FY 2024 How to Best Meet the Need Justification for Each Service Category – Workgroup #3 COUNCIL APPROVED 06/08/23

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: 2020 Needs Assessment, 2022-2026 Integrated Plan, 2021 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) 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. (*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 03-14-23							
Emergency Financial Assistance – Other - Part A ***Workgroup #3*** ***Motion:** (Boyle/Galley)* *Votes: Y=11; N=0;* *Abstention= Leisher, Stacy*	___Yes ✔ No	☐ EIIHA ☐ Unmet Need ☐ Continuum of Care This service started 03/01/21.	Epi (2019): Current # of living HIV cases in EMA: 30,149 Need (2020): N/A Service Utilization (2022): # clients served: 116 *(19.5% increase v. 2021)*	This service was initially provided through a grant during COVID-19 epidemic. Covered under QHP? ___Yes ✔ No		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? Yes	**QI Motion:** Update the justification chart, keep the financial eligibility the same at 400%, and keep the service definition the same with the understanding that the Planning Council may add additional services based upon additional information, which is to be provided soon.

‡ 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: 2020 Needs Assessment, 2022-2026 Integrated Plan, 2021 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) 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. (*Motion approved by QI 03/15/22)*
Hospice ‡ ***Workgroup #3*** ***Motion:** (Boyle/Galley)* *Votes: Y=12; N=0;* *Abstention=Stacy*	✔ Yes ___No	☐ EIIHA ☒ Unmet Need ☒ Continuum of Care Unmet Need: Facilitating entry into/return of the out-of-care into primary care is the intent of reducing unmet need. Hospice contributes to this goal by providing facility-based skilled nursing and palliative care for those with a terminal diagnosis. This, in turn, may prevent PLWH from becoming out-of-care. In 2015, 19% of people with a Stage 3 HIV diagnosis were out-of-care in the EMA. Hospice ensures clients with co-morbidities remain in HIV care. As a result, this service also addresses local priorities related to mental health and	Epi (2019): Current # of living HIV cases in EMA: 30,149 Need (2020):N/a Service Utilization (2022): # clients served: 29 *(3% decrease v. 2021)* Chart Review (2019): 92% of charts had records of palliative therapy as ordered and 100% had medication administration records on file. Records indicated that bereavement counseling was offered to client's family in 10% of applicable cases. Pops. with difficulty accessing needed services: N/a	Medicaid, Medicare Covered under QHP? ✔ Yes ___No	Justify the use of funds: This service category: - Is a HRSA-defined Core Medical Service - Prevents unmet need among PWA and those with co-occurring conditions - Facilitates national, state, and local goals related to retention in care and reducing unmet need - Addresses a system-level objective (#8) from the Comprehensive Plan and addresses certain Special Populations named in the Plan Is this a duplicative service or activity? - This service is funded	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? N/A	**05/09/23 – the QI committee approved the HTBMN wg recommendation** **Wg Motion:** Update the justification chart, keep the service definition and the financial eligibility the same: 300%.

‡ 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: 2020 Needs Assessment, 2022-2026 Integrated Plan, 2021 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) 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. (*Motion approved by QI 03/15/22)*
		substance abuse co-morbidities. Continuum of Care: Hospice services support re-linkage and maintenance/retention in care for PLWH by providing facility-based skilled nursing and palliative care for those with a terminal diagnosis, preventing PLWH from falling out of care.			locally by other public sources for those meeting income, disability, and/or age-related eligibility criteria		
Linguistic Services‡ ***Workgroup #3*** ***Motion:** (Boyle/Galley)* *Votes: Y=12; N=0;* *Abstention=Leisher, Vargas*	___Yes ✔ No	☐ EIIHA ☒ Unmet Need ☒ Continuum of Care Unmet Need: Facilitating entry into/return of the out-of-care into primary care is the intent of reducing unmet need. By eliminating language barriers in RW-funded HIV care, this	Epi (2019): Current # of living HIV cases in EMA: 30,149 Need (2020):N/a Service Utilization (2022): # clients served: 57 *(14% increase v. 2021)* *48% of Linguistics clients were African American /*	RW providers must have the capacity to serve monolingual Spanish-speakers; Medicaid may provide language translation for *non-Spanish* monolingual clients Covered under QHP? ___Yes ✔ No	Justify the use of funds: This service category: - Is a HRSA-defined Support Service - Has limited or no alternative funding source - Removes potential barriers to entry/retention in HIV care for monolingual PLWH, thereby	Can we make this service more efficient? No Can we bundle this service? No Has a recent capacity issue been identified? There is no waiting list at this	**QI Motion:** Update the justification chart, keep the service definition the same, and increase the financial eligibility to 500%. Also, explore ways to use virtual technology as much as possible to make this service more

‡ 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: 2020 Needs Assessment, 2022-2026 Integrated Plan, 2021 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) 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. (*Motion approved by QI 03/15/22)*
		service facilitates entry into care and helps prevent lapses in care for monolingual PLWH. <u>Continuum of Care</u>: Linguistic Services support linkage to care, maintenance/retention in care, and viral suppression by eliminating language barriers and facilitating effective communication for non-Spanish monolingual PLWH.	*African origin and 36% were Asian American / Asian origin* <u>Pops. with difficulty accessing needed services</u>: N/a		contributing to EIIHA goals and preventing unmet need - Facilitates national, state, and local goals related to retention in care and reducing unmet need - Linguistic and cultural competence is a Guiding Principle of the Integrated Plan Is this a duplicative service or activity? - No, there is no known alternative funding for this service as designed	time; however, the need for this service has the potential to exceed capacity due to new cohorts of languages spoken in the EMA/HSDA Does this service assist special populations to access primary care?	accessible and easier for consumers to use. And, ask the Quality Improvement Committee to explore language justice principles in order to make all Ryan White funded services inclusive of people from all cultures.

‡ 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: 2020 Needs Assessment, 2022-2026 Integrated Plan, 2021 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) 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. (*Motion approved by QI 03/15/22)*
Referral for Health Care – Incarcerated‡ ***Workgroup #3*** ***Motion:** (Boyle/Escamilla) Votes: Y=11; N=0; Abstention=Rowe, Vargas.*	___Yes ✔ No In 2022, this service transitioned from Early Intervention Services to Referral for Health Care and Support Services to better align with the scope of services provided. No data is available yet.	☒ EIIHA ☒ Unmet Need ☒ Continuum of Care EIIHA: Local jail policy mandates HIV testing within 14 days of incarceration, thereby identifying status-unaware members of this population. From 2016-2018, an estimated 693 PLWH were released from TDCJ into Harris County. During incarceration, 100% are linked to HIV care. This service ensures that the newly diagnosed identified in jail maintain their HIV care post-release by bridging re-entering PLWH into community-based primary care. Unmet Need: PLWH re-entering	Epi (2019): Current # of living HIV cases in EMA: 30,149	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? ___Yes ✔ No	Justify the use of funds: This service category: - Is a HRSA-defined Support Service - Links those newly diagnosed in a local EMA jail to community-based HIV primary care upon release, thereby maintaining linkage to care for and preventing unmet need in this Special Population - 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?	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?	**05/09/23 – the QI committee approved the HTBMN wg recommendation** **Wg Motion:** Update the justification chart, keep the service definition and the financial eligibility the same: 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, prevent, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2022-2026 Integrated Plan, 2021 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) 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. (*Motion approved by QI 03/15/22)*
		the community are at risk of lapsing their HIV care upon release from incarceration. This service helps to prevent unmet need among this population by bridging re-entering PLWH into community-based primary care post-release. Continuum of Care: This service supports linkage to care, maintenance/retention in care and viral suppression for PLWH.			No, there is no known alternative funding for this service as designed		
Transportation – Pt A (Van-based, bus passes & gas vouchers) ***Workgroup #3*** ***Motion:** (Boyle/Galley)* *Votes: Y=11; N=0;*	___Yes ✔ No	☐ EIIHA ☒ Unmet Need ☒ Continuum of Care Unmet Need: Lack of transportation is the *fourth* most commonly-cited barrier among PLWH to accessing HIV core medical services. Transportation	Epi (2019): Current # of living HIV cases in EMA: 30,149 Need (2020): Rank w/in funded services: *#9* Service Utilization (2022): # clients served:	Medicaid, RW Part D (small amount of funds for parking and other transportation needs), and by other public sources for (1) specific Special Populations (e.g., WICY), and (2) those meeting income, disability, and/or age-related	Justify the use of funds: This service category: - Is a HRSA-defined Support Service - Is ranked as the #2 need among Support Services by PLWH - Results in clients accessing	Can we make this service more efficient? No Can we bundle this service? No Has a recent capacity issue	**05/09/23 – the QI committee approved the HTBMN wg recommendation** **Wg Motion:** Update the justification chart; add ride

‡ 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: 2020 Needs Assessment, 2022-2026 Integrated Plan, 2021 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) 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. (*Motion approved by QI 03/15/22)*
Abstention= Vargas		services eliminate this barrier to care, thereby supporting PLWH in continuous HIV care. Continuum of Care: Transportation supports linkage, maintenance/retention in care, and viral suppression by helping PLWH attend HIV primary care visits, and other vital services.	*Van-based: 946 (15% decrease v. 2021)* *Bus pass: 1,334 (5.9% increase v. 2021)* Outcomes (FY2020): 67% of clients accessed primary care at least once after using van transportation; and 37% of clients accessed primary care after using bus pass services. Pops. with difficulty accessing needed services: Females (sex at birth), Other / multiracial, White, Homeless, OOC, RR	eligibility criteria. EHE funding provides ridesharing with no financial eligibility. Covered under QHP*? ___Yes ✔ No	HIV primary care - Removes potential barriers to entry/retention in HIV care, thereby contributing to EIIHA goals and preventing unmet need - Facilitates national, state, and local goals related to continuous HIV care and reducing unmet need Is this a duplicative service or activity? - This service is funded locally by other public sources for (1) specific Special Populations (e.g., WICY), and (2) those meeting income, disability, and/or age-related eligibility criteria.	been identified? No Does this service assist special populations to access primary care?	sharing to the service definition and the financial eligibility the same: 400%.

‡ 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 03-01-23 ***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 May 1, 2023. 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 (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.