Harris County

Public Health

Building a Healthy Community

How Best to Meet the Needs Training

EHE Overview

HCPHTX.ORG

Ending
the
HIV
Epidemic
A PLAN FOR AMERICA

GOAL:

75% reduction in new HIV infections by 2025

and at least

90% reduction by 2030.

www.hiv.gov

EHE Pillar Partners

Diagnose

City of Houston Health Department

- Ave 360 Health & Wellness
- St. Hope Foundation
- Legacy Community Health
- Harris Health System
- Harris County Clinics
- AIDS Health Care Foundation

Prevent

City of Houston Health Department

- Ave 360 Health & Wellness
- St. Hope Foundation
- Legacy Community Health
- Harris Health System
- Harris County Clinics
- AIDS Health Care Foundation

Treat

Harris County Public Health

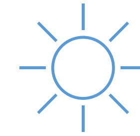
- Ave 360 Health & Wellness
- St. Hope Foundation
- Legacy Community Health
- Harris Health System
- Harris County Clinics
- AIDS Foundation Care Foundation

Respond

Harris County Public Health

City of Houston Health Department

Texas Department of Health and Human Services

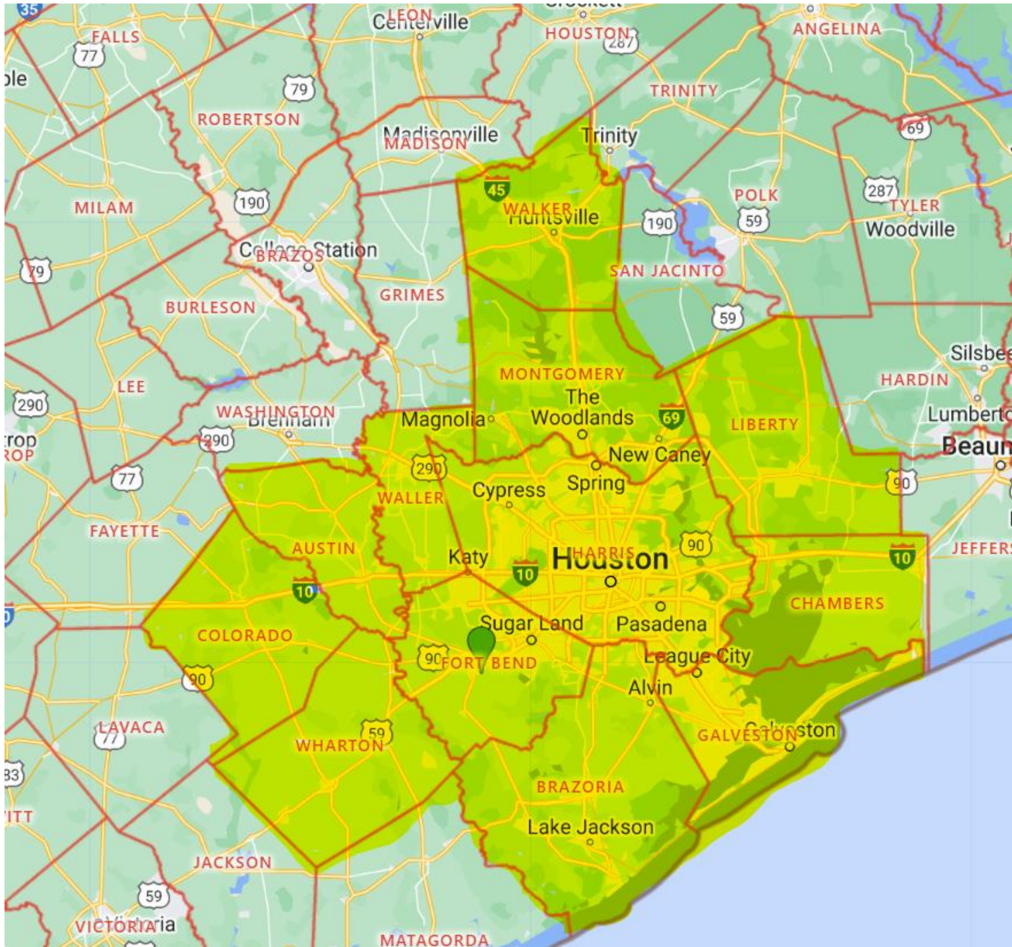


Quality of Life

Ryan White Planning Council

AIDS Education and Training Center – Baylor College of Medicine

EHE FY 24 Service Area



Houston HSDA:

- Austin, Chambers, Colorado, Fort Bend, Harris, Liberty, Montgomery, Walker, Waller, Wharton

Galveston HSDA:

- Galveston, Brazoria, and Matagorda

EHE Activities 2024-2025

RAPID START

MEDICAL TRANSPORTATION

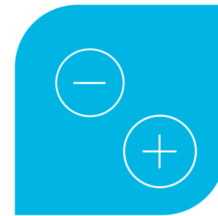
OUTREACH CAMPAIGN

DATA SYSTEM IMPROVEMENTS

HOUSING IS HEALTH CARE

QUALITY OF LIFE

THE MASTER PLAN



STATUS NEUTRAL APPROACH

EHE Subrecipients

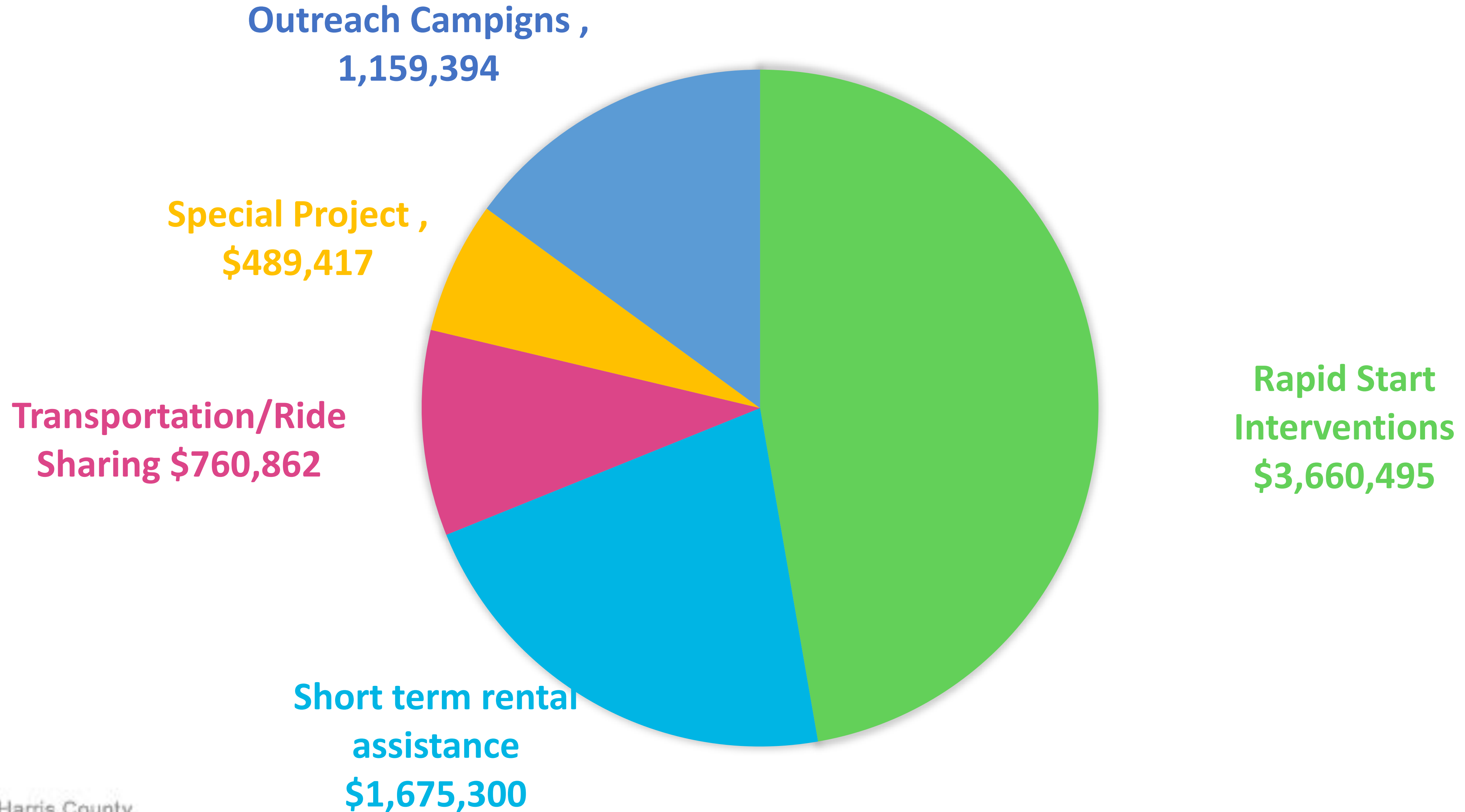
Types of EHE Clients, Priority Populations & Eligibility Requirements

- **Clients:**
  - Newly Diagnosed
  - Re-engaged in Care

- **Priority Populations**
  - African American MSM
  - African American Women
  - Hispanic MSM
  - Transwomen of Color

- **EHE Grant Eligibility Requirement**
  - Proof HIV Diagnosis

IN 2024, EHE-FUNDED SERVICES INCLUDED:



Current EHE-Funded Services

- **Rapid Start**
  - Primary Medical Care
  - ART Prescriptions
  - Non-Medical Case Management Services

- **Rental Assistance**
  - Up to six-months of assistance
  - Assistance based on 130% of current Fair Market Value
  - Access to clinical and non-medical case management services, including:
    - Linkage, retention, and re-engagement in care; financial education; workforce development; recovery support services
- **Rideshare**
  - For HIV-related medical appointments only

Proposed New EHE-Funded Services for FY24

- **Enhanced Service Delivery Support**
  - Mental Health
    - Assessments
    - Treatment Planning & Provision
    - Psychotherapy
    - Emergency & Crisis Intervention
  - Psychiatry
    - Diagnostic Assessments
    - Psychopharmacotherapy
    - Rehabilitation services
    - Health Insurance Assistance
- **Outreach Services**
  - HIV Education, Information & Referrals
  - Medical Appointment Setting Assistance
  - Enrollment in EHE-funded Services
  - Assistance based on 130% of current Fair Market Value
  - Access to clinical and non-medical case management services, including:
    - Linkage, retention, and re-engagement in care; financial education; workforce development; recovery support services
  - Target Populations: African American MSM, Hispanic/Latinx, African American Transgender Women

Proposed New Providers for FY24

- 2-Rapid Start Clinics
- 2-Rental Assistance Providers
- 3-Outreach Services Providers

EHE Clients Overview

Time

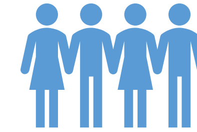
EHE Clients have access to EHE programs up to 30 days, with the goal of enrolling them into long-term HIV care, generally via RW Part A, soon thereafter.

EHE Clients can access Rapid Start services every six months or twice within a grant year

Recommendations

Improve transition to Part A through:

- Access to Case Management
- Appointment availability for newly DX and return to care clients



Retention

Model eligibility Requirements

Adopt Rapid start as THE standard of care

Evaluate Transportation options

Funding and access to mental health services

How is the RW/A Grant Intertwined with the EHE Grant?

- View all Ryan White-funded Services as one (1) BIG House
- HRSA owns the house
- RWGA serves as the landlord
- 9 RW/A-funded and 6 EHE-funded Subrecipients rent various rooms in the house depending on the RW-funded services they provide
    - Each room represents 11-funded RW Part A & 6-funded EHE Service Categories
- Clients are guests of the house visiting its various rooms depending on their care needs

How is the RW/A Grant Intertwined with the EHE Grant?

- The EHE grant serves as the entryway or foyer of the RW House for the newly diagnosed or clients who have re-engaged in care.
  - In the foyer, clients are provided with a **1. doctor's visit**, **2. 30-day supply of medication**, and **3. non-medical case management services** within 72 hours of entering the RW House. If needed, clients can also access **4. rental assistance** & **5. rideshare services.**

How is the RW/A Grant Intertwined with the EHE Grant?

- Once the EHE client has received their EHE services in the foyer, they are then enrolled in Ryan White Part A Services.
  - Once enrolled, the client has access to **all 11 rooms** of the RW House, including the living room (primary care), kitchen (medical case management), primary bedroom (LPAP), and spare bedrooms (medical nutrition therapy, substance abuse treatment, etc.)

- EHE clients use the front door to enter the house
- RW/A clients use the back door to enter the house

RWGA Staff Household Roles

- RWGA staff has a role in maintaining the Ryan White Home
- **EHE staff** manages the foyer and greets new and returning visitors who either have never been to the home or who haven't been in awhile
- **Grants Management Project Coordinator** drafts and manages the subrecipient leases (contracts), ensures the subrecipients adhere to their lease agreements, and prepares lease renewals and other documents related to renting bedrooms in the home.
- **Accounting Coordinator** processes the rent payments and ensures they are correct and on time

RWGA Staff Household Roles

- **Quality Assurance staff** works on projects to *fix* the house, keeping it maintained, and works with the subrecipients to maintain their rooms in accordance with their lease agreements
- **Quality Management staff** works with the subrecipients on projects to *improve* their rooms and the overall house
- **CPCDMS/IT staff** manages, maintains, and fixes the home's internal operating system (e.g., A/C units, gas stoves)
- **Data Analyst/Epidemiologist** collects neighborhood-related data and information, such as pricing comps, tax rates, school censuses, etc., to ensure the landlord has the most up-to-date information to manage the house, its tenants (subrecipients), and visitors (clients) effectively
- **Program Manager** manages the landlord's office
- **Program Coordinator** coordinates the activities of the landlord's office, e.g., ordering supplies, paying the utilities, and property tax bills, etc.

Questions

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