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, prevent, and respond.	**Documentation of Need** (Sources of Data include: America's HIV Epidemic Analysis (AHEAD.HIV.gov), Ryan White HIV/AIDS Program Compass Dashboard (ryanwhite.hrsa.gov/data/dashboard), 2020 Needs Assessment, 2022-2026 Integrated Plan, 2021 Ending the HIV Epidemic Plan, 2023 Outcome Measures, 2020 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?** **Is this service culturally appropriate for clients living with HIV?**	**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) Aging adults (50+) f) 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.
Part 1: Services offered by Ryan White Part A, Part B, and State Services in the Houston EMA/HSDA as of 03-19-24							
Health Insurance Premium and Co-Pay Assistance **- Part A, Part B, and State Services**	✔ Yes __No	☐ EIIHA ☒ EHE ☒ Unmet Need Continuum of Care (CoC) ☒ CoC RW eligible consumers ☒ CoC all PLWH in EMA/HSDA		Covered under QHP?* ___Yes ✔ No			

‡ 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, prevent, and respond.	Documentation of Need (Sources of Data include: America's HIV Epidemic Analysis (AHEAD.HIV.gov), Ryan White HIV/AIDS Program Compass Dashboard (ryanwhite.hrsa.gov/data/dashboard), 2020 Needs Assessment, 2022-2026 Integrated Plan, 2021 Ending the HIV Epidemic Plan, 2023 Outcome Measures, 2020 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? Is this service culturally appropriate for clients living with HIV?	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) Aging adults (50+) f) 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.
Medical Nutritional Supplements and Therapy - Part A	✔ Yes ___No	☐ EIIHA ☒ EHE ☒ Unmet Need Continuum of Care (CoC) ☒ CoC RW eligible consumers ☐ CoC all PLWH in EMA/HSDA		Covered under QHP?* ___Yes ✔ No			
Mental Health Services‡ (Professional Counseling)	✔ Yes ___No	☐ EIIHA ☒ EHE ☒ Unmet Need Continuum of Care (CoC) ☒ CoC RW eligible consumers ☐ CoC all PLWH in EMA/HSDA		Covered under QHP?* ✔ Yes ___No			

‡ 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, prevent, and respond.	Documentation of Need (Sources of Data include: America's HIV Epidemic Analysis (AHEAD.HIV.gov), Ryan White HIV/AIDS Program Compass Dashboard (ryanwhite.hrsa.gov/data/dashboard), 2020 Needs Assessment, 2022-2026 Integrated Plan, 2021 Ending the HIV Epidemic Plan, 2023 Outcome Measures, 2020 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? Is this service culturally appropriate for clients living with HIV?	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) Aging adults (50+) f) 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.
Oral Health Untargeted – Part B Rural (North) – Part A	✔ Yes ___No	☐ EIIHA ☐ EHE ☒ Unmet Need Continuum of Care (CoC) ☒ CoC RW eligible consumers ☐ CoC all PLWH in EMA/HSDA		Covered under QHP?* ___Yes ✔ No	-		
Substance Abuse Treatment – Part A		☐ EIIHA ☒ EHE ☒ Unmet Need Continuum of Care (CoC) ☒ CoC RW eligible consumers ☒ CoC all PLWH in EMA/HSDA		Covered under QHP?* ✔ Yes ___No			

‡ 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, prevent, and respond.	**Documentation of Need** (Sources of Data include: America's HIV Epidemic Analysis (AHEAD.HIV.gov), Ryan White HIV/AIDS Program Compass Dashboard (ryanwhite.hrsa.gov/data/dashboard), 2020 Needs Assessment, 2022-2026 Integrated Plan, 2021 Ending the HIV Epidemic Plan, 2023 Outcome Measures, 2020 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?** **Is this service culturally appropriate for clients living with HIV?**	**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) Aging adults (50+) f) 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.
Case Management – Non-Medical - State Services‡ (Targeting Substance Use Disorders)		☒ EIIHA ☒ EHE ☒ Unmet Need Continuum of Care (CoC) ☒ CoC RW eligible consumers ☒ CoC all PLWH in EMA/HSDA		Covered under QHP?* ___Yes ✔ No			

‡ Service Category for Part B/State Services only.

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 03-01-24 ***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 5:00 p.m. on April 29, 2024. This form is available by calling the Office of Support: 832 927-7926***	
Ambulatory/Outpatient Primary Medical Care – Pediatric (incl. Medical Case Management and Service Linkage)	Service available from alternative sources.
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/Home Delivered Meals (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.
Home and Community-based Health Services (facility-based)	Category unfunded due to many years of underutilization.
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.
Legal Assistance	Vendor returned funds; service is still provided through alternative funding sources.
Minority Capacity Building Program	The Capacity Building program targeted to minority substance abuse providers was a one-year program in FY2004.
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.

‡ Service Category for Part B/State Services only.