Health Department (HHD) has received funding under PS19-1906 for Accelerating State and Local HIV Planning to End the HIV Epidemic. Several Houston area FQHCs received a combined total of $1,067,555 from	- Referring and linking the out-of-care to Primary Care is the goal of reducing unmet need - Facilitates national, state, and local goals related to continuous HIV care, reducing unmet need, and viral load suppression - Addresses specific activities from Strategy #3 of the Comprehensive Plan and addresses certain Special Populations named in the Plan Is this a duplicative service or activity? - This service is funded locally by other public and		

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Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, protect, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. *Motion approved by QI 03/15/22*
			MCM were virally suppressed; *Outreach:* 34% of clients accessed HIV care w/in 3 mos.; 45% were virally suppressed w/in 12 mos.; *Non-Medical Case Mgmt, or Service Linkage:* 49% of clients were in continuous HIV care following Service Linkage Pops. with difficulty accessing needed services: *Primary Care*: HL, 18-24, 25-49, Rural, OOC, MSM *LPAP/EFA*: Females (sex at birth), HL, 25-49, Homeless, MSM, Rural *Outreach*: Males (sex at	HRSA's Ending the HIV Epidemic-Primary Care HIV Prevention (PCHP) Grant. Covered under QHP? ✔ Yes ___No	private sources for (1) specific Special Populations (e.g., WICY), (2) those meeting income, disability, and/or age-related eligibility criteria, and (3) those with private sector health insurance.		

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Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, protect, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. *Motion approved by QI 03/15/22*
			birth), White, 18 – 24, Homeless, MSM, RR, Transgender *Case Management:* Other/multiracial, Black/AA, 18-24, OOC, Transgender, RR, Homeless				

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Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, protect, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. *Motion approved by QI 03/15/22*
Pediatric – Part A ***Workgroup #1*** ***Motion:** (Kelly/Boyle)* *Votes: Y=9; N=0;* *Abstentions= Aloysius, Castillo, de la Cruz, Leisher, Kelly, Miertschin, Robinson*	✔ Yes ___No	☒ EIIHA ☒ Unmet Need ☒ Continuum of Care EIIHA: The purpose of the HRSA EIIHA initiative is to identify the status-*unaware* and facilitate their entry into Primary Care Unmet Need: Facilitating entry/reentry into Primary Care reduces unmet need. Continuum of Care: Primary Care, MCM, and Service Linkage support maintenance/retention in care and viral suppression for PLWH.	Epi (2019): An estimated 6,825 people in the EMA are living with HIV and unaware of their status. The current estimate of unmet need in the EMA is 7,187, or 25% of all PLWH. Current # of living HIV cases in EMA: 30,149 Need (2020): Rank w/in funded services: *Primary Care: #1* *Case Management: #3* Service Utilization (2021): # clients served: *Primary Care: 9,397 (slight increase v. 2020)* *Medical Case Mgmt: 5,263 (3.9% decrease v. 2020)* *Non-Medical Case Mgmt,*	Primary Care: Medicaid, Medicare, RW Part D, and private providers, including federal health insurance marketplace participants Medical Case Management: RW Part C and D Service Linkage: RW Part C and D, HOPWA, and a grant from a private foundation EHE Funding: RWGA received $1,794,295 in HRSA funding for Year 1 implementation of EHE activities. Houston Health Department (HHD) has	Justify the use of funds: This service category: - Is a HRSA-defined Core Medical Service - Is ranked as the #1 service need by PLWH; and use has increased - Adheres to a medical home model and is bundled with Medical Case Management and Service Linkage - Results in desirable health outcomes for clients who access the service - Referring and linking the status-unaware to Primary Care is the goal of the national and local EIIHA initiative - Referring and linking the	Can we make this service more efficient? No Can we bundle this service? Currently bundled with: Medical Case Management and Service Linkage Has a recent capacity issue been identified? No Does this service assist special populations to access primary care?	**05/03/22 – the QI committee approved the HTBMN wg recommendation** **Wg Motion:** Update the justification chart, keep the service definition and the financial eligibility the same: PriCare=300%, MCM=none, SLW=none.

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, protect, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. *Motion approved by QI 03/15/22*
			or Service Linkage: 7,581 (8.9% decrease v. 2020) Outcomes (FY2020): *Primary Care:* 79% of Primary Care clients were virally suppressed; *Medical Case Mgmt:* 50% of clients were in continuous HIV care following MCM; 68% of clients who received MCM were virally suppressed; *Non-Medical Case Mgmt, or Service Linkage:* 49% of clients were in continuous HIV care following Service Linkage Pops. with difficulty accessing	received funding under PS19-1906 for Accelerating State and Local HIV Planning to End the HIV Epidemic. Several Houston area FQHCs received a combined total of $1,067,555 from HRSA's Ending the HIV Epidemic-Primary Care HIV Prevention (PCHP) Grant. Covered under QHP? ✔ Yes ___No	out-of-care to Primary Care is the goal of reducing unmet need - Facilitates national, state, and local goals related to continuous HIV care, reducing unmet need, and viral load suppression - Addresses specific activities from Strategy #3 of the Comprehensive Plan and addresses certain Special Populations named in the Plan Is this a duplicative service or activity? - This service is funded locally by other public and private sources for (1)		

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Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, protect, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. *Motion approved by QI 03/15/22*
			<u>needed services</u>: *Primary Care*: HL, 18-24, 25-49, Rural, OOC, MSM *Case Management:* Other/multiracial, Black/AA, 18-24, OOC, Transgender, RR, Homeless		specific Special Populations (e.g., WICY), (2) those meeting income, disability, and/or age-related eligibility criteria, and (3) those with private sector health insurance.		

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, protect, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. *Motion approved by QI 03/15/22*
Clinical Case Management - Part A ***Workgroup #1*** ***Motion 1:** (Kelly/Pradia) Votes: Y=10; N=0; Abstentions= Aloysius, Castillo, de la Cruz, Leisher, Kelly, Miertschin, Robinson* ***Motion 2:** (Pradia/Kelly) Votes: Y=10; N=0; Abstentions= Aloysius, Castillo, de la Cruz, Leisher, Kelly, Miertschin, Robinson*	✔ Yes ___No	☐ EIIHA ☒ Unmet Need ☒ Continuum of Care Unmet Need: Among PLWH with a history of unmet need, substance use is the #2 reason cited for falling out-of-care, making CCM is a strategy for preventing unmet need. CCM also addresses local priorities related to mental health and substance abuse co-morbidities Continuum of Care: CCM supports maintenance/ retention in care and viral suppression for PLWH.	Epi (2019): Current # of living HIV cases in EMA: 30,149 Need (2020): Rank w/in funded services:*#3* Service Utilization (2021): # clients served: 1,198 *(7.5% decrease v. 2020)* Outcomes (FY2020): 56% of clients were in continuous care following receipt of CCM. 73% of clients utilizing CCM were virally suppressed. Pops. with difficulty accessing needed services: Other/multiracial, Black/AA, 18-24, OOC, Transgender,	RW Part C EHE Funding: RWGA received $1,794,295 in HRSA funding for Year 1 implementation of EHE activities. Houston Health Department (HHD) has received funding under PS19-1906 for Accelerating State and Local HIV Planning to End the HIV Epidemic. Several Houston area FQHCs received a combined total of $1,067,555 from HRSA's Ending the HIV Epidemic-Primary Care HIV Prevention (PCHP) Grant. Covered under QHP?	Justify the use of funds: This service category: - Is a HRSA-defined Core Medical Service - Is ranked as the #2 service need by PLWH - Results in desirable health outcomes for clients who access the service - Prevents unmet need by addressing co-morbidities related to substance abuse and mental health - Facilitates national, state, and local goals related to continuous HIV care and reducing unmet need - Addresses a system-level objective (#8) from the Comprehensive Plan and	Can we make this service more efficient? No Can we bundle this service? No Has a recent capacity issue been identified? No Does this service assist special populations to access primary care?	**05/03/22 – the QI committee approved the HTBMN wg recommendations** **Wg Motion 1:** Recommend that the Priority & Allocations Committee increase funding for all Case Management services specifically to increase salaries to reduce staff turnover. **Wg Motion 2:** Update the justification chart, keep the service definition and

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, protect, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency **Can we make this service more efficient? For:** a) Clients b) Providers **Can we bundle this service?** **Has a recent capacity issue been identified?** **Does this service assist special populations to access primary care?** *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. *Motion approved by QI 03/15/22*
			RR, Homeless	___Yes ✔ No	addresses certain Special Populations named in the Plan Is this a duplicative service or activity? - This service is funded locally by other RW Parts for specific Special Populations and for clients served by specific funded agencies/programs only		the financial eligibility the same: none.

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Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, protect, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. *Motion approved by QI 03/15/22*
Case Management – Non-Medical - Part A (Service Linkage at testing sites) ***Workgroup #1*** ***Motion 1:** (Kelly/Pradia) Votes: Y=10; N=0; Abstentions= Aloysius, Castillo, de la Cruz, Leisher, Kelly, Miertschin, Robinson* ***Motion 2:** (Pradia/Kelly) Votes: Y=10; N=0; Abstentions= Aloysius, Castillo, de la Cruz, Leisher, Kelly, Miertschin,*	___Yes __✔__ No	☒ EIIHA ☒ Unmet Need ☒ Continuum of Care EIIHA: The EMA's EIIHA Strategy identifies Service Linkage as a local strategy for attaining Goals #3-4 of the national EIIHA initiative. Additionally, linking the newly diagnosed into HIV care via strategies such as Service Linkage fulfills the national, state, and local goal of linkage to HIV medical care ≤ 1 month of diagnosis. In 2018, 40% of the newly diagnosed in the EMA were *not* linked within this timeframe. Unmet Need: Service Linkage	Epi (2019): Current # of living HIV cases in EMA: 30,149 Need (2020): Rank w/in funded services:*#3* Service Utilization (2021): # clients served: 127 *(6% decrease v. 2020)* Outcomes (FY2020): Following Service Linkage, 49% of clients were in continuous HIV care, and 50% accessed HIV primary care for the first time Pops. with difficulty accessing needed services: Other/multiracial, Black/AA, 18-24, OOC, Transgender,	RW Part C and D, HOPWA, and a grant from a private foundation EHE Funding: RWGA received $1,794,295 in HRSA funding for Year 1 implementation of EHE activities. Houston Health Department (HHD) has received funding under PS19-1906 for Accelerating State and Local HIV Planning to End the HIV Epidemic. Several Houston area FQHCs received a combined total of $1,067,555 from HRSA's Ending the HIV Epidemic-Primary Care HIV Prevention (PCHP) Grant.	Justify the use of funds: This service category: - Is a HRSA-defined Support Service - Results in desirable health outcomes for clients who access the service - Is a strategy for attaining national EIIHA goals locally - Prevents the newly diagnosed from having unmet need - Facilitates national, state, and local goals related to linkage to care Is this a duplicative service or activity? - This service is funded locally by other RW Parts	Can we make this service more efficient? No Can we bundle this service? No Has a recent capacity issue been identified? No Does this service assist special populations to access primary care?	**05/03/22 – the QI committee approved the HTBMN wg recommendations** **Wg Motion 1:** Recommend that the Priority & Allocations Committee increase funding for all Case Management services specifically to increase salaries to reduce staff turnover. **Wg Motion 2:** Update the justification chart, keep the service definition and

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? *EIIHA: Early Identification of Individuals with HIV/AIDS seeks to identify the status-unaware and link them into care *Unmet Need: Individuals diagnosed with HIV but with no evidence of care for 12 months *Continuum of Care: The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. *Ending the HIV Epidemic: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, protect, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. *Motion approved by QI 03/15/22*
Robinson		at HIV testing sites is specifically designed to prevent newly diagnosed PLWH from falling out-of-care by facilitating entry into HIV primary care immediately upon diagnosis. In 2015, 12% of the newly diagnosed PLWH were not linked to care by the end of the year. Continuum of Care: Service Linkage supports linkage to care, maintenance/retention in care and viral suppression for PLWH.	RR, Homeless	Covered under QHP? ___Yes ✔ No	for specific Special Populations and for clients served by specific funded agencies/programs only		the financial eligibility the same: none.

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Vision – Part A ***Workgroup #1*** ***Motion:** (Kelly/Pradia)* *Votes: Y=10; N=0;* *Abstentions= Aloysius*	✔ Yes ___No	☐ EIIHA ☐ Unmet Need ☒ Continuum of Care Continuum of Care: Vision services support maintenance/ retention in HIV care by increasing access to care and treatment for HIV-related and general ocular diagnoses. Untreated ocular diagnoses may act as logistical or financial barriers to HIV care.	Epi (2019): Current # of living HIV cases in EMA: 30,149 Need (2020): Rank w/in funded services:#5 Service Utilization (2021): # clients served: 3,059 *(1.6% decrease v. 2020)* Outcomes (FY2020): 750 diagnoses were reported for HIV-related ocular disorders, 97% of which were managed appropriately Pops. with difficulty accessing needed services: Females (sex at birth), other/ multiracial, 18-24, Homeless, OOC.	No known alternative funding sources exist for this service Covered under QHP?* ___Yes ✔ No *QHPs cover pediatric vision	No known alternative funding sources exist for this service	Can we make this service more efficient? No Can we bundle this service? Currently bundled with Primary Care Has a recent capacity issue been identified? No Does this service assist special populations to access primary care?	**05/03/22 – the QI committee approved the HTBMN wg recommendation** **Wg Motion:** Update the justification chart, keep the service definition and the financial eligibility the same: 400%.

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Service Category	Justification for Discontinuing the Service
Part 2: Services *allowed* by HRSA but not offered by Part A, Part B or State Services funding in the Houston EMA/HSDA as of 03-01-22 *(In order for any of the services listed below to be considered for funding, a New Idea Form must be submitted to the Office of Support for the Ryan White Planning Council no later than **5 p.m. on May 2, 2022**. This form is available by calling the Office of Support: 832 927-7926)*	
Buddy Companion/Volunteerism	Low use, need and gap according to the 2002 Needs Assessment (NA).
Childcare Services (In Home Reimbursement; at Primary Care sites)	Primary care sites have alternative funding to provide this service so clients will continue to receive the service through alternative sources.
Food Pantry (Urban)	Service available from alternative sources.
HE/RR	In order to eliminate duplication, eliminate this service but strengthen the patient education component of primary care.
Home and Community-based Health Services (In-home services)	Category unfunded due to difficulty securing vendor.
Housing Assistance (Emergency rental assistance) **Housing Related Services** (Housing Coordination)	According to the HOPWA representative, they provide significant funding for emergency rent and utility assistance. (See City Council approved allocations.) But, HOPWA does not give emergency shelter vouchers because they feel there are shelters for this purpose and because it is more prudent to use limited resources to provide long-term housing.
Minority Capacity Building Program	The Capacity Building program targeted to minority substance abuse providers was a one-year program in FY2004.
Outreach Services	Significant alternative funding.
Psychosocial Support Services (Counseling/Peer)	Duplicates patient education program in primary care and case management. The boundary between peer and client gets confusing and difficult to supervise. Not cost effective, costs almost as much per client as medical services.
Rehabilitation	Service available from alternative sources.

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