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Houston Area HIV Services Ryan White Planning Council

Quality Improvement Committee

11:00 am, May 11, 2021

Location: Online or via phone – Please do not come in person
Join Zoom Meeting by clicking on this link:
https://us02web.zoom.us/j/84828793096?pwd=NFZmUEtOTGJ2cGRUMFdWSzhLbTZGZz09
Meeting ID: 848 2879 3096 Passcode: 231231
Or, call in by dialing: 346 248 7799

Agenda

* Indicates that the report will be provided at the meeting

I. Call to Order — Kevin Aloysius and Steven Vargas, Co-Chairs
   A. Moment of Appreciation and Reflection
   B. Adoption of Agenda
   C. Approval of Minutes
      1. 03-16-21 Joint Committee Meeting
      2. 03-16-21 Quality Improvement Committee Meeting

II. Public Comment

(NOTE: If you wish to speak during the Public Comment portion of the meeting, please sign up on the clipboard at the front of the room. No one is required to give his or her name or HIV status. All meetings are audio taped by the Office of Support for use in creating the meeting minutes. The audiotape and the minutes are public record. If you state your name or HIV status it will be on public record. If you would like your health status known, but do not wish to state your name, you can simply say: "I am a person living with HIV", before stating your opinion. If you represent an organization, please state that you are representing an agency and give the name of the organization. If you work for an organization, but are representing your self, please state that you are attending as an individual and not as an agency representative. Individuals can also submit written comments to a member of the staff who would be happy to read the comments on behalf of the individual at this point in the meeting. All information from the public must be provided in this portion of the meeting.)

III. Reports from Ryan White Administrative Agents
   A. Ryan White Part A — Carin Martin
      - FY20 RW Part A and MAI Procurement Report, 03/25/21
      - Client Satisfaction Report — Rebecca Edwards
   B. Ryan White Part B and State Services* — Patrick Martin

IV. The FY 2022 How to Best Meet the Need (HTBMN) Process — Tori Williams
   A. FY 2022 HTBMN Workgroup Recommendations
   B. FY 2022 HIV Targeting Chart

V. Old Business
   A. 2021 Committee Goals

VI. New Business
   A. Quarterly Committee Report

VII. Announcements

V. Adjourn

Optional: New members meet with committee mentor — Tana Pradia

Houston Area HIV Services Ryan White Planning Council
2223 West Loop South, Houston, Texas 77027

Joint Meeting of the Affected Community,
Quality Improvement, Priority and Allocations and other Committees
1:00 p.m., Tuesday, March 16, 2021
Meeting Location: Zoom teleconference

Minutes

Purpose of the Joint Meeting: To determine the criteria used to select the FY 2022 Service Categories.

QI MEMBERS PRESENT	OTHER MEMBERS PRESENT	OTHERS PRESENT
Steven Vargas, Co-Chair (CHP)	Enrique Chavez (ACC)	Allen Murray, RWPC Chair
Kevin Aloysius, Co-Chair	Bobby Cruz (OP, PA)	Carin Martin, RWGA
Johanna Castillo	Kimberley Collins (PA)	Heather Keizman, RWGA
Josh Mica (PA)	Tony Crawford (ACC)	Patrick Martin, TRG
Oscar Perez	Johnny Deal (ACC, OP)	Tiffany Shepherd, TRG
Pete Rodriguez	Lisa Felix (CHP)	Tori Williams, Ofc of Support
Gloria Sierra	Ronnie Galley (ACC, OP)	Ricardo Mora, Ofc of Support
Crystal Starr (OP)	Diana Morgan (ACC)	Diane Beck, Ofc of Support
Cecilia Ligons	Matilda Padilla (OP)	
Karla Mills	Robert Sliepka (CHP, PA)	
Tana Pradia		
Deborah Somoye		

C=Affected Community Committee; CHP=Comprehensive HIV Planning; OP=Operations; PA=Priority and Allocations

Call to Order: Steven Vargas, Co-Chair, Quality Improvement Committee, called the meeting to order at 1:07 p.m. and asked for a moment of reflection.

Adoption of the Agenda: ***Motion #1****: it was moved and seconded (Sliepka, Ligons) to adopt the agenda.* **Motion carried unanimously**.

Public Comment: Vargas summarized the written comment he presented to the Planning Council on March 11 regarding planning with social and racial justice lenses.

HRSA Service Categories: Tori Williams, Office of Support, briefly summarized the attached documents: HRSA Part A and B Fundable Program Services List and Definitions for Eligible Services, FY 2021 Houston Part A, B and State Services-funded service categories and Ryan White Program legislation regarding Core Services. She explained that the list of funded service categories could change if a proposed idea is approved. A new service must be on the list of allowable services and within the parameters of what can be provided and the Council must justify why a service is funded and/or continues to be funded.

Justification Tool: The committee members reviewed the FY 2021 Justification Chart, which lists the criteria used to select Ryan White Part A and B, and State Service funded services. Sierra suggested

adding the question under service efficiency: 'Does this service support youth transitioning to adult care?'. The committee agreed and discussed adding additional special populations - recently released transitioning to free world care and pregnant women transitioning out of OB care. ***Motion #2****: it was moved and seconded (Ligons, Starr) to accept the FY 2022 Justification Chart criteria with the suggested changes.* **Motion carried unanimously.**

Announcements: None.

Adjournment: ***Motion****: it was moved and seconded (Crawford Starr) to adjourn the meeting at 1:15 pm.* **Motion carried.**

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Submitted by:

Approved by:

_____ _____

Tori Williams, Director Date

Committee Chair Date

Houston Area HIV Services Ryan White Planning Council

Quality Improvement Committee
2:00 p.m., Tuesday, March 16, 2021
Meeting Location: Zoom teleconference

Minutes

MEMBERS PRESENT	MEMBERS ABSENT	OTHERS PRESENT
Steven Vargas, Co-Chair	Ahmier Gibson	Allen Murray, RWPC Chair
Kevin Aloysius, Co-Chair	Nkechi Onyewuenyi, excused	Patrick Martin, TRG
Johanna Castillo	Oscar Perez	Tiffany Shepherd, TRG
Josh Mica	Andrew Wilson	Carin Martin, RWGA
Pete Rodriguez	Marcely Macias, excused	Heather Keizman, RWGA
Gloria Sierra		Rebecca Edwards, RWGA
Crystal Starr		Tori Williams, Ofc of Support
Cecilia Ligons		Ricardo Mora, Ofc of Support
Karla Mills		Diane Beck, Ofc of Support
Tana Pradia		
Deborah Somoye		

Call to Order: Steven Vargas, Co-Chair, called the meeting to order at 2:00 p.m. and asked for a moment of reflection.

Adoption of the Agenda: ***Motion #1****: it was moved and seconded (Starr, Pradia) to adopt the agenda.* **Motion carried**.

Approval of the Minutes: ***Motion #2****: it was moved and seconded (Starr, Somoye) to approve the November 17, 2020 meeting minutes.* **Motion carried**. Abstentions: Aloysius, Castillo, Ligons, Mica, Mills, Pradia, Sierra.

Nuts & Bolts, Petty Cash, Open Meetings Act Training: Williams reviewed the attached documents related to: Nuts and Bolts for New Members, End of Year Petty Cash Procedures, and the Open Meetings Act Training.

2021 Committee Meeting Date and Time: Williams reviewed the attached calendar.

FY22 Service Category Criteria and Justification Chart: See attached. ***Motion #3****: it was moved and seconded (Pradia, Starr) to accept the FY 2022 Service Category Criteria and Justification Chart.* **Motion carried.** Abstention: Aloysius.

Public Comment: Vargas summarized the written comment he presented to the Planning Council on March 11 regarding planning with a social and racial justice lens.

Committee Orientation: Williams reviewed the attached documents: Committee Description, Conflict of Interest Statement and Voting Policy, and Timeline of Critical 2021 Council Activities.

2021 Committee Goals: ***Motion #4****: it was moved and seconded (Starr, Mica) to table the committee goals until the May committee meeting.* **Motion carried**.

Training in How to Read Reports from the Administrative Agents:
Reports from The Resource Group - P. Martin presented the attached training on How to Read TRG Reports. Shepherd reviewed changes to the FY 2021 Part B/State Services Standards of Care. See attached. ***Motion #5****: it was moved and seconded (Starr, Mica) to endorse the recommended changes to the attached 2021-2022 Ryan White Part B/State Services funded Standards of Care.* **Motion carried**.

Reports from Ryan White Grant Administration - C. Martin explained to Committee members how to review a Part A and MAI quarterly Service Utilization Report and a Procurement Report. See reports dated November 2020. Keizman presented the results of the Part A Clinical Quality Management Committee Quarterly Report. See attached dated 02/09/2021. Keizman presented a PowerPoint presentation *Summary of Ryan White Clinical Care Chart Review Findings* from the 2019 Chart Review Packet regarding Primary Care, Oral Health – Rural Target, and Vision Care. Edwards presented a PowerPoint presentation *Summary of Ryan White Clinical Care Chart Review Findings* from the 2019 Chart Review Packet regarding Case Management.

Elect a Vice Chair: Starr was nominated. She accepted the nomination and was elected via acclamation.

Announcements: The April committee meeting is cancelled so that members can participate in the HTBMN training and workgroups. Pradia, committee mentor, said if anyone needs to meet with her they can call or text her.

Adjourn: ***Motion #6:*** *it was moved and seconded (Starr, Mica) to adjourn the meeting at 3:21 p.m.* **Motion carried.**

Submitted by: Approved by:

_____ _____

Tori Williams, Director Date Committee Chair Date

Scribe: D. Beck

JA = Just arrived at meeting
LR = Left room temporarily
LM = Left the meeting
C = Chaired the meeting

2021 Quality Improvement Meeting Voting Record for Meeting Date 03/16/21

MEMBERS:	**Motion #1** Agenda				**Motion #2** Minutes				**Motion #3** FY22 Svc Cat Justification Chart				**Motion #4** Table 2021 Committee Goals				**Motion #5** 2021-22 Pt B/SS Standards of Care			
	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN
Steven Vargas, Co- Chair				**C**				**C**				**C**				**C**				**C**
Kevin Aloysius, Co-Chair		**X**						**X**				**X**		**X**				**X**		
Johanna Castillo		**X**						**X**		**X**				**X**				**X**		
Ahmier Gibson	**X**				**X**				**X**				**X**				**X**			
Josh Mica		**X**						**X**		**X**				**X**				**X**		
Nkechi Onyewuenyi	**X**				**X**				**X**				**X**				**X**			
Oscar Perez	**X**				**X**				**X**				**X**				**X**			
Pete Rodriguez		**X**				**X**				**X**				**X**				**X**		
Gloria Sierra		**X**						**X**		**X**				**X**				**X**		
Crystal Starr		**X**				**X**				**X**				**X**				**X**		
Andrew Wilson	**X**				**X**				**X**				**X**				**X**			
Cecilia Ligons		**X**						**X**		**X**				**X**				**X**		
Marcely Macias	**X**				**X**				**X**				**X**				**X**			
Karla Mills		**X**						**X**		**X**				**X**				**X**		
Tana Pradia		**X**						**X**		**X**				**X**				**X**		
Deborah Somoye		**X**				**X**				**X**				**X**				**X**		

Part A Reflects "Increase" Funding Scenario
MAI Reflects "Increase" Funding Scenario

FY 2020 Ryan White Part A and MAI Procurement Report

Priority	Service Category	Original Allocation *RWPC Approved Level Funding Scenario*	Award Reconcilation (b)	July Adjustments (carryover)	October Adjustments	Final Quarter Adjustments	Total Allocation	Percent of Grant Award	Amount Procured (a)	Procure-ment Balance	Original Date Procured	Expended YTD	Percent YTD	Percent Expected YTD
[redacted]	HCPH/RWGA Section	1,271,050		0		0	1,271,050	5.55%	1,271,050	0	N/A	$1,048,070	82%	92%
PC	RWPC Support*	524,908			0	0	524,908	2.29%	524,908	0	N/A	409,904	78%	92%
[redacted]	Quality Management	412,940		0	0	0	412,940	1.80%	412,940	0	N/A	$264,399	64%	92%
		22,065,113	84,963	595,485	317,595	0	23,063,156	98.86%	22,919,496	143,660	[redacted]	14,468,120	63%	92%
								Unallocated	Unobligated					[redacted]
	Part A Grant Award:	22,309,011	*Carry Over:*	595,485		*Total Part A:*	22,904,496	-158,660	143,660					

[redacted]	Original Allocation	Award Reconcilation (b)	July Adjusments (carryover)	October Adjustments	Final Quarter Adjustments	Total Allocation	Percent	Total Expended on Services	Percent	[redacted]
Core (must not be less than 75% of total service dollars)	17,105,302	84,963	478,485	362,595	0	18,031,345	86.46%	9,401,642	79.36%	
Non-Core (may not exceed 25% of total service dollars)	2,750,913	0	117,000	-45,000	0	2,822,913	13.54%	2,444,581	20.64%	
Total Service Dollars (does not include Admin and QM)	19,856,215	84,963	595,485	317,595	0	20,854,258	[redacted]	11,846,223	[redacted]	
Total Admin (must be ≤ 10% of total Part A + MAI)	1,795,958	0	0	0	0	1,795,958	7.06%			
Total QM (must be ≤ 5% of total Part A + MAI)	412,940	0	0	0	0	412,940	1.62%			

MAI Procurement Report

Priority	Service Category	Original Allocation *RWPC Approved Level Funding Scenario*	Award Reconcilation (b)	July Adjustments (carryover)	October Adjustments	Final Quarter Adjustments	Total Allocation	Percent of Grant Award	Amount Procured (a)	Procure-ment Balance	Date of Procure-ment	Expended YTD	Percent YTD	Percent Expected YTD
1	**Outpatient/Ambulatory Primary Care**	1,887,283	115,502	106,554	0	0	2,109,339	86.82%	2,109,339	0	[redacted]	1,151,700	55%	92%
1.b (MAI)	Primary Care - CBO Targeted to African American	954,912	58,441	53,277			1,066,630	43.90%	1,066,630	0	3/1/2020	$663,300	62%	92%
1.c (MAI)	Primary Care - CBO Targeted to Hispanic	932,371	57,061	53,277			1,042,709	42.92%	1,042,709	0	3/1/2020	$488,400	47%	92%
2	**Medical Case Management**	320,100	0	0	0	0	320,100	13.18%	320,100	0	[redacted]	$159,938	50%	92%
2.c (MAI)	MCM - Targeted to African American	160,050					160,050	6.59%	160,050	0	3/1/2020	$77,205	48%	92%
2.d (MAI)	MCM - Targeted to Hispanic	160,050					160,050	6.59%	160,050	0	3/1/2020	$82,732	52%	92%
[redacted]	**Total MAI Service Funds**	2,207,383	115,502	106,554	0	0	2,429,439	100.00%	2,429,439	0	[redacted]	1,311,638	54%	92%
[redacted]	Grant Administration	0	0	0	0	0	0	0.00%	0	0	[redacted]	0	0%	0%
[redacted]	Quality Management	0	0	0	0	0	0	0.00%	0	0	[redacted]	0	0%	0%
[redacted]	**Total MAI Non-service Funds**	0	0	0	0	0	0	0.00%	0	0	[redacted]	0	0%	0%
[redacted]	**Total MAI Funds**	2,207,383	115,502	106,554	0	0	2,429,439	100.00%	2,429,439	0	[redacted]	1,311,638	54%	92%
	MAI Grant Award	2,429,513	*Carry Over:*	106,554		*Total MAI:*	2,536,067							[redacted]
	Combined Part A and MAI Orginial Allocation Total	24,272,496												

Footnotes:

All	When reviewing bundled categories expenditures must be evaluated both by individual service category and by combined categories. One category may exceed 100% of available funding so long as other category offsets this overage.
(a)	Single local service definition is four (4) HRSA service categories (Pcare, LPAP, MCM, Non Med CM). Expenditures must be evaluated both by individual service category and by combined service categories.
(a.1)	Single local service definition is three (3) HRSA service categories (does not include LPAP). Expenditures must be evaluated both by individual service category and by combined service categories.
(b)	Adjustments to reflect actual award based on Increase or Decrease funding scenario.
(c)	Funded under Part B and/or SS
(d)	Not used at this time
(e)	10% rule reallocations

Part A Reflects "Increase" Funding Scenario
MAI Reflects "Increase" Funding Scenario

FY 2020 Ryan White Part A and MAI Procurement Report

Priority	Service Category	Original Allocation *RWPC Approved Level Funding Scenario*	Award Reconcilation (b)	July Adjustments (carryover)	October Adjustments	Final Quarter Adjustments	Total Allocation	Percent of Grant Award	Amount Procured (a)	Procure-ment Balance	Original Date Procured	Expended YTD	Percent YTD	Percent Expected YTD
1	**Outpatient/Ambulatory Primary Care**	**9,869,619**	**201,116**	**413,485**	**387,595**	**0**	**10,871,815**	**47.47%**	**10,723,155**	**148,660**	[redacted]	**6,151,454**	**57%**	**92%**
1.a	Primary Care - Public Clinic (a)	3,591,064					3,591,064	15.68%	3,591,064	0	3/1/2020	$1,088,970	30%	92%
1.b	Primary Care - CBO Targeted to AA (a) (e) (f)	952,498		121,162	142,532		1,216,192	5.31%	1,216,192	0	3/1/2020	$1,286,665	106%	92%
1.c	Primary Care - CBO Targeted to Hispanic (a) (e)	798,473		121,162	142,532		1,062,167	4.64%	1,062,167	0	3/1/2020	$1,065,798	100%	92%
1.d	Primary Care - CBO Targeted to White/MSM (a) (e)	1,035,846		121,162	142,531		1,299,539	5.67%	1,299,539	0	3/1/2020	$436,510	34%	92%
1.e	Primary Care - CBO Targeted to Rural (a) (e)	1,149,761		25,000	-76,000		1,098,761	4.80%	1,098,761	0	3/1/2020	$976,351	89%	92%
1.f	Primary Care - Women at Public Clinic (a)	1,874,540					1,874,540	8.18%	1,874,540	0	3/1/2020	$925,380	49%	92%
1.g	Primary Care - Pediatric (a.1)	15,437	1,116				16,553	0.07%	16,553	0	3/1/2020	$6,600	40%	92%
1.h	Vision	452,000		25,000	36,000		513,000	2.24%	513,000	0	3/1/2020	$365,180	71%	92%
1.x	Primary Care Health Outcome Pilot	0	200,000				200,000	0.87%	51,340	148,660	7/14/2020	$0	0%	92%
2	**Medical Case Management**	**2,185,802**	**-160,051**	**25,000**	**-5,000**	**0**	**2,045,751**	**8.93%**	**2,050,751**	**-5,000**	[redacted]	**1,512,185**	**74%**	**92%**
2.a	Clinical Case Management	488,656		25,000			513,656	2.24%	513,656	0	3/1/2020	$389,337	76%	92%
2.b	Med CM - Public Clinic (a)	427,722					427,722	1.87%	427,722	0	3/1/2020	$199,017	47%	92%
2.c	Med CM - Targeted to AA (a) (e)	266,070					266,070	1.16%	266,070	0	3/1/2020	$297,222	112%	92%
2.d	Med CM - Targeted to H/L (a) (e)	266,072					266,072	1.16%	266,072	0	3/1/2020	$145,074	55%	92%
2.e	Med CM - Targeted to W/MSM (a) (e)	52,247					52,247	0.23%	52,247	0	3/1/2020	$88,231	169%	92%
2.f	Med CM - Targeted to Rural (a)	273,760					273,760	1.20%	273,760	0	3/1/2020	$152,029	56%	92%
2.g	Med CM - Women at Public Clinic (a)	125,311					125,311	0.55%	125,311	0	3/1/2020	$147,672	118%	92%
2.h	Med CM - Targeted to Pedi (a.1)	160,051	-160,051				0	0.00%	0	0	3/1/2020	$0	#DIV/0!	92%
2.i	Med CM - Targeted to Veterans	80,025			-5,000		75,025	0.33%	80,025	-5,000	3/1/2020	$55,696	70%	92%
2.j	Med CM - Targeted to Youth	45,888					45,888	0.20%	45,888	0	3/1/2020	$37,908	83%	92%
3	**Local Pharmacy Assistance Program**	**3,157,166**	**0**	**0**	**0**	**0**	**3,157,166**	**13.78%**	**3,157,166**	**0**	3/1/2020	**$1,278,027**	**40%**	**92%**
3.a	Local Pharmacy Assistance Program-Public Clinic (a) (e)	610,360					610,360	2.66%	610,360	0	3/1/2020	$164,552	27%	92%
3.b	Local Pharmacy Assistance Program-Untargeted (a) (e)	2,546,806					2,546,806	11.12%	2,546,806	0	3/1/2020	$1,113,474	44%	92%
4	**Oral Health**	**166,404**	**0**	**0**	**-20,000**	**0**	**146,404**	**0.64%**	**146,404**	**0**	3/1/2020	**111,750**	**76%**	**92%**
4.a	Oral Health - Untargeted (c)	0					0	0.00%	0	0	N/A	$0	0%	**0%**
4.b	Oral Health - Targeted to Rural	166,404			-20,000		146,404	0.64%	146,404	0	3/1/2020	$111,750	76%	92%
5	**Health Insurance (c)**	**1,339,239**	**43,898**	**0**	**0**	**0**	**1,383,137**	**6.04%**	**1,383,137**	**0**	3/1/2020	**$897,673**	**65%**	**92%**
6	**Mental Health Services (c)**	**0**					**0**	**0.00%**	**0**	**0**	**NA**	**$0**	**0%**	**0%**
7	**Early Intervention Services (c)**	**0**					**0**	**0.00%**	**0**	**0**	**NA**	**$0**	**0%**	**0%**
8	**Home and Community-Based Services (c)**	**0**					**0**	**0.00%**	**0**	**0**	**NA**	**$0**	**0%**	**0%**
9	**Substance Abuse Services - Outpatient**	**45,677**	**0**	**0**	**0**	**0**	**45,677**	**0.20%**	**45,677**	**0**	3/1/2020	**$1,850**	**0%**	**92%**
10	**Medical Nutritional Therapy (supplements)**	**341,395**	**0**	**40,000**	**0**	**0**	**381,395**	**1.67%**	**381,395**	**0**	3/1/2020	**$348,227**	**91%**	**92%**
11	**Hospice Services**	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**	**NA**	**$0**	**0%**	**0%**
12	**Outreach Services**	**420,000**	**0**				**420,000**	**1.83%**	**420,000**	**0**	**3/1/2020**	**$289,007**	**69%**	**92%**
13	**Emergency Financial Assistance**	**525,000**	**0**	**0**	**0**	**0**	**525,000**	**2.29%**	**525,000**	**0**	**3/1/2020**	**$597,273**	**114%**	**92%**
14	**Referral for Health Care and Support Services (c)**	**0**	**0**	**0**			**0**	**0.00%**	**0**	**0**	NA	$0	**0%**	**0%**
15	**Non-Medical Case Management**	**1,381,002**	**0**	**117,000**	**-45,000**	**0**	**1,453,002**	**6.34%**	**1,453,002**	**0**	[redacted]	**1,168,452**	**80%**	**92%**
15.a	Service Linkage targeted to Youth	110,793					110,793	0.48%	110,793	0	3/1/2020	$71,824	65%	92%
15.b	Service Linkage targeted to Newly-Diagnosed/Not-in-Care	100,000			-45,000		55,000	0.24%	55,000	0	3/1/2020	$30,734	56%	92%
15.c	Service Linkage at Public Clinic (a)	427,000					427,000	1.86%	427,000	0	3/1/2020	$378,271	89%	92%
15.d	Service Linkage embedded in CBO Pcare (a) (e)	743,209		117,000			860,209	3.76%	860,209	0	3/1/2020	$687,624	80%	92%
16	**Medical Transportation**	**424,911**	**0**	**0**	**0**	**0**	**424,911**	**1.86%**	**424,911**	**0**	[redacted]	**389,848**	**92%**	**92%**
16.a	Medical Transportation services targeted to Urban	252,680					252,680	1.10%	252,680	0	3/1/2020	$222,014	88%	92%
16.b	Medical Transportation services targeted to Rural	97,185					97,185	0.42%	97,185	0	3/1/2020	$92,788	95%	92%
16.c	Transportation vouchering (bus passes & gas cards)	75,046					75,046	0.33%	75,046	0	3/1/2020	$75,046	100%	0%
17	**Linguistic Services (c)**	**0**					**0**	**0.00%**	**0**	**0**	**NA**	$0	**0%**	**0%**
[redacted]	**Total Service Dollars**	**19,856,215**	**84,963**	**595,485**	**317,595**	**0**	**20,854,258**	**89.22%**	**20,710,598**	**143,660**	[redacted]	**12,745,746**	**62%**	**92%**
[redacted]	**Grant Administration**	**1,795,958**	**0**	**0**	**0**	**0**	**1,795,958**	**7.84%**	**1,795,958**	**0**	**N/A**	**1,457,975**	**81%**	**92%**

As of: 3/25/2021

Harris County
Public Health
Building a Healthy Community

Ryan White Part A
Quality Management Program- Houston EMA
2020 Client Satisfaction Survey and Focus Group Report
Ryan White Grant Administration

Table of Contents

Overview

At the center of the Ryan White Service delivery system are "ongoing efforts to obtain input from clients in the design and delivery of services." [1] To keep the core focus of services on the client experience, the Ryan White Grant Administration Quality Management team collects client feedback to continuously improve services and understand how to best meet the needs of the clients. This process is a piece of an overall system of evaluation which strives to provide the highest quality services for Individuals living with HIV/AIDS.

Qualitative and Quantitative data was collected through 2 methods: an online client satisfaction survey and a focus group.

For the survey, data was collected using standardized client satisfaction surveys for each service provided through Part A of the Ryan White Program. The survey tools were developed to gather information on both service-specific and agency-focused topics. Each Part A service category utilizes a unique survey tool, with certain agency-focused questions being common to all surveys. This methodology allows for analysis of satisfaction with care using a standardized approach which ensures consistent comparisons across provider agencies and service areas. This also allows for examination of general trends in satisfaction each year. The results for all services surveyed in 2020 are attached.

Ryan White Part-A funds an array of services allocated by the Planning Council. The Services which were surveyed during the 2020 data collection period include outpatient/ambulatory care, case management, dental care, transportation, legal, local pharmacy assistance program, health insurance assistance, nutritional supplements, professional counseling, substance use disorder treatment, vision care, and rehabilitation. The service specific results presented in this report are limited to outpatient/ambulatory care and case management services as these are two of the most critical services provided to clients through Part A in the Houston EMA.

For the focus group, Ryan White Grant Administration enlisted the help of the Office of support to help recruit volunteers to participate on March 10, 2021. The goal was to evaluate clients' perceptions and satisfaction with the services they received from Houston EMA funded Ryan White Part A Organizations. The purpose of the focus groups was to obtain both positive and negative feedback to enhance overall client satisfaction with HIV related services. The discussion provided valuable information from a unique perspective based on experience.

The Method

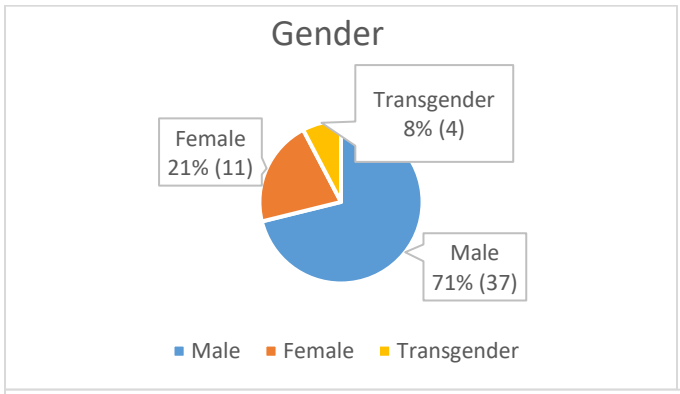
Ryan White Grant Administration in the Houston EMA conducted a web-based survey process through the Centralized Patient Care Data Management System (CPCDMS) to measure client satisfaction. Survey completion was initiated by service providers reaching out to their client population to request participation. Instructions for access and completion of the survey was flexible for service providers so that they could best provide for their clients. The basics of needing to complete the survey were 1) ensuring clients had the link and instructions to complete the survey online 2) knowing their personal client access code needed to get the

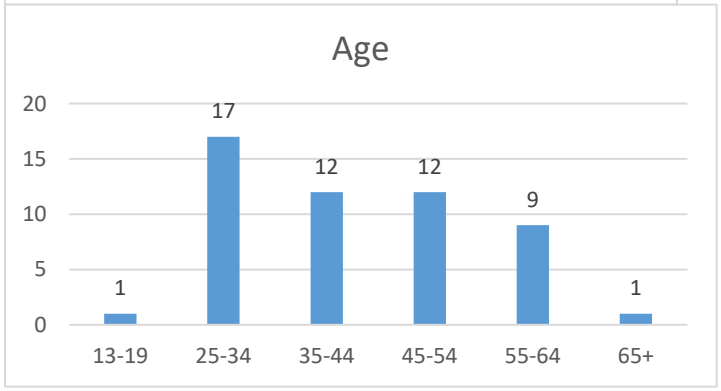
[1] HRSA/HAB DMHAP & DSHAP National Monitoring Standards – Universal - Part A & B April, 2013 (https://hab.hrsa.gov/sites/default/files/hab/Global/universalmonitoringpartab.pdf)

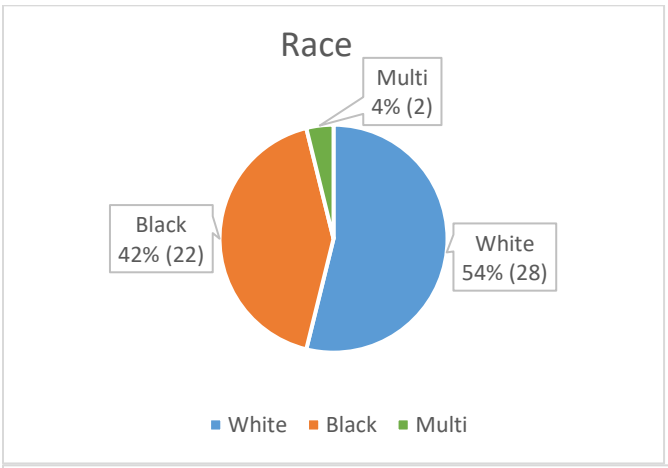
personalized survey questions 3) having internet access to put the process in to motion. Case Managers generally know which of their clients have access to computers, internet, smartphones, or community resources. Agencies also had the option to provide a private location at their office with internet access where the client could complete the survey.

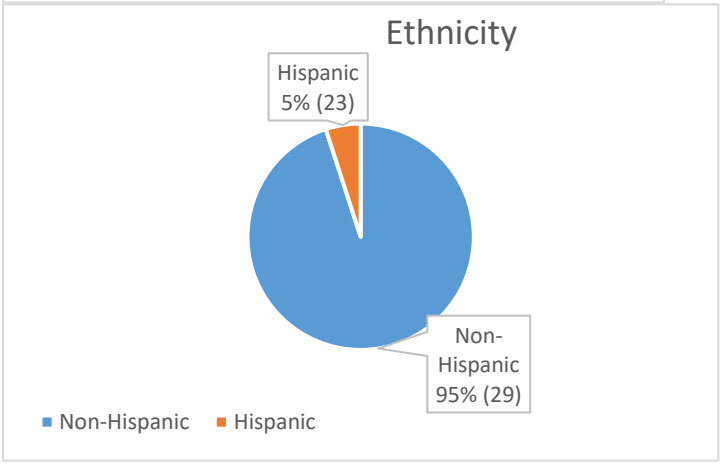
Survey Respondents Demographics

A convenience sample was used to obtain respondents. There was a total of 52 unduplicated clients that completed a survey. Data collection commenced in February 2021 and concluded the middle of March 2021. Below is a cumulative summary of the respondents' demographic information:







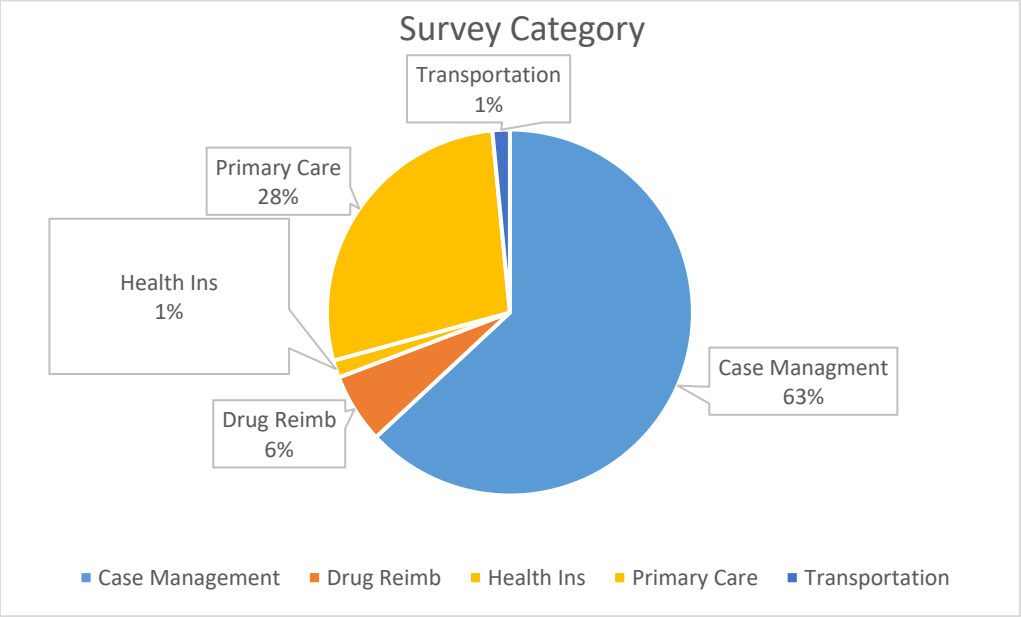


Cumulative Summaries

Service Areas Surveyed

Overall, Surveys were received for the following service areas:

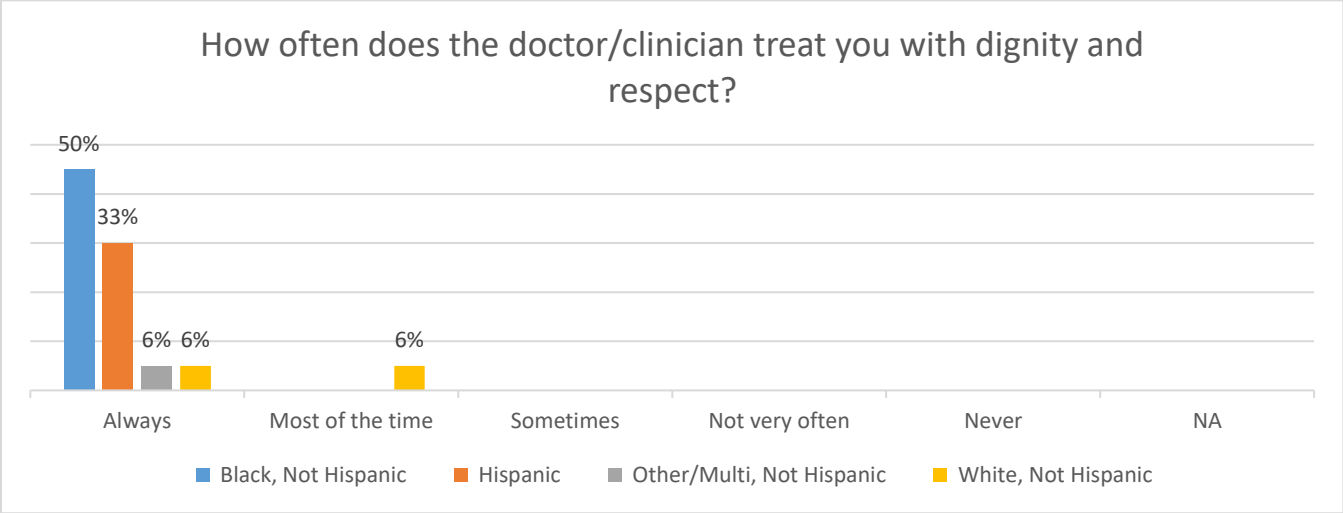
- Drug Reimbursement Program
- Case Management
- Health Insurance Assistance
- Primary Care
- Transportation

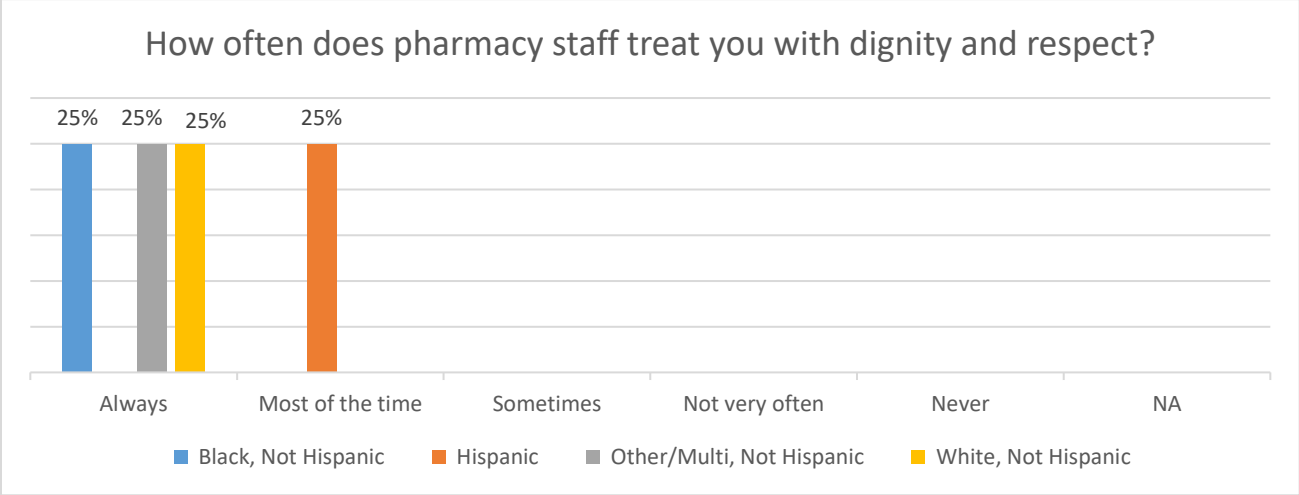


There was a total of 65 surveys taken. Several clients took more than one survey, but each survey was for a different service area. Fifty-two (52) of the total surveys were taken in English and thirteen (13) were taken in Spanish.

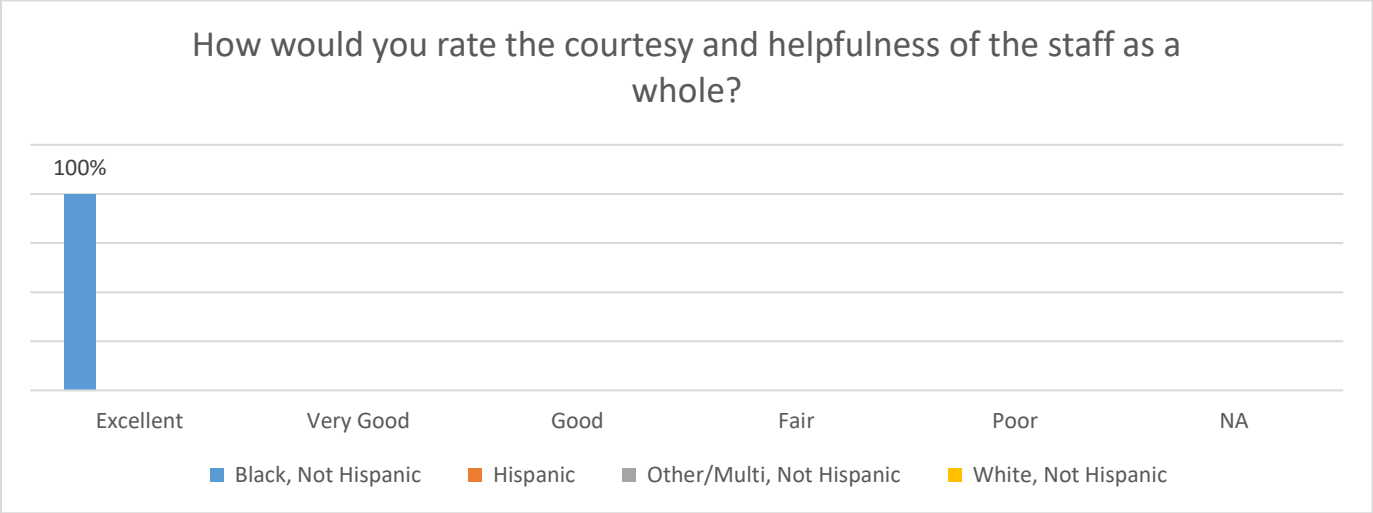
Respondents were asked to rate their satisfaction with services on a scale of 1-6 with 1 being the best and 5 being the worst. 6 means "Not Applicable".
The graphs in the following sections show aggregate numbers broken out by race and ethnicity for all survey questions. They have been categorized into overall themes. You can see results broken down by service category in Attachment 1.

Respect

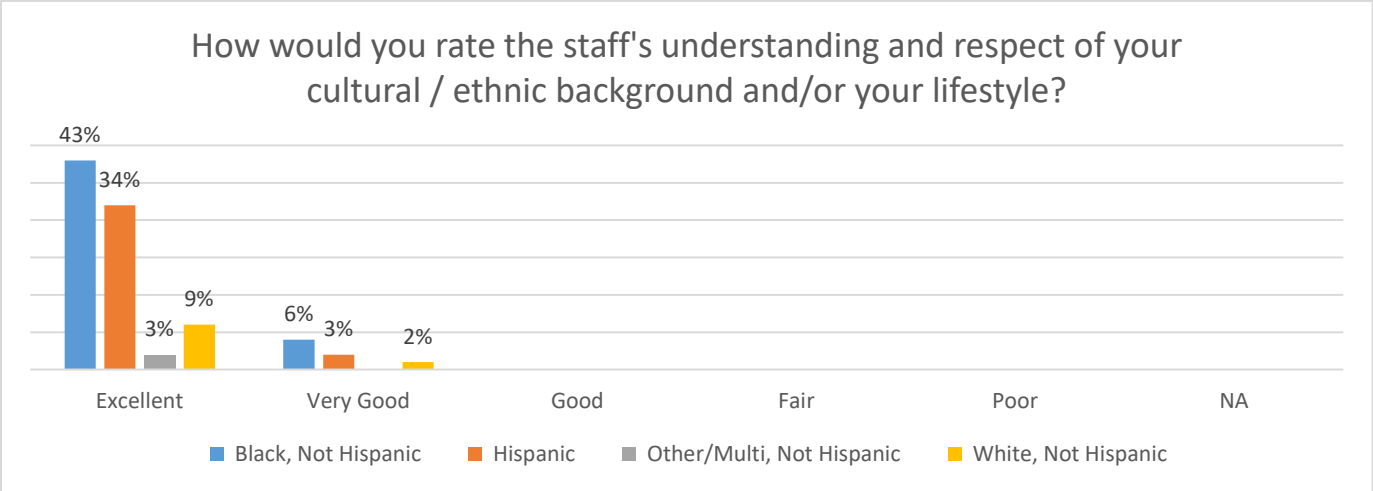

How often does the doctor/clinician treat you with dignity and respect?
50%
33%
6%
6%
6%
Always
Most of the time
Sometimes
Not very often
Never
NA
Black, Not Hispanic
Hispanic
Other/Multi, Not Hispanic
White, Not Hispanic

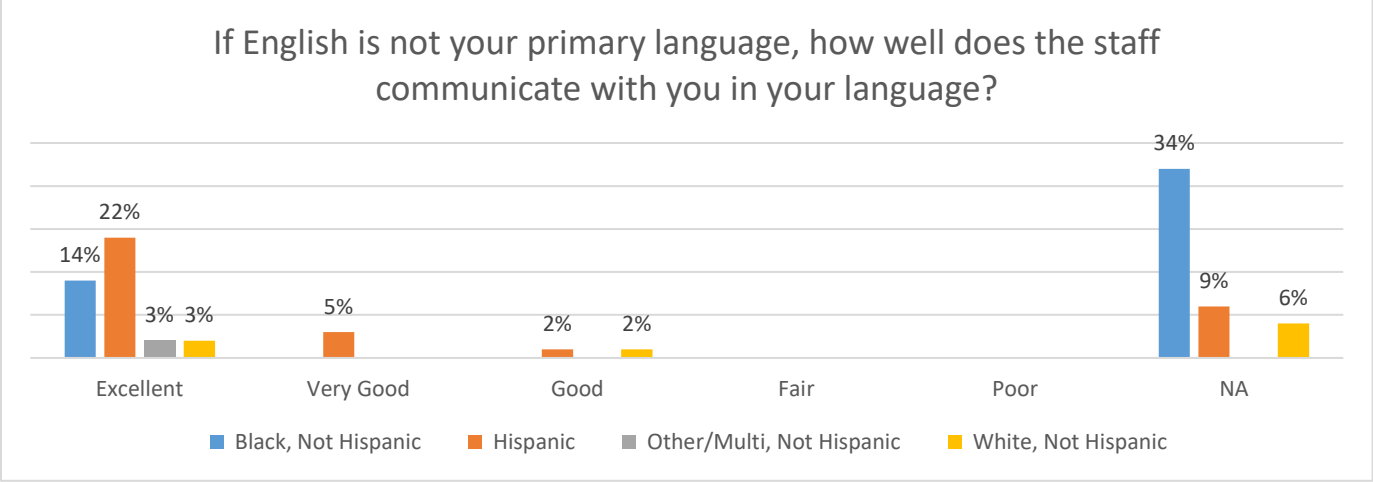

How often does pharmacy staff treat you with dignity and respect?
25%
25%
25%
25%
Always
Most of the time
Sometimes
Not very often
Never
NA
Black, Not Hispanic
Hispanic
Other/Multi, Not Hispanic
White, Not Hispanic

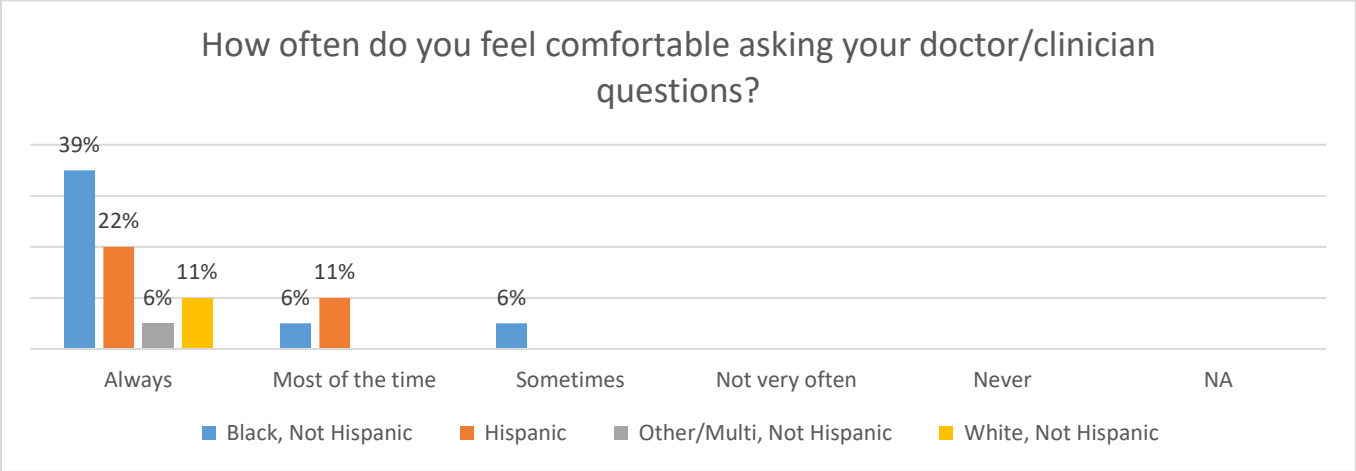

How often does the staff treat you with dignity and respect?
100%
Always
Most of the time
Sometimes
Not very often
Never
NA
Black, Not Hispanic
Hispanic
Other/Multi, Not Hispanic
White, Not Hispanic



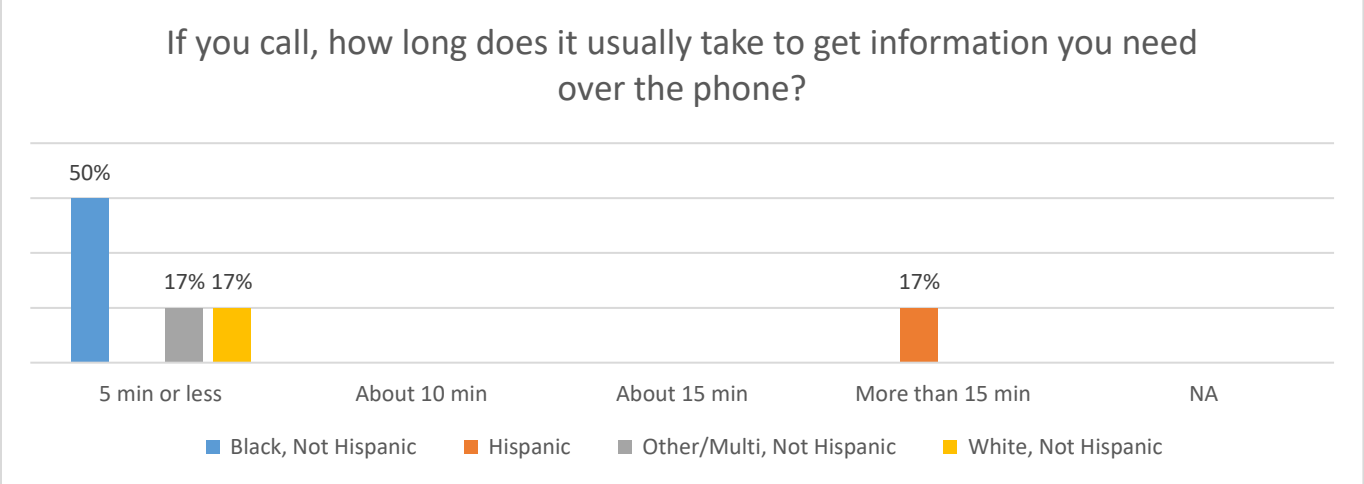
Culturally Responsive services

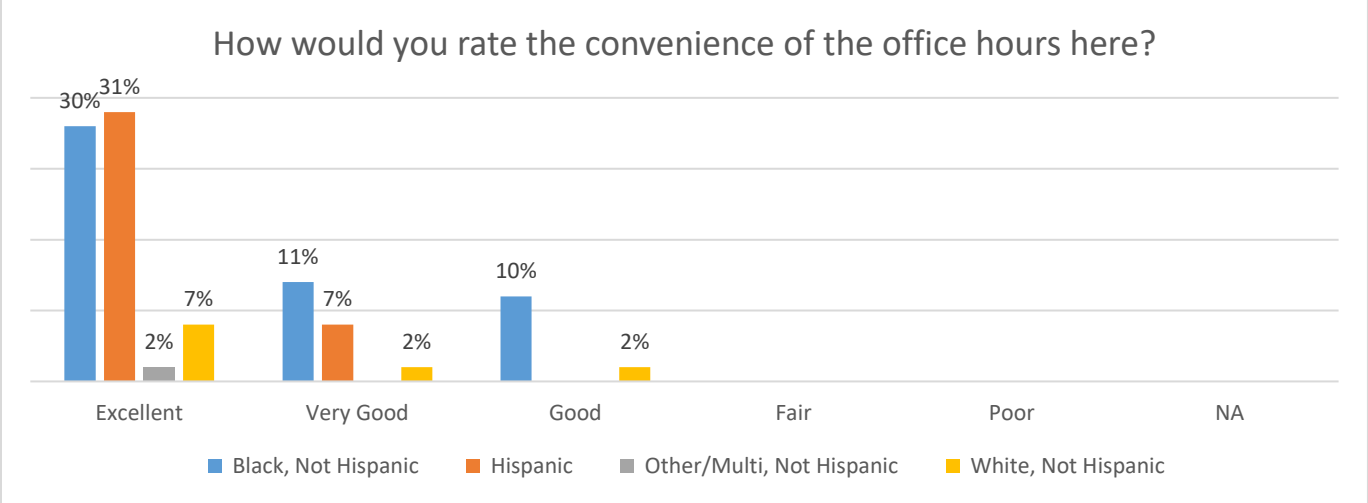


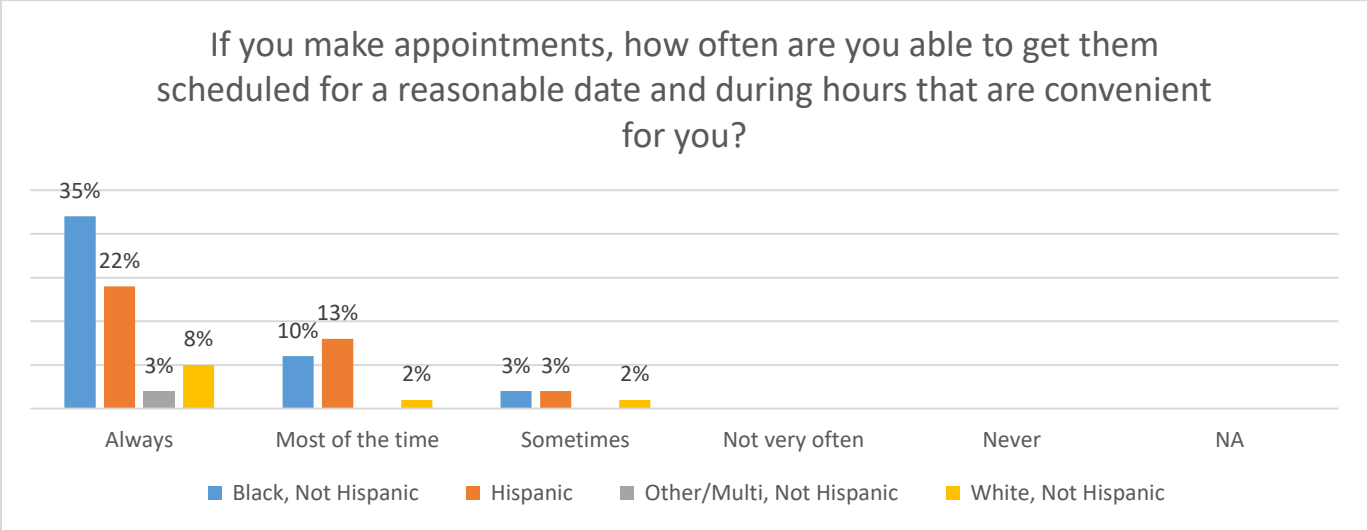


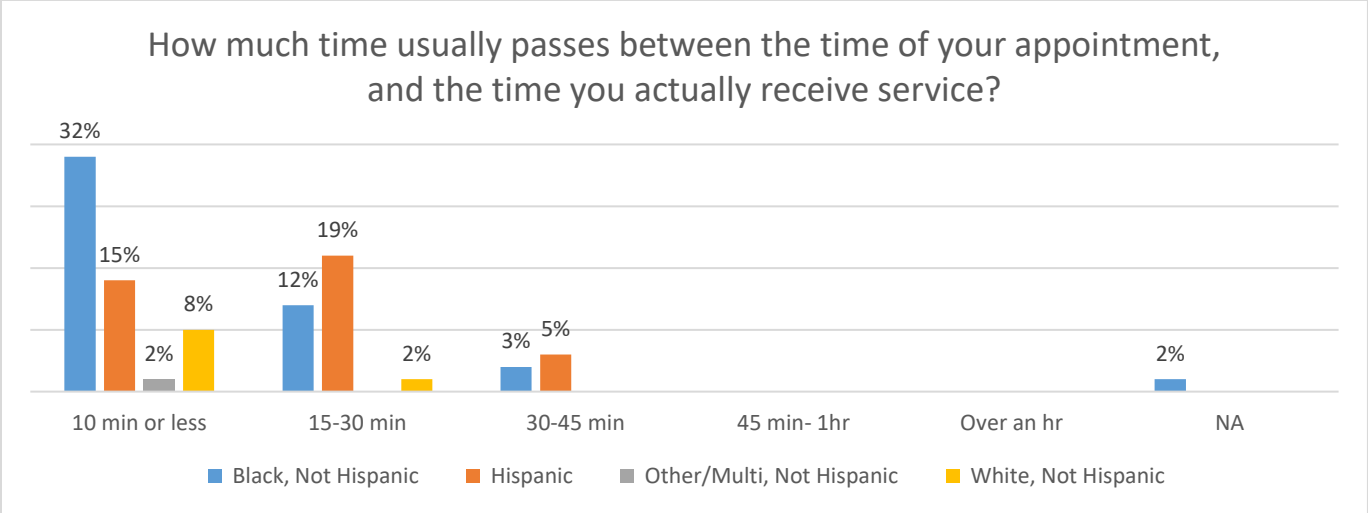


Convenience

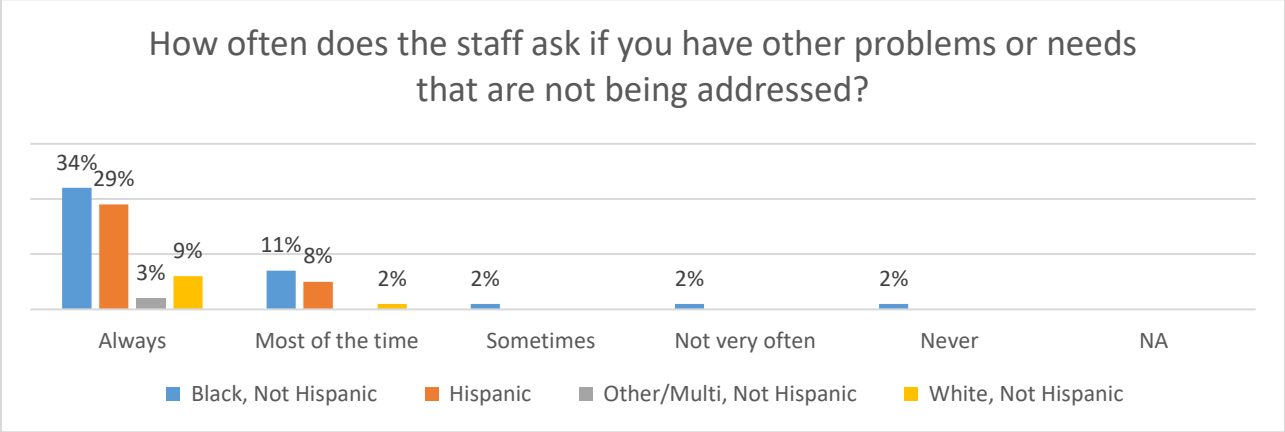


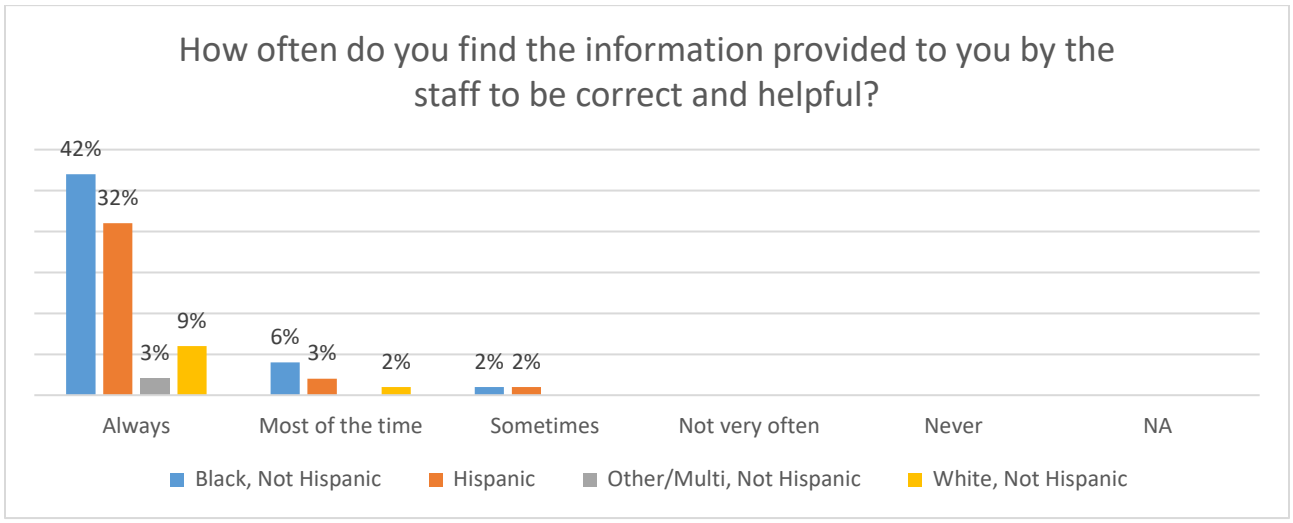


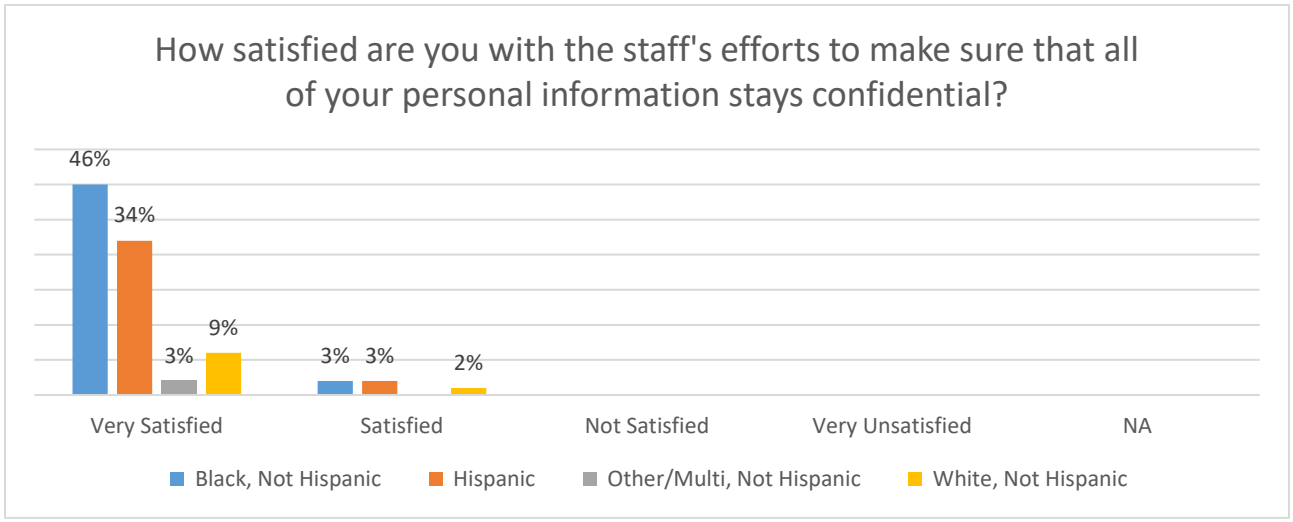


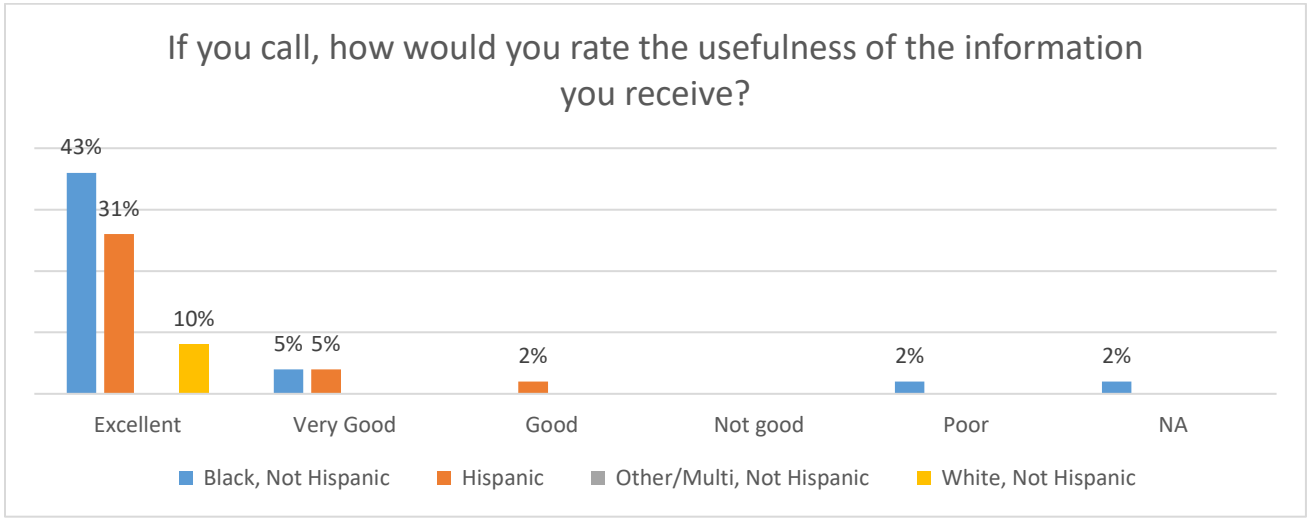


Information and Communication

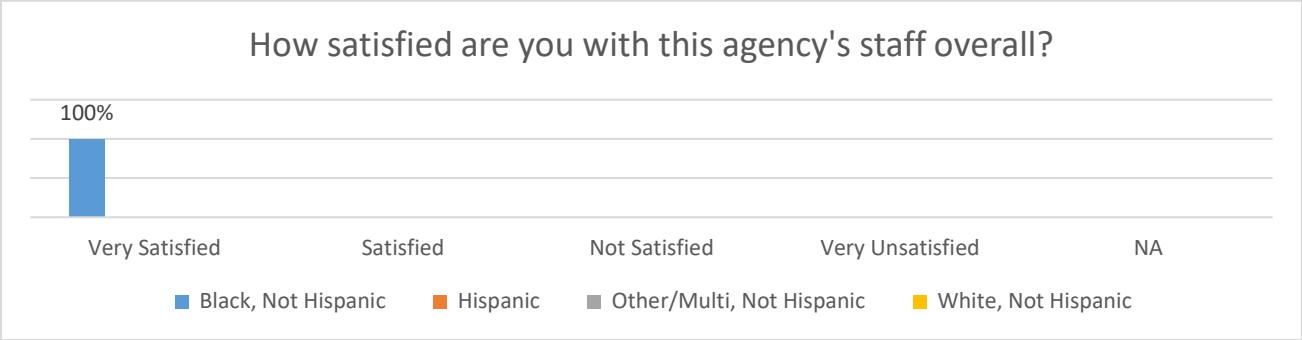


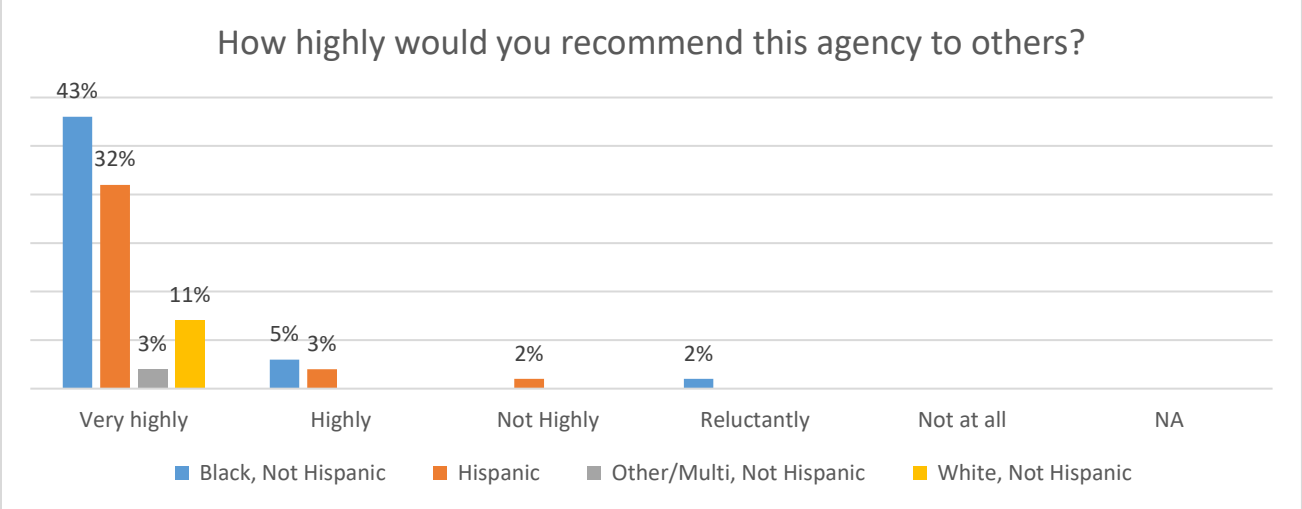

How often do you find the information provided to you by the staff to be correct and helpful?
42%
32%
3%
9%
6%
3%
2%
2%
2%
Always
Most of the time
Sometimes
Not very often
Never
NA
Black, Not Hispanic
Hispanic
Other/Multi, Not Hispanic
White, Not Hispanic

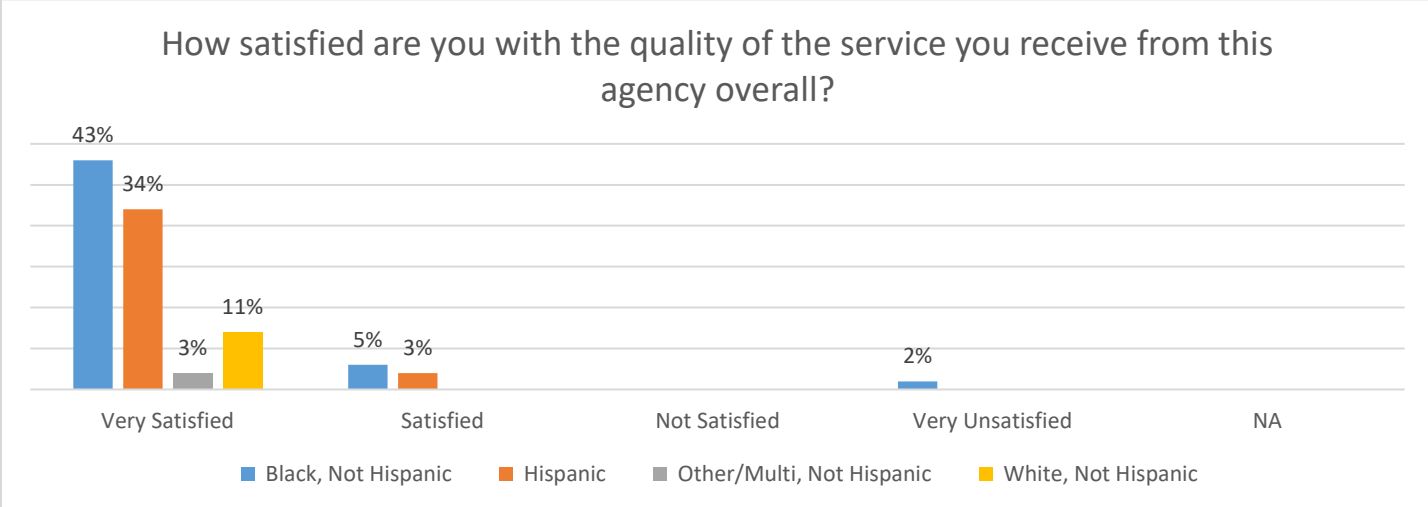

How satisfied are you with the staff's efforts to make sure that all of your personal information stays confidential?
46%
34%
3%
9%
3%
3%
2%
Very Satisfied
Satisfied
Not Satisfied
Very Unsatisfied
NA
Black, Not Hispanic
Hispanic
Other/Multi, Not Hispanic
White, Not Hispanic


If you call, how would you rate the usefulness of the information you receive?
43%
31%
10%
5%
5%
2%
2%
2%
Excellent
Very Good
Good
Not good
Poor
NA
Black, Not Hispanic
Hispanic
Other/Multi, Not Hispanic
White, Not Hispanic

Overall Satisfaction







Focus Group

Methodology

The methodology used was aimed at obtaining general background information regarding clients' experiences, services accessed, and more specifically, clients' satisfaction after receiving a Ryan White Part A funded service. Additional objectives included 1) gathering information on clients' priorities when receiving services, 2) gaining further insight into how comfortable clients are when they receive services, and 3) determining through what methods clients prefer to interact with their providers.

The focus group took place with a simultaneous mix of zoom and in-person attendees. The in-person attendees all wore masks and were socially distanced in a conference room at a Harris County Public Health location. The format was a group discussion. The group session was used because conversations among participants allow for a combined perspective as well as an opportunity to elaborate on what is important to them in a way that doesn't dictate a limited response (such as a "yes" or "no" or multiple choice question). It also allows for follow up questions. Seven (7) individuals participated. The group composition was homogenous in that all seven participants identified as males. Of the seven participants, three were Hispanic three were African American and one was white. Two individuals participating in the focus group were Veterans. An audio recording was kept for the purpose of review to ensure accuracy. The discussion lasted approximately 70 minutes.

Prior to the beginning the discussion ground rules were established by the Facilitator. The importance of confidentiality was emphasized followed by examples of what that might look like. The participants were free to talk about their experience or some of the experiences that might have come up during the session, but they could not say who said what or who participated in the group. This is to ensure honesty and openness during the session. Participants confirmed their understanding that everything said during the session was to remain confidential. Second, only one person was to speak at a time. This was to facilitate the note taking process. Last, participation was completely voluntary. Participants had the right to stop participation at any time. They are not compelled to answer any question they don't want to answer but would be given the opportunity to provide information if they wished. Each participant was eligible to receive an incentive card as appreciation for their time and valuable feedback. Everyone was informed of the purpose of the discussion and that the information would be used to improve services.

Discussion Overview

Participants reported receiving services at the following agencies: Avenue 360, Legacy Community Health, St. Hope Foundation, Thomas Street, Montrose Center, VA. The services they listed as receiving were: Case Management, Substance Use Disorder treatment, Mental Health services, Primary Care, Vision, Dental, Medications, Emergency Assistance related to COVID. Almost all participants reported that walk-in services were available to them. There was one exception where a client had a question around walk-in dental

services. Although the client expressed that if it were an emergency, he always felt he would be taken care of by the staff. Most clients reported that after a medical visit, they scheduled their next appointment before leaving the clinic. Concerns were raised around staffing issues causing delays with scheduling appointments. One client mentioned a wait time of between 8-9 months to meet with a specialist.

Communication methods between agencies and clients seemed to vary by agency and situations. All respondents did indicate receiving some form of electronic and verbal information from their respective agencies. Comments on virtual platforms/apps received high praise for ease of access and responsiveness. Everyone agreed that they felt comfortable talking to their doctors and other care staff and that they had their questions answered. An exception was when a specialist was involved and didn't explain information in a way that the client understood.

All responding clients indicated that a top priority when accessing services was receiving respect. Three clients shared experiences where they did not feel that they were treated with respect. Two of those clients reported changing clinics after they addressed concerns with staff and either didn't see changes or didn't feel heard. Everyone participating in the discussion shared examples of when or how they do feel respected when receiving care. Importance was placed on "talking to you as an equal," not using a "be grateful" attitude, and respecting their time. Hurtful comments were mentioned such as a client being told "you don't have anywhere else to go" when they expressed frustration around the service they received. Location, safety around the clinic, clinic culture and atmosphere were also listed as important to the participants. Being recognized and welcomed individually made them feel valued. There was agreeance amongst the group that physical and visual comfort of a clinic made a difference in how they felt about their care. Some examples given were brightly painted walls, decorations, and comfortable chairs. Comfort also came in to play when there might be wait times at the clinic before getting to talk with a provider. One client reported having to arrive very early to appointments because of riding the bus. He didn't mind because of the comfort level of the clinic once he arrived. Clients commented that while some clinics are in old buildings, the staff was friendly, and everything was clean. There was follow up discussion about how new buildings and offices were needed for some clinics because a run-down building wasn't welcoming.

Some feedback was specific to situations related to the COVID pandemic. When asked about telehealth visits, most everyone agreed that they preferred in-person interaction. One reason was that the personal and sensitive nature of some conversations needed to take place in person and "couldn't happen over the phone." While they appreciated the safety measures being taken, they looked forward to going to their provider visits in-person once it was safe. Some participants expressed that they did not receive any or enough information on HIV and COVID or communication around what resources were available to them.

Conclusion

The data collected represents a small sample of clients served in the Houston EMA so it cannot be generalized for the entire Ryan White population. But every individual's feedback is valuable and even with a small sample, the information should be taken seriously and incorporated into future conversations on improvement. Generally, most clients reported overall satisfaction with services received. Along with the positive feedback, there were areas that stood out as needing improvement.

The level of satisfaction was lower in areas focused on convenience of services. This included office hours, ability to get appointments, and wait times. Many clients also answered that they are not often asked if their needs are being met or if there is something else that they need.

Veterans also reported feeling that they were receiving lower quality care than other Ryan White clients. They did not report the same level of access to resources and information as other clients. Training, resources, and communication with agencies surrounding Veterans should be reviewed for gaps and areas of needed improvement.

Appendix **1 (All survey data)**

HARRIS COUNTY PUBLIC HEALTH AND ENVIRONMENTAL SERVICES - RWGA

Client Satisfaction Survey Results

HARRIS COUNTY PUBLIC HEALTH AND ENVIRONMENTAL SERVICES - RWGA

Client Satisfaction Survey Results

Surveys record last update date between **1/1/21** and **12/31/21**
[Agency]: **ALL** [SLG#]: **(22) CLIENT SATIS - OUTPATIENT/AMBULAT CARE**
[Analysis Type]: **COMMON** [Question(s)]: **All**
[Sort]: **Race/Ethnicity** [Blanks]: **EXCLUDE**

Question Text	Answer	Black,	Hispanic		White,	Total
How often does the doctor/clinician treat you with dignity and respect?	1	9	6	1	1	**17**
	2				1	**1**
		9	**6**	**1**	**2**	**18**
How often do you feel comfortable asking your doctor/clinician questions?	1	7	4	1	2	**14**
	2	1	2			**3**
	3	1				**1**
		9	**6**	**1**	**2**	**18**
How would you rate the staff's understanding and respect of your cultural / ethnic	1	7	6	1	1	**15**
	2	2			1	**3**
		9	**6**	**1**	**2**	**18**
If English is not your primary language, how well does the staff communicate with you in your language?	1	4	2	1	1	**8**
	2		1			**1**
	6	5	3		1	**9**
		9	**6**	**1**	**2**	**18**
How often does the staff ask if you have other problems or needs that are not being addressed?	1	6	4	1	1	**12**
	2	2	2		1	**5**
	3	1				**1**
		9	**6**	**1**	**2**	**18**
How satisfied are you with the staff's efforts to make sure that all of your personal	1	9	6	1	1	**17**
	2				1	**1**
		9	**6**	**1**	**2**	**18**
How often do you find the information provided to you by the staff to be correct and	1	6	6	1	1	**14**
	2	3			1	**4**
		9	**6**	**1**	**2**	**18**
How much time usually passes between the time of your appointment, and the time you actually receive service?	1	7	1	1	1	**10**
	2	2	4		1	**7**
	3		1			**1**
		9	**6**	**1**	**2**	**18**
How would you rate the convenience of the office hours here?	1	5	4	1	1	**11**
	2	3	2		1	**6**
	3	1				**1**
		9	**6**	**1**	**2**	**18**
If you make appointments, how often are you able to get them scheduled for a reasonable date and during	1	5	2	1	1	**9**
	2	3	4		1	**8**
	3	1				**1**
		9	**6**	**1**	**2**	**18**
How highly would you recommend this agency to others?	1	7	6	1	2	**16**
	2	2				**2**
		9	**6**	**1**	**2**	**18**
How satisfied are you with the quality of the service you receive from this agency	1	8	6	1	2	**17**
	2	1				**1**
		9	**6**	**1**	**2**	**18**

HARRIS COUNTY PUBLIC HEALTH AND ENVIRONMENTAL SERVICES - RWGA

Client Satisfaction Survey Results

Surveys record last update date between 1/1/21 and 12/31/21
[Agency]: ALL [SLG#]: (3) CLIENT SATIS - CASE MGMT
[Analysis Type]: COMMON [Question(s)]: All
[Sort]: Race/Ethnicity [Blanks]: EXCLUDE

Question Text	Answer	Black, Not Hispanic	Hispanic	White, Not Hispanic	Total
How often does your case manager treat you with dignity and respect?	1	20 100%	17 100%	4 100%	**41** **100%**
		20	**17**	**4**	**41**
How would you rate the staff's understanding and respect of your cultural / ethnic background and/or your lifestyle?	1	18 90%	16 94%	4 100%	**38** **93%**
	2	2 10%	1 6%	0%	**3** **7%**
		20	**17**	**4**	**41**
If English is not your primary language, how well does the staff communicate with you in your language?	1	5 26%	12 71%	1 25%	**18** **45%**
	2	0%	2 12%	0%	**2** **5%**
	3	0%	0%	1 25%	**1** **2%**
	6	14 74%	3 18%	2 50%	**19** **48%**
		19	**17**	**4**	**40**
How often does the staff ask if you have other problems or needs that are not being addressed?	1	14 70%	15 88%	4 100%	**33** **80%**
	2	4 20%	2 12%	0%	**6** **15%**
	4	1 5%	0%	0%	**1** **2%**
	5	1 5%	0%	0%	**1** **2%**
		20	**17**	**4**	**41**
How satisfied are you with the staff's efforts to make sure that all of your personal information stays confidential?	1	18 90%	16 94%	4 100%	**38** **93%**

	2	2 10%	1 6%	0%	**3** **7%**
		20	**17**	**4**	**41**
How often do you find the information provided to you by the staff to be correct and helpful?	1	18 90%	15 88%	4 100%	**37** **90%**
	2	1 5%	2 12%	0%	**3** **7%**
	3	1 5%	0%	0%	**1** **2%**
		20	**17**	**4**	**41**
If you call, how would you rate the usefulness of the information you receive?	1	16 80%	13 81%	4 100%	**33** **82%**
	2	2 10%	2 12%	0%	**4** **10%**
	3	0%	1 6%	0%	**1** **2%**
	5	1 5%	0%	0%	**1** **2%**
	6	1 5%	0%	0%	**1** **2%**
		20	**16**	**4**	**40**
How much time usually passes between the time of your appointment, and the time you actually receive	1	12 60%	8 47%	4 100%	**24** **59%**

service?	2	5 25%	7 41%	0%	**12** **29%**
	3	2 10%	2 12%	0%	**4** **10%**
	6	1 5%	0%	0%	**1** **2%**
		20	**17**	**4**	**41**
How would you rate the convenience of the office hours here?	1	11 55%	15 88%	3 75%	**29** **71%**
	2	4 20%	2 12%	0%	**6** **15%**
	3	5 25%	0%	1 25%	**6** **15%**
		20	**17**	**4**	**41**
If you make appointments, how often are you able to get them scheduled for a reasonable date and during hours that are convenient for you?	1	16 80%	12 71%	4 100%	**32** **78%**
	2	3 15%	4 24%	0%	**7** **17%**
	3	1 5%	1 6%	0%	**2** **5%**
		20	**17**	**4**	**41**
How highly would you recommend this agency to others?	1	18 90%	15 88%	4 100%	**37** **90%**
	2	1 5%	2 12%	0%	**3** **7%**
	4	1 5%	0%	0%	**1** **2%**
		20	**17**	**4**	**41**
How satisfied are you with the quality of the service you receive from this agency overall?	1	17 85%	16 94%	4 100%	**37** **90%**
	2	2 10%	1 6%	0%	**3** **7%**
	4	1 5%	0%	0%	**1** **2%**
		20	**17**	**4**	**41**

HARRIS COUNTY PUBLIC HEALTH AND ENVIRONMENTAL SERVICES - RWGA

Client Satisfaction Survey Results

Surveys record last update date between **1/1/21** and **12/31/21**

[Agency]: **ALL** [SLG#]: (**14**) **CLIENT SATIS - HEALTH INSURA**

[Analysis Type]: **COMMON** [Question(s)]: **All**

[Sort]: **LAST STAGE OF ILLNESS** [Blanks]: **EXCLUDE**

Question Text	Answer	HIV+, Not AIDS	Total
How often does the staff treat you with dignity and respect?	1	1 100%	1 100%
		1	1
How would you rate the courtesy and helpfulness of the staff as a whole?	1	1 100%	1 100%
		1	1
How would you rate the staff's understanding and respect of your cultural / ethnic background and/or your lifestyle?	1	1 100%	1 100%
		1	1
If English is not your primary language, how well does the staff communicate with you in your language?	6	1 100%	1 100%
		1	1
How often does the staff ask if you have other problems or needs that are not being addressed?	1	1 100%	1 100%
		1	1
How satisfied are you with the staff's efforts to make sure that all of your personal information stays confidential?	1	1 100%	1 100%
		1	1
How often do you find the information provided to you by the staff to be correct and helpful?	1	1 100%	1 100%
		1	1
How satisfied are you with this agency's staff overall?	1	1 100%	1 100%
		1	1
If you call, how long does it usually take to get information you need over the phone?	1	1 100%	1 100%
		1	1

If you call, how would you rate the usefulness of the information you receive?	1	1 100%	**1** **100%**
		1	**1**
How would you rate the convenience of the office hours here?	1	1 100%	**1** **100%**
		1	**1**
How would you rate the convenience of the location of this agency?	6	1 100%	**1** **100%**
		1	**1**
How highly would you recommend this agency to others?	1	1 100%	**1** **100%**
		1	**1**
How satisfied are you with the quality of the service you receive from this agency overall?	1	1 100%	**1** **100%**
		1	**1**

HARRIS COUNTY PUBLIC HEALTH AND ENVIRONMENTAL SERVICES - RWGA

Client Satisfaction Survey Results

Surveys record last update date between **1/1/21** and **12/31/21**

[Agency]: **ALL** [SLG#]: (**26**) **CLIENT SATIS - TRANSPORTATION**

[Analysis Type]: **COMMON** [Question(s)]: **All**

[Sort]: **Race/Ethnicity** [Blanks]: **EXCLUDE**

Question Text	Answer	Black, Not Hispanic	Total
How often does the staff treat you with dignity and respect?	1	1 100%	1 100%
		1	1
How would you rate the courtesy and helpfulness of the staff as a whole?	1	1 100%	1 100%
		1	1
How would you rate the staff's understanding and respect of your cultural / ethnic background and/or your lifestyle?	1	1 100%	1 100%
		1	1
If English is not your primary language, how well does the staff communicate with you in your language?	6	1 100%	1 100%
		1	1
How often does the staff ask if you have other problems or needs that are not being addressed?	2	1 100%	1 100%
		1	1
How satisfied are you with the staff's efforts to make sure that all of your personal information stays confidential?	1	1 100%	1 100%
		1	1
How often do you find the information provided to you by the staff to be correct and helpful?	1	1 100%	1 100%
		1	1
How satisfied are you with this agency's staff overall?	1	1 100%	1 100%
		1	1
If you call, how long does it usually take to get information you need over the phone?	1	1 100%	1 100%
		1	1

If you call, how would you rate the usefulness of the information you receive?	1	1 100%	**1** **100%**
		1	**1**
How would you rate the convenience of the office hours here?	1	1 100%	**1** **100%**
		1	**1**
How highly would you recommend this agency to others?	1	1 100%	**1** **100%**
		1	**1**
How satisfied are you with the quality of the service you receive from this agency overall?	1	1 100%	**1** **100%**
		1	**1**

The Houston Regional HIV/AIDS Resource Group, Inc.
FY 2021 DSHS State Services
Procurement Report
September 1, 2020 - August 31, 2021

Chart reflects spending through January 2021

Spending Target: 41%

Revised 3/29/2021

Priority	Service Category	Original Allocation per RWPC	% of Grant Award	Amendments per RWPC	Contractual Amount	Amendment	Contractual Amount	Date of Original Procurement	Expended YTD	Percent YTD
5	Health Insurance Premiums and Cost Sharing (1)	$864,506	43%	$0	$864,506	$0	$864,506	9/1/2020	$0	0%
6	Mental Health Services (2)	$300,000	15%	$0	$300,000	$0	$300,000	9/1/2020	$50,958	17%
7	EIS - Incarcerated	$175,000	9%	$0	$175,000	$0	$175,000	9/1/2020	$69,547	40%
11	Hospice	$259,832	13%	$0	$259,832	$0	$259,832	9/1/2020	$91,080	35%
	Non Medical Case Management	$350,000	17%	$0	$350,000	$0	$350,000	9/1/2020	$107,043	31%
15	Linguistic Services (3)	$68,000	3%	$0	$68,000	$0	$68,000	9/1/2020	$18,413	27%
	Increased award amount -Approved by RWPC for Health Insurance (a)	$0	0%	$0						
	Total Houston HSDA	2,017,338	100%	$0	$2,017,338	$0	$2,017,338		337,041	17%

Note

(1) HIP- Funded by Part A, B and State Services. Provider spends grant funds by ending dates Part A -2/28; B-3/31;SS-8/31.

(2) Mental Health - One month behind in reporting and service is under utilized.

(3) Linguistic- Service utilization has decreased due to the interruption of COVID-19.

The Houston Regional HIV/AIDS Resource Group, Inc.
FY 2021 Ryan White Part B
Procurement Report
April 1, 2020 - March 31, 2021

Reflects spending through January 2021

Spending Target: 83%

Revised 3/29/21

Priority	Service Category	Original Allocation per RWPC	% of Grant Award	Amendment*	Contractual Amount	Amendment	Contractual Amount	Date of Original Procurement	Expended YTD	Percent YTD
4	Oral Health Care (1)	$1,758,878	52%	$0	$1,758,878	$0	$1,758,878	4/1/2020	$858,000	49%
	Oral Health Care -Prosthodontics	$460,000	14%	$0	$460,000	$0	$460,000	4/1/2020	$362,400	79%
5	Health Insurance Premiums and Cost Sharing	$1,028,433	31%	$0	$1,028,433	$0	$1,028,433	4/1/2020	$767,238	75%
8	Home and Community Based Health Services (2)	$113,315	3%	$0	$113,315	$0	$113,315	4/1/2020	$50,240	44%
	Increased RWB Award added to OHS per Increase Scenario*	$0	0%	$0	$0					
	Total Houston HSDA	3,360,626	100%	0	3,360,626	$0	$2,900,626		2,037,878	70%

Note: Spending variances of 10% of target will be addressed:

(1) OHC- Service utilization has decreased due to the interruption of COVID-19. Expected increase in billing for final two months.
(2) HCB- Service utilization has decreased due to the interruption of COVID-19.
*Note TRG may reallocated funds to avoid lapse in funds

Houston Ryan White Health Insurance Assistance Service Utilization Report

Period Reported: 09/01/2020-2/28/21

Revised: 3/30/2021

	Assisted			NOT Assisted		
Request by Type	Number of Requests (UOS)	*Dollar Amount of Requests*	Number of Clients (UDC)	*Number of Requests (UOS)*	*Dollar Amount of Requests*	*Number of Clients (UDC)*
Medical Co-Payment	728	$77,002.41	352			*0*
Medical Deductible	0	$0.00	0			*0*
Medical Premium	3381	$1,151,966.63	750			*0*
Pharmacy Co-Payment	7829	$248,886.98	1024			*0*
APTC Tax Liability	1	$500.00	1			*0*
Out of Network Out of Pocket	0	$0.00	0			*0*
ACA Premium Subsidy Repayment	10	$9,129.00	0	*NA*	*NA*	*NA*
Totals:	11949	$1,469,227.02	2127	0	$0.00	

Comments: This report represents services provided under all grants.

DRAFT

Houston Area HIV Services Ryan White Planning Council

FY 2022 How to Best Meet the Need Workgroup
Service Category Recommendation Summary (as of 04/23/21)

Those services for which no change is recommended include:

Ambulatory Outpatient Medical Care (includes Medical Case Management, Local Pharmacy Assistance, Emergency Financial Assistance - Pharmacy Assistance, Outreach, and Service Linkage)

Case Management (Clinical, Non-Medical Service Linkage and Non-Medical Targeting Substance Use Disorders)

Early Intervention Services (targeting the Incarcerated)

Health Insurance Premium and Cost Sharing Assistance

Hospice Services

Linguistic Services

Medical Nutritional Therapy/Supplements

Oral Health (Untargeted and Targeting the Northern Rural Area)

Transportation

Services <u>with</u> recommended changes include the following:

Emergency Financial Assistance - Other

- Accept the service definition as presented and keep the financial eligibility the same; ask the Office of Support to highlight the service in Road 2 Success and ask the AAs to actively promote the service.

Home and Community Based Health Services (Adult Day Treatment)

- Accept the service definition as presented and increase the financial eligibility from 300 to 400% FPL*. Also, ask the Office of Support to highlight the service in Road 2 Success and ask the AAs to actively promote the service.

Mental Health Services

- Accept the service definition as presented and increase the financial eligibility from 400 to 500% FPL*.

Referral for Health Care and Support Services

- Accept the service definition as presented and increase the financial eligibility from 300 to 500% FPL* to be in line with HIV medications in LPAP.

Substance Abuse Treatment

- Accept the service definition as presented and increase the financial eligibility from 300 to 500% FPL*. Also, ask the Office of Support to highlight the service in Road 2 Success.

Vision Care

- Accept the service definition as presented and increase the financial eligibility from 300 to 400% FPL*.

**FPL = Federal Poverty Level.*

Table of Contents

FY 2022 Houston EMA/HSDA Service Categories Definitions
Ryan White Part A, Part B and State Services

FY 2020 Houston EMA Ryan White Part A/MAI Service Definition **Comprehensive Outpatient Primary Medical Care including Medical Case Management, Service Linkage, Outreach, Emergency Financial Assistance - Pharmacy Assistance and Local Pharmacy Assistance Program (LPAP) Services**	
HRSA Service Category Title: **RWGA Only**	1. Outpatient/Ambulatory Medical Care 2. Medical Case Management 3. AIDS Pharmaceutical Assistance (local) 4. Case Management (non-Medical) 5. Emergency Financial Assistance – Pharmacy Assistance 6. Outreach
Local Service Category Title:	Adult Comprehensive Primary Medical Care - CBO i. Community-based Targeted to African American ii. Community-based Targeted to Hispanic iii. Community-based Targeted to White/MSM
Amount Available: **RWGA Only**	Total estimated available funding: $0.00 (to be determined) Note: The Houston Ryan White Planning Council (RWPC) determines overall annual Part A and MAI service category allocations & reallocations. RWGA has sole authority over contract award amounts.
Target Population:	**Comprehensive Primary Medical Care – Community Based:** i. Targeted to African American: African American ages 13 or older ii. Targeted to Hispanic: Hispanic ages 13 or older iii. Targeted to White: White (non-Hispanic) ages 13 or older **Outreach:** Services will be available to eligible HIV-infected clients residing in the Houston EMA/HSDA with priority given to clients most in need. Services are restricted to those clients who meet the contractor's RWGA approved Outreach Inclusion Criteria. The Outreach Inclusion Criteria components must include, at minimum 2 consecutive missed primary care provider and/or HIV lab appointments. Outreach Inclusion Criteria may also include VL suppression, substance abuse, and ART treatment failure components.
Client Eligibility: Age, Gender, Race, Ethnicity, Residence, etc.	PLWHA residing in the Houston EMA (prior approval required for non-EMA clients). Contractor must adhere to Targeting requirements and Budget limitations as applicable.
Financial Eligibility:	*See Current Approved Financial Eligibility for Houston EMA/HSDA*

Budget Type: **RWGA Only**	Hybrid Fee for Service
Budget Requirement or Restrictions: **RWGA Only**	**Primary Medical Care:** No less than 75% of clients served in a Targeted subcategory must be members of the targeted population with the following exceptions: 100% of clients served with MAI funds must be members of the targeted population. 10% of funds designated to primary medical care must be reserved for invoicing diagnostic procedures at actual cost. Contractors may not exceed the allocation for each individual service component (Primary Medical Care, Medical Case Management, Local Pharmacy Assistance Program and Service Linkage) without prior approval from RWGA. **Local Pharmacy Assistance Program (LPAP):** Houston RWPC guidelines for Local Pharmacy Assistance Program (LPAP) services: Contractor shall offer HIV medications from an approved formulary for a total not to exceed $18,000 per contract year per client. Contractor shall offer HIV-related medications for a total not to exceed $3,000 per contract year per client. These guidelines are determined by the RWPC. The RWPC determines the subcategories that shall include Ryan White LPAP funding. Medications must be provided in accordance with Houston EMA guidelines, HRSA/HAB rules and regulations and applicable Office of Pharmacy Affairs 340B guidelines. At least 75% of the total amount of the budget for LPAP services must be solely allocated to the actual cost of medications and may not include any storage, administrative, processing or other costs associated with managing the medication inventory or distribution. **Emergency Financial Assistance – Pharmacy Assistance** Direct cash payments to clients are not permitted. It is expected that all other sources of funding in the community for emergency financial assistance will be effectively used and that any allocation of RWHAP funds for these purposes will be as the payer of last resort, and for limited amounts, uses, and periods of time. Continuous provision of an allowable service to a client should not be funded through emergency financial assistance. **Outreach**

	Outreach services are restricted to those patients who have not returned for scheduled appointments with Provider as outlined in the RWGA approved Outreach Inclusion Criteria, and are included on the Outreach list.
Service Unit Definition/s: **RWGA Only**	• Outpatient/Ambulatory Medical Care: One (1) unit of service = One (1) primary care office/clinic visit which includes the following: • Primary care physician/nurse practitioner, physician's assistant or clinical nurse specialist examination of the patient, and • Medication/treatment education • Medication access/linkage • OB/GYN specialty procedures (as clinically indicated) • Nutritional assessment (as clinically indicated) • Laboratory (as clinically indicated, not including specialized tests) • Radiology (as clinically indicated, not including CAT scan or MRI) • Eligibility verification/screening (as necessary) • Follow-up visits wherein the patient is not seen by the MD/NP/PA are considered to be a component of the original primary care visit. • Outpatient Psychiatric Services: 1 unit of service = A single (1) office/clinic visit wherein the patient is seen by a State licensed and board-eligible Psychiatrist or qualified Psychiatric Nurse Practitioner. This visit may or may not occur on the same date as a primary care office visit. • Nutritional Assessment and Plan: 1 unit of service = A single comprehensive nutritional assessment and treatment plan performed by a Licensed, Registered Dietician initiated upon a physician's order. Does not include the provision of Supplements or other products (clients may be referred to the Ryan White funded Medical Nutritional Therapy provider for provision of medically necessary supplements). The nutritional assessment visit may or may not occur on the same date as a medical office visit. • AIDS Pharmaceutical Assistance (local): A unit of service = a transaction involving the filling of a prescription or any other allowable medication need ordered by a qualified medical practitioner. The transaction will involve at least one item being provided for the client, but can be any multiple. The cost of medications provided to the client must be invoiced at actual cost. • Medical Case Management: 1 unit of service = 15 minutes of direct medical case management services to an eligible PLWHA performed by a qualified medical case manager. • Service Linkage (non-Medical Case Management): 1 unit of service = 15 minutes of direct service linkage services to an

	eligible PLWHA performed by a qualified service linkage worker. • Outreach: 15 Minutes = 1 Unit • Emergency Financial Assistance – Pharmacy Assistance: A unit of service = a transaction involving the filling of a prescription or any other allowable HIV treatment medication need ordered by a qualified medical practitioner. The transaction will involve at least one item being provided for the client, but can be any multiple. The cost of medications provided to the client must be invoiced at actual cost.
HRSA Service Category Definition: **RWGA Only**	• **Outpatient/Ambulatory medical care** is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings. Services includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies. • **AIDS Pharmaceutical Assistance (local)** includes local pharmacy assistance programs implemented by Part A or Part B Grantees to provide HIV/AIDS medications to clients. This assistance can be funded with Part A grant funds and/or Part B base award funds. Local pharmacy assistance programs are not funded with ADAP earmark funding. • **Medical Case Management** services (including treatment adherence) are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence

	to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication. • **Case Management (non-Medical)** includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does. • **Emergency Financial Assistance** provides limited one-time or short-term payments to assist the RWHAP client with an emergent need for paying for essential utilities, housing, food (including groceries, and food vouchers), transportation, and medication. Emergency financial assistance can occur as a direct payment to an agency or through a voucher program. • **Outreach Services** include the provision of the following three activities: Identification of people who do not know their HIV status and linkage into Outpatient/Ambulatory Health Services, Provision of additional information and education on health care coverage options, Reengagement of people who know their status into Outpatient/Ambulatory Health Services
Standards of Care:	Contractors must adhere to the most current published Part A/B Standards of Care for the Houston EMA/HSDA. **Services must meet or exceed applicable United States Department of Health and Human Services (DHHS) guidelines for the Treatment of HIV/AIDS.**
Local Service Category Definition/Services to be Provided:	**Outpatient/Ambulatory Primary Medical Care:** Services include on-site physician, physician extender, nursing, phlebotomy, radiographic, laboratory, pharmacy, intravenous therapy, home health care referral, licensed dietician, patient medication education, and patient care coordination. The Contractor must provide continuity of care with inpatient services and subspecialty services (either on-site or through specific referral to appropriate medical provider upon primary care Physician's order). Services provided to women shall further include OB/GYN physician & physician extender services on-site or by referral, OB/GYN services, colposcopy, nursing, phlebotomy, radiographic, laboratory, pharmacy, intravenous therapy, home health care referral, licensed dietician, patient medication/women's health

	education, patient care coordination, and social services. The Contractor must provide continuity of care with inpatient services and subspecialty services (either on-site or through specific referral protocols to appropriate agencies upon primary care Physician's order). **Outpatient/Ambulatory Primary Medical Care must provide:** • Continuity of care for all stages of adult HIV infection; • Laboratory and pharmacy services including intravenous medications (either on-site or through established referral systems); • Outpatient psychiatric care, including lab work necessary for the prescribing of psychiatric medications when appropriate (either on-site or through established referral systems); • Access to the Texas ADAP program (either on-site or through established referral systems); • Access to compassionate use HIV medication programs (either directly or through established referral systems); • Access to HIV related research protocols (either directly or through established referral systems); • Must at a minimum, comply with Houston EMA/HSDA Part A/B Standards for HIV Primary Medical Care. The Contractor must demonstrate on an ongoing basis the ability to provide state-of-the-art HIV-related primary care medicine in accordance with the most recent DHHS HIV treatment guidelines. Rapid advances in HIV treatment protocols require that the Contractor provide services that to the greatest extent possible maximize a patient's opportunity for long-term survival and maintenance of the highest quality of life possible. • On-site Outpatient Psychiatry services. • On-site Medical Case Management services. • On-site Medication Education. • Physical therapy services (either on-site or via referral). • Specialty Clinic Referrals (either on-site or via referral). • On-site pelvic exams as needed for female patients with appropriate follow-up treatment and referral. • On site Nutritional Counseling by a Licensed Dietitian. **Services for women must also provide:** • Well woman care, including but not limited to: PAP, pelvic exam, HPV screening, breast examination, mammography, hormone replacement and education, pregnancy testing, contraceptive services excluding birth control medications. • Obstetric Care: ante-partum through post-partum services, child birth/delivery services. Perinatal preventative education and treatment.

	• On-site or by referral Colposcopy exams as needed, performed by an OB/GYN physician, or physician extender with a colposcopy provider qualification. • Social services, including but not limited to, providing women access to child care, transportation vouchers, food vouchers and support groups at the clinic site. **Nutritional Assessment:** Services include provision of information about therapeutic nutritional/supplemental foods that are beneficial to the wellness and increased health conditions of clients by a Licensed Dietitian. Services may be provided either through educational or counseling sessions. Clients who receive these services may utilize the Ryan White Part A-funded nutritional supplement provider to obtain recommended nutritional supplements in accordance with program rules. Clients are limited to one (1) nutritional assessment per calendar year without prior approval of RWGA. Patient Medication Education Services must adhere to the following requirements: • Medication Educators must be State Licensed Medical Doctor (MD), Nurse Practitioner (NP), Physician Assistant PA), Nurse (RN, LVN) or Pharmacist. Prior approval must be obtained prior to utilizing any other health care professional not listed above to provide medication education. • Clients who will be prescribed ongoing medical regimens (i.e. ART) must be assessed for adherence to treatment at every clinical encounter using the EMA's approved adherence assessment tool. Clients with adherence issues related to lack of understanding must receive more education regarding their medical regimen. Clients with adherence issues that are behavioral or involve mental health issues must be provided counseling by the Medical Case Manager, Physician or Physician Extender and/or licensed nursing staff and, if clinically indicated, assessment and treatment by a qualified Psychiatrist or Psychiatric Nurse Practitioner. **Outpatient Psychiatric Services:** The program must provide: • Diagnostic Assessments: comprehensive evaluation for identification of psychiatric disorders, mental status evaluation, differential diagnosis which may involve use of other clinical and laboratory tests, case formulation, and treatment plans or disposition. • Emergency Psychiatric Services: rapid evaluation, differential diagnosis, acute treatment, crisis intervention, and referral. Must be available on a 24 hour basis including emergency room referral.

	• Brief Psychotherapy: individual, supportive, group, couple, family, hypnosis, biofeedback, and other psychophysiological treatments and behavior modification. • Psychopharmacotherapy: evaluation and medication treatment of psychiatric disorders, including, but not limited to, anxiety disorders, major depression, pain syndromes, habit control problems, psychosis and organic mental disorders. • Rehabilitation Services: Physical, psychosocial, behavioral, and/or cognitive training. Screening for Eye Disorders: Contractor must ensure that patients receive appropriate screening and treatment for CMV, glaucoma, cataracts, and other related problems. **Local Medication Assistance Program (LPAP):** LPAP provides pharmaceuticals to patients otherwise ineligible for medications through private insurance, Medicaid/Medicare, State ADAP, SPAP or other sources. Allowable medications are only those on the Houston EMA Ryan White Part A Formulary. Eligible clients may be provided Fuzeon™ on a case-by-case basis with prior approval of Ryan White Grant Administration (RWGA). The cost of Fuzeon™ does not count against a client's annual maximum. HIV-related medication services are the provision of physician or physician-extender prescribed HIV-related medications to prevent serious deterioration of health. Does not include drugs available to the patient from other programs or payers or free of charge (such as birth control and TB medications) or medications available over the counter (OTC) without prescription. Contractor must offer all medications on the Texas ADAP formulary, for a total not to exceed $18,000.00 per contract year per client. Contractor must provide allowable HIV-related medications (i.e. non-HIV medications) for a total not to exceed $3,000 per contract year per client. Contractor may be reimbursed ADAP dispensing fees (e.g. $5/Rx) in accordance with RWGA business rules for those ADAP clients who are unable to pay the ADAP dispensing fee. **Medical Case Management Services:** Services include screening all primary medical care patients to determine each patient's level of need for Medical Case Management services, performing a comprehensive assessment, including an assessment of the patient's health literary, and developing a medical service plan for each client that demonstrates a documented need for such services, monitoring medical service plan to ensure its implementation, and educating client regarding wellness, medication and health care appointment adherence. The Medical Case Manager serves as an advocate for the client and as a liaison with medical providers on behalf of the client. The Medical Case Manager ensures linkage to

	mental health, substance abuse and other client services as indicated by the medical service plan. **Service Linkage:** The purpose of Service Linkage is to assist clients with the procurement of needed services so that the problems associated with living with HIV are mitigated. Service Linkage is a working agreement between a client and a Service Linkage Worker for an indeterminate period, based on client need, during which information, referrals and service linkage are provided on an as-needed basis. Service Linkage assists clients who do not require the intensity of Medical Case Management per RWGA Quality Management guidelines. Service Linkage is both office-based and field based. Service Linkage Workers are expected to coordinate activities with referral sources where newly-diagnosed or not-in-care PLWHA may be identified, including 1:1 case conferences with testing site personnel to ensure the successful transition of referrals into Primary Care Services. Such incoming referral coordination includes meeting prospective clients at the referring Provider location in order to develop rapport with individuals prior to the individual's initial Primary Care appointment and ensuring such new intakes to Primary Care services have sufficient support to make the often difficult transition into ongoing primary medical care. Service Linkage also includes follow-up to re-engage lost-to-care patients. Lost-to-care patients are those patients who have not returned for scheduled appointments with Provider nor have provided Provider with updated information about their current Primary Medical Care provider (in the situation where patient may have obtained alternate service from another medical provider). Contractor must document efforts to re-engage lost-to-care patients prior to closing patients in the CPCDMS. Service Linkage extends the capability of existing programs by providing "hands-on" outreach and linkage to care services to those PLWHA who are not currently accessing primary medical care services. Service Linkage includes the issuance of bus pass vouchers and gas cards per published RWGA guidelines. Service Linkage complements and extends the service delivery capability of Medical Case Management services. **Outreach**: Providing allowable Ryan White Program outreach and service linkage activities to PLWHA who know their status but are not actively engaged in outpatient primary medical care with information, referrals and assistance with medical appointment setting, mental health, substance abuse and psychosocial services as needed; advocating on behalf of clients to decrease service gaps and remove barriers to services helping clients develop and utilize independent living skills and strategies. Assist clients in obtaining needed resources, including bus pass vouchers and gas cards per published HCPH/RWGA policies. Outreach services must be conducted at times and in places where there is a high probability

	that individuals with HIV infection will be contacted, designed to provide quantified program reporting of activities and outcomes to accommodate local evaluation of effectiveness, planned and delivered in coordination with local and state HIV prevention outreach programs to avoid duplication of effort, targeted to populations known, through review of clinic medical records, to be at disproportionate risk of disengagement with primary medical care services. **Emergency Financial Assistance – Pharmacy Assistance** provides limited one-time and/or short-term 30-day supply of pharmaceuticals to patients otherwise ineligible for medications through private insurance, Medicaid/Medicare, State ADAP, SPAP or other sources. One refill for up to 30-day supply available with RWGA prior approval. Allowable medications are only those on the Houston EMA Ryan White Part A Formulary. HIV-related medication services are the provision of physician or physician-extender prescribed medications to prevent serious deterioration of health. Does not include drugs available to the patient from other programs or payers or free of charge or medications available over the counter (OTC) without prescription. Contractor must offer all medications on the Texas ADAP formulary.
Agency Requirements:	**Providers and system must be Medicaid/Medicare certified.** **Eligibility and Benefits Coordination:** Contractor must implement consumer-friendly, culturally and linguistically appropriate new and ongoing patient eligibility verification and benefit coordination processes that ensure accountability with Ryan White Payer of Last Resort requirements while achieving maximum utilization of eligible benefits. Eligibility processes should provide clients with a meaningful understanding of their benefits, expected out-of-pocket expenses and other information needed to ensure full and continued participation in care. **LPAP and EFA – Pharmacy Assistance Services:** Contractor must: Provide pharmacy services on-site or through an established contractual relationship that meets all requirements. Alternate (off-site) approaches must be approved prior to implementation by RWGA. Either directly, or via subcontract with an eligible 340B Pharmacy program entity, must: Ensure a comprehensive financial intake application to determine client eligibility for this program to insure that these funds are used as a last resort for purchase of medications.

	Ensure the documented capability of interfacing with the Texas HIV Medication Program operated by the Texas Department of State Health Services. This capability must be fully documented and is subject to independent verification by RWGA. Ensure medication assistance provided to clients does not duplicate services already being provided in the Houston area. The process for accomplishing this must be fully documented and is subject to independent verification by RWGA. Ensure, either directly or via a 340B Pharmacy Program Provider, at least 2 years of continuous documented experience in providing HIV/AIDS medication programs utilizing Ryan White Program or similar public sector funding. This experience must be documented and is subject to independent verification by RWGA. Ensure all medications are purchased via a qualified participant in the federal 340B Drug Pricing Program and Prime Vendor Program, administered by the HRSA Office of Pharmacy Affairs. Note: failure to maintain 340B or Prime Vendor drug pricing may result in a negative audit finding, cost disallowance or termination of contract awarded. Contractor must maintain 340B Program participation throughout the contract term. All eligible medications must be purchased in accordance with Program 340B guidelines and program requirements. Ensure Houston area HIV/AIDS service providers are informed of this program and how the client referral and enrollment processes functions. Contractor must maintain documentation of such marketing efforts. Implement a consistent process to enroll eligible patients in available pharmaceutical company Patient Assistance Programs prior to using Ryan White Part A funded LPAP resources. Ensure information regarding the program is provided to PLWHA, including historically under-served and unserved populations (e.g., African American, Hispanic/Latino, Asian, Native American, Pacific Islander) and women not currently obtaining prescribed HIV and HIV-related medications. Offer, at no charge to the client, delivery options for medication refills, including but not limited to courier, USPS or other package delivery service. **Case Management Operations and Supervision:** The Service Linkage Workers (SLW) and Medical Case Managers (MCM) must function within the clinical infrastructure of Contractor and receive ongoing supervision that meets or exceeds published Standards of Care. An MCM may supervise SLWs.

Staff Requirements:	Contractor is responsible for ensuring that services are provided by State licensed internal medicine and OB/GYN physicians, specialty care physicians, psychiatrists, registered nurses, nurse practitioners, vocational nurses, pharmacists, physician assistants, clinical nurse specialists, physician extenders with a colposcopy provider qualification, x-ray technologists, State licensed dieticians, licensed social worker and ancillary health care providers in accordance with appropriate State licensing and/or certification requirements and with knowledge and experience of HIV disease. In addition, Contractor must ensure the following staff requirements are met: **Outpatient Psychiatric Services:** Director of the Program must be a Board Certified Psychiatrist. Licensed and/or Certified allied health professionals (Licensed Psychologists, Physicians, Psychiatric Nurse Practitioners, Licensed Master Social Workers, Licensed Professional Counselors, Licensed Marriage and Family Therapists, Certified Alcohol and Drug Abuse Counselors, etc.) must be used in all treatment modalities. Documentation of the Director's credentials, licensures and certifications must be included in the proposal. Documentation of the Allied Health professional licensures and certifications must be included in the proposal appendices. **Medication and Adherence Education:** The program must utilize an RN, LVN, PA, NP, pharmacist or MD licensed by the State of Texas, who has at least two (2) years paid experience in the preceding five (5) years in HIV/AIDS care, to provide the educational services. Licensed social workers who have at least two (2) years paid experience in the preceding five (5) years in HIV/AIDS care may also provide adherence education and counseling. **Nutritional Assessment (primary care):** Services must be provided by a licensed registered dietician. Dieticians must have a minimum of two (2) years of experience providing nutritional assessment and counseling to PLWHA. **Medical Case Management:** The program must utilize a state licensed Social Worker to provide Medical Case Management Services. The Contractor must maintain the assigned number of Medical Case Management FTEs throughout the contract term. **Contractor must provide to RWGA the names of each Medical Case Manager and the individual assigned to supervise those Medical Case Managers within 30 days of start of grant year, and thereafter within 15 days after hire.** **Service Linkage:** The program must utilize Service Linkage Workers who have at a minimum a Bachelor's degree from an accredited college or university with a major in social or behavioral sciences. Documented paid work experience in providing client

	services to PLWHA may be substituted for the Bachelor's degree requirement on a 1:1 basis (1 year of documented paid experience may be substituted for 1 year of college). All Service Linkage Workers must have a minimum of one (1) year paid work experience with PLWHA. Contractor must maintain the assigned number of Service Linkage FTEs throughout the contract term. **Contractor must provide to RWGA the names of each Service Linkage Worker and the individual assigned to supervise those Service Linkage Workers within 30 days of start of grant year, and thereafter within 15 days after hire.** **Supervision of Case Managers:** The Service Linkage Workers and Medical Case Managers must function within the clinical infrastructure of Contractor and receive ongoing supervision that meets or exceeds Houston EMA/HSDA Part A/B Standards of Care for Service Linkage and Medical Case Management as applicable. An MCM may supervise SLWs.
Special Requirements:	**All primary medical care services must meet or exceed current United States DHHS Treatment Guidelines for the treatment and management of HIV disease.** Contractor must provide all required program components - Primary Medical Care, Medical Case Management, Service Linkage (non-medical Case Management) and Local Pharmacy Assistance Program (LPAP) services. **Primary Medical Care Services:** Services funded under this grant cannot be used to supplant insurance or Medicare/Medicaid reimbursements for such services. Clients eligible for such reimbursement may not be billed to this contract. Medicare and private insurance co-payments may be eligible for reimbursement under Ryan White Health Insurance Assistance (HINS) program guidelines. Patients needing such assistance should be referred to the local Ryan White-funded HINS provider for assistance. Under no circumstances may the Contractor bill the County for the difference between the reimbursement from Medicaid, Medicare or Third Party insurance and the fee schedule under the contract. Furthermore, potential clients who are Medicaid/Medicare eligible or have other Third Party payers may not be denied services or referred elsewhere by the Contractor based on their reimbursement status (i.e. Medicaid/Medicare eligible clients may not be referred elsewhere in order that non-Medicaid/Medicare eligible clients may be added to the contract). Failure to serve Medicaid/Medicare eligible clients based on their reimbursement status will be grounds for the immediate termination of contract.

	For primary medical care services targeted to the Latino community at least 50% of the clinical care team must be fluent in Spanish. **Diagnostic Procedures:** A single Diagnostic Procedure limited to procedures on the approved list of diagnostic procedures (see below) without prior County approval. Approved diagnostic procedures will be reimbursed at invoice cost. Part A and Part A/MAI-funded programs must refer to the RWGA website for the most current list of approved diagnostic procedures and corresponding codes: www.hcphes.org/rwga. **Diagnostic procedures not listed on the website must have prior approval by RWGA.** **Outpatient Psychiatric Services:** Client must not be eligible for services from other programs/providers or any other reimbursement source (i.e. Medicaid, Medicare, private insurance) unless the client is in crisis and cannot be provided immediate services from the other programs/providers. In this case, clients may be provided services, as long as the client applies for the other programs/providers, until the other programs/providers can take over services. Program must be supervised by a Psychiatrist and include diagnostic assessments, emergency evaluations and psycho-pharmacotherapy. **Maintaining Referral Relationships** (Point of Entry Agreements): Contractor must maintain appropriate relationships with entities that constitute key points of access to the health care system for individuals with HIV disease, including but not limited to, Harris Health System and other Houston EMA-located emergency rooms, Harris County Jail, Texas Department of Criminal Justice incarceration facilities, Immigration detention centers, substance abuse treatment and detoxification programs, adult and juvenile detention facilities, Sexually Transmitted Disease clinics, federally qualified health centers (FQHC), HIV disease counseling and testing sites, mental health programs and homeless shelters. These referral relationships must be documented with written collaborative agreements, contracts or memoranda of understanding between Contractor and appropriate point of entry entities and are subject to audit by RWGA. Contractor and POE entity staff must regularly (e.g. weekly, bi-weekly depending on volume of referrals) meet 1:1 to discuss new referrals to primary medical care services. Such case conferences must be documented in the client record and properly entered into the CPCDMS. Use of CPCDMS Data System: Contractor must comply with CPCDMS business rules and procedures. Contractor must enter into the CPCDMS all required clinical data, including but not limited to, HAART treatment including all changes in medication

	regimens, Opportunistic Infections, screening and treatment for STDs and Hepatitis A, B, C and other clinical screening and treatment data required by HRSA, TDSHS and the County. Contractor must perform Registration updates in accordance with RWGA CPCDMS business rules for all clients wherein Contractor is client's CPCDMS record-owning agency. Contractor must utilize an electronic verification system to verify insurance/3rd party payer status monthly or per visit (whichever is less frequent). **Bus Pass Distribution:** The County will provide Contractor with METRO bus pass vouchers. Bus Pass vouchers must be distributed in accordance with RWGA policies and procedures, standards of care and financial eligibility guidelines. Contractor may only issue METRO bus pass vouchers to clients wherein the Contractor is the CPCDMS record owning Contractor. METRO bus pass vouchers shall be distributed as follows: **Expiration of Current Bus Pass:** In those situation wherein the bus pass expiration date does not coincide with the CPCDMS registration update the Contractor must distribute METRO bus pass vouchers to eligible clients upon the expiration of the current bus pass or when a Value-based bus card has been expended on eligible transportation needs. Contractor may issue METRO bus passes to eligible clients living outside the METRO service area in those situations where the Contractor has documented in the client record that the client will utilize the METRO system to access needed HIV-related health care services located in the METRO service area. **Gas Cards:** Primary Medical Care Contractors must distribute gasoline vouchers to eligible clients residing in the rural service area in accordance with RWGA policies and procedures, standards of care and financial eligibility guidelines. Gas Cards are only available to Rural primary medical care Contractors without prior approval by RWGA.

FY 2022 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/10/2021**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/03/2021**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Improvement Committee**		Date: **05/18/2021**
Recommendations:	Approved: Y:_ ___ No: _____ Approved With Changes: _____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMTN Workgroup #1**	Date: **04/20/2021**
Recommendations:	Financial Eligibility: PriCare=300%, EFA=500%, LPAP=400% +500%, MCM=none, SLW=none, Outreach=none
1. Accept the service definition as presented and keep the financial eligibility the same.	
2.	
3.	

FY 2020 Houston EMA Ryan White Part A/MAI Service Definition **Comprehensive Outpatient Primary Medical Care including Medical Case Management, Service Linkage and Local Pharmacy Assistance Program (LPAP) Services**	
HRSA Service Category Title: **RWGA Only**	1. Outpatient/Ambulatory Medical Care 2. Medical Case Management 3. AIDS Pharmaceutical Assistance (local) 4. Case Management (non-Medical) 5. Emergency Financial Assistance – Pharmacy Assistance 6. Outreach
Local Service Category Title:	Adult Comprehensive Primary Medical Care i. Targeted to Public Clinic ii. Targeted to Women at Public Clinic
Amount Available: **RWGA Only**	Total estimated available funding: $0.00 (to be determined) 1. Primary Medical Care: $0.00 (including MAI) i. Targeted to Public Clinic: $0.00 ii. Targeted to Women at Public Clinic: $0.00 2. LPAP $0.00 3. Medical Case Management: $0.00 i. Targeted to Public Clinic: $0.00 ii. Targeted to Women at Public Clinic: $0.00 4. Service Linkage: $0.00 Note: The Houston Ryan White Planning Council (RWPC) determines annual Part A and MAI service category allocations & reallocations. RWGA has sole authority over contract award amounts.
Target Population:	Comprehensive Primary Medical Care – Community Based i. Targeted to Public Clinic ii. Targeted to Women at Public Clinic **Outreach:** Services will be available to eligible HIV-infected clients residing in the Houston EMA/HSDA with priority given to clients most in need. Services are restricted to those clients who meet the contractor's RWGA approved Outreach Inclusion Criteria. The Outreach Inclusion Criteria components must include, at minimum 2 consecutive missed primary care provider and/or HIV lab appointments. Outreach Inclusion Criteria may also include VL suppression, substance abuse, and ART treatment failure components.

Client Eligibility: Age, Gender, Race, Ethnicity, Residence, etc.	PLWHA residing in the Houston EMA (prior approval required for non-EMA clients). Contractor must adhere to Targeting requirements and Budget limitations as applicable.
Financial Eligibility:	*See Current Year Approved Financial Eligibility for Houston EMA/HSDA*
Budget Type: **RWGA Only**	Hybrid Fee for Service
Budget Requirement or Restrictions: **RWGA Only**	**Primary Medical Care:** 100% of clients served under the *Targeted to Women at Public Clinic* subcategory must be female 10% of funds designated to primary medical care must be reserved for invoicing diagnostic procedures at actual cost. Contractors may not exceed the allocation for each individual service component (Primary Medical Care, Medical Case Management, Local Pharmacy Assistance Program and Service Linkage) without prior approval from RWGA. **Local Pharmacy Assistance Program (LPAP):** Houston RWPC guidelines for Local Pharmacy Assistance Program (LPAP) services: Contractor shall offer HIV medications from an approved formulary for a total not to exceed $18,000 per contract year per client. Contractor shall offer HIV-related medications for a total not to exceed $3,000 per contract year per client. These guidelines are determined by the RWPC. The RWPC determines the subcategories that shall include Ryan White LPAP funding. Medications must be provided in accordance with Houston EMA guidelines, HRSA/HAB rules and regulations and applicable Office of Pharmacy Affairs 340B guidelines. At least 75% of the total amount of the budget for LPAP services must be solely allocated to the actual cost of medications and may not include any storage, administrative, processing or other costs associated with managing the medication inventory or distribution. **Emergency Financial Assistance – Pharmacy Assistance** Direct cash payments to clients are not permitted. It is expected that all other sources of funding in the community for emergency financial assistance will be effectively used and that any allocation of RWHAP funds for these purposes will be as the payer of last

	resort, and for limited amounts, uses, and periods of time. Continuous provision of an allowable service to a client should not be funded through emergency financial assistance. **Outreach** Outreach services are restricted to those patients who have not returned for scheduled appointments with Provider as outlined in the RWGA approved Outreach Inclusion Criteria, and are included on the Outreach list.
Service Unit Definition/s: **RWGA Only**	• Outpatient/Ambulatory Medical Care: One (1) unit of service = One (1) primary care office/clinic visit which includes the following: • Primary care physician/nurse practitioner, physician's assistant or clinical nurse specialist examination of the patient, and • Medication/treatment education • Medication access/linkage • OB/GYN specialty procedures (as clinically indicated) • Nutritional assessment (as clinically indicated) • Laboratory (as clinically indicated, not including specialized tests) • Radiology (as clinically indicated, not including CAT scan or MRI) • Eligibility verification/screening (as necessary) • Follow-up visits wherein the patient is not seen by the MD/NP/PA are considered to be a component of the original primary care visit. • Outpatient Psychiatric Services: 1 unit of service = A single (1) office/clinic visit wherein the patient is seen by a State licensed and board-eligible Psychiatrist or qualified Psychiatric Nurse Practitioner. This visit may or may not occur on the same date as a primary care office visit. • Medication Education: 1 unit of service = A single pharmacy visit wherein a Ryan White eligible client is provided medication education services by a qualified pharmacist. This visit may or may not occur on the same date as a primary care office visit. Maximum reimbursement allowable for a medication education visit may not exceed $50.00 per visit. The visit must include at least one prescription medication being provided to clients. A maximum of one (1) Medication Education Visit may be provided to an individual client per day, regardless of the number of prescription medications provided. • Nutritional Assessment and Plan: 1 unit of service = A single comprehensive nutritional assessment and treatment plan performed by a Licensed, Registered Dietician initiated upon a physician's order. Does not include the provision of Supplements or other products (clients may be referred to the

	Ryan White funded Medical Nutritional Therapy provider for provision of medically necessary supplements). The nutritional assessment visit may or may not occur on the same date as a medical office visit. • AIDS Pharmaceutical Assistance (local): A unit of service = a transaction involving the filling of a prescription or any other allowable medication need ordered by a qualified medical practitioner. The transaction will involve at least one item being provided for the client, but can be any multiple. The cost of medications provided to the client must be invoiced at actual cost. • Medical Case Management: 1 unit of service = 15 minutes of direct medical case management services to an eligible PLWHA performed by a qualified medical case manager. • Service Linkage (non-Medical Case Management): 1 unit of service = 15 minutes of direct service linkage services to an eligible PLWHA performed by a qualified service linkage worker. • Outreach: 15 Minutes = 1 Unit • Emergency Financial Assistance – Pharmacy Assistance: A unit of service = a transaction involving the filling of a prescription or any other allowable HIV treatment medication need ordered by a qualified medical practitioner. The transaction will involve at least one item being provided for the client, but can be any multiple. The cost of medications provided to the client must be invoiced at actual cost.
HRSA Service Category Definition: **RWGA Only**	• **Outpatient/Ambulatory medical care** is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings. Services includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies. • **AIDS Pharmaceutical Assistance (local)** includes local pharmacy assistance programs implemented by Part A or Part

	B Grantees to provide HIV/AIDS medications to clients. This assistance can be funded with Part A grant funds and/or Part B base award funds. Local pharmacy assistance programs are not funded with ADAP earmark funding. • **Medical Case Management** services (including treatment adherence) are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication. • **Case Management (non-Medical)** includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does. • **Emergency Financial Assistance** provides limited one-time or short-term payments to assist the RWHAP client with an emergent need for paying for essential utilities, housing, food (including groceries, and food vouchers), transportation, and medication. Emergency financial assistance can occur as a direct payment to an agency or through a voucher program. • **Outreach Services** include the provision of the following three activities: Identification of people who do not know their HIV status and linkage into Outpatient/Ambulatory Health Services, Provision of additional information and education on health care coverage options, Reengagement of people who know their status into Outpatient/Ambulatory Health Services
Standards of Care:	Contractors must adhere to the most current published Part A/B Standards of Care for the Houston EMA/HSDA. **Services must meet or exceed applicable United States Department of Health and Human Services (DHHS) guidelines for the Treatment of HIV/AIDS.**

Local Service Category Definition/Services to be Provided:	**Outpatient/Ambulatory Primary Medical Care:** Services include on-site physician, physician extender, nursing, phlebotomy, radiographic, laboratory, pharmacy, intravenous therapy, home health care referral, licensed dietician, patient medication education, and patient care coordination. The Contractor must provide continuity of care with inpatient services and subspecialty services (either on-site or through specific referral to appropriate medical provider upon primary care Physician's order). Services provided to women shall further include OB/GYN physician & physician extender services on-site or by referral, OB/GYN services, colposcopy, nursing, phlebotomy, radiographic, laboratory, pharmacy, intravenous therapy, home health care referral, licensed dietician, patient medication/women's health education, patient care coordination, and social services. The Contractor must provide continuity of care with inpatient services and subspecialty services (either on-site or through specific referral protocols to appropriate agencies upon primary care Physician's order). **Outpatient/Ambulatory Primary Medical Care must provide:** • Continuity of care for all stages of adult HIV infection; • Laboratory and pharmacy services including intravenous medications (either on-site or through established referral systems); • Outpatient psychiatric care, including lab work necessary for the prescribing of psychiatric medications when appropriate (either on-site or through established referral systems); • Access to the Texas ADAP program (either on-site or through established referral systems); • Access to compassionate use HIV medication programs (either directly or through established referral systems); • Access to HIV related research protocols (either directly or through established referral systems); • Must at a minimum, comply with Houston EMA/HSDA Part A/B Standards for HIV Primary Medical Care. The Contractor must demonstrate on an ongoing basis the ability to provide state-of-the-art HIV-related primary care medicine in accordance with the most recent DHHS HIV treatment guidelines. Rapid advances in HIV treatment protocols require that the Contractor provide services that to the greatest extent possible maximize a patient's opportunity for long-term survival and maintenance of the highest quality of life possible. • On-site Outpatient Psychiatry services. • On-site Medical Case Management services. • On-site Medication Education. • Physical therapy services (either on-site or via referral). • Specialty Clinic Referrals (either on-site or via referral).

	• On-site pelvic exams as needed for female patients with appropriate follow-up treatment and referral. • On site Nutritional Counseling by a Licensed Dietitian. **Women's Services must also provide:** • Well woman care, including but not limited to: PAP, pelvic exam, HPV screening, breast examination, mammography, hormone replacement and education, pregnancy testing, contraceptive services excluding birth control medications. • Obstetric Care: ante-partum through post-partum services, child birth/delivery services. Perinatal preventative education and treatment. • On-site or by referral Colposcopy exams as needed, performed by an OB/GYN physician, or physician extender with a colposcopy provider qualification. • Social services, including but not limited to, providing women access to child care, transportation vouchers, food vouchers and support groups at the clinic site; **Nutritional Assessment:** Services include provision of information about therapeutic nutritional/supplemental foods that are beneficial to the wellness and increased health conditions of clients by a Licensed Dietitian. Services may be provided either through educational or counseling sessions. Clients who receive these services may utilize the Ryan White Part A-funded nutritional supplement provider to obtain recommended nutritional supplements in accordance with program rules. Clients are limited to one (1) nutritional assessment per calendar year without prior approval of RWGA. Patient Medication Education Services must adhere to the following requirements: • Medication Educators must be State Licensed Medical Doctor (MD), Nurse Practitioner (NP), Physician Assistant PA), Nurse (RN, LVN) or Pharmacist. Prior approval must be obtained prior to utilizing any other health care professional not listed above to provide medication education. • Clients who will be prescribed ongoing medical regimens (i.e. ART) must be assessed for adherence to treatment at every clinical encounter using the EMA's approved adherence assessment tool. Clients with adherence issues related to lack of understanding must receive more education regarding their medical regimen. Clients with adherence issues that are behavioral or involve mental health issues must be provided counseling by the Medical Case Manager, Physician or Physician Extender and/or licensed nursing staff and, if

clinically indicated, assessment and treatment by a qualified Psychiatrist or Psychiatric Nurse Practitioner.

Outpatient Psychiatric Services:

The program must provide:

- Diagnostic Assessments: comprehensive evaluation for identification of psychiatric disorders, mental status evaluation, differential diagnosis which may involve use of other clinical and laboratory tests, case formulation, and treatment plans or disposition.
- Emergency Psychiatric Services: rapid evaluation, differential diagnosis, acute treatment, crisis intervention, and referral. Must be available on a 24 hour basis including emergency room referral.
- Brief Psychotherapy: individual, supportive, group, couple, family, hypnosis, biofeedback, and other psychophysiological treatments and behavior modification.
- Psychopharmacotherapy: evaluation and medication treatment of psychiatric disorders, including, but not limited to, anxiety disorders, major depression, pain syndromes, habit control problems, psychosis and organic mental disorders.
- Rehabilitation Services: Physical, psychosocial, behavioral, and/or cognitive training.

Screening for Eye Disorders: Contractor must ensure that patients receive appropriate screening and treatment for CMV, glaucoma, cataracts, and other related problems.

Local Medication Assistance Program (LPAP): LPAP provides pharmaceuticals to patients otherwise ineligible for medications through private insurance, Medicaid/Medicare, State ADAP, SPAP or other sources. Allowable medications are only those on the Houston EMA Ryan White Part A Formulary. Eligible clients may be provided Fuzeon™ on a case-by-case basis with prior approval of Ryan White Grant Administration (RWGA). The cost of Fuzeon™ does not count against a client's annual maximum. HIV-related medication services are the provision of physician or physician-extender prescribed HIV-related medications to prevent serious deterioration of health. Does not include drugs available to the patient from other programs or payers or free of charge (such as birth control and TB medications) or medications available over the counter (OTC) without prescription.

Contractor must offer all medications on the Texas ADAP formulary, for a total not to exceed $18,000.00 per contract year per client. Contractor must provide allowable HIV-related medications (i.e. non-HIV medications) for a total not to exceed $3,000 per contract year per client. Contractor may be reimbursed ADAP

	dispensing fees (e.g. $5/Rx) in accordance with RWGA business rules for those ADAP clients who are unable to pay the ADAP dispensing fee. **Medical Case Management Services:** Services include screening all primary medical care patients to determine each patient's level of need for Medical Case Management services, performing a comprehensive assessment, including an assessment of the patient's health literary, and developing a medical service plan for each client that demonstrates a documented need for such services, monitoring medical service plan to ensure its implementation, and educating client regarding wellness, medication and health care appointment adherence. The Medical Case Manager serves as an advocate for the client and as a liaison with medical providers on behalf of the client. The Medical Case Manager ensures linkage to mental health, substance abuse and other client services as indicated by the medical service plan. **Service Linkage:** The purpose of Service Linkage is to assist clients with the procurement of needed services so that the problems associated with living with HIV are mitigated. Service Linkage is a working agreement between a client and a Service Linkage Worker for an indeterminate period, based on client need, during which information, referrals and service linkage are provided on an as-needed basis. Service Linkage assists clients who do not require the intensity of Medical Case Management per RWGA Quality Management guidelines. Service Linkage is both office-based and field based. Service Linkage Workers are expected to coordinate activities with referral sources where newly-diagnosed or not-in-care PLWHA may be identified, including 1:1 case conferences with testing site personnel to ensure the successful transition of referrals into Primary Care Services. Such incoming referral coordination includes meeting prospective clients at the referring Provider location in order to develop rapport with individuals prior to the individual's initial Primary Care appointment and ensuring such new intakes to Primary Care services have sufficient support to make the often difficult transition into ongoing primary medical care. Service Linkage also includes follow-up to re-engage lost-to-care patients. Lost-to-care patients are those patients who have not returned for scheduled appointments with Provider nor have provided Provider with updated information about their current Primary Medical Care provider (in the situation where patient may have obtained alternate service from another medical provider). Contractor must document efforts to re-engage lost-to-care patients prior to closing patients in the CPCDMS. Service Linkage extends the capability of existing programs by providing "hands-on" outreach and linkage to care services to those PLWHA who are not currently accessing primary medical care services. Service Linkage includes the issuance of

	bus pass vouchers and gas cards per published RWGA guidelines. Service Linkage complements and extends the service delivery capability of Medical Case Management services. **Outreach**: Providing allowable Ryan White Program outreach and service linkage activities to PLWHA who know their status but are not actively engaged in outpatient primary medical care with information, referrals and assistance with medical appointment setting, mental health, substance abuse and psychosocial services as needed; advocating on behalf of clients to decrease service gaps and remove barriers to services helping clients develop and utilize independent living skills and strategies. Assist clients in obtaining needed resources, including bus pass vouchers and gas cards per published HCPH/RWGA policies. Outreach services must be conducted at times and in places where there is a high probability that individuals with HIV infection will be contacted, designed to provide quantified program reporting of activities and outcomes to accommodate local evaluation of effectiveness, planned and delivered in coordination with local and state HIV prevention outreach programs to avoid duplication of effort, targeted to populations known, through review of clinic medical records, to be at disproportionate risk of disengagement with primary medical care services. **Emergency Financial Assistance – Pharmacy Assistance** provides limited one-time and/or short-term 30-day supply of pharmaceuticals to patients otherwise ineligible for medications through private insurance, Medicaid/Medicare, State ADAP, SPAP or other sources. One refill for up to 30-day supply available with RWGA prior approval. Allowable medications are only those on the Houston EMA Ryan White Part A Formulary. HIV-related medication services are the provision of physician or physician-extender prescribed medications to prevent serious deterioration of health. Does not include drugs available to the patient from other programs or payers or free of charge or medications available over the counter (OTC) without prescription. Contractor must offer all medications on the Texas ADAP formulary.
Agency Requirements:	**Providers and system must be Medicaid/Medicare certified.** **Eligibility and Benefits Coordination:** Contractor must implement consumer-friendly, culturally and linguistically appropriate new and ongoing patient eligibility verification and benefit coordination processes that ensure accountability with Ryan White Payer of Last Resort requirements while achieving maximum utilization of eligible benefits. Eligibility processes should provide clients with a meaningful understanding of their benefits, expected out-of-pocket expenses and other information needed to ensure full and continued participation in care.

	LPAP and EFA – Pharmacy Assistance Services: Contractor must: Provide pharmacy services on-site or through an established contractual relationship that meets all requirements. Alternate (off-site) approaches must be approved prior to implementation by RWGA. Either directly, or via subcontract with an eligible 340B Pharmacy program entity, must: Ensure a comprehensive financial intake application to determine client eligibility for this program to insure that these funds are used as a last resort for purchase of medications. Ensure the documented capability of interfacing with the Texas HIV Medication Program operated by the Texas Department of State Health Services. This capability must be fully documented and is subject to independent verification by RWGA. Ensure medication assistance provided to clients does not duplicate services already being provided in the Houston area. The process for accomplishing this must be fully documented and is subject to independent verification by RWGA. Ensure, either directly or via a 340B Pharmacy Program Provider, at least 2 years of continuous documented experience in providing HIV/AIDS medication programs utilizing Ryan White Program or similar public sector funding. This experience must be documented and is subject to independent verification by RWGA. Ensure all medications are purchased via a qualified participant in the federal 340B Drug Pricing Program and Prime Vendor Program, administered by the HRSA Office of Pharmacy Affairs. Note: failure to maintain 340B or Prime Vendor drug pricing may result in a negative audit finding, cost disallowance or termination of contract awarded. Contractor must maintain 340B Program participation throughout the contract term. All eligible medications must be purchased in accordance with Program 340B guidelines and program requirements. Ensure Houston area HIV/AIDS service providers are informed of this program and how the client referral and enrollment processes functions. Contractor must maintain documentation of such marketing efforts. Implement a consistent process to enroll eligible patients in available pharmaceutical company Patient Assistance Programs prior to using Ryan White Part A funded LPAP resources.

	Ensure information regarding the program is provided to PLWHA, including historically under-served and unserved populations (e.g., African American, Hispanic/Latino, Asian, Native American, Pacific Islander) and women not currently obtaining prescribed HIV and HIV-related medications. Offer, at no charge to the client, delivery options for medication refills, including but not limited to courier, USPS or other package delivery service. **Case Management Operations and Supervision:** The Service Linkage Workers (SLW) and Medical Case Managers (MCM) must function within the clinical infrastructure of Contractor and receive ongoing supervision that meets or exceeds published Standards of Care. An MCM may supervise SLWs.
Staff Requirements:	Contractor is responsible for ensuring that services are provided by State licensed internal medicine and OB/GYN physicians, specialty care physicians, psychiatrists, registered nurses, nurse practitioners, vocational nurses, pharmacists, physician assistants, clinical nurse specialists, physician extenders with a colposcopy provider qualification, x-ray technologists, State licensed dieticians, licensed social worker and ancillary health care providers in accordance with appropriate State licensing and/or certification requirements and with knowledge and experience of HIV disease. In addition, Contractor must ensure the following staff requirements are met: **Outpatient Psychiatric Services:** Director of the Program must be a Board Certified Psychiatrist. Licensed and/or Certified allied health professionals (Licensed Psychologists, Physicians, Psychiatric Nurse Practitioners, Licensed Master Social Workers, Licensed Professional Counselors, Licensed Marriage and Family Therapists, Certified Alcohol and Drug Abuse Counselors, etc.) must be used in all treatment modalities. Documentation of the Director's credentials, licensures and certifications must be included in the proposal. Documentation of the Allied Health professional licensures and certifications must be included in the proposal appendices. **Medication and Adherence Education:** The program must utilize an RN, LVN, PA, NP, pharmacist or MD licensed by the State of Texas, who has at least two (2) years paid experience in the preceding five (5) years in HIV/AIDS care, to provide the educational services. Licensed social workers who have at least two (2) years paid experience in the preceding five (5) years in HIV/AIDS care may also provide adherence education and counseling. **Nutritional Assessment (primary care):** Services must be provided by a licensed registered dietician. Dieticians must have a

	minimum of two (2) years of experience providing nutritional assessment and counseling to PLWHA. **Medical Case Management:** The program must utilize a state licensed Social Worker to provide Medical Case Management Services. The Contractor must maintain the assigned number of Medical Case Management FTEs throughout the contract term. **Contractor must provide to RWGA the names of each Medical Case Manager and the individual assigned to supervise those Medical Case Managers by 03/30/15, and thereafter within 15 days after hire.** **Service Linkage:** The program must utilize Service Linkage Workers who have at a minimum a Bachelor's degree from an accredited college or university with a major in social or behavioral sciences. Documented paid work experience in providing client services to PLWHA may be substituted for the Bachelor's degree requirement on a 1:1 basis (1 year of documented paid experience may be substituted for 1 year of college). All Service Linkage Workers must have a minimum of one (1) year paid work experience with PLWHA. Contractor must maintain the assigned number of Service Linkage FTEs throughout the contract term. **Contractor must provide to RWGA the names of each Service Linkage Worker and the individual assigned to supervise those Service Linkage Workers by 03/30/15, and thereafter within 15 days after hire.** **Supervision of Case Managers:** The Service Linkage Workers and Medical Case Managers must function within the clinical infrastructure of Contractor and receive ongoing supervision that meets or exceeds Houston EMA/HSDA Part A/B Standards of Care for Service Linkage and Medical Case Management as applicable. An MCM may supervise SLWs.

Special Requirements: **RWGA Only**	**All primary medical care services must meet or exceed current United States DHHS Treatment Guidelines for the treatment and management of HIV disease.** Contractor must provide all required program components - Primary Medical Care, Medical Case Management, Service Linkage (non-medical Case Management) and Local Pharmacy Assistance Program (LPAP) services. **Primary Medical Care Services:** Services funded under this grant cannot be used to supplant insurance or Medicare/Medicaid reimbursements for such services. Clients eligible for such reimbursement may not be billed to this contract. Medicare and private insurance co-payments may be eligible for reimbursement under Ryan White Health Insurance Assistance (HINS) program guidelines. Patients needing such assistance should be referred to the local Ryan White-funded HINS provider for assistance. Under no circumstances may the Contractor bill the County for the difference between the reimbursement from Medicaid, Medicare or Third Party insurance and the fee schedule under the contract. Furthermore, potential clients who are Medicaid/Medicare eligible or have other Third Party payers may not be denied services or referred elsewhere by the Contractor based on their reimbursement status (i.e. Medicaid/Medicare eligible clients may not be referred elsewhere in order that non-Medicaid/Medicare eligible clients may be added to the contract). Failure to serve Medicaid/Medicare eligible clients based on their reimbursement status will be grounds for the immediate termination of contract. **Diagnostic Procedures:** A single Diagnostic Procedure limited to procedures on the approved list of diagnostic procedures (see below) without prior County approval. Approved diagnostic procedures will be reimbursed at invoice cost. Part A and Part A/MAI-funded programs must refer to the RWGA website for the most current list of approved diagnostic procedures and corresponding codes: www.hcphes.org/rwga. **Diagnostic procedures not listed on the website must have prior approval by RWGA.** **Outpatient Psychiatric Services:** Client must not be eligible for services from other programs/providers or any other reimbursement source (i.e. Medicaid, Medicare, private insurance) unless the client is in crisis and cannot be provided immediate services from the other programs/providers. In this case, clients may be provided services, as long as the client applies for the other programs/providers, until the other programs/providers can take over services. Program must be supervised by a Psychiatrist and

	include diagnostic assessments, emergency evaluations and psycho-pharmacotherapy. **Maintaining Referral Relationships** (Point of Entry Agreements): Contractor must maintain appropriate relationships with entities that constitute key points of access to the health care system for individuals with HIV disease, including but not limited to, Harris Health System and other Houston EMA-located emergency rooms, Harris County Jail, Texas Department of Criminal Justice incarceration facilities, Immigration detention centers, substance abuse treatment and detoxification programs, adult and juvenile detention facilities, Sexually Transmitted Disease clinics, federally qualified health centers (FQHC), HIV disease counseling and testing sites, mental health programs and homeless shelters. These referral relationships must be documented with written collaborative agreements, contracts or memoranda of understanding between Contractor and appropriate point of entry entities and are subject to audit by RWGA. Contractor and POE entity staff must regularly (e.g. weekly, bi-weekly depending on volume of referrals) meet 1:1 to discuss new referrals to primary medical care services. Such case conferences must be documented in the client record and properly entered into the CPCDMS. Use of CPCDMS Data System: Contractor must comply with CPCDMS business rules and procedures. Contractor must enter into the CPCDMS all required clinical data, including but not limited to, HAART treatment including all changes in medication regimens, Opportunistic Infections, screening and treatment for STDs and Hepatitis A, B, C and other clinical screening and treatment data required by HRSA, TDSHS and the County. Contractor must perform Registration updates in accordance with RWGA CPCDMS business rules for all clients wherein Contractor is client's CPCDMS record-owning agency. Contractor must utilize an electronic verification system to verify insurance/3rd party payer status monthly or per visit (whichever is less frequent). **Bus Pass Distribution:** The County will provide Contractor with METRO bus pass vouchers. Bus Pass vouchers must be distributed in accordance with RWGA policies and procedures, standards of care and financial eligibility guidelines. Contractor may only issue METRO bus pass vouchers to clients wherein the Contractor is the CPCDMS record owning Contractor. METRO bus pass vouchers shall be distributed as follows: **Expiration of Current Bus Pass:** In those situation wherein the bus pass expiration date does not coincide with the CPCDMS registration update the Contractor must distribute METRO bus pass vouchers to eligible clients upon the expiration of the current bus pass or when a Value-based bus card has been expended on eligible

	transportation needs. Contractor may issue METRO bus passes to eligible clients living outside the METRO service area in those situations where the Contractor has documented in the client record that the client will utilize the METRO system to access needed HIV-related health care services located in the METRO service area. **Gas Cards:** Primary Medical Care Contractors must distribute gasoline vouchers to eligible clients residing in the rural service area in accordance with RWGA policies and procedures, standards of care and financial eligibility guidelines. Gas Cards are only available to Rural primary medical care Contractors without prior approval by RWGA.

FY 2022 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/10/2021**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/03/2021**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Improvement Committee**		Date: **05/18/2021**
Recommendations:	Approved: Y:_ ___ No: _____ Approved With Changes: _____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMTN Workgroup #1**	Date: **04/20/2021**
Recommendations:	Financial Eligibility: PriCare=300%, EFA=500%, LPAP=400% +500%, MCM=none, SLW=none, Outreach=none
1. Accept the service definition as presented and keep the financial eligibility the same.	
2.	
3.	

FY 2020 Houston EMA Ryan White Part A/MAI Service Definition **Comprehensive Outpatient Primary Medical Care including Medical Case Management, Service Linkage and Local Pharmacy Assistance Program (LPAP) Services - Rural**	
HRSA Service Category Title: **RWGA Only**	1. Outpatient/Ambulatory Medical Care 2. Medical Case Management 3. AIDS Pharmaceutical Assistance (local) 4. Emergency Financial Assistance – Pharmacy Assistance 5. Case Management (non-Medical)
Local Service Category Title:	Adult Comprehensive Primary Medical Care - Targeted to Rural
Amount Available: **RWGA Only**	Total estimated available funding: $0.00 (to be determined) 1. Primary Medical Care: $0.00 2. LPAP $0.00 3. Medical Case Management: $0.00 4. Service Linkage: $0.00 Note: The Houston Ryan White Planning Council (RWPC) determines overall annual Part A and MAI service category allocations & reallocations. RWGA has sole authority over contract award amounts.
Target Population:	Comprehensive Primary Medical Care – Targeted to Rural
Client Eligibility: Age, Gender, Race, Ethnicity, Residence, etc.	PLWHA residing in the Houston EMA/HSDA counties **other than Harris County** (prior approval required for non-EMA clients). Contractor must adhere to Targeting requirements and Budget limitations as applicable.
Financial Eligibility:	*See Current Year Approved Financial Eligibility for Houston EMA/HSDA*
Budget Type: **RWGA Only**	Hybrid Fee for Service
Budget Requirement or Restrictions: **RWGA Only**	**Primary Medical Care:** No less than 75% of clients served in a Targeted subcategory must be members of the targeted population with the following exceptions: 10% of funds designated to primary medical care must be reserved for invoicing diagnostic procedures at actual cost. Contractors may not exceed the allocation for each individual service component (Primary Medical Care, Medical Case Management, Local Pharmacy Assistance Program and Service Linkage) without prior approval from RWGA.

	Local Pharmacy Assistance Program (LPAP): Houston RWPC guidelines for Local Pharmacy Assistance Program (LPAP) services: Contractor shall offer HIV medications from an approved formulary for a total not to exceed $18,000 per contract year per client. Contractor shall offer HIV-related medications for a total not to exceed $3,000 per contract year per client. These guidelines are determined by the RWPC. The RWPC determines the subcategories that shall include Ryan White LPAP funding. Medications must be provided in accordance with Houston EMA guidelines, HRSA/HAB rules and regulations and applicable Office of Pharmacy Affairs 340B guidelines. At least 75% of the total amount of the budget for LPAP services must be solely allocated to the actual cost of medications and may not include any storage, administrative, processing or other costs associated with managing the medication inventory or distribution. **Emergency Financial Assistance – Pharmacy Assistance** Direct cash payments to clients are not permitted. It is expected that all other sources of funding in the community for emergency financial assistance will be effectively used and that any allocation of RWHAP funds for these purposes will be as the payer of last resort, and for limited amounts, uses, and periods of time. Continuous provision of an allowable service to a client should not be funded through emergency financial assistance.
Service Unit Definition/s:	• Outpatient/Ambulatory Medical Care: One (1) unit of service = One (1) primary care office/clinic visit which includes the following: • Primary care physician/nurse practitioner, physician's assistant or clinical nurse specialist examination of the patient, and • Medication/treatment education • Medication access/linkage • OB/GYN specialty procedures (as clinically indicated) • Nutritional assessment (as clinically indicated) • Laboratory (as clinically indicated, not including specialized tests) • Radiology (as clinically indicated, not including CAT scan or MRI) • Eligibility verification/screening (as necessary)

	• Follow-up visits wherein the patient is not seen by the MD/NP/PA are considered to be a component of the original primary care visit. • Outpatient Psychiatric Services: 1 unit of service = A single (1) office/clinic visit wherein the patient is seen by a State licensed and board-eligible Psychiatrist or qualified Psychiatric Nurse Practitioner. This visit may or may not occur on the same date as a primary care office visit. • Nutritional Assessment and Plan: 1 unit of service = A single comprehensive nutritional assessment and treatment plan performed by a Licensed, Registered Dietician initiated upon a physician's order. Does not include the provision of Supplements or other products (clients may be referred to the Ryan White funded Medical Nutritional Therapy provider for provision of medically necessary supplements). The nutritional assessment visit may or may not occur on the same date as a medical office visit. • AIDS Pharmaceutical Assistance (local): A unit of service = a transaction involving the filling of a prescription or any other allowable medication need ordered by a qualified medical practitioner. The transaction will involve at least one item being provided for the client, but can be any multiple. The cost of medications provided to the client must be invoiced at actual cost. • Medical Case Management: 1 unit of service = 15 minutes of direct medical case management services to an eligible PLWHA performed by a qualified medical case manager. • Service Linkage (non-Medical Case Management): 1 unit of service = 15 minutes of direct service linkage services to an eligible PLWHA performed by a qualified service linkage worker. • Emergency Financial Assistance – Pharmacy Assistance: A unit of service = a transaction involving the filling of a prescription or any other allowable HIV treatment medication need ordered by a qualified medical practitioner. The transaction will involve at least one item being provided for the client, but can be any multiple. The cost of medications provided to the client must be invoiced at actual cost.
HRSA Service Category Definition:	• **Outpatient/Ambulatory medical care** is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or

RWGA Only	nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings. Services includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies. • **AIDS Pharmaceutical Assistance (local)** includes local pharmacy assistance programs implemented by Part A or Part B Grantees to provide HIV/AIDS medications to clients. This assistance can be funded with Part A grant funds and/or Part B base award funds. Local pharmacy assistance programs are not funded with ADAP earmark funding. • **Medical Case Management** services (including treatment adherence) are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case

	management including face-to-face, phone contact, and any other forms of communication. • **Case Management (non-Medical)** includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does. • **Emergency Financial Assistance** provides limited one-time or short-term payments to assist the RWHAP client with an emergent need for paying for essential utilities, housing, food (including groceries, and food vouchers), transportation, and medication. Emergency financial assistance can occur as a direct payment to an agency or through a voucher program.
Standards of Care:	Contractors must adhere to the most current published Part A/B Standards of Care for the Houston EMA/HSDA. **Services must meet or exceed applicable United States Department of Health and Human Services (DHHS) guidelines for the Treatment of HIV/AIDS.**
Local Service Category Definition/Services to be Provided:	**Outpatient/Ambulatory Primary Medical Care:** Services include on-site physician, physician extender, nursing, phlebotomy, radiographic, laboratory, pharmacy, intravenous therapy, home health care referral, licensed dietician, patient medication education, and patient care coordination. The Contractor must provide continuity of care with inpatient services and subspecialty services (either on-site or through specific referral to appropriate medical provider upon primary care Physician's order). Services provided to women shall further include OB/GYN physician & physician extender services on-site or by referral, OB/GYN services, colposcopy, nursing, phlebotomy, radiographic, laboratory, pharmacy, intravenous therapy, home health care referral, licensed dietician, patient medication/women's health education, patient care coordination, and social services. The Contractor must provide continuity of care with inpatient services and subspecialty services (either on-site or through specific referral protocols to appropriate agencies upon primary care Physician's order). **Outpatient/Ambulatory Primary Medical Care must provide:** • Continuity of care for all stages of adult HIV infection;

	• Laboratory and pharmacy services including intravenous medications (either on-site or through established referral systems); • Outpatient psychiatric care, including lab work necessary for the prescribing of psychiatric medications when appropriate (either on-site or through established referral systems); • Access to the Texas ADAP program (either on-site or through established referral systems); • Access to compassionate use HIV medication programs (either directly or through established referral systems); • Access to HIV related research protocols (either directly or through established referral systems); • Must at a minimum, comply with Houston EMA/HSDA Part A/B Standards for HIV Primary Medical Care. The Contractor must demonstrate on an ongoing basis the ability to provide state-of-the-art HIV-related primary care medicine in accordance with the most recent DHHS HIV treatment guidelines. Rapid advances in HIV treatment protocols require that the Contractor provide services that to the greatest extent possible maximize a patient's opportunity for long-term survival and maintenance of the highest quality of life possible. • On-site Outpatient Psychiatry services. • On-site Medical Case Management services. • On-site Medication Education. • Physical therapy services (either on-site or via referral). • Specialty Clinic Referrals (either on-site or via referral). • On-site pelvic exams as needed for female patients with appropriate follow-up treatment and referral. • On site Nutritional Counseling by a Licensed Dietitian. **Services for women must also provide:** • Well woman care, including but not limited to: PAP, pelvic exam, HPV screening, breast examination, mammography, hormone replacement and education, pregnancy testing, contraceptive services excluding birth control medications. • Obstetric Care: ante-partum through post-partum services, child birth/delivery services. Perinatal preventative education and treatment. • On-site or by referral Colposcopy exams as needed, performed by an OB/GYN physician, or physician extender with a colposcopy provider qualification.

	• Social services, including but not limited to, providing women access to child care, transportation vouchers, food vouchers and support groups at the clinic site; **Nutritional Assessment:** Services include provision of information about therapeutic nutritional/supplemental foods that are beneficial to the wellness and increased health conditions of clients by a Licensed Dietitian. Services may be provided either through educational or counseling sessions. Clients who receive these services may utilize the Ryan White Part A-funded nutritional supplement provider to obtain recommended nutritional supplements in accordance with program rules. Clients are limited to one (1) nutritional assessment per calendar year without prior approval of RWGA. Patient Medication Education Services must adhere to the following requirements: • Medication Educators must be State Licensed Medical Doctor (MD), Nurse Practitioner (NP), Physician Assistant PA), Nurse (RN, LVN) or Pharmacist. Prior approval must be obtained prior to utilizing any other health care professional not listed above to provide medication education. • Clients who will be prescribed ongoing medical regimens (i.e. ART) must be assessed for adherence to treatment at every clinical encounter using the EMA's approved adherence assessment tool. Clients with adherence issues related to lack of understanding must receive more education regarding their medical regimen. Clients with adherence issues that are behavioral or involve mental health issues must be provided counseling by the Medical Case Manager, Physician or Physician Extender and/or licensed nursing staff and, if clinically indicated, assessment and treatment by a qualified Psychiatrist or Psychiatric Nurse Practitioner. **Outpatient Psychiatric Services:** The program must provide: • Diagnostic Assessments: comprehensive evaluation for identification of psychiatric disorders, mental status evaluation, differential diagnosis which may involve use of other clinical and laboratory tests, case formulation, and treatment plans or disposition.

	• Emergency Psychiatric Services: rapid evaluation, differential diagnosis, acute treatment, crisis intervention, and referral. Must be available on a 24 hour basis including emergency room referral. • Brief Psychotherapy: individual, supportive, group, couple, family, hypnosis, biofeedback, and other psychophysiological treatments and behavior modification. • Psychopharmacotherapy: evaluation and medication treatment of psychiatric disorders, including, but not limited to, anxiety disorders, major depression, pain syndromes, habit control problems, psychosis and organic mental disorders. • Rehabilitation Services: Physical, psychosocial, behavioral, and/or cognitive training. Screening for Eye Disorders: Contractor must ensure that patients receive appropriate screening and treatment for CMV, glaucoma, cataracts, and other related problems. **Local Medication Assistance Program (LPAP):** LPAP provides pharmaceuticals to patients otherwise ineligible for medications through private insurance, Medicaid/Medicare, State ADAP, SPAP or other sources. Allowable medications are only those on the Houston EMA Ryan White Part A Formulary. Eligible clients may be provided Fuzeon™ on a case-by-case basis with prior approval of Ryan White Grant Administration (RWGA). The cost of Fuzeon™ does not count against a client's annual maximum. HIV-related medication services are the provision of physician or physician-extender prescribed HIV-related medications to prevent serious deterioration of health. Does not include drugs available to the patient from other programs or payers or free of charge (such as birth control and TB medications) or medications available over the counter (OTC) without prescription. Contractor must offer all medications on the Texas ADAP formulary, for a total not to exceed $18,000.00 per contract year per client. Contractor must provide allowable HIV-related medications (i.e. non-HIV medications) for a total not to exceed $3,000 per contract year per client. Contractor may be reimbursed ADAP dispensing fees (e.g. $5/Rx) in accordance with RWGA business rules for those ADAP clients who are unable to pay the ADAP dispensing fee. **Medical Case Management Services:** Services include screening all primary medical care patients to determine each patient's level of need for Medical Case Management services, performing a comprehensive assessment, including an assessment of the patient's health literary, and developing a medical service plan for each client that demonstrates a documented need for such services, monitoring medical service plan to ensure its implementation, and

	educating client regarding wellness, medication and health care appointment adherence. The Medical Case Manager serves as an advocate for the client and as a liaison with medical providers on behalf of the client. The Medical Case Manager ensures linkage to mental health, substance abuse and other client services as indicated by the medical service plan. **Service Linkage:** The purpose of Service Linkage is to assist clients with the procurement of needed services so that the problems associated with living with HIV are mitigated. Service Linkage is a working agreement between a client and a Service Linkage Worker for an indeterminate period, based on client need, during which information, referrals and service linkage are provided on an as-needed basis. Service Linkage assists clients who do not require the intensity of Medical Case Management per RWGA Quality Management guidelines. Service Linkage is both office-based and field based. Service Linkage Workers are expected to coordinate activities with referral sources where newly-diagnosed or not-in-care PLWHA may be identified, including 1:1 case conferences with testing site personnel to ensure the successful transition of referrals into Primary Care Services. Such incoming referral coordination includes meeting prospective clients at the referring Provider location in order to develop rapport with individuals prior to the individual's initial Primary Care appointment and ensuring such new intakes to Primary Care services have sufficient support to make the often difficult transition into ongoing primary medical care. Service Linkage also includes follow-up to re-engage lost-to-care patients. Lost-to-care patients are those patients who have not returned for scheduled appointments with Provider nor have provided Provider with updated information about their current Primary Medical Care provider (in the situation where patient may have obtained alternate service from another medical provider). Contractor must document efforts to re-engage lost-to-care patients prior to closing patients in the CPCDMS. Service Linkage extends the capability of existing programs by providing "hands-on" outreach and linkage to care services to those PLWHA who are not currently accessing primary medical care services. Service Linkage includes the issuance of bus pass vouchers and gas cards per published RWGA guidelines. Service Linkage complements and extends the service delivery capability of Medical Case Management services. **Emergency Financial Assistance – Pharmacy Assistance** provides limited one-time and/or short-term 30-day supply of pharmaceuticals to patients otherwise ineligible for medications through private insurance, Medicaid/Medicare, State ADAP, SPAP or other sources. One refill for up to 30-day supply available with RWGA prior approval. Allowable medications are only those on the Houston EMA Ryan White Part A Formulary. HIV-related

	medication services are the provision of physician or physician-extender prescribed medications to prevent serious deterioration of health. Does not include drugs available to the patient from other programs or payers or free of charge or medications available over the counter (OTC) without prescription. Contractor must offer all medications on the Texas ADAP formulary.
Agency Requirements:	**Providers and system must be Medicaid/Medicare certified.** **Eligibility and Benefits Coordination:** Contractor must implement consumer-friendly, culturally and linguistically appropriate new and ongoing patient eligibility verification and benefit coordination processes that ensure accountability with Ryan White Payer of Last Resort requirements while achieving maximum utilization of eligible benefits. Eligibility processes should provide clients with a meaningful understanding of their benefits, expected out-of-pocket expenses and other information needed to ensure full and continued participation in care. **LPAP and EFA – Pharmacy Assistance Services:** Contractor must: Provide pharmacy services on-site or through an established contractual relationship that meets all requirements. Alternate (off-site) approaches must be approved prior to implementation by RWGA. Either directly, or via subcontract with an eligible 340B Pharmacy program entity, must: Ensure a comprehensive financial intake application to determine client eligibility for this program to insure that these funds are used as a last resort for purchase of medications. Ensure the documented capability of interfacing with the Texas HIV Medication Program operated by the Texas Department of State Health Services. This capability must be fully documented and is subject to independent verification by RWGA. Ensure medication assistance provided to clients does not duplicate services already being provided in the Houston area. The process for accomplishing this must be fully documented and is subject to independent verification by RWGA. Ensure, either directly or via a 340B Pharmacy Program Provider, at least 2 years of continuous documented experience in providing HIV/AIDS medication programs utilizing Ryan White Program or similar public sector funding. This experience must be documented and is subject to independent verification by RWGA.

	Ensure all medications are purchased via a qualified participant in the federal 340B Drug Pricing Program and Prime Vendor Program, administered by the HRSA Office of Pharmacy Affairs. Note: failure to maintain 340B or Prime Vendor drug pricing may result in a negative audit finding, cost disallowance or termination of contract awarded. Contractor must maintain 340B Program participation throughout the contract term. All eligible medications must be purchased in accordance with Program 340B guidelines and program requirements. Ensure Houston area HIV/AIDS service providers are informed of this program and how the client referral and enrollment processes functions. Contractor must maintain documentation of such marketing efforts. Implement a consistent process to enroll eligible patients in available pharmaceutical company Patient Assistance Programs prior to using Ryan White Part A funded LPAP resources. Ensure information regarding the program is provided to PLWHA, including historically under-served and unserved populations (e.g., African American, Hispanic/Latino, Asian, Native American, Pacific Islander) and women not currently obtaining prescribed HIV and HIV-related medications. Offer, at no charge to the client, delivery options for medication refills, including but not limited to courier, USPS or other package delivery service. **Case Management Operations and Supervision:** The Service Linkage Workers (SLW) and Medical Case Managers (MCM) must function within the clinical infrastructure of Contractor and receive ongoing supervision that meets or exceeds published Standards of Care. An MCM may supervise SLWs.
Staff Requirements:	Contractor is responsible for ensuring that services are provided by State licensed internal medicine and OB/GYN physicians, specialty care physicians, psychiatrists, registered nurses, nurse practitioners, vocational nurses, pharmacists, physician assistants, clinical nurse specialists, physician extenders with a colposcopy provider qualification, x-ray technologists, State licensed dieticians, licensed social worker and ancillary health care providers in accordance with appropriate State licensing and/or certification requirements and with knowledge and experience of HIV disease. In addition, Contractor must ensure the following staff requirements are met: **Outpatient Psychiatric Services:** Director of the Program must be a Board Certified Psychiatrist. Licensed and/or Certified allied health professionals (Licensed Psychologists, Physicians, Psychiatric Nurse Practitioners, Licensed Master Social Workers,

	Licensed Professional Counselors, Licensed Marriage and Family Therapists, Certified Alcohol and Drug Abuse Counselors, etc.) must be used in all treatment modalities. Documentation of the Director's credentials, licensures and certifications must be included in the proposal. Documentation of the Allied Health professional licensures and certifications must be included in the proposal appendices. **Medication and Adherence Education:** The program must utilize an RN, LVN, PA, NP, pharmacist or MD licensed by the State of Texas, who has at least two (2) years paid experience in the preceding five (5) years in HIV/AIDS care, to provide the educational services. Licensed social workers who have at least two (2) years paid experience in the preceding five (5) years in HIV/AIDS care may also provide adherence education and counseling. **Nutritional Assessment (primary care):** Services must be provided by a licensed registered dietician. Dieticians must have a minimum of two (2) years of experience providing nutritional assessment and counseling to PLWHA. **Medical Case Management:** The program must utilize a state licensed Social Worker to provide Medical Case Management Services. The Contractor must maintain the assigned number of Medical Case Management FTEs throughout the contract term. **Contractor must provide to RWGA the names of each Medical Case Manager and the individual assigned to supervise those Medical Case Managers by 03/30/15, and thereafter within 15 days after hire.** **Service Linkage:** The program must utilize Service Linkage Workers who have at a minimum a Bachelor's degree from an accredited college or university with a major in social or behavioral sciences. Documented paid work experience in providing client services to PLWHA may be substituted for the Bachelor's degree requirement on a 1:1 basis (1 year of documented paid experience may be substituted for 1 year of college). All Service Linkage Workers must have a minimum of one (1) year paid work experience with PLWHA. Contractor must maintain the assigned number of Service Linkage FTEs throughout the contract term. **Contractor must provide to RWGA the names of each Service Linkage Worker and the individual assigned to supervise those Service Linkage Workers by 03/30/15, and thereafter within 15 days after hire.** **Supervision of Case Managers:** The Service Linkage Workers and Medical Case Managers must function within the clinical infrastructure of Contractor and receive ongoing supervision that meets or exceeds Houston EMA/HSDA Part A/B Standards of Care

	for Service Linkage and Medical Case Management as applicable. An MCM may supervise SLWs.
Special Requirements: **RWGA Only**	**All primary medical care services must meet or exceed current United States DHHS Treatment Guidelines for the treatment and management of HIV disease.** Contractor must provide all required program components - Primary Medical Care, Medical Case Management, Service Linkage (non-medical Case Management) and Local Pharmacy Assistance Program (LPAP) services. **Primary Medical Care Services:** Services funded under this grant cannot be used to supplant insurance or Medicare/Medicaid reimbursements for such services. Clients eligible for such reimbursement may not be billed to this contract. Medicare and private insurance co-payments may be eligible for reimbursement under Ryan White Health Insurance Assistance (HINS) program guidelines. Patients needing such assistance should be referred to the local Ryan White-funded HINS provider for assistance. Under no circumstances may the Contractor bill the County for the difference between the reimbursement from Medicaid, Medicare or Third Party insurance and the fee schedule under the contract. Furthermore, potential clients who are Medicaid/Medicare eligible or have other Third Party payers may not be denied services or referred elsewhere by the Contractor based on their reimbursement status (i.e. Medicaid/Medicare eligible clients may not be referred elsewhere in order that non-Medicaid/Medicare eligible clients may be added to the contract). Failure to serve Medicaid/Medicare eligible clients based on their reimbursement status will be grounds for the immediate termination of contract. **For primary medical care services targeted to the Latino community at least 50% of the clinical care team must be fluent in Spanish.** **Diagnostic Procedures:** A single Diagnostic Procedure limited to procedures on the approved list of diagnostic procedures (see below) without prior County approval. Approved diagnostic procedures will be reimbursed at invoice cost. Part A and Part A/MAI-funded programs must refer to the RWGA website for the most current list of approved diagnostic procedures and corresponding codes: www.hcphes.org/rwga. **Diagnostic procedures not listed on the website must have prior approval by RWGA.** **Outpatient Psychiatric Services:** Client must not be eligible for services from other programs/providers or any other reimbursement source (i.e. Medicaid, Medicare, private insurance) unless the client

	is in crisis and cannot be provided immediate services from the other programs/providers. In this case, clients may be provided services, as long as the client applies for the other programs/providers, until the other programs/providers can take over services. Program must be supervised by a Psychiatrist and include diagnostic assessments, emergency evaluations and psycho-pharmacotherapy. **Maintaining Referral Relationships** (Point of Entry Agreements): Contractor must maintain appropriate relationships with entities that constitute key points of access to the health care system for individuals with HIV disease, including but not limited to, Harris Health System and other Houston EMA-located emergency rooms, Harris County Jail, Texas Department of Criminal Justice incarceration facilities, Immigration detention centers, substance abuse treatment and detoxification programs, adult and juvenile detention facilities, Sexually Transmitted Disease clinics, federally qualified health centers (FQHC), HIV disease counseling and testing sites, mental health programs and homeless shelters. These referral relationships must be documented with written collaborative agreements, contracts or memoranda of understanding between Contractor and appropriate point of entry entities and are subject to audit by RWGA. Contractor and POE entity staff must regularly (e.g. weekly, bi-weekly depending on volume of referrals) meet 1:1 to discuss new referrals to primary medical care services. Such case conferences must be documented in the client record and properly entered into the CPCDMS. Use of CPCDMS Data System: Contractor must comply with CPCDMS business rules and procedures. Contractor must enter into the CPCDMS all required clinical data, including but not limited to, HAART treatment including all changes in medication regimens, Opportunistic Infections, screening and treatment for STDs and Hepatitis A, B, C and other clinical screening and treatment data required by HRSA, TDSHS and the County. <u>Contractor must perform Registration updates in accordance with RWGA CPCDMS business rules for all clients wherein Contractor is client's CPCDMS record-owning agency. Contractor must utilize an electronic verification system to verify insurance/3rd party payer status monthly or per visit (whichever is less frequent).</u> **Bus Pass Distribution:** The County will provide Contractor with METRO bus pass vouchers. Bus Pass vouchers must be distributed in accordance with RWGA policies and procedures, standards of care and financial eligibility guidelines. Contractor may only issue METRO bus pass vouchers to clients wherein the Contractor is the CPCDMS record owning Contractor. METRO bus pass vouchers shall be distributed as follows:

	Expiration of Current Bus Pass: In those situation wherein the bus pass expiration date does not coincide with the CPCDMS registration update the Contractor must distribute METRO bus pass vouchers to eligible clients upon the expiration of the current bus pass or when a Value-based bus card has been expended on eligible transportation needs. Contractor may issue METRO bus passes to eligible clients living outside the METRO service area in those situations where the Contractor has documented in the client record that the client will utilize the METRO system to access needed HIV-related health care services located in the METRO service area. **Gas Cards:** Primary Medical Care Contractors must distribute gasoline vouchers to eligible clients residing in the rural service area in accordance with RWGA policies and procedures, standards of care and financial eligibility guidelines. Gas Cards are only available to Rural primary medical care Contractors without prior approval by RWGA.

FY 2022 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/10/2021**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/03/2021**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Improvement Committee**		Date: **05/18/2021**
Recommendations:	Approved: Y:_ ___ No: _____ Approved With Changes: _____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMTN Workgroup #1**	Date: **04/20/2021**
Recommendations:	Financial Eligibility: PriCare=300%, EFA=500%, LPAP=400% +500%, MCM=none, SLW=none, Outreach=none
1. Accept the service definition as presented and keep the financial eligibility the same.	
2.	
3.	

FY 2020 Houston EMA Ryan White Part A/MAI Service Definition **Comprehensive Outpatient Primary Medical Care including Medical Case Management and Service Linkage Services - Pediatric**	
HRSA Service Category Title: **RWGA Only**	1. Outpatient/Ambulatory Medical Care 2. Medical Case Management 3. Case Management (non-Medical)
Local Service Category Title:	Comprehensive Primary Medical Care Targeted to Pediatric
Target Population:	HIV-infected resident of the Houston EMA 0 – 18 years of age. Provider may continue services to previously enrolled clients until the client's 22nd birthday.
Financial Eligibility:	*See Current Fiscal Year Approved Financial Eligibility for Houston EMA/HSDA*
Budget Type: **RWGA Only**	Hybrid Fee for Service
Budget Requirement or Restrictions: **RWGA Only**	**Primary Medical Care:** 10% of funds designated to primary medical care must be reserved for invoicing diagnostic procedures at actual cost. Contractors may not exceed the allocation for each individual service component (Primary Medical Care, Medical Case Management and Service Linkage) without prior approval from RWGA.
Service Unit Definition/s: **RWGA Only**	• Outpatient/Ambulatory Medical Care: One (1) unit of service = One (1) primary care office/clinic visit which includes the following: • Primary care physician/nurse practitioner, physician's assistant or clinical nurse specialist examination of the patient, and • Medication/treatment education • Medication access/linkage • OB/GYN specialty procedures (as clinically indicated) • Nutritional assessment (as clinically indicated) • Laboratory (as clinically indicated, not including specialized tests) • Radiology (as clinically indicated, not including CAT scan or MRI) • Eligibility verification/screening (as necessary) • Follow-up visits wherein the patient is not seen by the MD/NP/PA are considered to be a component of the original primary care visit. • Outpatient Psychiatric Services: 1 unit of service = A single (1) office/clinic visit wherein the patient is seen by a State licensed and board-eligible Psychiatrist or qualified Psychiatric Nurse Practitioner. This visit may or may not occur on the same date as a primary care office visit. • Medical Case Management: 1 unit of service = 15 minutes of direct medical case management services to an eligible PLWHA performed by a qualified medical case manager. • Service Linkage (non-Medical Case Management): 1 unit of service = 15 minutes of direct service linkage services to an eligible

	PLWHA performed by a qualified service linkage worker.
HRSA Service Category Definition: **RWGA Only**	• **Outpatient/Ambulatory medical care** is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings. Services includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies. • **Medical Case Management** services (including treatment adherence) are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication. • **Case Management (non-Medical)** includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does.
Standards of Care:	Contractors must adhere to the most current published Part A/B Standards of Care for the Houston EMA/HSDA. **Services must meet or**

	exceed applicable United States Department of Health and Human Services (DHHS) guidelines for the Treatment of HIV/AIDS.
Local Service Category Definition/Services to be Provided:	**Outpatient/Ambulatory Primary Medical Care:** Services include on-site physician, physician extender, nursing, phlebotomy, radiographic, laboratory, pharmacy, intravenous therapy, home health care referral, licensed dietician, patient medication education, and patient care coordination. The Contractor must provide continuity of care with inpatient services and subspecialty services (either on-site or through specific referral to appropriate medical provider upon primary care Physician's order). Services provided to women shall further include OB/GYN physician & physician extender services on-site or by referral, OB/GYN services, colposcopy, nursing, phlebotomy, radiographic, laboratory, pharmacy, intravenous therapy, home health care referral, licensed dietician, patient medication/women's health education, patient care coordination, and social services. The Contractor must provide continuity of care with inpatient services and subspecialty services (either on-site or through specific referral protocols to appropriate agencies upon primary care Physician's order). **Outpatient/Ambulatory Primary Medical Care must provide:** • Continuity of care for all stages of adult HIV infection; • Laboratory and pharmacy services including intravenous medications (either on-site or through established referral systems); • Outpatient psychiatric care, including lab work necessary for the prescribing of psychiatric medications when appropriate (either on-site or through established referral systems); • Access to the Texas ADAP program (either on-site or through established referral systems); • Access to compassionate use HIV medication programs (either directly or through established referral systems); • Access to HIV related research protocols (either directly or through established referral systems); • Must at a minimum, comply with Houston EMA/HSDA Part A/B Standards for HIV Primary Medical Care. The Contractor must demonstrate on an ongoing basis the ability to provide state-of-the-art HIV-related primary care medicine in accordance with the most recent DHHS HIV treatment guidelines. Rapid advances in HIV treatment protocols require that the Contractor provide services that to the greatest extent possible maximize a patient's opportunity for long-term survival and maintenance of the highest quality of life possible. • On-site Outpatient Psychiatry services. • On-site Medical Case Management services. • On-site Medication Education. • Physical therapy services (either on-site or via referral).

	• Specialty Clinic Referrals (either on-site or via referral). • On-site pelvic exams as needed for female patients with appropriate follow-up treatment and referral. • On site Nutritional Counseling by a Licensed Dietitian. **Services for females of child bearing age must also provide:** • Well woman care, including but not limited to: PAP, pelvic exam, breast examination, mammography, hormone replacement and education, pregnancy testing, contraceptive services excluding birth control medications. • Obstetric Care: ante-partum through post-partum services, child birth/delivery services. Perinatal preventative education and treatment. • On-site or by referral Colposcopy exams as needed, performed by an OB/GYN physician, or physician extender with a colposcopy provider qualification. • Social services, including but not limited to, providing women access to child care, transportation vouchers, food vouchers and support groups at the clinic site; Patient Medication Education Services must adhere to the following requirements: • Medication Educators must be State Licensed Medical Doctor (MD), Nurse Practitioner (NP), Physician Assistant PA), Nurse (RN, LVN) or Pharmacist. Prior approval must be obtained prior to utilizing any other health care professional not listed above to provide medication education. • Clients who will be prescribed ongoing medical regimens (i.e. ART) must be assessed for adherence to treatment at every clinical encounter using the EMA's approved adherence assessment tool. Clients with adherence issues related to lack of understanding must receive more education regarding their medical regimen. Clients with adherence issues that are behavioral or involve mental health issues must be provided counseling by the Medical Case Manager, Physician or Physician Extender and/or licensed nursing staff and, if clinically indicated, assessment and treatment by a qualified Psychiatrist or Psychiatric Nurse Practitioner. **Outpatient Psychiatric Services:** The program must provide: • Diagnostic Assessments: comprehensive evaluation for identification of psychiatric disorders, mental status evaluation, differential diagnosis which may involve use of other clinical and laboratory tests, case formulation, and treatment plans or disposition. • Emergency Psychiatric Services: rapid evaluation, differential diagnosis, acute treatment, crisis intervention, and referral. Must be available on a 24 hour basis including emergency room referral.

	• Brief Psychotherapy: individual, supportive, group, couple, family, hypnosis, biofeedback, and other psychophysiological treatments and behavior modification. • Psychopharmacotherapy: evaluation and medication treatment of psychiatric disorders, including, but not limited to, anxiety disorders, major depression, pain syndromes, habit control problems, psychosis and organic mental disorders. • Rehabilitation Services: Physical, psychosocial, behavioral, and/or cognitive training. Screening for Eye Disorders: Contractor must ensure that patients receive appropriate screening and treatment for CMV, glaucoma, cataracts, and other related problems. **Medical Case Management Services:** Services include screening all primary medical care patients to determine each patient's level of need for Medical Case Management services, performing a comprehensive assessment, including an assessment of the patient's health literary, and developing a medical service plan for each client that demonstrates a documented need for such services, monitoring medical service plan to ensure its implementation, and educating client regarding wellness, medication and health care appointment adherence. The Medical Case Manager serves as an advocate for the client and as a liaison with medical providers on behalf of the client. The Medical Case Manager ensures linkage to mental health, substance abuse and other client services as indicated by the medical service plan. **Service Linkage:** The purpose of Service Linkage is to assist clients with the procurement of needed services so that the problems associated with living with HIV are mitigated. Service Linkage is a working agreement between a client and a Service Linkage Worker for an indeterminate period, based on client need, during which information, referrals and service linkage are provided on an as-needed basis. Service Linkage assists clients who do not require the intensity of Medical Case Management per RWGA Quality Management guidelines. Service Linkage is both office-based and field based. Service Linkage Workers are expected to coordinate activities with referral sources where newly-diagnosed or not-in-care PLWHA may be identified, including 1:1 case conferences with testing site personnel to ensure the successful transition of referrals into Primary Care Services. Such incoming referral coordination includes meeting prospective clients at the referring Provider location in order to develop rapport with individuals prior to the individual's initial Primary Care appointment and ensuring such new intakes to Primary Care services have sufficient support to make the often difficult transition into ongoing primary medical care. Service Linkage also includes follow-up to re-engage lost-to-care patients. Lost-to-care patients are those patients who have not returned for scheduled appointments with Provider nor have provided Provider with updated information about their current Primary Medical Care provider (in the

	situation where patient may have obtained alternate service from another medical provider). Contractor must document efforts to re-engage lost-to-care patients prior to closing patients in the CPCDMS. Service Linkage extends the capability of existing programs by providing "hands-on" outreach and linkage to care services to those PLWHA who are not currently accessing primary medical care services. Service Linkage includes the issuance of bus pass vouchers and gas cards per published RWGA guidelines. Service Linkage complements and extends the service delivery capability of Medical Case Management services.
Agency Requirements:	**Providers and system must be Medicaid/Medicare certified.** **Eligibility and Benefits Coordination:** Contractor must implement consumer-friendly, culturally and linguistically appropriate new and ongoing patient eligibility verification and benefit coordination processes that ensure accountability with Ryan White Payer of Last Resort requirements while achieving maximum utilization of eligible benefits. Eligibility processes should provide clients with a meaningful understanding of their benefits, expected out-of-pocket expenses and other information needed to ensure full and continued participation in care. **Case Management Operations and Supervision:** The Service Linkage Workers (SLW) and Medical Case Managers (MCM) must function within the clinical infrastructure of Contractor and receive ongoing supervision that meets or exceeds published Standards of Care. An MCM may supervise SLWs.
Staff Requirements:	Contractor is responsible for ensuring that services are provided by State licensed internal medicine and OB/GYN physicians, specialty care physicians, psychiatrists, registered nurses, nurse practitioners, vocational nurses, pharmacists, physician assistants, clinical nurse specialists, physician extenders with a colposcopy provider qualification, x-ray technologists, State licensed dieticians, licensed social worker and ancillary health care providers in accordance with appropriate State licensing and/or certification requirements and with knowledge and experience of HIV disease. In addition, Contractor must ensure the following staff requirements are met: **Outpatient Psychiatric Services:** Director of the Program must be a Board Certified Psychiatrist. Licensed and/or Certified allied health professionals (Licensed Psychologists, Physicians, Psychiatric Nurse Practitioners, Licensed Master Social Workers, Licensed Professional Counselors, Licensed Marriage and Family Therapists, Certified Alcohol and Drug Abuse Counselors, etc.) must be used in all treatment modalities. Documentation of the Director's credentials, licensures and certifications must be included in the proposal. Documentation of the Allied Health professional licensures and certifications must be included in the proposal appendices. **Medication and Adherence Education:** The program must utilize an RN, LVN, PA, NP, pharmacist or MD licensed by the State of Texas,

	who has at least two (2) years paid experience in the preceding five (5) years in HIV/AIDS care, to provide the educational services. Licensed social workers who have at least two (2) years paid experience in the preceding five (5) years in HIV/AIDS care may also provide adherence education and counseling. **Medical Case Management:** The program must utilize a state licensed Social Worker to provide Medical Case Management Services. The Contractor must maintain the assigned number of Medical Case Management FTEs throughout the contract term. **Contractor must provide to RWGA the names of each Medical Case Manager and the individual assigned to supervise those Medical Case Managers by 03/30/17, and thereafter within 15 days after hire.** **Service Linkage:** The program must utilize Service Linkage Workers who have at a minimum a Bachelor's degree from an accredited college or university with a major in social or behavioral sciences. Documented paid work experience in providing client services to PLWHA may be substituted for the Bachelor's degree requirement on a 1:1 basis (1 year of documented paid experience may be substituted for 1 year of college). All Service Linkage Workers must have a minimum of one (1) year paid work experience with PLWHA. Contractor must maintain the assigned number of Service Linkage FTEs throughout the contract term. **Contractor must provide to RWGA the names of each Service Linkage Worker and the individual assigned to supervise those Service Linkage Workers by 03/30/17, and thereafter within 15 days after hire.** **Supervision of Case Managers:** The Service Linkage Workers and Medical Case Managers must function within the clinical infrastructure of Contractor and receive ongoing supervision that meets or exceeds Houston EMA/HSDA Part A/B Standards of Care for Service Linkage and Medical Case Management as applicable. An MCM may supervise SLWs.
Special Requirements: **RWGA Only**	**All primary medical care services must meet or exceed current United States DHHS Treatment Guidelines for the treatment and management of HIV disease.** Contractor must provide all required program components - Primary Medical Care, Medical Case Management and Service Linkage (non-medical Case Management) services. **Primary Medical Care Services:** Services funded under this grant cannot be used to supplant insurance or Medicare/Medicaid reimbursements for such services. Clients eligible for such reimbursement may not be billed to this contract. Medicare and private insurance co-payments may be eligible for reimbursement under Ryan White Health Insurance Assistance (HINS) program guidelines. Patients needing such assistance should be referred to the local Ryan White-funded HINS provider for assistance. Under no circumstances may the

	Contractor bill the County for the difference between the reimbursement from Medicaid, Medicare or Third Party insurance and the fee schedule under the contract. Furthermore, potential clients who are Medicaid/Medicare eligible or have other Third Party payers may not be denied services or referred elsewhere by the Contractor based on their reimbursement status (i.e. Medicaid/Medicare eligible clients may not be referred elsewhere in order that non-Medicaid/Medicare eligible clients may be added to the contract). Failure to serve Medicaid/Medicare eligible clients based on their reimbursement status will be grounds for the immediate termination of contract. **Diagnostic Procedures:** A single Diagnostic Procedure limited to procedures on the approved list of diagnostic procedures (see below) without prior County approval. Approved diagnostic procedures will be reimbursed at invoice cost. Part A and Part A/MAI-funded programs must refer to the RWGA website for the most current list of approved diagnostic procedures and corresponding codes: www.hcphes.org/rwga. **Diagnostic procedures not listed on the website must have prior approval by RWGA.** **Outpatient Psychiatric Services:** Client must not be eligible for services from other programs/providers or any other reimbursement source (i.e. Medicaid, Medicare, private insurance) unless the client is in crisis and cannot be provided immediate services from the other programs/providers. In this case, clients may be provided services, as long as the client applies for the other programs/providers, until the other programs/providers can take over services. Program must be supervised by a Psychiatrist and include diagnostic assessments, emergency evaluations and psycho-pharmacotherapy. **Maintaining Referral Relationships** (Point of Entry Agreements): Contractor must maintain appropriate relationships with entities that constitute key points of access to the health care system for individuals with HIV disease, including but not limited to, Harris Health System and other Houston EMA-located emergency rooms, Harris County Jail, Texas Department of Criminal Justice incarceration facilities, Immigration detention centers, substance abuse treatment and detoxification programs, adult and juvenile detention facilities, Sexually Transmitted Disease clinics, federally qualified health centers (FQHC), HIV disease counseling and testing sites, mental health programs and homeless shelters. These referral relationships must be documented with written collaborative agreements, contracts or memoranda of understanding between Contractor and appropriate point of entry entities and are subject to audit by RWGA. Contractor and POE entity staff must regularly (e.g. weekly, bi-weekly depending on volume of referrals) meet 1:1 to discuss new referrals to primary medical care services. Such case conferences must be documented in the client record and properly entered into the CPCDMS. Use of CPCDMS Data System: Contractor must comply with CPCDMS

	business rules and procedures. Contractor must enter into the CPCDMS all required clinical data, including but not limited to, HAART treatment including all changes in medication regimens, Opportunistic Infections, screening and treatment for STDs and Hepatitis A, B, C and other clinical screening and treatment data required by HRSA, TDSHS and the County. Contractor must perform Registration updates in accordance with RWGA CPCDMS business rules for all clients wherein Contractor is client's CPCDMS record-owning agency. Contractor must utilize an electronic verification system to verify insurance/3rd party payer status monthly or per visit (whichever is less frequent). **Bus Pass Distribution:** The County will provide Contractor with METRO bus pass vouchers. Bus Pass vouchers must be distributed in accordance with RWGA policies and procedures, standards of care and financial eligibility guidelines. Contractor may only issue METRO bus pass vouchers to clients wherein the Contractor is the CPCDMS record owning Contractor. METRO bus pass vouchers shall be distributed as follows: **Expiration of Current Bus Pass:** In those situation wherein the bus pass expiration date does not coincide with the CPCDMS registration update the Contractor must distribute METRO bus pass vouchers to eligible clients upon the expiration of the current bus pass or when a Value-based bus card has been expended on eligible transportation needs. Contractor may issue METRO bus passes to eligible clients living outside the METRO service area in those situations where the Contractor has documented in the client record that the client will utilize the METRO system to access needed HIV-related health care services located in the METRO service area.

FY 2022 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/10/2021**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Steering Committee**		Date: **06/03/2021**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Improvement Committee**		Date: **05/18/2021**
Recommendations:	Approved: Y:_ ___ No: _____ Approved With Changes: _____	If approved with changes list changes below:
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Step in Process: **HTBMTN Workgroup #1**	Date: **04/20/2021**
Recommendations:	Financial Eligibility: PriCare=300%, MCM=none, SLW=none
1. Accept the service definition as presented and keep the financial eligibility the same.	
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FY 2020 Houston EMA Ryan White Part A/MAI Service Definition Clinical Case Management	
HRSA Service Category Title: **RWGA Only**	**Medical Case Management**
Local Service Category Title:	**Clinical Case Management (CCM)**
Budget Type: **RWGA Only**	**Unit Cost**
Budget Requirements or Restrictions: **RWGA Only**	Not applicable.
HRSA Service Category Definition: **RWGA Only**	***Medical Case Management services (including treatment adherence)*** are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication.
Local Service Category Definition:	**Clinical Case Management**: Identifying and screening clients who are accessing HIV-related services from a clinical delivery system that provides Mental Health treatment/counseling and/or Substance Abuse treatment services; assessing each client's medical and psychosocial history and current service needs; developing and regularly updating a clinical service plan based upon the client's needs and choices; implementing the plan in a timely manner; providing information, referrals and assistance with linkage to medical and psychosocial services as needed; monitoring the efficacy and quality of services through periodic reevaluation; advocating on behalf of clients to decrease service gaps and remove barriers to services helping clients develop and utilize independent living skills and strategies. Assist clients in obtaining needed resources, including bus pass vouchers and gas cards per published HCPHS/RWGA policies.
Target Population (age,	Services will be available to eligible HIV-infected clients residing in

gender, geographic, race, ethnicity, etc.):	the Houston EMA with priority given to clients most in need. All clients who receive services will be served without regard to age, gender, race, color, religion, national origin, sexual orientation, or handicap. Services will target low income individuals with HIV/AIDS who demonstrate multiple medical, mental health, substance use/abuse and psychosocial needs including, but not limited to: mental health counseling (i.e. professional counseling), substance abuse treatment, primary medical care, specialized care, alternative treatment, medications, placement in a medical facility, emotional support, basic needs for food, clothing, and shelter, transportation, legal services and vocational services. Services will also target clients who cannot function in the community due to barriers which include, but are not limited to, mental illness and psychiatric disorders, drug addiction and substance abuse, extreme lack of knowledge regarding available services, inability to maintain financial independence, inability to complete necessary forms, inability to arrange and complete entitlement and medical appointments, homelessness, deteriorating medical condition, illiteracy, language/cultural barriers and/or the absence of speech, sight, hearing, or mobility. *Clinical Case Management* is intended to serve eligible clients, especially those underserved or unserved population groups which include: African American, Hispanic/Latino, Women and Children, Veteran, Deaf/Hard of Hearing, Substance Abusers, Homeless and Gay/Lesbian/Transsexual.
Services to be Provided:	Provision of Clinical Case Management activities performed by the Clinical Case Manager. *Clinical Case Management* is a working agreement between a client and a Clinical Case Manager for a defined period of time based on the client's assessed needs. *Clinical Case Management* services include performing a comprehensive assessment and developing a clinical service plan for each client; monitoring plan to ensure its implementation; and educating client regarding wellness, medication and health care compliance in order to maximize benefit of mental health and/or substance abuse treatment services. The *Clinical Case Manager* serves as an advocate for the client and as a liaison with mental health, substance abuse and medical treatment providers on behalf of the client. The Clinical Case Manager ensures linkage to mental health, substance abuse, primary medical care and other client services as indicated by the clinical service plan. The Clinical Case Manager will perform *Mental Health* and *Substance Abuse/Use Assessments* in accordance with RWGA Quality Management guidelines. Service plan must reflect an ongoing discussion of mental health treatment and/or substance abuse treatment, primary medical care and medication adherence, per client need. *Clinical Case Management is* both office and community-based. Clinical

	Case Managers will interface with the primary medical care delivery system as necessary to ensure services are integrated with, and complimentary to, a client's medical treatment plan.
Service Unit Definition(s): **RWGA Only**	One unit of service is defined as 15 minutes of direct client services and allowable charges.
Financial Eligibility:	Refer to the RWPC's approved *Financial Eligibility for Houston EMA Services*.
Client Eligibility:	HIV-infected individuals residing in the Houston EMA.
Agency Requirements:	*Clinical Case Management* services will comply with the HCPHS/RWGA published Clinical Case Management Standards of Care and policies and procedures as published and/or revised, including linkage to the CPCDMS data system *Clinical Case Management Services* must be provided by an agency with a documented history of, and current capacity for, providing mental health counseling services (categories b., c. and d. as listed under *Amount Available* above) or substance abuse treatment services to PLWH/A (category a. under *Amount Available* above) in the Houston EMA. Specifically, an applicant for this service category must clearly demonstrate it has provided mental health treatment services (e.g. professional counseling) or substance abuse treatment services (as applicable to the specific CCM category being applied for) in the previous calendar or grant year to individuals with an HIV diagnosis. Acceptable documentation for such treatment activities includes standardized reporting documentation from the County's *CPCDMS* or Texas Department of State Health Services' *ARIES* data systems, Ryan White Services Report (RSR), SAMSHA or TDSHS/SAS program reports or other verifiable published data. Data submitted to meet this requirement is subject to audit by HCPHS/RWGA prior to an award being recommended. **Agency-generated non-verifiable data is not acceptable.** In addition, applicant agency must demonstrate it has the capability to continue providing mental health treatment and/or substance abuse treatment services for the duration of the contract term and any subsequent one-year contract renewals. Acceptable documentation of such continuing capability includes current funding from Ryan White (all Parts), TDSHS HIV-related funding (Ryan White, State Services, State-funded Substance Abuse Services), SAMSHA and other ongoing federal, state and/or public or private foundation HIV-related funding for mental health treatment and/or substance abuse treatment services. Proof of such funding must be documented in the application and is subject to independent verification by HCPHS/RWGA prior to an award being recommended. Loss of funding and corresponding loss of capacity to provide mental health counseling or substance abuse treatment services as applicable may result in the termination of Clinical Case Management Services

	awarded under this service category. Continuing eligibility for Clinical Case Management Services funding is explicitly contingent on applicant agency maintaining verifiable capacity to provide mental health counseling or substance abuse treatment services as applicable to PLWH/A during the contract term. **Applicant agency must be Medicaid and Medicare Certified**.
Staff Requirements:	Clinical Case Managers must spend at least 42% (867 hours per FTE) of their time providing direct case management services. Direct case management services include any activities with a client (face-to-face or by telephone), communication with other service providers or significant others to access client services, monitoring client care, and accompanying clients to services. Indirect activities include travel to and from a client's residence or agency, staff meetings, supervision, community education, documentation, and computer input. Direct case management activities must be documented in the Centralized Patient Care Data Management System (CPCDMS) according to CPCDMS business rules. *Must comply with applicable HCPHS/RWGA Houston EMA/HSDA Part A/B Ryan White Standards of Care:* Minimum Qualifications: **Clinical Case Managers** must have at a minimum a Bachelor's degree from an accredited college or university with a major in social or behavioral sciences and have a current and in good standing State of Texas license (LBSW, LSW, LMSW, LCSW, LPC, LPC-I, LMFT, LMFT-A or higher level of licensure). The Clinical Case Manager may supervise the Service Linkage Worker. CCM targeting Hispanic PLWHA must demonstrate both written and verbal fluency in Spanish. Supervision: The **Clinical Case Manager** (CCM) must function with the clinical infrastructure of the applicant agency and receive supervision in accordance with the CCM's licensure requirements. At a minimum, the CCM must receive ongoing supervision that meets or exceeds HCPHS/RWGA published Ryan White Part A/B Standards of Care for Clinical Case Management. If applicant agency also has Service Linkage Workers funded under Ryan White Part A the CCM may supervise the Service Linkage Worker(s). Supervision provided by a CCM that is not client specific is considered **indirect time** and is not billable.
Special Requirements: **RWGA Only**	Contractor must employ full-time Clinical Case Managers. Prior approval must be obtained from RWGA to split full-time equivalent (FTE) CCM positions among other contracts or to employ part-time staff. **Contractor must provide to RWGA the names of each Clinical Case Manager and the program supervisor no later than 3/30/17. Contractor must inform RWGA in writing of any**

	changes in personnel assigned to contract within seven (7) business days of change. Contractor must comply with CPCDMS data system business rules and procedures. Contractor must perform CPCDMS new client registrations and registration updates for clients needing ongoing case management services as well as those clients who may only need to establish system of care eligibility. Contractor must issue bus pass vouchers in accordance with HCPHS/RWGA policies and procedures.

FY 2022 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/10/2021**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Steering Committee**		Date: **06/03/2021**
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Step in Process: **Quality Improvement Committee**		Date: **05/18/2021**
Recommendations:	Approved: Y:_ ___ No: _____ Approved With Changes: _____	If approved with changes list changes below:
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Step in Process: **HTBMTN Workgroup #1**	Date: **04/20/2021**
Recommendations:	Financial Eligibility: None
1. Accept the service definition as presented and keep the financial eligibility the same.	
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FY 2020 Houston EMA Ryan White Part A/MAI Service Definition **Service Linkage at Testing Sites**	
HRSA Service Category Title: **RWGA Only**	**Non-medical Case Management**
Local Service Category Title:	**A. Service Linkage targeted to Not-In-Care and Newly-Diagnosed PLWHA in the Houston EMA/HDSA** **Not-In-Care PLWHA** are individuals who know their HIV status but have not been actively engaged in outpatient primary medical care services for more than six (6) months. **Newly-Diagnosed** PLWHA are individuals who have learned their HIV status within the previous six months and are not currently receiving outpatient primary medical care or case management services as documented in the CPCDMS data system. **B.** ***Youth targeted Service Linkage, Care and Prevention:*** Service Linkage Services targeted to Youth (13 – 24 years of age), including a focus on not-in-care and newly-diagnosed Youth in the Houston EMA. *Not-In-Care PLWHA are Youth who know their HIV status but have not been actively engaged in outpatient primary medical care services in the previous six (6) months. *Newly-Diagnosed Youth are Youth who have learned their HIV status within the previous six months and are not currently receiving outpatient primary medical care or case management services as documented in the CPCDMS data system.
Budget Type: **RWGA Only**	Fee-for-Service
Budget Requirements or Restrictions: **RWGA Only**	Early intervention services, including HIV testing and Comprehensive Risk Counseling Services (CRCS) must be supported via alternative funding (e.g. TDSHS, CDC) and may not be charged to this contract.
HRSA Service Category Definition: **RWGA Only**	***Case Management (non-Medical)*** includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does. ***Early intervention services (EIS)*** include counseling individuals with respect to HIV/AIDS; testing (including tests to confirm the presence of the disease, tests to diagnose to extent of immune deficiency, tests to provide information on appropriate therapeutic measures); referrals; other clinical and diagnostic services regarding HIV/AIDS; periodic medical evaluations for individuals with HIV/AIDS; and providing therapeutic measures.
Local Service Category Definition:	**A.** ***Service Linkage:*** Providing allowable Ryan White Program outreach and service linkage activities to newly-diagnosed and/or ***Not-In-Care*** PLWHA who know their status but are not currently enrolled

	in outpatient primary medical care with information, referrals and assistance with linkage to medical, mental health, substance abuse and psychosocial services as needed; advocating on behalf of clients to decrease service gaps and remove barriers to services helping clients develop and utilize independent living skills and strategies. Assist clients in obtaining needed resources, including bus pass vouchers and gas cards per published HCPHS/RWGA policies. **B. *Youth targeted Service Linkage, Care and Prevention:*** Providing Ryan White Program appropriate outreach and service linkage activities to newly-diagnosed and/or not-in-care HIV-positive Youth who know their status but are not currently enrolled in outpatient primary medical care with information, referrals and assistance with linkage to medical, mental health, substance abuse and psychosocial services as needed; advocating on their behalf to decrease service gaps and remove barriers to services; helping Youth develop and utilize independent living skills and strategies. Assist clients in obtaining needed resources, including bus pass vouchers and gas cards per published HCPHS/RWGA policies. Provide comprehensive medical case management to HIV-positive youth identified through outreach and in-reach activities.
Target Population (age, gender, geographic, race, ethnicity, etc.):	**A. Service Linkage:** Services will be available to eligible HIV-infected clients residing in the Houston EMA/HSDA with priority given to clients most in need. All clients who receive services will be served without regard to age, gender, race, color, religion, national origin, sexual orientation, or handicap. Services will target low income individuals with HIV/AIDS who demonstrate multiple medical, mental health, substance use/abuse and psychosocial needs including, but not limited to: mental health counseling, substance abuse treatment, primary medical care, specialized care, alternative treatment, medications, placement in a medical facility, emotional support, basic needs for food, clothing, and shelter, transportation, legal services and vocational services. Services will also target clients who cannot function in the community due to barriers which include, but are not limited to, mental illness and psychiatric disorders, drug addiction and substance abuse, extreme lack of knowledge regarding available services, inability to maintain financial independence, inability to complete necessary forms, inability to arrange and complete entitlement and medical appointments, homelessness, deteriorating medical condition, illiteracy, language/cultural barriers and/or the absence of speech, sight, hearing, or mobility. **Service Linkage** is intended to serve eligible clients in the Houston EMA/HSDA, especially those underserved or unserved population groups which include: African American, Hispanic/Latino, Women and Children, Veteran, Deaf/Hard of Hearing, Substance Abusers, Homeless and Gay/Lesbian/Transsexual. **B. *Youth targeted Service Linkage, Care and Prevention:*** Services will be available to eligible HIV-infected Youth (ages 13 – 24) residing

	in the Houston EMA/HSDA with priority given to clients most in need. All Youth who receive services will be served without regard to age (i.e. limited to those who are between 13- 24 years of age), gender, race, color, religion, national origin, sexual orientation, or handicap. Services will target low income Youth living with HIV/AIDS who demonstrate multiple medical, mental health, substance use/abuse and psychosocial needs including, but not limited to: mental health counseling, substance abuse treatment, primary medical care, specialized care, alternative treatment, medications, placement in a medical facility, emotional support, basic needs for food, clothing, and shelter, transportation, legal services and vocational services. Services will also target Youth who cannot function in the community due to barriers which include, but are not limited to, mental illness and psychiatric disorders, drug addiction and substance abuse, extreme lack of knowledge regarding available services, inability to maintain financial independence, inability to complete necessary forms, inability to arrange and complete entitlement and medical appointments, homelessness, deteriorating medical condition, illiteracy, language/cultural barriers and/or the absence of speech, sight, hearing, or mobility. ***Youth Targeted Service Linkage, Care and Prevention*** is intended to serve eligible youth in the Houston EMA/HSDA, especially those underserved or unserved population groups which include: African American, Hispanic/Latino, Substance Abusers, Homeless and Gay/Lesbian/Transsexual.
Services to be Provided:	**Goal (A): Service Linkage:** The expectation is that a single Service Linkage Worker Full Time Equivalent (FTE) targeting Not-In-Care and/or newly-diagnosed PLWHA can serve approximately 80 newly-diagnosed or not-in-care PLWH/A per year. The purpose of **Service Linkage** is to assist clients with the procurement of needed services so that the problems associated with living with HIV are mitigated. **Service Linkage** is a working agreement between a client and a Service Linkage Worker (SLW) for an indeterminate period, based on client need, during which information, referrals and service linkage are provided on an as-needed basis. The purpose of **Service Linkage** is to assist clients who do not require the intensity of *Clinical or Medical Case Management*, as determined by RWGA Quality Management guidelines. **Service Linkage** is both office- and field-based and **may include the issuance of bus pass vouchers and gas cards per published guidelines.** Service Linkage targeted to Not-In-Care and/or Newly-Diagnosed PLWHA extends the capability of existing programs with a documented track record of identifying Not-In-Care and/or newly-diagnosed PLWHA by providing "hands-on" outreach and linkage to care services to those PLWHA who are not currently accessing primary medical care services.

	In order to ensure linkage to an ongoing support system, eligible clients identified funded under this contract, including clients who may obtain their medical services through non-Ryan White-funded programs, must be transferred to a Ryan White-funded Primary Medical Care, Clinical Case Management or Service Linkage program within 90 days of initiation of services as documented in both ECLIPS and CPCDMS data systems. Those clients who choose to access primary medical care from a non-Ryan White source, including private physicians, may receive ongoing service linkage services from provider or must be transferred to a Clinical (CCM) or Primary Care/Medical Case Management site per client need and the preference of the client**.** **GOAL (B):** This effort will continue a program of ***Service Linkage, Care and Prevention to Engage HIV Seropositive Youth*** targeting youth (ages 13-24) with a focus on Youth of color. This service is designed to reach HIV seropositive youth of color not engaged in clinical care and to link them to appropriate clinical, supportive, and preventive services. The specific objectives are to: (1) conduct outreach (service linkage) to assist seropositive Youth learn their HIV status, (2) link HIV-infected Youth with primary care services, and (3) prevent transmission of HIV infection from targeted clients.
Service Unit Definition(s): **RWGA Only**	One unit of service is defined as 15 minutes of direct client services and allowable charges.
Financial Eligibility:	Refer to the RWPC's approved *Financial Eligibility for Houston EMA/HSDA Services.*
Client Eligibility:	Not-In-Care and/or newly-diagnosed HIV-infected individuals residing in the Houston EMA.
Agency Requirements:	**Service Linkage** services will comply with the HCPHS/RWGA published **Service Linkage** Standards of Care and policies and procedures as published and/or revised, including linkage to the CPCDMS data system. Agency must comply with all applicable City of Houston DHHS *ECLIPS* and RWGA/HCPHS *CPCDMS* business rules and policies & procedures. **Service Linkage** targeted to Not-In-Care and/or newly diagnosed PLWHA must be planned and delivered in coordination with local HIV prevention/outreach programs to avoid duplication of services and be designed with quantified program reporting that will accommodate local effectiveness evaluation. Contractor must document established linkages with agencies that serve HIV-infected clients or serve individuals who are members of high-risk population groups (e.g., men who have sex with men, injection drug users, sex-industry workers, youth who are sentenced under the juvenile justice system, inmates of state and local jails and prisons). Contractor must have formal collaborative, referral or Point of Entry (POE) agreements with Ryan White funded HIV/AIDS primary care providers.

Staff Requirements:	Service Linkage Workers must spend at least 42% (867 hours per FTE) of their time providing direct client services. Direct service linkage and case management services include any activities with a client (face-to-face or by telephone), communication with other service providers or significant others to access client services, monitoring client care, and accompanying clients to services. Indirect activities include travel to and from a client's residence or agency, staff meetings, supervision, community education, documentation, and computer input. Direct case management activities must be documented in the CPCDMS according to system business rules. *Must comply with applicable HCPHS/RWGA published Ryan White Part A/B Standards of Care:* Minimum Qualifications: **Service Linkage Workers** must have at a minimum a Bachelor's degree from an accredited college or university with a major in social or behavioral sciences. Documented paid work experience in providing client services to PLWH/A may be substituted for the Bachelor's degree requirement on a 1:1 basis (1 year of documented paid experience may be substituted for 1 year of college). All Service Linkage Workers must have a minimum of one (1) year paid work experience with PLWHA. Supervision: The Service Linkage Worker must function within the clinical infrastructure of the applicant agency and receive ongoing supervision that meets or exceeds HCPHS/RWGA published Ryan White Part A/B Standards of Care for Service Linkage.
Special Requirements: **RWGA Only**	Contractor must be have the capability to provide Public Health Follow-Up by qualified Disease Intervention Specialists (DIS) to locate, identify, inform and refer newly-diagnosed and not-in-care PLWHA to outpatient primary medical care services. Contractor must perform CPCDMS new client registrations and, for those newly-diagnosed or out-of-care clients referred to non-Ryan White primary care providers, registration updates per RWGA business rules for those needing ongoing service linkage services as well as those clients who may only need to establish system of care eligibility. This service category does not routinely distribute Bus Passes. However, if so directed by RWGA, Contractor must issue bus pass vouchers in accordance with HCPHS/RWGA policies and procedures.

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Step in Process: **Quality Improvement Committee**		Date: **05/18/2021**
Recommendations:	Approved: Y:_ ___ No: _____ Approved With Changes: _____	If approved with changes list changes below:
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Step in Process: **HTBMTN Workgroup #1**	Date: **04/20/2021**
Recommendations:	Financial Eligibility: None
1. Accept the service definition as presented and keep the financial eligibility the same.	
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2022-2023 Service Category Definition - DSHS State Services

Local Service Category:	**Care Coordination (Non-Medical Case Management) Targeting Substance Use Disorder**
Amount Available**:**	**To be determined**
Unit Cost	
Budget Requirements or Restrictions **(TRG Only)**:	Maximum 10% of budget for Administrative Cost. Direct medical costs and Substance Abuse Treatment/Counseling cannot be billed under this contract.
DSHS Service Category Definition:	**Care Coordination** is a continuum of services that allow people living with HIV to be served in a holistic method. Services that are a part of the Care Coordination Continuum include case management, (both medical and non-medical, outreach services, referral for health care, and health education/risk reduction. **Non-Medical Case Management (N-MCM)** model is responsive to the immediate needs of a person living with HIV (PLWH) and includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, entitlements, housing, and other needed services. **Non-Medical Case Management Services (N-MCM)** provide guidance and assistance in accessing medical, social, community, legal, financial, and other needed services. N-MCM services may also include assisting eligible persons living with HIV (PLWH) to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, or health insurance Marketplace plans. This service category includes several methods of communication (e.g., face-to-face, phone contact, and any other forms of communication) as deemed appropriate by the Texas DSHS HIV Care Services Group Ryan White Part B program. Limitation: Non-Medical Case Management services do not involve coordination and follow up of medical treatments.
Local Service Category Definition:	***Non-Medical Case Management:*** The purpose of Non-Medical Case Management targeting Substance Use Disorders (SUD) is to assist PLWHs with the procurement of needed services so that the problems associated with living with HIV are mitigated. N-MCM targeting SUD is intended to serve eligible people living with HIV in the Houston EMA/HSDA who are also facing the challenges of substance use disorder. Non-Medical Case Management is a working agreement between a PLWH and a Non-Medical Case Manager for an indeterminate period, based on PLWH need, during which information, referrals and Non-Medical Case Management is provided on an as- needed basis and assists PLWHs who do not require the intensity of Medical Case Management. Non-Medical Case Management is both office-based and field based. N-MCMs are expected to coordinate activities with referral sources where newly-

	diagnosed or not-in-care PLWH may be identified, including substance use disorder treatment/counseling and/or recovery support personnel. Such incoming referral coordination includes meeting prospective PLWHs at the referring provider location in order to develop rapport with and ensuring sufficient support is available. Non-Medical Case Management also includes follow-up to re-engage lost-to-care patients. Lost-to-care patients are those PLWHs who have not returned for scheduled appointments with the provider nor have provided updated information about their current Primary Medical Care provider (in the situation where PLWH may have obtained alternate service from another medical provider). Contractor must document efforts to re-engage lost-to-care patients prior to closing patients in the CPCDMS. Non-Medical Case Management extends the capability of existing programs by providing "hands-on" outreach and linkage to care services to those PLWH who are not currently accessing primary medical care services.
Target Population (age, gender, geographic, race, ethnicity, etc.):	**Non-Medical Case Management targeting SUD** is intended to serve eligible people living with HIV in the Houston EMA/HSDA, especially those underserved or unserved population groups who are also facing the challenges of substance use disorder. The target populations should also include individuals who misuse prescription medication or who use illegal substances or recreational drugs and are also: - Transgender, - Men who have sex with men (MSM), - Women or - Incarcerated/recently released from incarceration.
Services to be Provided:	**Goals:** The primary goal for N-MCM targeting SUD is to improve the health status of PLWHs who use substances by promoting linkages between community-based substance use disorder treatment programs, health clinics and other social service providers. N-MCM targeting SUD shall have a planned and coordinated approach to ensure that PLWHs have access to all available health and social services necessary to obtain an optimum level of functioning. N-MCM targeting SUD shall focus on behavior change, risk and harm reduction, retention in HIV care, and lowering risk of HIV transmission. The expectation is that each Non-Medical Case Management Full Time Equivalent (FTE) targeting SUD can serve approximately 80 PLWHs per year. **Purpose:** To promote Human Immunodeficiency Virus (HIV) disease management and recovery from substance use disorder by providing comprehensive Non-Medical Case Management and support for PWLH who are also dealing with substance use disorder and providing support to their families and significant others. **N-MCM targeting SUD** assists PLWHs with the procurement of needed services so that the problems associated with living with HIV

	are mitigated. **N-MCM targeting SUD** is a working agreement between a person living with HIV and a Non-Medical Case Manager (N-MCM) for an indeterminate period, based on identified need, during which information, referrals and Non-Medical Case Management is provided on an as- needed basis. The purpose of **N-MCM targeting SUD** is to assist PLWHs who do not require the intensity of *Clinical or Medical Case Management*. **N-MCM targeting SUD** is community-based (i.e. both office- and field-based). This Non-Medical Case Management targets PLWHs who are also dealing with the challenges of substance use disorder. N-MCMs also provide "hands-on" outreach and linkage to care services to those PLWHA who are not currently accessing primary medical care services. Efforts may include coordination with other case management providers to ensure the specialized needs of PLWHs who are dealing with substance use disorder are thoroughly addressed. For this population, this is not a duplication of service but rather a set of agreed upon coordinated activities that clearly delineate the unique and separate roles of N-MCMs and medical case managers who work jointly and collaboratively with the PLWH's knowledge and consent to partialize and prioritize goals in order to effectively achieve those goals. N-MCMs should provide activities that enhance the motivation of PLWHs on N-MCM's caseload to reduce their risks of overdose and how risk-reduction activities may be impacted by substance use and sexual behaviors. N-MCMs shall use motivational interviewing techniques and the Transtheoretical Model of Change, (DiClemente and Prochaska - Stages of Change). N-MCMs should promote and encourage entry into substance use disorder services and make referrals, if appropriate, for PLWHs who are in need of formal substance use disorder treatment or other recovery support services. However, N-MCMs shall ensure that PLWHs are not required to participate in substance use disorder treatment services as a condition for receiving services. For those PLWH in treatment, N-MCMs should address ongoing services and support for discharge, overdose prevention, and aftercare planning during and following substance use disorder treatment and medically-related hospitalizations. N-MCMs should ensure that appropriate harm- and risk-reduction information, methods and tools are used in their work with the PLWH. Information, methods and tools shall be based on the latest scientific research and best practices related to reducing sexual risk and HIV transmission risks. Methods and tools must include, but are not limited to, a variety of effective condoms and other safer sex tools as well as substance abuse risk-reduction tools, information, discussion and

	referral about Pre- Exposure Prophylactics (PrEP) for PLWH's sexual or drug using partners and overdose prevention. N-MCMs should make information and materials on overdose prevention available to appropriate PLWHs as a part of harm- and risk-reduction. Those PLWHs who choose to access primary medical care from a non-Ryan White source, including private physicians, may receive ongoing Non-Medical Case Management services from provider**.**
Service Unit Definition(s) **(TRG Only)**:	One unit of service is defined as 15 minutes of direct services or coordination of care on behalf of PLWH.
Financial Eligibility:	Refer to the RWPC's approved *Financial Eligibility for Houston EMA Services*.
Client Eligibility:	PLWHs dealing with challenges of substance use/abuse and dependence. Resident of the Houston HSDA.
Agency Requirements **(TRG Only)**:	These services will comply with the TRG's published **Non-Medical Case Management Targeting Substance Use Disorder** Standards of Care and policies and procedures as published and/or revised, including linkage to the CPCDMS data system as well as DSHS Universal Standards and Non-Medical Case Management Standards of Care. **Non-Medical Case Management targeted SUD** must be planned and delivered in coordination with local HIV treatment/prevention/outreach programs to avoid duplication of services and be designed with quantified program reporting that will accommodate local effectiveness evaluation. Subrecipients must document established linkages with agencies that serve PLWH or serve individuals who are members of high-risk population groups (e.g., men who have sex with men, injection drug users, sex-industry workers, youth who are sentenced under the juvenile justice system, inmates of state and local jails and prisons). Contractor must have formal collaborative, referral or Point of Entry (POE) agreements with Ryan White funded HIV primary care providers.
Staff Requirements:	<u>Minimum Qualifications:</u> **Non-Medical Case Management Workers** must have at a minimum a Bachelor's degree from an accredited college or university with a major in social or behavioral sciences. Documented paid work experience in providing services to PLWH may be substituted for the Bachelor's degree requirement on a 1:1 basis (1 year of documented paid experience may be substituted for 1 year of college). All Non-Medical Case Management Workers must have a minimum of one (1) year work experience with PLWHA and/or substance use disorders. <u>Supervision:</u> The Non-Medical Case Management Worker must function within the clinical infrastructure of the applicant agency and receive ongoing supervision that meets or exceeds TRG's published **Non-Medical Case Management Targeting Substance Use Disorder** Standards of Care.

2022-2023 Service Category Definition - DSHS State Services

Special Requirements **(TRG Only)**:	Must comply with the Houston EMA/HSDA Standards of Care. The agency must comply with **the DSHS Universal Standards and non-Medical Case Management Standards of Care**. The agency must have policies and procedures in place that comply with the standards ***prior*** to delivery of the service. Contractor must be licensed in Texas to directly provide substance use treatment/counseling. Non-medical Case Management services can be delivered via telehealth and must follow applicable federal and State of Texas privacy laws.

FY 2022 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/10/2021**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Steering Committee**		Date: **06/03/2021**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Improvement Committee**		Date: **05/18/2021**
Recommendations:	Approved: Y:_ ___ No: _____ Approved With Changes: _____	If approved with changes list changes below:
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Step in Process: **HTBMTN Workgroup #2**	Date: **04/20/2021**
Recommendations:	Financial Eligibility: None.
1. Accept the service definition as presented and keep the financial eligibility the same.	
2.	
3.	

2022-2023 Service Category Definition - DSHS State Services

Local Service Category:	**Early Intervention Services – Incarcerated**
Amount Available**:**	**To be determined**
Unit Cost	
Budget Requirements or Restrictions **(TRG Only)**:	Maximum 10% of budget for Administrative Cost. No direct medical costs may be billed to this grant.
DSHS Service Category Definition:	Support of Early Intervention Services (EIS) that include identification of individuals at points of entry and access to services and provision of: • HIV Testing and Targeted counseling • Referral services • Linkage to care • Health education and literacy training that enable PLWHs to navigate the HIV system of care These services must focus on expanding key points of entry and documented tracking of referrals. Counseling, testing, and referral activities are designed to bring people living with HIV into Outpatient Ambulatory Medical Care. The goal of EIS is to decrease the number of underserved individuals with HIV/AIDS by increasing access to care. EIS also provides the added benefit of educating and motivating PLWHs on the importance and benefits of getting into care. Limitations: Funds can only be sed for HIV testing where existing federal, state, and local funds are not adequate *and* funds will supplement, ***not supplant***, existing funds for testing. Funds cannot be used to purchase at-home testing kits.
Local Service Category Definition:	This service includes the connection of incarcerated in the Harris County Jail into medical care, the coordination of their medical care while incarcerated, and the transition of their care from Harris County Jail to the community. Services must include: assessment of the PLWH, provision of education regarding disease and treatment, education and skills building to increase PLWH's health literacy, completion of THMP/ADAP application and submission via ARIES upload process, care coordination with medical resources within the jail, care coordination with service providers outside the jail, and discharge planning.
Target Population (age, gender, geographic, race, ethnicity, etc.):	People living with HIV (PLWHs) incarcerated in The Harris County Jail.
Services to be Provided:	Services include but are not limited to CPCDMS registration/update, assessment, provision of education, coordination of medical care services provided while incarcerated, medication regimen transition, multidisciplinary team review, discharge planning, and referral to community resources.

	EIS for the Incarcerated is provided at Harris County Jail. HCJ's population includes both individuals who are actively progressing through the criminal justice system (toward a determination of guilt or innocence), individuals who are serving that sentence in HCJ, and individuals who are awaiting transfer to Texas Department of Criminal Justice (TDCJ). The complexity of this population has proven a challenge in service delivery. Some individuals in HCJ have a firm release date. Others may attend and be released directly from court. Therefore, EIS for the Incarcerated has been designed to consider the uncertain nature of length of stay in the service delivery. Three tiers of service provision haven been designated. They are: • **Tier 0:** The individuals in this tier do **not** stay in HCJ long enough to receive a clinical appointment while incarcerated. The use of zero for this tier's designation reinforces the understanding that the interaction with funded staff will be minimal. The length of stay in this tier is traditionally less than 14 days. • **Tier 1:** The individuals in this tier stay in HCJ long enough to receive a clinical appointment while incarcerated. This clinical appointment triggers the ability of staff to conduct multiple interactions to assure that certain benchmarks of service provision should be met. The length of stay in this tier is traditionally 15-30 days. • **Tier 2:** The individuals in this tier remain in HCJ long enough to get additional interactions and potentially multiple clinical appointments. The length of stay in this tier is traditionally 30 or more days. Service provision builds on the activities of the previous tier if the individual remains in HCJ. Each tier helps the staff to focus interactions to address the highest priority needs of the individual. Each interaction is conducted as if it is the only opportunity to conduct the intervention with the individual.
Service Unit Definition(s) **(TRG Only)**:	One unit of service is defined as 15 minutes of direct PLWH services or coordination of care on behalf of PLWH.
Financial Eligibility:	Due to incarceration, no income or residency documentation is required.
Eligibility for Service:	People living with HIV incarcerated in the Harris County Jail.
Agency Requirements **(TRG Only)**:	As applicable. the agency's facility(s) shall be appropriately licensed or certified as required by Texas Department of State Health Services, for the provision of HIV Early Intervention Services, including phlebotomy services.

	Agency/staff will establish memoranda of understanding (MOUs) with key points of entry into care to facilitate access to care for those who are identified by testing in HCJ. Agency must execute Memoranda of Understanding with Ryan White funded Outpatient Ambulatory Medical Care providers. The Administrative Agency must be notified in writing if any OAMC providers refuse to execute an MOU.
Staff Requirements:	Not Applicable.
Special Requirements **(TRG Only)**:	Must comply with the Houston EMA/HSDA Standards of Care. The agency must comply with **the DSHS Early Intervention Services Standards of Care** and **the Houston HSDA Early Intervention Services for the Incarcerated Standards of Care**. The agency must have policies and procedures in place that comply with the standards ***prior*** to delivery of the service.

FY 2022 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/10/2021**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Steering Committee**		Date: **06/03/2021**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Improvement Committee**		Date: **05/18/2021**
Recommendations:	Approved: Y:_ ___ No: _____ Approved With Changes: _____	If approved with changes list changes below:
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Step in Process: **HTBMTN Workgroup #3**	Date: **04/21/2021**
Recommendations:	Financial Eligibility: None
1. Accept the service definition as presented and keep the financial eligibility the same.	
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Houston EMA/HSDA Ryan White Part A Service Definition **Emergency Financial Assistance – Other** (Revised April 2020)	
HRSA Service Category Title:	**Emergency Financial Assistance**
Local Service Category Title:	**Emergency Financial Assistance - Other**
Service Category Code **(RWGA use only):**	
Amount Available **(RWGA use only):**	
Budget Type **(RWGA use only):**	**Hybrid**
Budget Requirements or Restrictions:	Direct cash payments to clients are not permitted. It is expected that all other sources of funding in the community for emergency financial assistance will be effectively used and that any allocation of RWHAP funds for these purposes will be as the payer of last resort, and for limited amounts, uses, and periods of time. Continuous provision of an allowable service to a client must not be funded through EFA. The agency must set priorities, delineate and monitor what part of the overall allocation for emergency assistance is obligated for each subcategory. Careful monitoring of expenditures within a subcategory of "emergency assistance" is necessary to assure that planned amounts for specific services are being implemented, and to determine when reallocations may be necessary. At least **75%** of the total amount of the budget must be solely allocated to the actual cost of disbursements. Maximum allowable unit cost for provision of food vouchers or and/or utility assistance to an eligible client = $xx.00/unit
HRSA Service Category Definition **(do <u>not</u> change or alter):**	**Emergency Financial Assistance -** Provides limited one-time or short-term payments to assist the RWHAP client with an emergent need for paying for essential utilities, housing, food (including groceries, and food vouchers), transportation, and medication. Emergency financial assistance can occur as a direct payment to an agency or through a voucher program.
Local Service Category Definition:	**Emergency Financial Assistance** is provided with limited frequency and for a limited period of time, with specified frequency and duration of assistance. Emergent need must be documented each time funds are used. Emergency essential living needs include food, telephone, and utilities (i.e. electricity, water, gas and all required fees) for eligible PLWH.
Target Population (age, gender, geographic, race, ethnicity, etc.):	PLWH living within the Houston Eligible Metropolitan Area (EMA).

Services to be Provided:	**Emergency Financial Assistance** provides funding through: • Short-term payments to agencies • Establishment of voucher programs Service to be provided include: • Food Vouchers • Utilities (gas, water, basic telephone service and electricity) The agency must adhere to the following guidelines in providing these services: • Assistance must be in the form of vouchers made payable to vendors, merchants, etc. No payments may be made directly to individual clients or family members. • Limitations on the provision of emergency assistance to eligible individuals/households should be delineated and consistently applied to all clients. • Allowable support services with an $800/year/client cap.
Service Unit Definition(s): **(HIV Services use only)**	A unit of service is defined as provision of food vouchers or and/or utility assistance to an eligible client.
Financial Eligibility:	Refer to the RWPC's approved *Financial Eligibility for Houston EMA Services*.
Client Eligibility:	PLWHA residing in the Houston EMA (prior approval required for non-EMA clients).
Agency Requirements:	Agency must be dually awarded as HOWPA sub-recipient work closely with other service providers to minimize duplication of services and ensure that assistance is given only when no reasonable alternatives are available. It is expected that all other sources of funding in the community for emergency assistance will be effectively used and that any allocation of EFA funding for these purposes will be the payer of last resort, and for limited amounts, limited use, and limited periods of time. Additionally, agency must document ability to refer clients for food, transportation, and other needs from other service providers when client need is justified.
Staff Requirements:	None.
Special Requirements:	Agency must: Comply with the Houston EMA/HSDA Standards of Care and Emergency Financial Assistance service category program policies.

FY 2022 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/10/2021**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Steering Committee**		Date: **06/03/2021**
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Step in Process: **Quality Improvement Committee**		Date: **05/18/2021**
Recommendations:	Approved: Y:_ ___ No: _____ Approved With Changes: _____	If approved with changes list changes below:
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Step in Process: **HTBMTN Workgroup #3**	Date: **04/21/2021**
Recommendations:	Financial Eligibility: 400%
1.Accept the service definition as presented and keep the financial eligibility the same. Ask the Office of Support to highlight the service in Road 2 Success and ask the AAs to actively promote the service.	
2.	
3.	

2022-2023 Service Category Definition - Part B / DSHS State Services

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Local Service Category:	**Health Insurance Premium and Cost Sharing Assistance**
Amount Available**:**	**To be determined**
Budget Requirements or Restrictions **(TRG Only)**:	Contractor must spend no more than 20% of funds on disbursement transactions. The remaining 80% of funds must be expended on the actual cost of the payment(s) disbursed. ADAP dispensing fees are not allowable under this service category.
Local Service Category Definition:	**Health Insurance Premium and Cost Sharing Assistance:** The Health Insurance Premium and Cost Sharing Assistance service category is intended to help people living with HIV maintain continuity of medical care without gaps in health insurance coverage or disruption of treatment. A program of financial assistance for the payment of health insurance premiums and co-pays, co-insurance and deductibles to enable eligible individuals with HIV disease to utilize their existing third party or public assistance (e.g. Medicare) medical insurance. For purposes of this service category, health insurance also includes standalone dental insurance. Co-Payment: A cost-sharing requirement that requires the insured to pay a specific dollar amount for each unit of service. Co-Insurance: A cost-sharing requirement that requires the insured to pay a percentage of costs for covered services/prescription Deductible: A cost-sharing requirement that requires the insured pay a certain amount for health care or prescription, before the prescription drug plan or other insurance begins to pay. Premium: The amount paid by the insured to an insurance company to obtain or maintain and insurance policy. Advance Premium Tax Credit (APTC) Tax Liability: Tax liability associated with the APTC reconciliation; reimbursement cap of 50% of the tax due up to a maximum of $500.
Target Population (age, gender, geographic, race, ethnicity, etc.):	All Ryan White eligible clients with 3rd party insurance coverage (COBRA, private policies, Qualified Health Plans, CHIP, Medicaid, Medicare and Medicare Supplemental plans) within the Houston HSDA.
Services to be Provided:	Contractor may provide assistance with: • Insurance premiums, • And deductibles, co-insurance and/or co-payments.
Service Unit Definition **(TRG Only)**:	A unit of service will consist of payment of health insurance premiums, co-payments, co-insurance, deductible, or a combination.
Financial Eligibility:	Affordable Care Act (ACA) Marketplace Plans: 100-400% of federal poverty guidelines. All other insurance plans at or below 400% of federal poverty guidelines. Exception: Clients who were enrolled prior to November 1, 2015 will maintain their eligibility in subsequent plan years even if below 100% or between 400-500% of federal poverty guidelines.
Client Eligibility:	People living with HIV in the Houston HSDA and have insurance or be eligible (within local financial eligibility guidelines) to purchase a Qualified Health Plan through the Marketplace.

2022-2023 Service Category Definition - Part B / DSHS State Services

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Agency Requirements **(TRG Only)**:	Agency must: • Provide a comprehensive financial intake/application to determine client eligibility for this program to insure that these funds are used as a last resort in order for the client to utilize his/her existing insurance or be eligible to purchase a qualified health plan through the Marketplace. • Clients will not be put on wait lists nor will Health Insurance Premium and Cost Sharing Assistance services be postponed or denied due to funding without notifying the Administrative Agency. • Conduct marketing in-services with Houston area HIV/AIDS service providers to inform them of this program and how the client referral and enrollment processes function. • Establish formal written agreements with all Houston HSDA Ryan White-funded (Part A, B, C, D) primary care, mental health and substance abuse provider agencies to enable clients of these agencies to enroll in Health Insurance assistance at his/her primary care, mental health or substance abuse provider site. (i.e. No need for client to physically present to Health Insurance provider.) • Utilizes the RW Planning Council-approved prioritization of cost sharing assistance when limited funds warrant it (premiums take precedence). o **Priority Ranking of Requests (in descending order)**: ▪ HIV medication co-pays and deductibles (medications on the Texas ADAP formulary) ▪ Non-HIV medication co-pays and deductibles ▪ Co-payments for provider visits (eg. physician visit and/or lab copayments) ▪ Medicare Part D (Rx) premiums ▪ APTC Tax Liability ▪ Out of Network out-of-pocket expenses • Utilizes the RW Planning Council –approved consumer out-of-pocket methodology.
Special Requirements **(TRG Only)**:	Must comply with the **DSHS Health Insurance Assistance Standards of Care** and the **Houston HSDA Health Insurance Assistance Standards of Care.** Must comply with updated guidance from DSHS. Must comply with the Eastern HASA Health Insurance Assistance Policy and Procedure.

2022-2023 Service Category Definition - Part B / DSHS State Services

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FY 2022 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/10/2021**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Steering Committee**		Date: **06/03/2021**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Improvement Committee**		Date: **05/18/2021**
Recommendations:	Approved: Y:_ ___ No: _____ Approved With Changes: _____	If approved with changes list changes below:
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Step in Process: **HTBMTN Workgroup #2**	Date: **04/20/2021**
Recommendations:	Financial Eligibility: 0 - 400% ACA plans: must have a subsidy (see Part B service definition for exception)
1. Accept the service definition as presented and keep the financial eligibility the same.	
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3.	

FY 2020 Houston EMA Ryan White Part A/MAI Service Definition Health Insurance Co-Payments and Co-Insurance Assistance	
HRSA Service Category Title:	**Health Insurance Premium and Cost Sharing Assistance**
Local Service Category Title:	**Health Insurance Co-Payments and Co-Insurance**
Budget Type**:**	**Hybrid Fee for Service**
Budget Requirements or Restrictions:	Agency must spend no more than 20% of funds on disbursement transactions. The remaining 80% of funds must be expended on the actual cost of the payment(s) disbursed.
HRSA Service Category Definition**:**	***Health Insurance Premium & Cost Sharing Assistance*** is the provision of financial assistance for eligible individuals living with HIV to maintain a continuity of health insurance or to receive medical benefits under a health insurance program. This includes premium payments, risk pools, co-payments, and deductibles.
Local Service Category Definition:	A program of financial assistance for the payment of health insurance premiums, deductibles, co-insurance, co-payments and tax liability payments associated with Advance Premium Tax Credit (APTC) reconciliation to enable eligible individuals with HIV disease to utilize their existing third party or public assistance (e.g. Medicare) medical insurance. Co-Payment: A cost-sharing requirement that requires the insured to pay a specific dollar amount for each unit of service. Co-Insurance: A cost-sharing requirement that requires the insured to pay a percentage of costs for covered services/prescription Deductible: A cost-sharing requirement that requires the insured to pay a certain amount for health care or prescription, before the prescription drug plan or other insurance begins to pay. Premium: The amount paid by the insured to an insurance company to obtain or maintain and insurance policy. APTC Tax Liability: The difference paid on a tax return if the advance credit payments that were paid to a health care provider were more than the actual eligible credit.
Target Population (age, gender, geographic, race, ethnicity, etc.):	All Ryan White eligible clients with 3rd party insurance coverage (COBRA, private policies, Qualified Health Plans, CHIP, Medicaid, Medicare and Medicare Supplemental) within the Houston EMA.
Services to be Provided:	Provision of financial assistance with premiums, deductibles, co-insurance, and co-payments. Also includes tax liability payments associated with APTC reconciliation up to 50% of liability with a $500 maximum.
Service Unit Definition(s): **(RWGA only)**	1 unit of service = A payment of a premium, deductible, co-insurance, co-payment or tax liability associated with APTC reconciliation for an HIV-infected person with insurance coverage.

Financial Eligibility:	Refer to the RWPC's approved *Financial Eligibility for Houston EMA/HSDA Services*.
Client Eligibility:	HIV-infected individuals residing in the Houston EMA meeting financial eligibility requirements and have insurance or be eligible to purchase a Qualified Health Plan through the Marketplace.
Agency Requirements:	Agency must: • Provide a comprehensive financial intake/application to determine client eligibility for this program to insure that these funds are used as a last resort in order for the client to utilize his/her existing insurance or be eligible to purchase a qualified health plan through the Marketplace. • Ensure that assistance provided to clients does not duplicate services already being provided through Ryan White Part B or State Services. The process for ensuring this requirement must be fully documented. • Have mechanisms to vigorously pursue any excess premium tax credit a client receives from the IRS upon submission of the client's tax return for those clients that receive financial assistance for eligible out of pocket costs associated with the purchase and use of Qualified Health Plans obtained through the Marketplace. • Conduct marketing with Houston area HIV/AIDS service providers to inform such entities of this program and how the client referral and enrollment processes function. Marketing efforts must be documented and are subject to review by RWGA. • Clients will not be put on wait lists nor will Health Insurance Premium and Cost Sharing Assistance services be postponed or denied without notifying the Administrative Agency. • Establish formal written agreements with all Houston HSDA Ryan White-funded (Part A, B, C, D) primary care, mental health and substance abuse provider agencies to enable clients of these agencies to enroll in Health Insurance assistance at his/her primary care, mental health or substance abuse provider site. (i.e. No need for client to physically present to Health Insurance provider.) • Utilize RWGA approved prioritization of cost sharing assistance, when limited funds warrant it. • Utilize consumer out-of-pocket methodology approved by RWGA.
Staff Requirements:	None
Special Requirements:	Agency must: • Comply with the Houston EMA/HSDA Standards of Care and Health Insurance Assistance service category program policies.

FY 2022 RWPC "How to Best Meet the Need" Decision Process

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Step in Process: **Steering Committee**		Date: **06/03/2021**
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Step in Process: **Quality Improvement Committee**		Date: **05/18/2021**
Recommendations:	Approved: Y:_ ___ No: _____ Approved With Changes: _____	If approved with changes list changes below:
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Step in Process: **HTBMTN Workgroup #2**	Date: **04/20/2021**
Recommendations:	Financial Eligibility: 0 - 400% ACA plans: must have a subsidy (see Part B service definition for exception)
1. Accept the service definition as presented and keep the financial eligibility the same.	
2.	
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2022-2023 Service Category Definition - Part B

Local Service Category:	**Home and Community-Based Health Services (Facility-Based)**
Amount Available**:**	**To be determined**
Unit Cost	
Budget Requirements or Restrictions:	Maximum of 10% of budget for Administrative Cost
DSHS Service Category Definition:	Home and Community-Based Health Care Services are therapeutic, nursing, supportive and/or compensatory health services provided by a licensed/certified home health agency in a home or community-based setting in accordance with a written, individualized plan of care established by a licensed physician. Home and Community-Based Health Services include the following: • **Para–professional care** is the provision of services by a home health aide, personal caretaker, or attendant caretaker. This definition also includes non–medical, non–nursing assistance with cooking and cleaning activities to help clients remain in their homes. • **Professional care** is the provision of services in the home by licensed health care workers such as nurses. • **Specialized care** is the provision of services that include intravenous and aerosolized treatment, parenteral feeding, diagnostic testing, and other high–tech therapies. physical therapy, social worker services. Home and Community-Based Health Care Providers work closely with the multidisciplinary care team that includes the client's case manager, primary care provider, and other appropriate health care professionals. Allowable services include: • Durable medical equipment • Home health aide and personal care services • Day treatment or other partial hospitalization services • Home intravenous and aerosolized drug therapy (including prescription drugs administered as part of such therapy) • Routine diagnostic testing • Appropriate mental health, developmental, and rehabilitation services • Specialty care and vaccinations for hepatitis co-infection, provided by public and private entities
Local Service Category Definition:	***Home and Community-based Health Services (facility-based)*** *is* defined as a day treatment program that includes Physician ordered therapeutic nursing, supportive and/or compensatory health services based on a written plan of care established by an interdisciplinary care team that includes appropriate healthcare professionals and paraprofessionals. Services include skilled nursing, nutritional counseling, evaluations and education, and additional therapeutic services and activities. Inpatient hospitals services, nursing home and other long-term care facilities are **NOT** included.

2022-2023 Service Category Definition - Part B

Target Population (age, gender, geographic, race, ethnicity, etc.):	Eligible recipients for home and community-based health services are persons living with HIV residing within the Houston HIV Service Delivery Area (HSDA) who are at least 18 years of age.
Services to be Provided:	Community-Based Health Services are designed to support the increased functioning and the return to self-sufficiency of clients through the provision of treatment and activities of daily living. Services must include: • **Skilled Nursing:** Services to include medication administration, medication supervision, medication ordering, filling pill box, wound dressing changes, straight catheter insertion, education of family/significant others in patient care techniques, ongoing monitoring of patients' physical condition and communication with attending physicians (s), personal care, and diagnostics testing. • **Other Therapeutic Services:** Services to include recreational activities (fine/gross motor skills and cognitive development), replacement of durable medical equipment, information referral, peer support, and transportation. • **Nutrition:** Services to include evaluation and counseling, supplemental nutrition, and daily nutritious meals. • **Education:** Services to include instructional workshops of HIV related topics and life skills. Services will be provided at least Monday through Friday for a minimum of 10 hours/day.
Service Unit Definition(s):	A unit of service is defined as one (1) visit/day of care for one (1) client for a minimum of four hours. Services consist of medical health care and social services at a licensed adult day.
Financial Eligibility:	Income at or below 300% of Federal Poverty Guidelines
Client Eligibility:	People living with HIV at least 18 years of age residing within the Houston HSDA.
Agency Requirements:	Must be licensed by the Texas Department of Aging and Disability Services (DADS) as an Adult Day Care provider.
Staff Requirements:	• **Skilled Nursing Services** must be provided by a Licensed Vocational or Registered Nurse. • **Other Therapeutic Services** are provided by paraprofessionals, such as an activities coordinator, and counselors (LPC, LMSW, and LMFTA). • **Nutritional Services** are provided by a Registered Dietician and food managers. • **Education Services** are provided by a health educator.
Special Requirements:	Must comply with the Houston EMA/HSDA Standards of Care. The agency must comply with **the DSHS Home and Community-Based Health Services Standards of Care** and **Houston HSDA**. The agency must have policies and procedures in place that comply with the standards ***prior*** to delivery of the service.

2022-2023 Service Category Definition - Part B

FY 2022 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/10/2021**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Steering Committee**		Date: **06/03/2021**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Improvement Committee**		Date: **05/18/2021**
Recommendations:	Approved: Y:_ ___ No: _____ Approved With Changes: _____	If approved with changes list changes below:
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Step in Process: **HTBMTN Workgroup #3**	Date: **04/21/2021**
Recommendations:	Financial Eligibility: 400%
1. Accept the service definition as presented and increase the financial eligibility from 300 to 400% FPL. Also, ask the Office of Support to highlight the service in Road 2 Success and ask the AAs to actively promote the service.	
2.	
3.	

2022-2023 Service Category Definition - DSHS State Services

Local Service Category:	**Hospice Services**
Amount Available**:**	**To be determined**
Unit Cost	
Budget Requirements or Restrictions:	Maximum 10% of budget for Administrative Cost
DSHS Service Category Definition:	Provision of end-of-life care provided by licensed hospice care providers to clients in the terminal stages of an HIV-related illness, in a home or other residential setting, including a non-acute-care section of a hospital that has been designated and staffed to provide hospice care for terminal patients. Hospice services include, but are not limited to, the palliation and management of the terminal illness and conditions related to the terminal illness. Allowable Ryan White/State Services funded services are: • Room • Board • Nursing care • Mental health counseling, to include bereavement counseling • Physician services • Palliative therapeutics Ryan White/State Service funds may not be used for funeral, burial, cremation, or related expenses. Funds may not be used for nutritional services, durable medical equipment and medical supplies or case management services.
Local Service Category Definition:	Hospice services encompass palliative care for terminally ill clients and support services for clients and their families. Services are provided by a licensed nurse and/or physical therapist. Additionally, unlicensed personnel may deliver services under the delegation of a licensed nurse or physical therapist, to a client or a client's family as part of a coordinated program. A physician must certify that a patient is terminal, defined under Medicaid hospice regulations as having a life expectancy of 6 months or less. Services must include but are not limited to medical and nursing care, palliative care, and psychosocial support for the patient, as well as a mechanism for bereavement referral for surviving family members. Counseling services provided in the context of hospice care must be consistent with the (Ryan White) definition of mental health counseling. Palliative therapies must be consistent with those covered under respective State Medicaid Program.
Target Population (age, gender, geographic, race, ethnicity, etc.):	People living with HIV and having a life expectancy of 6 months or less residing in the Houston HIV Service Delivery (HSDA).

2022-2023 Service Category Definition - DSHS State Services

Services to be Provided:	Services must include but are not limited to medical and nursing care, palliative care, psychosocial support and spiritual guidance for the patient, as well as a mechanism for bereavement referral for surviving family members. Counseling services provided in the context of hospice care must be consistent with the (Ryan White) definition of mental health counseling. Palliative therapies must be consistent with those covered under respective State Medicaid Program. Allowable Ryan White/State Services funded services are: • Room • Board • Nursing care • Mental health counseling, to include bereavement counseling • Physician services • Palliative therapeutics Services NOT allowed under this category: • HIV medications under hospice care unless paid for by the client. • Medical care for acute conditions or acute exacerbations of chronic conditions other than HIV for potentially Medicaid eligible residents. • Funeral, burial, cremation, or related expenses. • Nutritional services, • Durable medical equipment and medical supplies. • Case management services. • Although Texas Medicaid can pay for bereavement counseling for family members for up to a year after the patient's death and can be offered in a skilled nursing facility or nursing home, Ryan White funding CANNOT pay for these services per legislation.
Service Unit Definition(s):	A unit of service is defined as one (1) twenty-four (24) hour day of hospice services that includes a full range of physical and psychological support to HIV patients in the final stages of AIDS.
Financial Eligibility:	Income at or below 300% Federal Poverty Guidelines.
Client Eligibility:	Individuals with an AIDS diagnosis and certified by his or her physician that the individual's prognosis is for a life expectancy of six (6) months or less if the terminal illness runs its normal course
Agency Requirements:	Agency/provider is a licensed hospital/facility and maintains a valid State license with a residential AIDS Hospice designation or is certified as a Special Care Facility with Hospice designation. Provider must inform Administrative Agency regarding issue of long-term care facilities denying admission for people living with HIV based on inability to provide appropriate level of skilled nursing care.

2022-2023 Service Category Definition - DSHS State Services

	Services must be provided by a medically directed interdisciplinary team, qualified in treating individual requiring hospice services. Staff will refer Medicaid/Medicare eligible clients to a Hospice Provider for medical, support, and palliative care. Staff will document an attempt has been made to place Medicaid/Medicare eligible clients in another facility prior to admission.
Staff Requirements:	All hospice care staff who provide direct-care services and who require licensure or certification, must be properly licensed or certified by the State of Texas.
Special Requirements:	These services must be: a) Available 24 hours a day, seven days a week, during the last stages of illness, during death, and during bereavement; b) Provided by a medically directed interdisciplinary team; c) Provided in nursing home, residential unit, or inpatient unit according to need. These services do not include inpatient care normally provided in a licensed hospital to a terminally ill person who has not elected to be a hospice client. d) Residents seeking care for hospice at Agency must first seek care from other facilities and denial must be documented in the resident's chart. Must comply with the **Houston HSDA Hospice Standards of Care**. The agency must comply with **the DSHS Hospice Standards of Care**. The agency must have policies and procedures in place that comply with the standards ***prior*** to delivery of the service.

FY 2022 RWPC "How to Best Meet the Need" Decision Process

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Step in Process: **Quality Improvement Committee**		Date: **05/18/2021**
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Step in Process: **HTBMTN Workgroup #3**	Date: **04/21/2021**
Recommendations:	Financial Eligibility: 300%
1. Accept the service definition as presented and keep the financial eligibility the same.	
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2022-2023 Service Category Definition - DSHS State Services

Local Service Category:	**Linguistics Services**
Amount Available**:**	**To be determined**
Unit Cost**:**	
Budget Requirements or Restrictions **(TRG Only)**:	Maximum of 10% of budget for Administrative Cost.
DSHS Service Category Definition	Support for Linguistic Services includes interpretation (oral) and translation (written) services, provided by qualified individuals as a component of HIV service delivery between the provider and the client, when such services are necessary to facilitate communication between the provider and client and/or support delivery of Ryan White-eligible services. Linguistic Services include interpretation/translation services provided by qualified interpreters to people living with HIV (including those who are deaf/hard of hearing and non-English speaking individuals) for the purpose of ensuring communication between client and providers while accessing medical and Ryan White fundable support services that have a direct impact on primary medical care. These standards ensure that language is not barrier to any client seeking HIV related medical care and support; and linguistic services are provided in a culturally appropriate manner. Services are intended to be inclusive of all cultures and sub-cultures and not limited to any particular population group or sets of groups. They are especially designed to assure that the needs of racial, ethnic, and linguistic populations severely impacted by the HIV epidemic receive quality, unbiased services.
Local Service Category Definition:	To provide one hour of interpreter services including, but not limited to, sign language for deaf and /or hard of hearing and native language interpretation for monolingual people living with HIV.
Target Population (age, gender, geographic, race, ethnicity, etc.):	People living with HIV in the Houston HIV Service Delivery Area (HSDA).
Services to be Provided:	Services include language translation and signing for deaf and/or hearing-impaired HIV+ persons. Services exclude Spanish Translation Services.
Service Unit Definition(s) **(TRG Only)**:	A unit of service is defined as one hour of interpreter services to an eligible client.
Financial Eligibility:	Income at or below 300% Federal Poverty Guidelines.
Client Eligibility:	People living with HIV in the Houston HSDA
Agency Requirements **(TRG Only)**:	Any qualified and interested agency may apply and subcontract actual interpretation services out to various other qualifying agencies.
Staff Requirements:	ASL interpreters must be certified. Language interpreters must have completed a forty (40) hour community interpreter training course approved by the DSHS.
Special Requirements **(TRG Only)**:	Must comply with the Houston HSDA **Linguistic Services Standards of Care**. The agency must comply with **the DSHS Linguistic Services Standards of Care**. The agency must have policies and procedures in place that comply with the standards ***prior*** to delivery of the service.

FY 2022 RWPC "How to Best Meet the Need" Decision Process

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Step in Process: **HTBMTN Workgroup #3**	Date: **04/21/2021**
Recommendations:	Financial Eligibility: 300%
1. Accept the service definition as presented and keep the financial eligibility the same.	
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FY 2020 Houston EMA Ryan White Part A/MAI Service Definition Medical Nutritional Therapy	
HRSA Service Category Title: **RWGA Only**	**Medical Nutritional Therapy**
Local Service Category Title:	**Medical Nutritional Therapy and Nutritional Supplements**
Budget Type: **RWGA Only**	**Hybrid**
Budget Requirements or Restrictions: **RWGA Only**	***Supplements:*** An individual client may not exceed $1,000.00 in supplements annually without **prior** approval by RWGA. ***Nutritional Therapy:*** An individual nutritional education/counseling session lasting a minimum of 45 minutes. Provision of professional (licensed registered dietician) education/counseling concerning the therapeutic importance of foods and nutritional supplements that are beneficial to the wellness and improved health conditions of clients. Medically, it is expected that symptomatic or mildly symptomatic clients will be seen once every 12 weeks while clients with higher acuity will be seen once every 6 weeks.
HRSA Service Category Definition: **RWGA Only**	***Medical nutrition therapy*** is provided by a licensed registered dietitian outside of a primary care visit **and may include the provision of nutritional supplements.**
Local Service Category Definition:	***Supplements:*** Up to a 90-day supply at any given time, per client, of approved nutritional supplements that are listed on the Houston EMA/HSDA Nutritional Supplement Formulary. Nutritional counseling must be provided for each disbursement of nutritional supplements. ***Nutritional Therapy:*** An individual nutritional education/counseling session lasting a minimum of 45 minutes. Provision of professional (licensed registered dietician) education/counseling concerning the therapeutic importance of foods and nutritional supplements that are beneficial to the wellness and improved health conditions of clients. Medically, it is expected that symptomatic or mildly symptomatic clients will be seen once every 12 weeks while clients with higher acuity will be seen once every 6 weeks. Services must be provided under written order from a state licensed medical provider (MD, DO or PA) with prescribing privileges and must be based on a written nutrition plan developed by a licensed registered dietician.
Target Population (age, gender, geographic, race, ethnicity, etc.):	HIV/AIDS infected persons living within the Houston Eligible Metropolitan Area (EMA) or HIV Service Delivery Area (HSDA).
Services to be Provided:	***Supplements:*** The provision of nutritional supplements to eligible clients with a written referral from a licensed physician or PA that specifies frequency, duration and amount and includes a written nutritional plan prepared by a licensed, registered dietician. *Nutritional Supplement Disbursement Counseling* is a component of

	Medical Nutritional Therapy. *Nutritional Supplement Disbursement Counseling* is a component of the disbursement transaction and is defined as the provision of information by a licensed registered dietitian about therapeutic nutritional and/or supplemental foods that are beneficial to the wellness and increased health condition of clients provided in conjunction with the disbursement of supplements. Services may be provided either through educational or counseling sessions. Also included in this service are follow up sessions with clients' Primary Care provider regarding the effectiveness of the supplements. The number of sessions for each client shall be determined by a written assessment conducted by the Licensed Dietitian but may not exceed twelve (12) sessions per client per contract year. ***Medical Nutritional Therapy:*** Service must be provided under written order of a state licensed medical provider (MD, DO, PA) with prescribing privileges and must include a written plan developed by state licensed registered dietician. Client must receive a full range of medical nutritional therapy services including, but not limited to, diet history and recall; estimation of nutrition intake; assessment of weight change; calculation of nutritional requirements related to specific medication regimes and disease status, meal preparation and selection suggestions; calorie counts; evaluation of clinically appropriate laboratory results; assessment of medication-nutrient interactions; and bio-impedance assessment. If patient evaluation indicates the need for interventions such as nutritional supplements, appetite stimulants, or treatment of underlying pathogens, the dietician must share such findings with the patient's primary medical provider (MD, DO or PE) and provide recommendations. Clients needing additional nutritional resources will be referred to case management services as appropriate and/or local food banks. Provider must furnish information on this service category to at least the health care providers funded by Ryan White Parts A, B, C and D and TDSHS State Services.
Service Unit Definition(s): **RWGA Only**	***Supplements:*** One (1) unit of service = a single visit wherein an eligible client receives allowable nutritional supplements (up to a 90 day supply) and nutritional counseling by a licensed dietician as clinically indicated. A visit wherein the client receives counseling but no supplements is not a billable disbursement transaction. ***Medical Nutritional Therapy:*** An individual nutritional counseling session lasting a minimum of 45 minutes.
Financial Eligibility:	Refer to the RWPC's approved *Financial Eligibility for Houston EMA/HSDA Services*.
Client Eligibility:	***Nutritional Supplements:*** HIV-infected and documentation that the client is actively enrolled in primary medical care.

	Medical Nutritional Therapy: HIV-infected resident and documentation that the client is actively enrolled in primary medical care.
Agency Requirements:	None.
Staff Requirements:	The nutritional counseling services under this category must be provided by a licensed registered dietician. Dieticians must have a minimum of two (2) years experience providing nutritional assessment and counseling to PLWHA.
Special Requirements: **RWGA Only**	Must comply with Houston EMA/HSDA Part A/B Standards of Care, HHS treatment guidelines and applicable HRSA/HAB HIV Clinical Performance Measures. Must comply with the Houston EMA/HSDA approved Medical Nutritional Therapy Formulary.

FY 2022 RWPC "How to Best Meet the Need" Decision Process

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Step in Process: **HTBMTN Workgroup #2**	Date: **04/20/2021**
Recommendations:	Financial Eligibility: 400%
1. Accept the service definition as presented and keep the financial eligibility the same.	
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Local Service Category:	**Mental Health Services**
Amount Available**:**	**To be determined**
Unit Cost	
Budget Requirements or Restrictions **(TRG Only)**:	Maximum of 10% of budget for Administrative Cost.
DSHS Service Category Definition	Mental Health Services include psychological and psychiatric treatment and counseling services offered to individuals with a diagnosed mental illness, conducted in a family/couples, group or individual setting, based on a detailed treatment plan, and provided by a mental health professional licensed or authorized within the State to provide such services, typically including psychiatrists, psychologists, and licensed clinical social workers. Mental health counseling services includes outpatient mental health therapy and counseling (individual and family/couple) provided solely by Mental Health Practitioners licensed in the State of Texas. Mental health services include: • Mental Health Assessment • Treatment Planning • Treatment Provision • Individual psychotherapy • Family psychotherapy • Conjoint psychotherapy • Group psychotherapy • Psychiatric medication assessment, prescription and monitoring • Psychotropic medication management • Drop-In Psychotherapy Groups • Emergency/Crisis Intervention General mental health therapy, counseling and short-term (based on the mental health professional's judgment) bereavement support is available for family members or significant others of people living with HIV.
Local Service Category Definition:	**Individual Therapy/counseling** is defined as 1:1 or family-based crisis intervention and/or mental health therapy provided by a licensed mental health practitioner to an eligible person living with HIV. **Family/Couples Therapy/Counseling** is defined as crisis intervention and/or mental health therapy provided by a licensed mental health practitioner to a family or couple (opposite-sex, same-sex, transgendered or non-gender conforming) that includes an eligible person living with HIV. **Support Groups** are defined as professionally led (licensed therapists or counselor) groups that comprise people living with HIV, family

	members, or significant others for the purpose of providing emotional support directly related to the stress of caring for people living with HIV.
Target Population (age, gender, geographic, race, ethnicity, etc.):	People living with HIV and affected individuals living within the Houston HIV Service Delivery Area (HSDA).
Services to be Provided:	Agencies are encouraged to have available to clients all modes of counseling services, i.e., crisis, individual, family, and group. Sessions may be conducted in-home. Agency must provide professional support group sessions led by a licensed counselor.
Service Unit Definition(s) **(TRG Only)**:	**Individual Crisis Intervention and/or Therapy:** A unit of service is defined as an individual counseling session lasting a minimum of 45 minutes. **Family/Couples Crisis Intervention and/or Therapy:** A unit of service is defined as a family/couples counseling session lasting a minimum of 90 minutes. **Group Therapy:** A unit of service is defined as one (1) eligible client attending 90 minutes of group therapy. The minimum time allowable for a single group session is 90 minutes and maximum time allowable for a single group session is 120 minutes. No more than one unit may be billed per session for an individual or group session. A minimum of three (3) clients must attend a group session in order for the group session to eligible for reimbursement. **Consultation:** One unit of service is defined as 15 minutes of communication with a medical or other appropriate provider to ensure case coordination.
Financial Eligibility:	Income at or below 400% Federal Poverty Guidelines.
Client Eligibility:	For individual therapy session, person living with HIV or the affected significant other of a person living with HIV, resident of Houston HSDA. Person living with HIV must have a current DSM diagnosis eligible for reimbursement under the State Medicaid Plan. Client must not be eligible for services from other programs or providers (i.e. MHMRA of Harris County) or any other reimbursement source (i.e. Medicaid, Medicare, Private Insurance) unless the client is in crisis and cannot be provided immediate services from the other programs/providers. In this case, clients may be provided services, if the

	client applies for the other programs /providers, until the other programs/providers can take over services. Medicaid/Medicare, Third Party Payer and Private Pay status of clients receiving services under this grant must be verified by the provider prior to requesting reimbursement under this grant. For support group sessions, client must be either a person living with HIV or the significant other of person living with HIV. Affected significant other is eligible for services only related to the stress of caring for a person living with HIV.
Agency Requirements **(TRG Only)**:	Agency must provide assurance that the mental health practitioner shall be supervised by a licensed therapist qualified by the State to provide clinical supervision. This supervision should be documented through supervision notes. Keep attendance records for group sessions. Must provide 24-hour access to a licensed counselor for current clients with emotional emergencies. Clients eligible for Medicaid or 3rd party payer reimbursement may not be billed to grant funds. Medicare Co-payments may be billed to the contract as ½ unit of service. Documentation of at least one therapist certified by Medicaid/Medicare on the staff of the agency must be provided in the proposal. All funded agencies must maintain the capability to serve and seek reimbursement from Medicaid/Medicare throughout the term of their contract. Potential clients who are Medicaid/ Medicare eligible may not be denied services by a funded agency based on their reimbursement status (Medicaid/Medicare eligible clients may not be referred elsewhere in order that non-Medicaid/Medicare eligible clients may be added to this grant). Failure to serve Medicaid/Medicare eligible clients based on their reimbursement status will be grounds for the immediate termination of the provider's contract. Must comply with the State Services Standards of Care. Must provide a plan for establishing criteria for prioritizing participation in group sessions and for termination from group participation. Providers and system must be Medicaid/Medicare certified to ensure that Ryan White funds are the payer of last resort.
Staff Requirements:	It is required that counselors have the following qualifications: Licensed Mental Health Practitioner by the State of Texas (LCSW,

	LMSW, LPC PhD, Psychologist, or LMFT). At least two years' experience working with HIV disease or two years' work experience with chronic care of a catastrophic illness. Counselors providing family sessions must have at least two years' experience in family therapy. Counselors must be covered by professional liability insurance with limits of at least $300,000 per occurrence.
Special Requirements **(TRG Only)**:	All mental health interventions must be based on proven clinical methods and in accordance with legal and ethical standards. The importance of maintaining confidentiality is of critical importance and cannot be overstated unless otherwise indicated based on Federal, state and local laws and guidelines (i.e. abuse, self or other harm). All programs must comply with the Health Insurance Portability and Accountability Act (HIPAA) standards for privacy practices of protected health information (PHI) information. Mental health services can be delivered via telehealth and must follow applicable federal and State of Texas privacy laws. Mental health services that are provided via telehealth must be in accordance with State of Texas mental health provider practice requirements, see Texas Occupations Code, Title 3 Health Professions and chapter 111 for Telehealth & Telemedicine. When psychiatry is provided as a mental health service via telehealth then the provider must follow guidelines for telemedicine as noted in Texas Medical Board (TMB) guidelines for providing telemedicine, Texas Administrative Code, Texas Medical Board, Rules, Title 22, Part 9, Chapter 174, RULE §174.1 to §174.12 Medicare and private insurance co-payments are eligible for reimbursement under this grant (in this situation the agency will be reimbursed the client's co-payment only, not the cost of the session which must be billed to Medicare and/or the Third-party payer). Extensions will be addressed on an individual basis when meeting the criteria of counseling directly related to HIV illness. Under no circumstances will the agency be reimbursed more than two (2) units of individual therapy per client in any single 24-hour period. Agency should develop services that focus on the most current Special Populations identified in the *Houston Area Comprehensive Plan for HIV Prevention and Care Services* including Adolescents, Homeless, Incarcerated & Recently Released (IRR), Injection Drug Users (IDU),

	Men who Have Sex with Men (MSM), and Transgender populations. Additionally, services should focus on increasing access for individuals living in rural counties. Must comply with the Houston EMA/HSDA Standards of Care. The agency must comply with **the DSHS Mental Health Services Standards of Care**. The agency must have policies and procedures in place that comply with the standards ***prior*** to delivery of the service.

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Step in Process: **HTBMTN Workgroup #2**	Date: **04/20/2021**
Recommendations:	Financial Eligibility: 500%
1. Accept the service definition as presented and increase the financial eligibility from 400 to 500% FPL.	
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Local Service Category:	**Oral Health Care**
Amount Available:	**To be determined**
Unit Cost**:**	
Budget Requirements or Restrictions **(TRG Only)**:	Maximum of 10% of budget for Administrative Costs
Local Service Category Definition:	Restorative dental services, oral surgery, root canal therapy, fixed and removable prosthodontics; periodontal services includes subgingival scaling, gingival curettage, osseous surgery, gingivectomy, provisional splinting, laser procedures and maintenance. Oral medication (including pain control) for HIV patients 15 years of age or older must be based on a comprehensive individual treatment plan. Prosthodontics services to people living with HIV including but not limited to examinations and diagnosis of need for dentures, crowns, bridgework and implants, diagnostic measurements, laboratory services, tooth extraction, relines and denture repairs. Emergency procedures will be treated on a walk-in basis as availability and funding allows. Funded Oral Health Care providers are permitted to provide necessary emergency care regardless of a client's annual benefit balance. If a provider cannot provide adequate services for emergency care, the patient should be referred to a hospital emergency room.
Target Population (age, gender, geographic, race, ethnicity, etc.):	People living with HIV residing in the Houston HIV Service Delivery Area (HSDA).
Services to be Provided:	Services must include, but are not limited to: individual comprehensive treatment plan; diagnosis and treatment of HIV-related oral pathology, including oral Kaposi's Sarcoma, CMV ulceration, hairy leukoplakia, xerostomia, lichen planus, aphthous ulcers and herpetic lesions; diffuse infiltrative lymphocytosis; standard oral health education and preventive procedures, including oral hygiene instruction, smoking/tobacco cessation (as indicated), diet counseling and home care program; oral prophylaxis; restorative care; oral surgery including dental implants; root canal therapy; fixed and removable prosthodontics including crowns and bridges; periodontal services, including subgingival scaling, gingival curettage, osseous surgery, gingivectomy, provisional splinting, laser procedures and maintenance. Proposer must have mechanism in place to provide oral pain medication as prescribed for clients by the dentist. Limitations: • Cosmetic dentistry for cosmetic purposes only is prohibited. • Maximum amount that may be funded by Ryan White/State Services per patient is $3,000/year. • In cases of emergency, the maximum amount may exceed the above cap

	• In cases where there is extensive care needed once the procedure has begun, the maximum amount may exceed the above cap. • Dental providers must document *via approved waiver* the reason for exceeding the yearly maximum amount.
Service Unit Definition(s) **(TRG Only)**:	General Dentistry: A unit of service is defined as one (1) dental visit which includes restorative dental services, oral surgery, root canal therapy, fixed and removable prosthodontics; periodontal services includes subgingival scaling, gingival curettage, osseous surgery, gingivectomy, provisional splinting, laser procedures and maintenance. Oral medication (including pain control) for HIV patients 15 years old or older must be based on a comprehensive individual treatment plan. Prosthodontics: A unit of services is defined as one (1) Prosthodontics visit.
Financial Eligibility:	Income at or below 300% Federal Poverty Guidelines. Maximum amount that may be funded by Ryan White/State Services per patient is $3,000/year.
Client Eligibility:	Person living with HIV; Adult resident of Houston HSDA
Agency Requirements **(TRG Only)**:	**To ensure that Ryan White is payer of last resort, Agency and/or dental providers (clinicians) must be Medicaid certified and enrolled in all Dental Plans offered to Texas STAR+PLUS eligible clients in the Houston EMA/HSDA**. Agency/providers must ensure Medicaid certification and billing capability for STAR+PLUS eligible patients remains current throughout the contract term. Agency must document that the primary patient care dentist has 2 years prior experience treating HIV disease and/or on-going HIV educational programs that are documented in personnel files and updated regularly. Dental facility and appropriate dental staff must maintain Texas licensure/certification and follow all applicable OSHA requirements for patient management and laboratory protocol.
Staff Requirements:	State of Texas dental license; licensed dental hygienist and state radiology certification for dental assistants.
Special Requirements **(TRG Only)**:	Must comply with the Houston EMA/HSDA Standards of Care. The agency must comply with **the DSHS Oral Health Care Standards of Care**. The agency must have policies and procedures in place that comply with the standards ***prior*** to delivery of the service.

FY 2022 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/10/2021**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Steering Committee**		Date: **06/03/2021**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Improvement Committee**		Date: **05/18/2021**
Recommendations:	Approved: Y:_ ___ No: _____ Approved With Changes: _____	If approved with changes list changes below:
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Step in Process: **HTBMTN Workgroup #2**	Date: **04/20/2021**
Recommendations:	Financial Eligibility: 300%
1. Accept the service definition as presented and keep the financial eligibility the same.	
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20 Houston EMA Ryan White Part A/MAI Service Definition **Oral Health/Rural**	
HRSA Service Category Title: **RWGA Only**	**Oral Health**
Local Service Category Title:	**Oral Health – <u>Rural (North)</u>**
Budget Type: **RWGA Only**	**Unit Cost**
Budget Requirements or Restrictions: **RWGA Only**	Not Applicable
HRSA Service Category Definition: **RWGA Only**	**Oral health care** includes diagnostic, preventive, and therapeutic services provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries, and other trained primary care providers.
Local Service Category Definition:	Restorative dental services, oral surgery, root canal therapy, fixed and removable prosthodontics; periodontal services includes subgingival scaling, gingival curettage, osseous surgery, gingivectomy, provisional splinting, laser procedures and maintenance. Oral medication (including pain control) for HIV patients 15 years old or older must be based on a comprehensive individual treatment plan. Prosthodontics services to HIV-infected individuals including, but not limited to examinations and diagnosis of need for dentures, diagnostic measurements, laboratory services, tooth extractions, relines and denture repairs.
Target Population (age, gender, geographic, race, ethnicity, etc.):	HIV/AIDS infected individuals residing in Houston Eligible Metropolitan Area (EMA) or Health Service Delivery Area (HSDA) counties other than Harris County. Comprehensive Oral Health services targeted to individuals residing in the northern counties of the EMA/HSDA, including Waller, Walker, Montgomery, Austin, Chambers and Liberty Counties.
Services to be Provided:	Services must include, but are not limited to: individual comprehensive treatment plan; diagnosis and treatment of HIV-related oral pathology, including oral Kaposi's Sarcoma, CMV ulceration, hairy leukoplakia, xerostomia, lichen planus, aphthous ulcers and herpetic lesions; diffuse infiltrative lymphocytosis; standard preventive procedures, including oral hygiene instruction, diet counseling and home care program; oral prophylaxis; restorative care; oral surgery including dental implants; root canal therapy; fixed and removable prosthodontics including crowns, bridges and implants; periodontal services, including subgingival scaling, gingival curettage, osseous surgery, gingivectomy, provisional splinting, laser procedures and maintenance. Proposer must have mechanism in place to provide oral pain medication as prescribed for clients by the dentist.
Service Unit Definition(s): **RWGA Only**	General Dentistry: A unit of service is defined as one (1) dental visit which includes restorative dental services, oral surgery, root

	canal therapy, fixed and removable prosthodontics; periodontal services includes subgingival scaling, gingival curettage, osseous surgery, gingivectomy, provisional splinting, laser procedures and maintenance. Oral medication (including pain control) for HIV patients 15 years old or older must be based on a comprehensive individual treatment plan. Prosthodontics: A unit of services is defined as one (1) Prosthodontics visit.
Financial Eligibility:	Refer to the RWPC's approved *Financial Eligibility for Houston EMA/HSDA Services*.
Client Eligibility:	HIV-infected adults residing in the rural area of Houston EMA/HSDA meeting financial eligibility criteria.
Agency Requirements:	Agency must document that the primary patient care dentist has 2 years prior experience treating HIV disease and/or on-going HIV educational programs that are documented in personnel files and updated regularly. Service delivery site must be located in one of the northern counties of the EMA/HSDA area: Waller, Walker, Montgomery, Austin, Chambers or Liberty Counties
Staff Requirements:	State of Texas dental license; licensed dental hygienist and state radiology certification for dental assistants.
Special Requirements: **RWGA Only**	Agency and/or dental providers (clinicians) must be Medicaid certified and enrolled in all Dental Plans offered to Texas STAR+PLUS eligible clients in the Houston EMA/HSDA. Agency/providers must ensure Medicaid certification and billing capability for STAR+PLUS eligible patients remains current throughout the contract term. Must comply with the joint Part A/B standards of care where applicable.

FY 2022 RWPC "How to Best Meet the Need" Decision Process

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Step in Process: **Quality Improvement Committee**		Date: **05/18/2021**
Recommendations:	Approved: Y:_ ___ No: _____ Approved With Changes: _____	If approved with changes list changes below:
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Step in Process: **HTBMTN Workgroup #2**	Date: **04/20/2021**
Recommendations:	Financial Eligibility: 300%
1. Accept the service definition as presented and keep the financial eligibility the same.	
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2022-2023 Service Category Definition - DSHS State Services

Local Service Category:	**Referral for Health Care: ADAP Enrollment Worker**
Amount Available**:**	**To be determined**
Unit Cost	
Budget Requirements or Restrictions **(TRG Only)**:	Maximum 10% of budget for Administrative Cost. No direct medical costs may be billed to this grant.
DSHS Service Category Definition:	Direct people living with HIV (PLWH) to a service in person or through telephone, written, or other types of communication, including management of such services where they are not provided as part of Ambulatory Outpatient Medical Care or Case Management Services.
Local Service Category Definition:	AIDS Drug Assistance Program (ADAP) Enrollment Workers (AEWs) are co-located at Ryan-White funded clinics to ensure the efficient and accurate submission of ADAP applications to the Texas HIV Medication Program (THMP). AEWs will meet with all potential ADAP enrollees to explain ADAP program benefits and requirements and assist PLWHs with the submission of complete and accurate ADAP applications. AEWs will ensure benefits continuation through timely completion of annual re-certifications by the last day of the PLWH's birth month and attestations six months later to ensure there is no lapse in ADAP eligibility and/or loss of benefits. Other responsibilities will include: • Track the ADAP application process to ensure submitted applications are processed as quick as possible, including prompt follow-up on pending applications to gather missing or questioned documentation as needed. • Maintain ongoing communication with designated THMP staff to aid in resolution of PLWH inquires and questioned applications; and to ensure any issues affecting pending applications and/or PLWHs are mediated as quickly as possible. AEWs must maintain relationships with the Ryan White ADAP Network (RWAN).
Target Population (age, gender, geographic, race, ethnicity, etc.):	People living with HIV in the Houston HDSA in need of medications through the Texas HIV Medication Program.
Services to be Provided:	Services include but are not limited to provision of education on available benefits programs applicable to the PLWH; completion of ADAP application including enrollment/recertification/six-month attestation; aid the PLWH in gathering all required supporting documentation to complete benefits application(s) including ADAP; provide a streamlined process for submission of completed ADAP applications and/or other benefits applications; assist in benefits continuation including six-month attestation and necessary follow-up; liaison with THMP and the PLWH throughout the ADAP application process

2022-2023 Service Category Definition - DSHS State Services

Service Unit Definition(s) **(TRG Only)**:	One unit of service is defined as 15 minutes of direct PLWH services or coordination of application process on behalf of PLWH.
Financial Eligibility:	Income at or below 300% of Federal Poverty Guidelines
Eligibility for Service:	People living with HIV in the Houston HDSA
Agency Requirements **(TRG Only)**:	Agency must be funded for Outpatient Ambulatory Medical Care bundled service category under Ryan White Part A/B/DSHS SS.
Staff Requirements:	Not Applicable.
Special Requirements **(TRG Only)**:	The agency must comply with **the DSHS Referral to Healthcare Standards of Care** and **the Houston HSDA Referral for Health Care and Support Services Standards of Care**. The agency must have policies and procedures in place that comply with the standards ***prior*** to delivery of the service.

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FY 2022 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/10/2021**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Steering Committee**		Date: **06/03/2021**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Improvement Committee**		Date: **05/18/2021**
Recommendations:	Approved: Y:_ ___ No: _____ Approved With Changes: _____	If approved with changes list changes below:
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Step in Process: **HTBMTN Workgroup #1**	Date: **04/20/2021**
Recommendations:	Financial Eligibility: 500%
1. Accept the service definition as presented and increase the financial eligibility from 300 to 500% FPL to be in line with HIV medications in LPAP.	
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FY 2020 Houston EMA Ryan White Part A/MAI Service Definition **Substance Abuse Services - Outpatient**	
HRSA Service Category Title: **RWGA Only**	Substance Abuse Services Outpatient
Local Service Category Title:	Substance Abuse Treatment/Counseling
Budget Type: **RWGA Only**	Fee-for-Service
Budget Requirements or Restrictions: **RWGA Only**	Minimum group session length is 2 hours
HRSA Service Category Definition: **RWGA Only**	***Substance abuse services outpatient*** is the provision of medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) in an outpatient setting, rendered by a physician or under the supervision of a physician, or by other qualified personnel.
Local Service Category Definition:	Treatment and/or counseling HIV-infected individuals with substance abuse disorders delivered in accordance with State licensing guidelines.
Target Population (age, gender, geographic, race, ethnicity, etc.):	HIV-infected individuals with substance abuse disorders, residing in the Houston Eligible Metropolitan Area (EMA/HSDA).
Services to be Provided:	Services for all eligible HIV/AIDS patients with substance abuse disorders. Services provided must be integrated with HIV-related issues that trigger relapse. All services must be provided in accordance with the Texas Department of Health Services/Substance Abuse Services (TDSHS/SAS) Chemical Dependency Treatment Facility Licensure Standards. Service provision must comply with the applicable treatment standards.
Service Unit Definition(s): **RWGA Only**	**Individual Counseling:** One unit of service = one individual counseling session of at least 45 minutes in length with one (1) eligible client. **A single session lasting longer than 45 minutes qualifies as only a single unit** – no fractional units are allowed. Two (2) units are allowed for initial assessment/orientation session. **Group Counseling:** One unit of service = 60 minutes of group treatment for one eligible client. A single session must last a minimum of 2 hours. Support Groups are defined as professionally led groups that are comprised of HIV-positive individuals, family members, or significant others for the purpose of providing Substance Abuse therapy.
Financial Eligibility:	Refer to the RWPC's approved *Financial Eligibility for Houston EMA/HSDA Services.*
Client Eligibility:	HIV-infected individuals with substance abuse co-morbidities/ disorders.
Agency Requirements:	Agency must be appropriately licensed by the State. All services must be provided in accordance with applicable Texas Department of State Health Services/Substance Abuse Services (TDSHS/SAS) Chemical Dependency Treatment Facility Licensure Standards. Client must not be eligible for services from other programs or providers (i.e. MHMRA of

	Harris County) or any other reimbursement source (i.e. Medicaid, Medicare, Private Insurance) unless the client is in crisis and cannot be provided immediate services from the other programs/providers. In this case, clients may be provided services, as long as the client applies for the other programs/providers, until the other programs/providers can take over services. All services must be provided in accordance with the TDSHS/SAS Chemical Dependency Treatment Facility Licensure Standards. Specifically, regarding service provision, services must comply with the most current version of the applicable Rules for Licensed Chemical Dependency Treatment. Services provided must be integrated with HIV-related issues that trigger relapse. Provider must provide a written plan no later than 3/30/17 documenting coordination with local TDSHS/SAS HIV Early Intervention funded programs if such programs are currently funded in the Houston EMA.
Staff Requirements:	Must meet all applicable State licensing requirements and Houston EMA/HSDA Part A/B Standards of Care.
Special Requirements: **RWGA Only**	Not Applicable.

FY 2022 RWPC "How to Best Meet the Need" Decision Process

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Step in Process: **Quality Improvement Committee**		Date: **05/18/2021**
Recommendations:	Approved: Y:_ ___ No: _____ Approved With Changes: _____	If approved with changes list changes below:
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Step in Process: **HTBMTN Workgroup #2**	Date: **04/20/2021**
Recommendations:	Financial Eligibility: 500%
1. Accept the service definition as presented and increase the financial eligibility to 500% FPL. Also, ask the Office of Support to highlight the service in Road 2 Success.	
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FY 2020 Houston EMA Ryan White Part A/MAI Service Definition Medical Transportation (Van Based)	
HRSA Service Category Title: **RWGA Only**	**Medical Transportation**
Local Service Category Title:	**a. Transportation targeted to Urban** **b. Transportation targeted to Rural**
Budget Type: **RWGA Only**	**Hybrid Fee for Service**
Budget Requirements or Restrictions: **RWGA Only**	• Units assigned to Urban Transportation must only be used to transport clients whose residence is in Harris County. • Units assigned to Rural Transportation may only be used to transport clients who reside in Houston EMA/HSDA counties other than Harris County. • Mileage reimbursed for transportation is based on the documented distance in miles from a client's Trip Origin to Trip Destination **as documented by a standard Internet-based mapping program (i.e. Google Maps, Map Quest, Yahoo Maps) approved by RWGA.** Agency must print out and file in the client record a trip plan from the appropriate Internet-based mapping program that clearly delineates the mileage between Point of Origin and Destination (and reverse for round trips). This requirement is subject to audit by the County. • Transportation to employment, employment training, school, or other activities not directly related to a client's treatment of HIV disease is not allowable. Clients may not be transported to entertainment or social events under this contract. • Taxi vouchers must be made available for documented emergency purposes and to transport a client to a disability hearing, emergency shelter or for a documented medical emergency. • Contractor must reserve 7% of the total budget for Taxi Vouchers. • Maximum monthly utilization of taxi vouchers cannot exceed 14% of the total amount of funding reserved for Taxi Vouchers. • Emergencies warranting the use of Taxi Vouchers include: van service is unavailable due to breakdown, scheduling conflicts or inclement weather or other unanticipated event. A spreadsheet listing client's 11-digit code, age, date of service, number of trips, and reason for emergency should be kept on-site and available for review during Site Visits. • **Contractor must provide RWGA a copy of the agreement between Contractor and a licensed taxi vendor by March 30, 2015.** • All taxi voucher receipts must have the taxi company's name, the driver's name and/or identification number, number of miles driven, destination (to and from), and exact cost of trip. The Contractor will add the client's 11-digit code to the receipt and include all receipts with the monthly Contractor Expense Report (CER).

	• A copy of the taxi company's statement (on company letterhead) must be included with the monthly CER. Supporting documentation of disbursement payments may be requested with the CER.
HRSA Service Category Definition: **RWGA Only**	**Medical transportation services** include conveyance services provided, directly or through voucher, to a client so that he or she may access health care services.
Local Service Category Definition:	a. Urban Transportation: Contractor will develop and implement a medical transportation program that provides essential transportation services to **HRSA-defined Core Services** through the use of individual employee or contract drivers with vehicles/vans to Ryan White Program-eligible individuals residing in Harris County. Clients residing outside of Harris County are ineligible for Urban transportation services. Exceptions to this requirement require prior written approval from RWGA. b. Rural Transportation: Contractor will develop and implement a medical transportation program that provides essential transportation services to **HRSA-defined Core Services** through the use of individual employee or contract drivers with vehicles/vans to Ryan White Program-eligible individuals residing in Houston EMA/HSDA counties other than Harris County. Clients residing in Harris County are ineligible for this transportation program. Exceptions to this requirement require prior written approval from RWGA. Essential transportation is defined as transportation to public and private outpatient medical care and physician services, substance abuse and mental health services, pharmacies and other services where eligible clients receive Ryan White-defined Core Services and/or medical and health-related care services, including clinical trials, essential to their well-being. The Contractor shall ensure that the transportation program provides taxi vouchers to eligible clients only in the following cases: • To access emergency shelter vouchers or to attend social security disability hearings; • Van service is unavailable due to breakdown or inclement weather; • Client's medical need requires immediate transport; • Scheduling Conflicts. **Contractor must provide clear and specific justification (reason) for the use of taxi vouchers and include the documentation in the client's file for each incident. RWGA must approve supporting documentation for taxi voucher reimbursements.** For clients living in the METRO service area, written certification from the client's principal medical provider (e.g. medical case manager or physician) is required to access van-based transportation, to be renewed every 180 days. **Medical Certifications should be maintained on-site by the provider in a single file (listed alphabetically by 11-digit code) and will be monitored at least annually during a Site Visit.** It is the

	Contractor's responsibility to determine whether a client resides within the METRO service area. Clients who live outside the METRO service area but within Harris County (e.g. Baytown) are not required to provide a written medical certification to access van-based transportation. All clients living in the Metro service area may receive a maximum of 4 non-certified round trips per year (including taxi vouchers). Non-certified trips will be reviewed during the annual Site Visit. Provider must maintain an up-to-date spreadsheet documenting such trips. The Contractor must implement the general transportation program in accordance with the Transportation Standards of Care that include entering all transportation services into the Centralized Patient Care Data Management System (CPCDMS) and providing eligible children with transportation services to Core Services appointments. Only actual mileage (documented per the selected Internet mapping program) transporting eligible clients from Origin to Destination will be reimbursed under this contract. The Contractor must make reasonable effort to ensure that routes are designed in the most efficient manner possible to minimize actual client time in vehicles.
Target Population (age, gender, geographic, race, ethnicity, etc.):	a. Urban Transportation: HIV/AIDS-infected and Ryan White Part A/B eligible affected individuals residing in Harris County. b. Rural Transportation: HIV/AIDS-infected and Ryan White Part A/B eligible affected individuals residing in Fort Bend, Waller, Walker, Montgomery, Austin, Colorado, Liberty, Chambers and Wharton Counties.
Services to be Provided:	To provide Medical Transportation services to access Ryan White Program defined **Core Services** for eligible individuals. Transportation will include round trips to single destinations and round trips to multiple destinations. Taxi vouchers will be provided to eligible clients only for identified emergency situations. Caregiver must be allowed to accompany the HIV-infected rider. **Eligibility for Transportation Services is determined by the client's County of residence as documented in the CPCDMS**.
Service Unit Definition(s): **RWGA Only**	One (1) unit of service = one (1) mile driven with an eligible client as passenger. Client cancellations and/or no-shows are <u>not</u> reimbursable.
Financial Eligibility:	Refer to the RWPC's approved *Financial Eligibility for Houston EMA/HSDA Services*.
Client Eligibility:	a. Urban Transportation: Only individuals diagnosed with HIV/AIDS and Ryan White Program eligible HIV-affected individuals residing inside Harris County will be eligible for services. b. Rural Transportation: Only individuals diagnosed with HIV/AIDS and Ryan White Program eligible HIV-affected individuals residing in Houston EMA/HSDA Counties other than Harris County are eligible for Rural Transportation services. Documentation of the client's eligibility in accordance with approved

	Transportation Standards of Care must be obtained by the Contractor prior to providing services. The Contractor must ensure that eligible clients have a signed consent for transportation services, client rights and responsibilities prior to the commencement of services. Affected significant others may accompany an HIV-infected person as medically necessary (minor children may accompany their caregiver as necessary). Ryan White Part A/B eligible affected individuals may utilize the services under this contract for travel to Core Services when the aforementioned criteria are met and the use of the service is directly related to a person with HIV infection. An example of an eligible transportation encounter by an affected individual is transportation to a Professional Counseling appointment.
Agency Requirements	Proposer must be a Certified Medicaid Transportation Provider. Contractor must furnish such documentation to Harris County upon request from Ryan White Grant Administration prior to March 1st annually. Contractor must maintain such certification throughout the term of the contract. Failure to maintain certification as a Medicaid Transportation provider may result in termination of contract. Contractor must provide each client with a written explanation of contractor's scheduling procedures upon initiation of their first transportation service, and annually thereafter. Contractor must provide RWGA with a copy of their scheduling procedures by March 30, 2014, and thereafter within 5 business days of any revisions. **Contractor must also have the following equipment dedicated to the general transportation program:** • A separate phone line from their main number so that clients can access transportation services during the hours of 7:00 a.m. to 10:00 p.m. directly at no cost to the clients. **The telephone line must be managed by a live person between the hours of 8:00 a.m. – 5:00 p.m.** Telephone calls to an answering machine utilized after 5:00 p.m. must be returned by 9:00 a.m. the following business day. • A fax machine with a dedicated line. • All equipment identified in the Transportation Standards of Care necessary to transport children in vehicles. • Contractor must assure clients eligible for Medicaid transportation are billed to Medicaid. This is subject to audit by the County. The Contractor is responsible for maintaining documentation to evidence that drivers providing services have a valid Texas Driver's License and have completed a State approved "Safe Driving" course. Contractor must maintain documentation of the automobile liability insurance of each vehicle utilized by the program as required by state law. All vehicles must have a current Texas State Inspection. The minimum acceptable limit of automobile liability insurance is $300,000.00 combined single limit. Agency must maintain detailed records of mileage driven and names of

	individuals provided with transportation, as well as origin and destination of trips. ***It is the Contractor's responsibility to verify the County in which clients reside in.***
Staff Requirements	A picture identification of each driver must be posted in the vehicle utilized to transport clients. Criminal background checks must be performed on all direct service transportation personnel prior to transporting any clients. Drivers must have annual proof of a safe driving record, which shall include history of tickets, DWI/DUI, or other traffic violations. Conviction on more than three (3) moving violations within the past year will disqualify the driver. Conviction of one (1) DWI/DUI within the past three (3) years will disqualify the driver.
Special Requirements: **RWGA Only**	Individuals who qualify for transportation services through Medicaid are not eligible for these transportation services. **Contractor must ensure the following criteria are met for all clients transported by Contractor's transportation program:** Transportation Provider must ensure that clients use transportation services for an appropriate purpose through one of the following three methods: 1. Follow-up hard copy verification between transportation provider and Destination Agency (DA) program confirming use of eligible service(s), or 2. Client provides receipt documenting use of eligible services at Destination Agency on the date of transportation, or 3. Scheduling of transportation services was made by receiving agency's case manager or transportation coordinator. The verification/receipt form must at a minimum include all elements listed below: • Be on Destination Agency letterhead • Date/Time • CPCDMS client code • Name and signature of Destination Agency staff member who attended to client (e.g. case manager, clinician, physician, nurse) • Destination Agency date stamp to ensure DA issued form.

FY 2022 RWPC "How to Best Meet the Need" Decision Process

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Step in Process: **Steering Committee**		Date: **06/03/2021**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Improvement Committee**		Date: **05/18/2021**
Recommendations:	Approved: Y:_ ___ No: _____ Approved With Changes: _____	If approved with changes list changes below:
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Step in Process: **HTBMTN Workgroup #3**	Date: **04/21/2021**
Recommendations:	Financial Eligibility: 400%
1. Accept the service definition as presented and keep the financial eligibility the same.	
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FY 2020 Houston EMA Ryan White Part A/MAI Service Definition **Vision Care**	
HRSA Service Category Title: **RWGA Only**	**Ambulatory/Outpatient Medical Care**
Local Service Category Title:	**Vision Care**
Budget Type: **RWGA Only**	**Fee for Service**
Budget Requirements or Restrictions: **RWGA Only**	Corrective lenses are not allowable under this category. Corrective lenses may be provided under Health Insurance Assistance and/or Emergency Financial Assistance as applicable/available.
HRSA Service Category Definition: **RWGA Only**	***Outpatient/Ambulatory medical care*** is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings. Services includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). *Primary medical care* for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies. HRSA policy notice 10-02 states funds awarded under Part A or Part B of the Ryan White CARE Act (Program) may be used for optometric or ophthalmic services under Primary Medical Care. Funds may also be used to purchase corrective lenses for conditions related to HIV infection, through either the Health Insurance Premium Assistance or Emergency Financial Assistance service categories as applicable.
Local Service Category Definition:	**Primary Care Office/Clinic Vision Care** is defined as a comprehensive examination by a qualified Optometrist or Ophthalmologist, including Eligibility Screening as necessary. A visit with a credentialed Ophthalmic Medical Assistant for any of the following is an allowable visit: • Routine and preliminary tests including Cover tests, Ishihara Color Test, NPC (Near Point of Conversion), Vision Acuity Testing, Lensometry. • Visual field testing • Glasses dispensing including fittings of glasses, visual acuity testing, measurement, segment height. • Fitting of contact lenses is not an allowable follow-up visit.

Target Population (age, gender, geographic, race, ethnicity, etc.):	HIV-infected individuals residing in the Houston EMA/HSDA.
Services to be Provided:	Services must be provided at an eye care clinic or Optometrist's office. Services must include but are not limited to external/internal eye health evaluations; refractions; dilation of the pupils; glaucoma and cataract evaluations; CMV screenings; prescriptions for eyeglasses and over the counter medications; provision of eyeglasses (contact lenses are not allowable); and referrals to other service providers (i.e. Primary Care Physicians, Ophthalmologists, etc.) for treatment of CMV, glaucoma, cataracts, etc. Agency must provide a written plan for ensuring that collaboration occurs with other providers (Primary Care Physicians, Ophthalmologists, etc.) to ensure that patients receive appropriate treatment for CMV, glaucoma, cataracts, etc.
Service Unit Definition(s): **RWGA Only**	One (1) unit of service = One (1) patient visit to the Optometrist, Ophthalmologist or Ophthalmic Assistant.
Financial Eligibility:	Refer to the RWPC's approved *Financial Eligibility for Houston EMA/HSDA Services.*
Client Eligibility:	HIV-infected resident of the Houston EMA/HSDA.
Agency Requirements:	Providers and system must be Medicaid/Medicare certified to ensure that Ryan White Program funds are the payer of last resort to the extent examinations and eyewear are covered by the State Medicaid program.
Staff Requirements:	Vendor must have on staff a Doctorate of Optometry licensed by the Texas Optometry Board as a Therapeutic Optometrist.
Special Requirements: **RWGA Only**	Vision care services must meet or exceed current U.S. Dept. of Health and Human Services (HHS) guidelines for the treatment and management of HIV disease as applicable to vision care.

FY 2022 RWPC "How to Best Meet the Need" Decision Process

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Step in Process: **HTBMTN Workgroup #1**	Date: **04/20/2021**
Recommendations:	Financial Eligibility: 400%
1. Accept the service definition as presented and increase the financial eligibility from 300 to 400% FPL.	
2.	
3.	

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? **Documentation of Need*** 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 infections 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, 2019 Outcome Measures, 2019 Chart Reviews, 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 funding or the need to fill in a gap.** (i.e., Alternative Funding Sources) 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 moving into free world care c) Pregnant women no longer needing OB/GYN care	**Recommendation(s)**
Part 1: Services offered by Ryan White Part A, Part B, and State Services in the Houston EMA/HSDA as of 03-16-21							
Ambulatory/Outpatient Primary Medical Care (incl. Vision):							
CBO, Adult – Part A, Including LPAP, MCM & Svc Linkage (Includes OB/GYN) *See below for Public Clinic, Rural, Pediatric, Vision* ***Workgroup #1*** ***Motion:** (Pradia/Sierra) Votes: Y=8; N=0; Abstentions= Aloysius, Leonard, Kelly, Padilla*	✔ 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.	Epi (2018): 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: 29,078 Need (2020): Rank w/in funded services: *Primary Care: #1* *LPAP/EFA: #2* *Case Management: #3* *Outreach: #14* Service Utilization (2020): # clients served:	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	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	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?	**Wg Motion:** Update the justification chart, keep the service definition and the financial eligibility the same: PriCare=300%, EFA=500%, LPAP=400% +500%, MCM=none, SLW=none, Outreach=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 infections 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, 2019 Outcome Measures, 2019 Chart Reviews, 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 funding or the need to fill in a gap.** (i.e., Alternative Funding Sources) 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 moving into free world care c) Pregnant women no longer needing OB/GYN care	**Recommendation(s)**
		Continuum of Care: Primary Care, MCM, and LPAP support maintenance/retention in care and viral suppression for PLWH.	*Primary Care: 9,357 (slight decrease v. 2019)* *LPAP: 5,559 (8.6% increase v. 2019)* *Medical Case Mgmt: 5,396 (1.5% increase v. 2019)* *EFA: 1,375 (10% decrease v. 2019)* *Outreach: 877 (12.6% increase v. 2019)* *Non-Medical Case Mgmt, or Service Linkage: 8,328 (8.9% decrease v. 2019)* Outcomes (FY2019): *Primary Care/LPAP:* 82% of Primary Care clients and 77% of LPAP clients were virally suppressed; *Medical Case Mgmt:* 50% of clients were in continuous HIV	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 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	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 Is this a duplicative service or activity? - This service is funded locally		

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			care following MCM; 73% of clients who received MCM were virally suppressed; *Outreach:* 34% of clients accessed HIV care w/in 3 mos.; 66% were virally suppressed w/in 3 mos.; *Non-Medical Case Mgmt, or Service Linkage:* 48% 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 birth),	from HRSA's Ending the HIV Epidemic-Primary Care HIV Prevention (PCHP) Grant. Covered under QHP? ✔ Yes ___No	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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			White, 18 – 24, Homeless, MSM, RR, Transgender *Case Management:* Other/multiracial, Black/AA, 18-24, OOC, Transgender, RR, Homeless				
Public Clinic, Adult – Part A, Including LPAP, MCM & Svc Linkage (Includes OB/GYN) *See below for Rural, Pediatric, Vision* ***Workgroup #1*** ***Motion:** (Pradia/Sierra) Votes: Y=8; N=0; Abstentions= Aloysius, Leonard, Kelly, Padilla*	✔ 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	Epi (2018): 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: 29,078 Need (2020): Rank w/in funded services: *Primary Care: #1* *LPAP/EFA: #2* *Case Management: #3* *Outreach: #14*	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	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	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	**Wg Motion:** Update the justification chart, keep the service definition and the financial eligibility the same: PriCare=300%, EFA=500%, LPAP=400% +500%, MCM=none, SLW=none, Outreach=none.

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		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 and viral suppression for PLWH.	Service Utilization (2020): # clients served: *Primary Care: 9,357* *(slight decrease v. 2019)* *LPAP: 5,559* *(8.6% increase v. 2019)* *Medical Case Mgmt: 5,396* *(1.5% increase v. 2019)* *EFA: 1,375* *(10% decrease v. 2019)* *Outreach: 877* *(12.6% increase v. 2019)* *Non-Medical Case Mgmt, or Service Linkage: 8,328* *(8.9% decrease v. 2018)* Outcomes (FY2019): *Primary Care/LPAP:* 82% of Primary Care clients and 77% of LPAP clients were virally suppressed;	private pharmacy benefit programs, 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 received funding under PS19-1906 for Accelerating State and Local HIV Planning to End the HIV Epidemic. Several	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 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	special populations to access primary care?	

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			Medical Case Mgmt: 50% of clients were in continuous HIV care following MCM; 73% of clients who received MCM were virally suppressed; *Outreach:* 34% of clients accessed HIV care w/in 3 mos.; 66% were virally suppressed w/in 3 mos.; *Non-Medical Case Mgmt, or Service Linkage:* 48% 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,	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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			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				
Rural, Adult – Part A, Including LPAP, MCM & Svc Linkage (Includes OB/GYN) *See below for Pediatric, Vision* ***Workgroup #1*** ***Motion:** (Pradia/Sierra) Votes: Y=8; N=0; Abstentions= Aloysius,*	✔ 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.	Epi (2018): 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: 29,078 Need (2020): Rank w/in funded services: *Primary Care: #1* *LPAP/EFA: #2*	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	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	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	**Wg Motion:** Update the justification chart, keep the service definition and the financial eligibility the same: PriCare=300%, EFA=500%, LPAP=400% +500%, MCM=none, SLW=none, Outreach=none.

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Leonard, Kelly, Padilla		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 and viral suppression for PLWH.	*Case Management: #3* *Outreach: #14* Service Utilization (2020): # clients served: *Primary Care: 9,357 (slight decrease v. 2019)* *LPAP: 5,559 (8.6% increase v. 2019)* *Medical Case Mgmt: 5,396 (1.5% increase v. 2018)* *EFA: 1,375 (10% decrease v. 2019)* *Outreach: 877 (12.6% increase v. 2019)* *Non-Medical Case Mgmt, or Service Linkage: 8,328 (8.9% decrease v. 2019)* Outcomes (FY2019): *Primary Care/LPAP:* 82% of Primary Care clients and 77%	program, private sector Patient Assistance Programs, and private pharmacy benefit programs, 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 received funding under PS19-1906 for Accelerating State	- 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 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	Does this service assist special populations to access primary care?	

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			of LPAP clients were virally suppressed; *Medical Case Mgmt:* 50% of clients were in continuous HIV care following MCM; 73% of clients who received MCM were virally suppressed; *Outreach:* 34% of clients accessed HIV care w/in 3 mos.; 66% were virally suppressed w/in 3 mos.; *Non-Medical Case Mgmt, or Service Linkage:* 48% 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	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	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) 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 infections 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, 2019 Outcome Measures, 2019 Chart Reviews, 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 funding or the need to fill in a gap. (i.e., Alternative Funding Sources) 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 moving into free world care c) Pregnant women no longer needing OB/GYN care	Recommendation(s)
			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				
Pediatric – Part A ***Workgroup #1*** ***Motion:** (Pradia/Sierra) Votes: Y=8; N=0; Abstentions= Aloysius, Leonard, Kelly, Padilla*	✔ 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	Epi (2018): 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: 29,078 Need (2020): Rank w/in funded services:	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:	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	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?	**Wg Motion:** Update the justification chart, keep the service definition and the financial eligibility the same: PriCare=300%, EFA=500%, LPAP=400% +500%, MCM=none, SLW=none, Outreach=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 infections 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, 2019 Outcome Measures, 2019 Chart Reviews, 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 funding or the need to fill in a gap.** (i.e., Alternative Funding Sources) 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 moving into free world care c) Pregnant women no longer needing OB/GYN care	**Recommendation(s)**
		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.	*Primary Care: #1* *Case Management: #3* Service Utilization (2020): # clients served: *Primary Care: 9,357 (slight decrease v. 2019)* *Medical Case Mgmt: 5,396 (1.5% increase v. 2019)* *Non-Medical Case Mgmt, or Service Linkage: 8,328 (8.9% decrease v. 2019)* Outcomes (FY2019): *Primary Care/LPAP:* 82% of Primary Care clients and 77% of LPAP clients were virally suppressed; *Medical Case Mgmt:* 50% of clients were in continuous HIV care following MCM; 73% of clients who received MCM	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. Covered under QHP?	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 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	No Does this service assist special populations to access primary care?	

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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 infections 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, 2019 Outcome Measures, 2019 Chart Reviews, 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 funding or the need to fill in a gap.** (i.e., Alternative Funding Sources) 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 moving into free world care c) Pregnant women no longer needing OB/GYN care	**Recommendation(s)**
			were virally suppressed; *Non-Medical Case Mgmt, or Service Linkage:* 48% 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 birth), White, 18 – 24, Homeless, MSM, RR, Transgender *Case Management:* Other/multiracial, Black/AA, 18-24, OOC, Transgender, 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 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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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 infections 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, 2019 Outcome Measures, 2019 Chart Reviews, 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 funding or the need to fill in a gap. (i.e., Alternative Funding Sources) 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 moving into free world care c) Pregnant women no longer needing OB/GYN care	Recommendation(s)
Vision – Part A ***Workgroup #1*** ***Motion:** (Pradia/Mica) Votes: Y=10; N=0; Abstentions= Aloysius, Padilla*	✔ 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 (2018): Current # of living HIV cases in EMA: 29,078 Need (2020): Rank w/in funded services:#5 Service Utilization (2020): # clients served: 3,109 *(8.5% increase v. 2019)* Outcomes (FY2019): 11 diagnoses were reported for HIV-related ocular disorders, all 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?	**Wg Motion:** Update the justification chart, keep the service definition the same and increase the financial eligibility to 400%.
Clinical Case	✔ Yes ___No	☐ EIIHA	Epi (2018):	RW Part C	Justify the use of funds: This	Can we make this service	**Wg Motion:** Update the

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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 infections 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, 2019 Outcome Measures, 2019 Chart Reviews, 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 funding or the need to fill in a gap. (i.e., Alternative Funding Sources) 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 moving into free world care c) Pregnant women no longer needing OB/GYN care	Recommendation(s)
Management - Part A ***Workgroup #1*** ***Motion:** (Vargas/Galley)* *Votes: Y=8; N=0;* *Abstentions= Aloysius, Kelly, Leonard, Padilla*		☒ 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.	Current # of living HIV cases in EMA: 29,078 Need (2020): Rank w/in funded services:*#3* Service Utilization (2019): # clients served: 1,316 *(15% increase v. 2018)* Outcomes (FY2018): 50% of clients were in continuous care following receipt of CCM. 79% of clients utilizing CCM were virally suppressed. Pops. with difficulty accessing needed services: Other/multiracial, Black/AA, 18-24, OOC, Transgender, RR, Homeless	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	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 addresses certain Special Populations named in the	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?	justification chart, keep the service definition and 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 infections 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, 2019 Outcome Measures, 2019 Chart Reviews, 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 funding or the need to fill in a gap. (i.e., Alternative Funding Sources) 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 moving into free world care c) Pregnant women no longer needing OB/GYN care	Recommendation(s)
					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 -		
Case Management – Non-Medical - Part A (Service Linkage at testing sites) ***Workgroup #1*** ***Motion:** (Pradia/Kelly)* *Votes: Y=8; N=0;*	___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	Epi (2018): Current # of living HIV cases in EMA: 29,078 Need (2020): Rank w/in funded services:*#3* Service Utilization (2020): # clients served: 135 *(23% decrease v. 2019)*	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	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	Can we make this service more efficient? No Can we bundle this service? No Has a recent capacity issue been identified? No	**Wg Motion:** Update the justification chart, keep the service definition and 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 infections 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, 2019 Outcome Measures, 2019 Chart Reviews, 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 funding or the need to fill in a gap. (i.e., Alternative Funding Sources) 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 moving into free world care c) Pregnant women no longer needing OB/GYN care	Recommendation(s)
Abstentions= Aloysius, Kelly, Leonard, Padilla		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 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.	Outcomes (FY2019): Following Service Linkage, 48% 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, RR, Homeless	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	- 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 for specific Special Populations and for clients served by specific funded agencies/programs only	Does this service assist special populations to access primary care?	

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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 infections 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, 2019 Outcome Measures, 2019 Chart Reviews, 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 funding or the need to fill in a gap. (i.e., Alternative Funding Sources) 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 moving into free world care c) Pregnant women no longer needing OB/GYN care	Recommendation(s)
		Continuum of Care: Service Linkage supports linkage to care, maintenance/retention in care and viral suppression for PLWH.					
Early Intervention Services (EIS)‡ (Incarcerated) (Harris County Jail) ***Workgroup #3*** ***Motion:** (Vargas/Kelly)* *Votes: Y=12; N=0;* *Abstentions=none*	✔ Yes ___No	☒ 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. EIS ensures that the newly diagnosed	Epi (2018): Current # of living HIV cases in EMA: 29,078 Need (2020): Rank w/in funded services: *#13* Service Utilization (2020): # clients served: 572 *(15% decrease v. 2019)* Chart Review (2019): Of the client records reviewed, 97% of clients had a discharge	RW Part C provides non-targeted EIS 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	Justify the use of funds: This service category: - Is a HRSA-defined Core Medical Service - Results in desirable outcomes for clients who access the 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	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?	**Wg Motion:** Update the justification chart, keep the service definition and 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 infections 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, 2019 Outcome Measures, 2019 Chart Reviews, 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 funding or the need to fill in a gap.** (i.e., Alternative Funding Sources) 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 moving into free world care c) Pregnant women no longer needing OB/GYN care	**Recommendation(s)**
		identified in jail maintain their HIV care post-release by bridging re-entering PLWH into community-based primary care. This is accomplished through care coordination by EIS staff in partnership with community-based providers/MOUs. <u>Unmet Need</u>: PLWH re-entering the community are at risk of lapsing their HIV care upon release from incarceration. EIS helps to prevent unmet need among this population by bridging re-entering PLWH into community-based primary care post-release. This is accomplished through care coordination by EIS staff in partnership with community-based	plan present and 9% of all client records reviewed had documentation that the client accessed HIV care after release. <u>Pops. with difficulty accessing needed services</u>: Other / multiracial, White, 25-49, RR, Homeless, Transgender, MSM	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	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? - No, there is no known alternative funding for this service as designed		

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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 infections 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, 2019 Outcome Measures, 2019 Chart Reviews, 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 funding or the need to fill in a gap. (i.e., Alternative Funding Sources) 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 moving into free world care c) Pregnant women no longer needing OB/GYN care	Recommendation(s)
		providers/MOUs. Continuum of Care: EIS supports linkage to care, maintenance/retention in care and viral suppression for PLWH.					
Emergency Financial Assistance - Other ***Workgroup #3*** ***Motion:** (Mica/Kelly)* *Votes: Y=11; N=0;* *Abstentions=none*	___Yes _✔_No	☐ EIIHA ☐ Unmet Need ☐ Continuum of Care This is a new service that started 03/01/21.		Covered under QHP? ___Yes ✔ No			**Wg Motion:** Update the justification chart; keep the service definition and the financial eligibility the same: 400%. Also ask the Office of Support to highlight in Road 2 Success and ask the AAs to actively promote the service.
Health Insurance Premium & Co-Pay	_✔_Yes __No	☐ EIIHA ☒ Unmet Need ☒ Continuum of Care	Epi (2018): Current # of living HIV cases in EMA: 29,078	No known alternative funding sources exist for this service, though consumers between	Justify the use of funds: This service category: - Is a HRSA-defined Core	Can we make this service more efficient? Yes, see attached service	**Wg Motion:** Update the justification chart, keep the

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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 infections 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, 2019 Outcome Measures, 2019 Chart Reviews, 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 funding or the need to fill in a gap. (i.e., Alternative Funding Sources) 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 moving into free world care c) Pregnant women no longer needing OB/GYN care	Recommendation(s)
Assistance **Part A, Part B, State Services** ***Workgroup #2*** ***Motion:** (Pradia/Mica)* *Votes: Y=8; N=0;* *Abstentions= Castillo, Padilla*		Unmet Need: Reductions in unmet need can be aided by *preventing* PLWH from lapsing their HIV care. This service category can directly prevent unmet need by removing financial barriers to HIV care for those who are eligible for public or private health insurance. Currently, 36% of RW clients have some form of health insurance, and 7% have Marketplace coverage. This service will assist those clients to remain in HIV care via all insurance resources; This will also be utilized to assist federal health insurance marketplace participants. Continuum of Care: Health	Need (2020): Rank w/in funded services: #7 *% of RW clients with health insurance: 37%* *% of RW clients with Marketplace coverage: 4%* Service Utilization (2020): # clients served: 2,361 *(0.5% decrease v. 2019)* Outcomes (FY2019): 81% of health insurance assistance clients were virally suppressed Pops. with difficulty accessing needed services: Other / multiracial, HL, 25-49, Transgender, Homeless, MSM, Rural	100% and 400% FPL may qualify for Advanced Premium Tax Credits (subsidies). COBRA plans seems to have fewer out-of-pocket costs. Covered under QHP? ___Yes ✔ No	Medical Service - Has limited or no alternative funding source - 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 retention in care and reducing unmet need - Supports federal health insurance marketplace participants Is this a duplicative service or activity? - No, there is no known alternative funding for this service as designed	definitions for changes. Can we bundle this service? No Has a recent capacity issue been identified? No Does this service assist special populations to access primary care?	service definition and the financial eligibility the same: 0 - 400%, ACA plans: must have a subsidy.

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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 infections 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, 2019 Outcome Measures, 2019 Chart Reviews, 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 funding or the need to fill in a gap. (i.e., Alternative Funding Sources) 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 moving into free world care c) Pregnant women no longer needing OB/GYN care	Recommendation(s)
		Insurance Assistance facilitates maintenance/ retention in care and viral suppression by increasing access to non-RW private and public medical and pharmaceutical coverage. The savings yielded by securing non-RW healthcare coverage for PLWH increases the amount of funding available to provide other needed services throughout the Continuum of Care.					
Home and Community-Based Services‡ (Facility-based) (Adult Day Treatment) ***Workgroup #3***	✔ 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. Adult Day	Epi (2018): Current # of living HIV cases in EMA: 29,078 Need (2020): Rank w/in funded services: *#11*	Medicaid Covered under QHP? ___Yes ✔ No	Justify the use of funds: This service category: - Is a HRSA-defined Core Medical Service; and use has increased - Results in desirable health outcomes for clients who	Can we make this service more efficient? No Can we bundle this service? No	**Wg Motion:** Update the justification chart; keep the service definition the same and increase the financial eligibility to 400%. Also ask the Office of Support to highlight in Road 2 Success

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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 infections 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, 2019 Outcome Measures, 2019 Chart Reviews, 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 funding or the need to fill in a gap. (i.e., Alternative Funding Sources) 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 moving into free world care c) Pregnant women no longer needing OB/GYN care	Recommendation(s)
***Motion:** (Mica/Vargas) Votes: Y=10; N=0; Abstentions=Stacy*		Treatment contributes to this goal by providing a community-based alternative to in-patient care facilities for those with advanced HIV-related health concerns. This, in turn, may prevent those with advanced stage illness or complex HIV-related health concerns from becoming out-of-care. In 2015, 19% of people with a Stage 3 HIV diagnosis were out-of-care in the EMA. In addition, the goal of Adult Day Treatment is to return clients to self-sufficient daily functioning, which includes maintenance in HIV care. Continuum of Care: Adult Day Treatment facilitates re-linkage and retention in care for PLWH by providing a community-based	Service Utilization (2020): # clients served: 21 *(22% decrease v. 2019)* Chart Review (2019): 82% of clients records had a complete care plan based on the primary medical care provider's order. 90% of records had evaluation of health, psychosocial, functional, and home environment status Pops. with difficulty accessing needed services: Other / multiracial, 25-49, Transgender, Homeless		access the service - Helps prevent unmet need for those with advanced HIV-related health concerns - Facilitates national, state, and local goals related to retention in care, reducing unmet need, and viral load suppression Is this a duplicative service or activity? - This service is funded locally by one other public source for those meeting income or disability-related eligibility criteria	Has a recent capacity issue been identified? No Does this service assist special populations to access primary care?	and ask the AAs to actively promote the service.

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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 infections 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, 2019 Outcome Measures, 2019 Chart Reviews, 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 funding or the need to fill in a gap. (i.e., Alternative Funding Sources) 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 moving into free world care c) Pregnant women no longer needing OB/GYN care	Recommendation(s)
		alternative to in-patient care facilities for those with advanced HIV-related health concerns, and may prevent those with advanced HIV-related health concerns from falling out-of-care.					
Hospice ‡ ***Workgroup #3*** ***Motion:** (Vargas/Sliepka)* *Votes: Y=9; N=0;* *Abstentions=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	Epi (2018): Current # of living HIV cases in EMA: 29,078 Need (2020):N/a Service Utilization (2020): # clients served: 18 *(36% decrease v. 2019)* Chart Review (2019): 92% of charts had records of palliative therapy as ordered and 100% had medication administration records on file.	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	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	**Wg Motion:** Update the justification chart, keep the service definition and the financial eligibility the same: 300%.

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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 infections 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, 2019 Outcome Measures, 2019 Chart Reviews, 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 funding or the need to fill in a gap. (i.e., Alternative Funding Sources) 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 moving into free world care c) Pregnant women no longer needing OB/GYN care	Recommendation(s)
		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 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.	Records indicated that bereavement counseling was offered to client's family in 10% of applicable cases. Pops. with difficulty accessing needed services: N/a		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 sources for those meeting income, disability, and/or age-related eligibility criteria	access primary care?	
Linguistic Services‡	___Yes ✔ No	☐ EIIHA ☒ Unmet Need ☒ Continuum of Care	Epi (2018): Current # of living HIV cases in EMA: 29,078	RW providers must have the capacity to serve monolingual Spanish-speakers; Medicaid	Justify the use of funds: This service category: - Is a HRSA-defined Support	Can we make this service more efficient? No	**Wg Motion:** Update the justification chart, keep the service definition and the

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Workgroup #3 ***Motion:** (Vargas/Sliepka)* *Votes: Y=10; N=0;* *Abstentions=none*		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 service facilitates entry into care and helps prevent lapses in care for monolingual PLWH. Continuum of Care: 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.	Need (2020):N/a Service Utilization (2020): # clients served: 52 *(4% decrease v. 2019)* *54% of Linguistics clients were African American / African origin and 31% were Asian American / Asian origin* Pops. with difficulty accessing needed services: N/a	may provide language translation for *non-Spanish* monolingual clients Covered under QHP? ___Yes ✔No	Service - Has limited or no alternative funding source - Removes potential barriers to entry/retention in HIV care for monolingual PLWH, thereby 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 Comprehensive HIV Plan Is this a duplicative service or activity? - No, there is no known alternative funding for this	Can we bundle this service? No Has a recent capacity issue been identified? There is no waiting list at this 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?	financial eligibility the same: 300%.

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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 infections 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, 2019 Outcome Measures, 2019 Chart Reviews, 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 funding or the need to fill in a gap. (i.e., Alternative Funding Sources) 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 moving into free world care c) Pregnant women no longer needing OB/GYN care	Recommendation(s)
					service as designed		
Medical Nutritional Supplements and Therapy - Part A ***Workgroup #2*** ***Motion:** (Sliepka/Mills)* *Votes: Y=8; N=0;* *Abstentions= Kelly*	✔ Yes ___No	☐ EIIHA ☒ Unmet Need ☒ Continuum of Care Unmet Need: The most commonly cited reason for referral to this service by a RW clinician is to mitigate side effects from HIV medication. Currently, 8% of PLWH report that side effects prevent them from taking HIV medication. This service category eliminates potential barriers to HIV medication adherence by helping to alleviate side effects. In addition, evidence of an ART prescription is a criterion for met need. Continuum of Care: Medical	Epi (2018): Current # of living HIV cases in EMA: 29,078 Need (2020): Rank w/in funded services: *#10* Service Utilization (2020): # clients served: 569 *(16% increase v. 2019)* Outcomes (FY2019): 50% of medical nutritional therapy clients with wasting syndrome or suboptimal body mass improved or maintained their body mass index. 81% of Medical Nutritional Therapy clients were virally suppressed	No known alternative funding sources exist for this service Covered under QHP?* ___Yes ✔ No *Some QHPs may cover prescribed supplements	Justify the use of funds: This service category: - Is a HRSA-defined Core Medical Service - Is ranked as the #9 service need by PLWH - Has limited or no alternative funding source - Results in desirable health outcomes for clients who access the service - Removes barriers to HIV medication adherence, thereby facilitating national, state, and local goals related to viral load suppression Is this a duplicative service or activity? - Alternative funding for this	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?	**Wg Motion:** Update the justification chart, keep the service definition and the financial eligibility the same: 400%.

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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 infections 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, 2019 Outcome Measures, 2019 Chart Reviews, 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 funding or the need to fill in a gap. (i.e., Alternative Funding Sources) 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 moving into free world care c) Pregnant women no longer needing OB/GYN care	Recommendation(s)
		Nutrition Therapy facilitates viral suppression by allowing PLWH to mitigate HIV medication side effects with supplements, and increasing medication adherence.	Pops. with difficulty accessing needed services: Females (sex at birth), Black/AA, 25-49, Homeless		service may be available through Medicaid.		
Mental Health Services‡ (Professional Counseling) ***Workgroup #2*** ***Motion:** (Pradia/Mica)* *Votes: Y=8; N=1;* *Abstentions= Sliepka*	✔ Yes ___No	☐ EIIHA ☒ Unmet Need ☒ Continuum of Care Unmet Need: Of 29% of 2016 Needs Assessment participants who reported falling out of care for >12 months since first entering care, 9% reported mental health concerns caused the lapse. Over half (57%) of participants recorded having a current mental health condition diagnosis, and 65% reported experiencing at least one	Epi (2018): Current # of living HIV cases in EMA: 29,078 Need (2020): Rank w/in funded services: *#8* Service Utilization (2020): # clients served: 217 *(23% decrease v. 2019)* Chart Review (2019): 96% of clients had treatment plans reviewed and/or modified at least every 90 days. 100% of charts reviewed	RW Part D (targets WICY), Medicaid, Medicare, private providers, and self-pay Some services provided by MHMRA Covered under QHP? ✔ Yes ___No	Justify the use of funds: This service category: - Is a HRSA-defined Core Medical Service - Is ranked as the #7 service need by PLWH - Facilitates national, state, and local goals related to retention in care and preventing unmet need - Addresses a system-level objective (#8) from the Comprehensive Plan and (as a result of the motion)	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?	**Wg Motion:** Update the justification chart, keep the service definition the same and increase the financial eligibility to 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 infections 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, 2019 Outcome Measures, 2019 Chart Reviews, 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 funding or the need to fill in a gap.** (i.e., Alternative Funding Sources) 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 moving into free world care c) Pregnant women no longer needing OB/GYN care	**Recommendation(s)**
		mental/emotional distress symptom in the past 12 months to such an extent that they desired professional help. Mental Health Services offers professional counseling for those with a mental health condition/concern, and, as a result, may help reduce lapses in HIV care. Mental Health Services also address local priorities related to mental health co-morbidities. Continuum of Care: Mental Health Services facilitate linkage, maintenance/retention in care, and viral suppression by helping PLWH manage mental and emotional health concerns that may act as barriers to HIV care.	contained evidence of appropriate coordination across all medical care team members Pops. with difficulty accessing needed services: Females (sex at birth), Other / multiracial, White, RR, Rural, Homeless		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) 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 infections 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, 2019 Outcome Measures, 2019 Chart Reviews, 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 funding or the need to fill in a gap. (i.e., Alternative Funding Sources) 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 moving into free world care c) Pregnant women no longer needing OB/GYN care	Recommendation(s)
Oral Health Untargeted – Part B Rural (North) – Part A ***Workgroup #2*** ***Motion:** (Pradia/Kelly)* *Votes: Y=7; N=1;* *Abstentions= Kelly*	✔ Yes ___No	☐ EIIHA ☐ Unmet Need ☒ Continuum of Care Continuum of Care: Oral Health services support maintenance in HIV care by increasing access to care and treatment for HIV-related and general oral health diagnoses. Untreated oral health diagnoses can create poor health outcomes and may act as a financial barrier to HIV care.	Epi (2018): Current # of living HIV cases in EMA: 29,078 Need (2020): Rank w/in funded services: *#4* Service Utilization (2020): # clients served: 3,544 *(7% decrease v. 2019)* Outcomes (FY2018): Oral Health Care – Rural Target: 100% of client charts had evidence of vital signs assessment, 92% had evidence of hard and soft tissue examinations, 94% had evidence of receipt of periodontal screening, and 99% had evidence of oral health education.	In FY12, Medicaid Managed Care expanded benefits to include oral health services Covered under QHP*? ___Yes ✔ No *Some QHPs cover pediatric dental; low-cost add-on dental coverage can be purchased in Marketplace	Justify the use of funds: This service category: - Is a HRSA-defined Core Medical Service - Is ranked as the #4 service need by PLWH. Is this a duplicative service or activity? - This service is funded locally by one other public sources for its Managed Care clients only	Can we make this service more efficient? No Can we bundle this service? No Has a recent capacity issue been identified? Yes, clients report waiting lists for this service Does this service assist special populations to access primary care?	**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 infections 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, 2019 Outcome Measures, 2019 Chart Reviews, 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 funding or the need to fill in a gap.** (i.e., Alternative Funding Sources) 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 moving into free world care c) Pregnant women no longer needing OB/GYN care	**Recommendation(s)**
			Oral Health Care – Untargeted: 99% had chart evidence for vital signs assessment at initial visit, 99% had updated health histories in their chart, 89% had a signed dental treatment plan established or updated within the last year, and 75% had chart evidence of receipt of oral health education including smoking cessation. Pops. with difficulty accessing needed services: Females (sex at birth), Other / multiracial, White, 25-49, OOC, RR, MSM				
Program Support: (WITHIN THE ADMINISTRATIVE BUDGET)							
Council Support	___Yes _✔_No						
Project LEAP	___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 infections 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, 2019 Outcome Measures, 2019 Chart Reviews, 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 funding or the need to fill in a gap. (i.e., Alternative Funding Sources) 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 moving into free world care c) Pregnant women no longer needing OB/GYN care	Recommendation(s)
Blue Book	___Yes _✔_No						
Referral for Health Care and Support Services‡ ***Workgroup #1*** ***Motion:** (Mica/Vargas) Votes: Y=7; N=0; Abstentions= Aloysius, Kelly, Padilla.*	___Yes _✔_No Referral For Health Care/Support Services – AIDS Drug Assistance Program Enrollment Worker at Ryan White Care Sites will fund one FTE ADAP enrollment worker per Ryan White Part A primary care site. Each ADAP enrollment worker will meet with all potential new ADAP enrollees, explain ADAP program benefits and requirements, and assist clients with submission of complete, accurate ADAP	☐ EIIHA ☒ Unmet Need ☒ Continuum of Care Unmet Need: Assistance submitting complete and accurate ADAP applications and re-certifications reduces unmet need by increasing the proportion of PLWH in the Houston EMA/HSDA with access to HIV medication coverage. Continuum of Care: Increased access to HIV medication coverage supports medication adherence and viral suppression.	Epi (2018): Current # of living HIV cases in EMA: 29,078 Need (2020): Rank w/in funded services: #6 Service Utilization (2020): # clients served: 7,002 *(15% increase v. 2019)* Chart Review (2019): 59% of AEW client had charts documented evidence of benefit applications completed as appropriate within 2 weeks the eligibility determination date. 59% had evidence of assistance provided to access health insurance or Marketplace plans. 73% had	Beyond assistance offered in the provision of case management care coordination, there is currently no funding to support dedicated ADAP Enrollment Workers at Ryan White primary care sites. Covered under QHP? ___Yes _✔_No	Justify the use of funds: This service category: - Is a HRSA-defined Support Service - State Services-Rebate (SS-R) funding is intended to ensure service continuation or bridge service gaps. - ADAP medication coverage reduces use of LPAP funding. Is this a duplicative service or activity? No	Can we make this service more efficient? Placement of ADAP Enrollment Workers at each Ryan White primary care site will make this service more efficient and accessible than placement at a single site. Can we bundle this service? N/a – this would be the only use of SS-R funding in the Houston EMA/HSDA Has a recent capacity issue been identified? No	**Wg Motion:** Update the justification chart, keep the service definition the same and increase the financial eligibility to 500% to be in line with HIV medications in LPAP.

‡ 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 infections 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, 2019 Outcome Measures, 2019 Chart Reviews, 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 funding or the need to fill in a gap. (i.e., Alternative Funding Sources) 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 moving into free world care c) Pregnant women no longer needing OB/GYN care	Recommendation(s)
	applications, as well as appropriate re-certifications and attestations.		evidence of completed secondary reviews of ADAP applications before submission to THMP. Pops. with difficulty accessing needed services: Other / multiracial, White, 50+, MSM, Homeless, Transgender, Rural, RR			Does this service assist special populations to access primary care?	
Substance Abuse Treatment – Part A ***Workgroup #2*** ***Motion:** (Mica/Pradia)* *Votes: Y=7; N=0;* *Abstentions= Mills, Sliepka*	✔ 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. Therefore, Substance Abuse Treatment services can directly prevent or reduce unmet need.	Epi (2018): Current # of living HIV cases in EMA: 29,078 Need (2020): Rank w/in funded services: *#12* Service Utilization (2020): # clients served: 20 *(26% decrease v. 2019)*	RW Part C, Medicaid, Medicare, private providers, and self-pay. Some services provided by SAMHSA Covered under QHP? ✔ Yes ___No	Justify the use of funds: This service category: - Is a HRSA-defined Core Medical Service - Removes potential barriers to early entry into HIV care, thereby contributing to EIIHA goals - Prevents unmet need by addressing the #2 cause	Can we make this service more efficient? No Can we bundle this service? No Has a recent capacity issue been identified? No	**Wg Motion:** Ask the Office of Support to highlight the service in Road 2 Success, update the justification chart, keep the service definition the same and increase the financial eligibility to 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 infections 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, 2019 Outcome Measures, 2019 Chart Reviews, 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 funding or the need to fill in a gap.** (i.e., Alternative Funding Sources) 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 moving into free world care c) Pregnant women no longer needing OB/GYN care	**Recommendation(s)**
		Substance Abuse Treatment also addresses local priorities related to substance abuse co-morbidities. Continuum of Care: Substance Abuse Treatment facilitates linkage, maintenance/retention in care, and viral suppression by helping PLWH manage substance abuse that may act as barriers to HIV care.	Outcomes (FY2019): 71% of clients accessed primary care at least once after receiving Substance Abuse Treatment services and 83% were virally suppressed. Pops. with difficulty accessing needed services: Black/AA, 18-24, RR, Homeless		cited by PLWH for lapses in HIV care - 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 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) those meeting income, disability, and/or age-related eligibility criteria, and (2) those with private sector health		

‡ 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 infections 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, 2019 Outcome Measures, 2019 Chart Reviews, 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 funding or the need to fill in a gap. (i.e., Alternative Funding Sources) 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 moving into free world care c) Pregnant women no longer needing OB/GYN care	Recommendation(s)
					insurance.		
Case Management – Non-Medical - State Services (Targeting Substance Use Disorders) ***Workgroup #2*** ***Motion:** (Pradia/Mica)* *Votes: Y=8; N=0;* *Abstentions= None*	___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 ≤ 3 months of diagnosis. In 2015, 19% of the newly diagnosed in the EMA were *not* linked within this timeframe. Unmet Need: Service Linkage at	Epi (2018): Current # of living HIV cases in EMA: 29,078 Need (2020): Rank of all types of case management w/in funded services: *#3* Service Utilization (2020): Service delivery began on September 1, 2019 Pops. with difficulty accessing needed services: *Case Management:* Other/multiracial, Black/AA, 18-24, OOC, Transgender, RR, Homeless	This service was previously funded under SAMHSA. Covered under QHP? ___Yes ✔ No	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 for	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?	**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 infections 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, 2019 Outcome Measures, 2019 Chart Reviews, 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 funding or the need to fill in a gap. (i.e., Alternative Funding Sources) 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 moving into free world care c) Pregnant women no longer needing OB/GYN care	Recommendation(s)
		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.			specific Special Populations and for clients served by specific funded agencies/programs only		
Transportation – Pt A (Van-based, bus passes & gas vouchers)	___Yes ✔ No	☐ EIIHA ☒ Unmet Need ☒ Continuum of Care Unmet Need: Lack of transportation is the *fourth* most	Epi (2018): Current # of living HIV cases in EMA: 29,078 Need (2020):	Medicaid, RW Part D (small amount of funds for parking and other transportation needs), and by other public sources for (1) specific Special	Justify the use of funds: This service category: - Is a HRSA-defined Support Service - Is ranked as the #2 need	Can we make this service more efficient? No Can we bundle this service?	**Wg Motion:** Update the justification chart, keep the service definition and the financial eligibility the

‡ 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 infections 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, 2019 Outcome Measures, 2019 Chart Reviews, 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 funding or the need to fill in a gap. (i.e., Alternative Funding Sources) 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 moving into free world care c) Pregnant women no longer needing OB/GYN care	Recommendation(s)
Workgroup #3 ***Motion:** (Vargas/Sliepka)* *Votes: Y=10; N=0;* *Abstentions=none*		commonly-cited barrier among PLWH to accessing HIV core medical services. Transportation 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.	Rank w/in funded services: #9 Service Utilization (2020): # clients served: *Van-based: 1,273 (38% increase v. 2019)* *Bus pass: 1,355 (38% decrease v. 2019)* Outcomes (FY2019): 69% 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	Populations (e.g., WICY), and (2) those meeting income, disability, and/or age-related eligibility criteria. Covered under QHP*? ___Yes ✔ No	among Support Services by PLWH - Results in clients accessing 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	No Has a recent capacity issue been identified? No Does this service assist special populations to access primary care?	same: 400%.

‡ 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 infections 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, 2019 Outcome Measures, 2019 Chart Reviews, 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 funding or the need to fill in a gap.** (i.e., Alternative Funding Sources) 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 moving into free world care c) Pregnant women no longer needing OB/GYN care	**Recommendation(s)**
					age-related eligibility criteria.		

‡ 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 03-01-21 *(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 3, 2021**. 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.

‡ Service Category for Part B/State Services only.

FY2021 HTBMN - Service Category Information Summary – Part A, MAI, Part B, SS

Last Updated: 4/13/21

Epidemiological Trends

Who is living with HIV in the Houston EMA?[a,b]

29,078 diagnosed people were living with HIV (**PLWH**) in the EMA at the end of 2018. Of all diagnosed PLWH in the EMA:

- 75% are male (sex at birth)
- 48% are Black/African American; 29% are Hispanic/Latinx
- 26% are between the ages of 45 and 54; 23% are 35 and 44
- 58% have MSM risk factor; 29% have sex with male/sex with female (heterosexual) risk factor
- There are 179 Ryan White clients in the Houston area who are transgender or gender non-conforming.

Who is newly diagnosed with HIV in the Houston EMA?[a]

1,350 people were newly diagnosed with HIV in the EMA in 2018. Of those newly diagnosed in 2018

- 78% are male (sex at birth)
- 44% are Black/African American; 37% are Hispanic/Latinx
- 36% were between the ages of 25 and 34; 23% were between the ages of 13 and 24
- 78% have MSM risk factor

It is estimated that an additional 6,825 people in the EMA are living with HIV but unaware of their status.

Which groups in the Houston EMA are experiencing increasing rates of new HIV diagnoses?[c]

Relative rate changes for new HIV diagnoses can indicate new and emerging populations while accounting for the size of each group within the population. Though the overall HIV diagnosis rate (per 100,000 population) decreased by 8.9% between 2013 (23.7) and 2018 (21.6), one population in the Houston EMA has experienced an increase in the relative rates of new diagnoses:

- 5.6% relative rate increase among Hispanic/Latinx individuals

Source:
[a]2020 Epidemiologic Supplement
[b]2019 Epidemiological Profile
[c]FY2020 Part A Grant Application

Unmet Need for HIV Care

What is unmet need?

Unmet need is when a person diagnosed with HIV is out of care. According to HRSA, a person is considered out of care if they have not had at least 1 of the following in 12 months: (1) an HIV medical care visit, (2) an HIV monitoring test (either a CD4 or viral load), or (3) a prescription for HIV medication.

How many people are out of care in the Houston EMA?[a]

- In 2018, there were 7,187 PLWH out of care in the EMA, or 25% of all diagnosed PLWH.

What trends can be seen among those out of care in the Houston EMA? [b,c]

The highest proportions of people out of care in 2017 were:

- 25% of male (sex at birth) diagnosed PLWH – ↓ from 37% in 2009
- 28% of other race/ethnicity diagnosed PLWH – ↓ from 41% in 2009
- 26% of Black/African American diagnosed PLWH – ↓ from 37% in 2009
- 25% of Hispanic diagnosed PLWH – ↓ from 36% in 2009
- 31% of diagnosed PLWH age 65+ - historic data for the 65+ age range unavailable
- 26% of diagnosed PLWH age 35-44 – ↓ from 36% in 2009;
  - The age range with highest unmet need in 2009 was age 25-34 at 39%
- 28% of diagnosed PLWH with an injection drug use risk factor – ↓ 39% in 2009
- 28% of diagnosed PLWH with perinatal transmission risk factor – ↓ 32% in 2009
- 26% of people diagnosed with HIV before 2011
  - In 2009, 38% of out of care PLWH were diagnosed between 2004 and 2006

32% of all PLWH in the 2020 Needs Assessment[b] reported stopping HIV medical care for 12 months or longer at some point since diagnosis. The most common reasons for falling out of care were: substance use, moving/relocating, and having other priorities at the time.

Sources:
[a]2020 Epidemiologic Supplement
[b]2019 Epidemiological Profile
[b]2020 Houston Area HIV Needs Assessment – approval pending

National, State, and Local Priorities

Initiatives at the national, state, and local level offer important guidance on how to design effective HIV care services for the Houston EMA:

Ending the HIV Epidemic: A Plan for America (EHE)

Released in February 2019, EHE includes four pillars intended to reach a 75% reduction in new HIV transmission by 2025 and at least 90% reduction by 2030:

- Diagnose all PLWH as early as possible after transmission.
- Treat HIV rapidly and effectively to achieve sustained viral suppression.
- Prevent new HIV transmissions by using proven interventions, including pre-exposure prophylaxis (**PrEP**) and syringe services programs (**SSPs**).
- Respond quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them.

National HIV/AIDS Strategy (NHAS) Updated for 2020

Released in July 2015, NHAS includes three broad outcomes for HIV care:

- Increase the percentage of newly diagnosed persons linked to HIV medical care within one month of their HIV diagnosis to at least 85%.
- Increase the percentage of persons with diagnosed HIV who are retained in HIV medical care to at least 90%.
- Increase the percentage of persons with diagnosed HIV who are virally suppressed to at least 80%.

Early Identification of Individuals with HIV/AIDS (EIIHA)

EIIHA is a HRSA initiative required of all Part A grantees. It has four goals:
1.) Identifying individuals unaware of their HIV status; 2.) Informing individuals unaware of their HIV status; 3.) Referring to medical care and services; and 4.) Linking to medical care

The EMA's EIIHA Strategy also includes a special populations focus:

1. African Americans
2. Hispanics/Latinos age 25 and over
3. Men who have Sex with Men (MSM)

HIV Care Continuum[a] (HCC)

Developed by the CDC in 2012, the HCC is a five-step model of PLWH engagement in HIV medical care. Using the model, local communities can identify specific areas for scaled-up engagement efforts. Steps include diagnosis, met need, retention in care, ART prescription, and viral suppression.

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Epidemiological Trends

Con't from Page 1

Which groups in the Houston EMA experience disproportionately higher rates of new HIV diagnoses?[a]

Using the total 2018 Houston EMA HIV diagnosis rate (21.6 per 100,000 population) as a benchmark, the following populations experience disproportionately higher rates of new HIV diagnoses:

- 149% higher rate among Black/African Americans individuals
- 138% higher rate among individuals age 25-34
- 58% higher rate among males (sex at birth)
- 38% higher rate among individuals age 13-24
- 29% higher rate among individuals age 35-44
- 11% higher rate among individuals age 45-54

While there has been no change in ***which*** groups experience disproportionally higher rates of new diagnoses since 2013, the ***extent of disproportionality*** within each population group changed in the Houston EMA between 2013 and 2018. Individuals ages 25-34 experienced the greatest increase in extent of disproportionality with a 19 percentage point increase, followed by Hispanic/Latinx individuals with a 13 percentage point increase in disproportionality. This may indicate that adults aged 25-34 and Hispanic/Latinx individuals bear a disproportionate burden of new HIV diagnoses in the EMA.

How does the Houston EMA compare to Texas and the U.S.?[b]

- The prevalence rate in the Houston EMA in 2018 (465 per 100,000 population) was higher than Texas (328 per 100,000 population) and the U.S. (309 per 100,000 population).
- The rate of new HIV diagnosis in the Houston EMA in 2018 (22 per 100,000 population) was also higher than Texas (16 per 100,000 population) and the U.S. (11 per 100,000 population).

Sources:
[a]FY2020 Part A Grant Application
[b]2020 Epidemiologic Supplement

Unmet Need for HIV Care

Con't from Page 1

What proportion of newly diagnosed PLWH are linked to care in the EMA?[a]

- 61% of those newly diagnosed in 2017 in the Houston EMA were linked to HIV medical care within 1 month of their diagnosis. An additional 19% were linked to care within 2-3 months of their diagnosis, 7% were linked to care within 4-12 months of their diagnosis, and 1% were linked to care over 12 months after they diagnosed.
- 12% of those newly diagnosed in 2017 in the EMA *were not* linked by the end of that year. This accounts for 149 newly diagnosed individuals. Most of these individuals were:
- 87% males (sex at birth)
  - Among unlinked males, 54% were Black/African American males and 35% were Hispanic males
- 58% Black/African American individuals
  - 80% of unlinked females were Black/African American
- 42% were individuals age 25-34
  - 27% were youth ages 13-24
- 78% were individuals with MSM risk factor
  - 16% were individuals with heterosexual risk factor

Which groups are experiencing concurrent (late) diagnosis?[a]

Of people newly diagnosed in the Houston EMA in 2016, 306 or 22% also received an HIV stage 3 (formerly AIDS) diagnosis within 3 months.

Populations disproportionately impacted by late/concurrent diagnoses in the Houston EMA in 2016 include females (23%); Hispanic/Latino individuals (27%); individuals ages 35-44 (30%), 45-54 (34%), 55-64 (34%) and 65+ (30%); and individuals with PWIDU (33%) and heterosexual (28%) risk factors.

Sources:
[a]2019 Epidemiological Profile

National, State, and Local Priorities

Con't from Page 1

The 2017-2021 Texas HIV Plan

The Texas Department of State Health Services (DSHS) has also developed a model of PLWH engagement in HIV medical care, which serves as the foundation for efforts to reduce HIV transmissions for the state as a whole. Goals specific to HIV care services improvements for the state are:

Achieving Together Plan (2018)

The Texas HIV Syndicate and Achieving Together Partners developed a plan to end the HIV epidemic in Texas through coordinating the statewide response to HIV, with the goals of reducing HIV transmission and acquisition, increasing viral suppression, eliminating health disparities, and cultivating a stigma-free climate.

Houston Area Comprehensive HIV Plan (2017 – 2021)

This document outlines strategies, activities, and benchmarks for improving the entire system of HIV prevention and care in the EMA. HIV care services improvements slated for achievement by 2021 are:

- ↑ newly-diagnosed PLWH linked to clinical HIV care within one month of their HIV diagnosis to at least 85%
- ↓ new HIV diagnoses with an HIV stage 3 diagnosis within one year by 25%
- ↓ new HIV diagnoses with an HIV stage 3 diagnosis within one year among Hispanic and Latino men age 35+ by 25%
- ↑ Ryan White Program clients who are in continuous HIV care to at least 90%
- ↑ diagnosed PLWH in the Houston Area who are retained in HIV medical care to at least 90%.
- ≥ Ryan White Program clients who are virally suppressed to at least 90%
- ↑ diagnosed PLWH in the Houston Area who are virally suppressed at least 80%

The plan also includes a special populations focus: Youth (13-24), Homeless, I/RR, IDU, MSM, Transgender & Gender Non-conforming, and Women of Color

Roadmap to Ending the HIV Epidemic in Houston (2017-2021)

This document offers over 30 recommendations to end the local HIV epidemic by decreasing new diagnoses to 600 per year; increasing the diagnosed proportion to 90%, fostering 90% retention in care, and supporting 90% of diagnosed PLWH in Houston/Harris County to achieve viral suppression.

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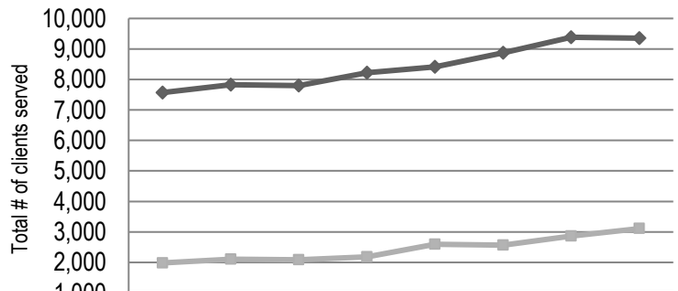
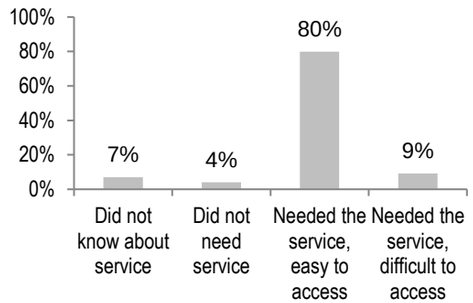
Service	Allocation	Client Utilization	Outcomes	Needs Assessment Data	National, State, and Local Priorities
Ambulatory Outpatient Medical Care (Adult and Pediatric) incl. Vision Care)	Part A: FY99: $1,231,605 FY00: $1,891,325 FY01: $1,679,294 FY02: $1,941,561 FY03: $1,966,899 FY04: $1,687,404 FY05: $2,319,440 FY06: $3,161,000 FY07: $3,161,000 Part A/MAI/B: FY08: $9,214,688 FY09: $9,454,433 FY10: $9,510,270 FY11: $9,964,057 FY12: $9,941,410 FY13: $11,043,672 FY14: $10,656,734 Part A/MAI: FY15: $11,181,410 FY16: $11,757,561 FY17: $11,853,686 FY18: $11,432,200 FY19: $11,630,314 FY20: $12,072,478 Source: FY 2020 Allocations - Level Funding Scenario Based - Approved 07/11/19	 CY13 CY14 CY15 CY16 CY17 CY18 CY19 CY20 PCare 7,570 7,830 7,799 8,224 8,416 8,874 9,384 9,357 Vision 1,984 2,108 2,087 2,186 2,598 2,565 2,865 3,109 Source: RWGA, 4/6//21	Primary Care[a,b]: • Following Primary Care, 75% of clients were in continuous HIV care (i.e., two or more primary care visits at least three months apart).[a] • 18% of primary care clients had CD4 < 200 within 90 days of enrollment in primary care.[a] • 78% of primary care clients were virally suppressed.[a] Vision Care: • 12 diagnoses were reported for HIV-related ocular disorders, all of which were managed appropriately.[c] • 97% of client records reviewed contained documentation of new prescription for lenses at the agency with the year.[c] • Overall performance rates of vision care providers have remained very high.[c] Source: [a] RWGA FY 2019 Highlights from Performance Measures [b]RWGA Primary Care Chart Review FY 2019 [c]RWGA Vision Care Chart Review FY 2019	Needs Assessment Rankings: Primary Care was surveyed as "*HIV medical care visits or clinic appointments with a doctor, nurse, or physician assistant (i.e., outpatient primary HIV medical care)"* in the 2020 Needs Assessment. Results as defined are below:  • 89% of respondents reported a need for Primary Care, placing this service as the highest ranked need surveyed. • The most common barrier reported for Primary Care was transportation issues (26% of all reported barriers to this service). • Females, white PLWH, and PLWH age 50+ reported the least difficulty accessing Primary Care. • Rural, out of care, and MSM PLWH reported more difficulty accessing Primary Care than the sample as a whole. Source: 2019 Houston Area HIV Needs Assessment	This service aligns with the following goals: EHE • Treat HIV rapidly and effectively to achieve sustained viral suppression NHAS • ↑ diagnosed PLWH retained in HIV medical care to at least 90%. • ↑ virally suppressed diagnosed PLWH to least 80%. HIV Care Continuum • ↑ percentage of diagnosed PLWH retained in HIV care • ↑ percentage of diagnosed PLWH with a suppressed viral load The Texas HIV Plan (2017-2021): • ↑ continuous participation in systems of care and treatment • ↑ viral suppression Achieving Together Plan (Texas, by 2030): • ↑ diagnosed PLWH on ART to 90% • ↑ diagnosed PLWH on ART who are virally suppressed to 90% • ↓ annual new diagnoses by 50% Comprehensive HIV Plan (2017-2021): • ↑ RW clients in continuous HIV care to ≥ 90% • ↑ PLWH who are retained in care to ≥ 90%. • ↑ RW clients who are virally suppressed to ≥ 90% • ↑ PLWH who are virally suppressed ≥80% The following Special Population is also specifically addressed by this service: • Youth (age 13 – 24) END Plan (2017-2021) • Foster 90% retention in care • Support 90% of diagnosed PLWH in Houston/Harris County to achieve viral suppression

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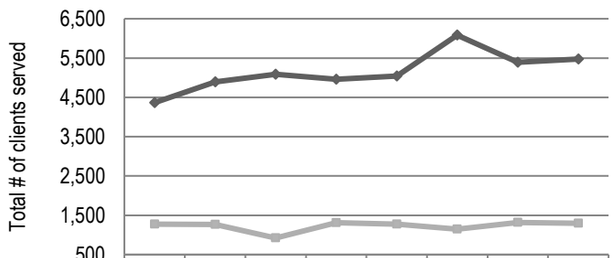
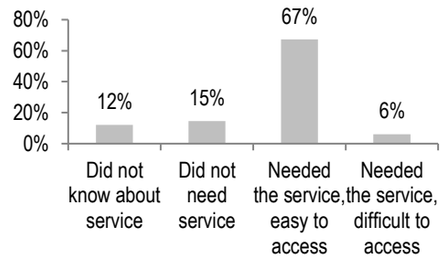
Service	Allocation	Client Utilization	Outcomes	Needs Assessment Data	National, State, and Local Priorities
Case Management - Medical (MCM) (incl. Clinical Case Management (CCM) for Mental Health/Sub Use)	Part A: FY99: $1,231,605 FY00: $1,891,325 FY01: $1,679,294 FY02: $1,941,561 FY03: $1,966,899 FY04: $1,687,404 FY05: $2,319,440 FY06: $3,161,000 FY07: $1,747,070 FY08: $2,210,511 FY09: $2,616,512 FY10: $2,616,512 FY11: $2,139,991 Part A/B: FY12: $1,990,481 FY13: $1,840,481 Part A FY14: $1,752,556 FY15: $2,031,556 FY16: $2,215,702 FY17: $2,215,702 Part A/MAI FY18: $2,855,902 FY19: $2,855,902 FY20: $2,505,902 Source: FY 2020 Allocations - Level Funding Scenario Based - Approved 07/11/19	 CY13 CY14 CY15 CY16 CY17 CY18 CY19 CY20 MCM 4,366 4,891 5,089 4,962 5,046 6,083 5,396 5,478 CCM 1,275 1,266 922 1,308 1,276 1,149 1,316 1,296 Source: RWGA, 4/6/21	Medical Case Management (MCM): • Following MCM, 50% of clients were in continuous HIV care (i.e., two or more primary care visits at least three months apart), and 3% accessed primary care for the first time. • Following MCM, 13% accessed mental health services at least once. • 73% of MCM clients had suppressed viral loads. Clinical Case Management (CCM): • Following CCM, 56% of clients were in continuous HIV care (i.e., two or more primary care visits at least three months apart). • Following CCM, 32% of clients accessed mental health services at least once. • 80% of CCM clients had suppressed viral loads Source: RWGA FY 2019 Highlights from Performance Measures	Needs Assessment Rankings: Medical, Clinical, and SLW Case Management were not each surveyed *explicitly* in the 2020 Needs Assessment, but rather as a general category entitled "Case Management" and defined as: "*these are people at your clinic or program who assess your needs, make referrals for you, and help you make/keep appointments.*" Results as defined are below:  • 73% of respondents reported a need for case management services, placing it as the 3rd highest ranked need. • The most common barrier reported was interactions with staff (37% of all barriers reported for case management). • Females, white PLWH, and age 50+ PLWH reported the least difficulty accessing case management services. • Out of care, transgender, recently released from incarceration, and homeless PLWH reported more difficulty accessing case management services that the sample as a whole. Source: 2020 Houston Area HIV Needs Assessment	This service aligns with the following goals: EHE • Treat HIV rapidly and effectively to achieve sustained viral suppression NHAS • ↑ diagnosed PLWH retained in HIV medical care to at least 90%. • ↑ virally suppressed diagnosed PLWH to least 80%. EIIHA • Referring and link to medical care and services HIV Care Continuum • ↑ percentage of diagnosed PLWH retained in HIV care • ↑ percentage of diagnosed PLWH with a suppressed viral load The Texas HIV Plan (2017-2021): • ↑ continuous participation in systems of care and treatment • ↑ viral suppression Achieving Together Plan (Texas, by 2030): • ↑ diagnosed PLWH on ART to 90% • ↑ diagnosed PLWH on ART who are virally suppressed to 90% Comprehensive HIV Plan (2017-2021): • ↑ RW clients in continuous HIV care to 80% • ↓ diagnosed individuals who are not in HIV care by 0.8% each year • ↑ of RW clients with UVL by 10% The following Special Populations are also specifically addressed by this service: • Youth (age 13 – 24) & PWID END Plan (2017-2021) • Foster 90% retention in care • Support 90% of diagnosed PLWH in Houston/Harris County to achieve viral suppression

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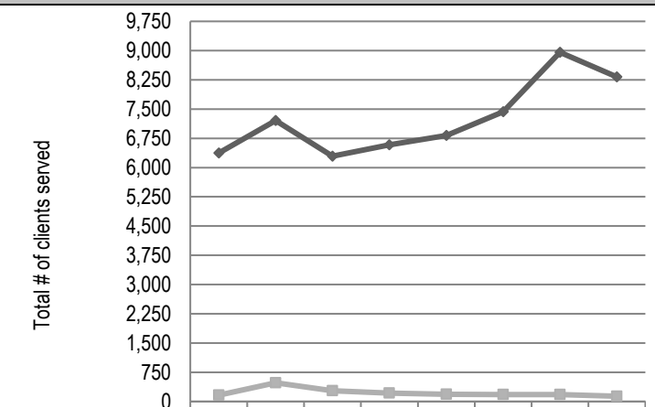
Service	Allocation	Client Utilization	Outcomes	Needs Assessment Data	National, State, and Local Priorities

Case Management - (Non-Medical / Service Linkage (SLW) (incl. SLW at public testing sites and SLW targeted to substance use)	Part A:
	FY99: $1,231,605
	FY00: $1,891,325
	FY01: $1,679,294
	FY02: $1,941,561
	FY03: $1,966,899
	FY04: $1,687,404
	FY05: $2,319,440
	FY06: $3,161,000
	FY07: $1,010,871
	FY08: $1,079,062
	FY09: $957,897
	FY10: $957,897
	FY11: $1,163,539
	FY12: $1,212,217
	FY13: $1,362,217
	FY14: $1,359,832
	FY15: $1,440,384
	FY16: $1,440,384
	FY17: $1,231,001
	FY18: $1,231,002
	
	Part A/SS:
	FY19: $1,456,002
	FY20: $1,731,002
	
	Source:
	FY 2020 Allocations - Level Funding Scenario Based - Approved 07/11/19
		
		*These are data for SLW at public testing sites only
		
		Source:
		RWGA, 4/6/21
			• Following receipt of SLW services, 48% of clients were in continuous HIV care (i.e., two or more primary care visits at least three months apart), and 50% accessed primary care for the first time.
			• The median number of days between first service linkage visit and first primary care visit was 14 days, a decrease from 40 days in FY 2017.
			
			Source:
			RWGA FY 2019 Highlights from Performance Measures
				Needs Assessment Rankings:
				
				Medical, Clinical, and SLW Case Management were not surveyed *explicitly* in the 2020 Needs Assessment. Please refer to Case Management-Medical for 2020 Needs Assessment results, ranking, and barriers relating to general case management.
				
				Other Needs Assessment Data Related to SLW:
				• Among participants who were newly diagnosed (≤2 years) or recently diagnosed (≤5 years) at the time of survey:
				  ○ 84% received a list of HIV clinics
				  ○ 75% were given an HIV care appt
				  ○ 81% were offered help to get into care
				  ○ 78% had someone available to answer all their questions about living with HIV
				  ○ 79% were informed they could get help paying for HIV care
				  ○ 61% were linked to care w/in 1 month
				
				• 43% of all respondents reported delayed entry (> 1 month) into HIV care. The most common reported reasons were denial, fear of status disclosure (19%), and not knowing that services exist to pay for HIV care.
				
				Source:
				2020 Houston Area HIV/AIDS Needs Assessment
					This service aligns with the following goals:
					
					EHE
					• Treat HIV rapidly and effectively to achieve sustained viral suppression
					
					NHAS
					• ↑ newly diagnosed PLWH linked to HIV medical care within one month to at least 85%.
					
					EIIHA
					• Referring to medical care and services
					• Linking to medical care
					This service also directly implements the EMA's EIIHA Strategy of linking the following special populations:
					1. African Americans
					2. Hispanics/Latinos age 25 and over
					3. Men who have Sex with Men (MSM)
					
					HIV Care Continuum
					• ↑ percentage of diagnosed PLWH linked to HIV care
					
					The Texas HIV Plan (2017-2021):
					• ↑ timely linkage to HIV-related care and treatment
					
					Achieving Together Plan (Texas, by 2030):
					• ↑ diagnosed PLWH on ART to 90%
					
					Comprehensive HIV Plan (2017-2021):
					• ↑ newly diagnosed individuals linked to care w/in 1 month diagnosis to ≥85%
					
					END Plan (2017-2021)
					• Foster 90% retention in care

	CY13	CY14	CY15	CY16	CY17	CY18	CY19	CY20
SLW	6,373	7,206	6,292	6,582	6,823	7,431	8,956	8,328
Testing Sites*	164	480	277	214	183	180	176	135

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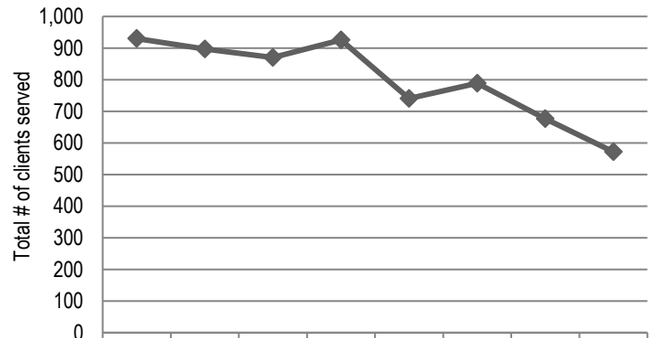
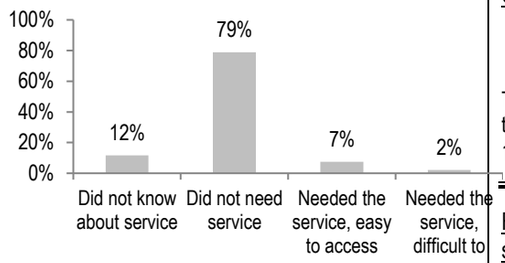
Service	Allocation	Client Utilization	Outcomes	Needs Assessment Data	National, State, and Local Priorities
Early Intervention Services (EIS) (Incarcerated)	Part A: FY03: $83,577 FY04: $60,588 SS: FY09: $166,211 FY10: $166,211 FY11: $166,211 FY12: $166,211 FY13: $166,211 FY14: $166,211 FY15: $166,211 FY16: $166,211 FY17: $166,211 FY18: $166,211 FY19: $166,211 FY20: $175,000 Source: FY 2020 Allocations - Level Funding Scenario Based - Approved 07/11/19	 CY13 CY14 CY15 CY16 CY17 CY18 CY19 CY20 EIS 930 897 870 926 741 789 677 572 Source: RWGA and The Resource Group, 4/8/21	• All client records reviewed showed a completed intake assessment. • All client records reviewed had documentation of the client being assessed for risk and provided targeted health literacy and education in the client record (including receipt of a BlueBook) • 97% of records reviewed for clients had a discharge plan present • 9% of records reviewed had documentation of access to medical care are upon release Source: TRG 2019 Chart Review Report	Needs Assessment Rankings:[a] EIS was surveyed as "*Pre-discharge Planning"* defined as: "*this is when jail staff help you plan for HIV medical care after your release"* in the 2020 Needs Assessment. Results as defined are below:  • 7% of respondents reported need for EIS services, placing it as the 2nd lowest ranked need. • The most common barrier reported was interactions with staff (67%). • Females, Hispanic/Latinx and PLWH age 18-24 reported the least difficulty accessing EIS services. • Recently released, homeless, transgender, and MSM PLWH reported more difficulty accessing EIS services than the sample as a whole. 2020 Needs Assessment Recently Released Profile:[b] • Recently released participants reported an undetectable viral load as a barrier to retention more often than all participants. • Only 58% of recently released participants reported no interruption in care (vs. 67% of all participants) • Education and awareness was cited as a service barrier more often for recently released participants (29% v. 19%). Source: [a] 2020 Houston Area HIV Needs Assessment [b] 2020 Houston Area HIV Needs Assessment: Profile of the Recently Released	This service aligns with the following goals: EHE • Treat HIV rapidly and effectively to achieve sustained viral suppression Comprehensive HIV Plan (2017-2021): • ↑ RW clients in continuous HIV care to ≥ 90% • ↑PLWH who are retained in care to ≥ 90%. The following Special Population is addressed by this service: 1. I/RR Focus on Addressing mental health, substance use, housing and criminal justice from Achieving Together Plan (Texas, by 2030): • Remove policies that perpetuate stigma and limit access for people with mental health and substance use disorders or who have been incarcerated. • Create and operationalize processes in order to provide seamless and comprehensive medical and supportive services for people who have been released from prisons and jails. Criminal Justice Recommendations from END Plan (2017-2021): 1. Create drop-in center(s) for persons recently released from incarceration 2. Make transition back into community less onerous 3. Implement the Healthy Person initiative to improve HIV literacy in the correctional system 4. Improve HIV/AIDS medical care in the correctional health system 5. Allow access to condoms in the correctional system

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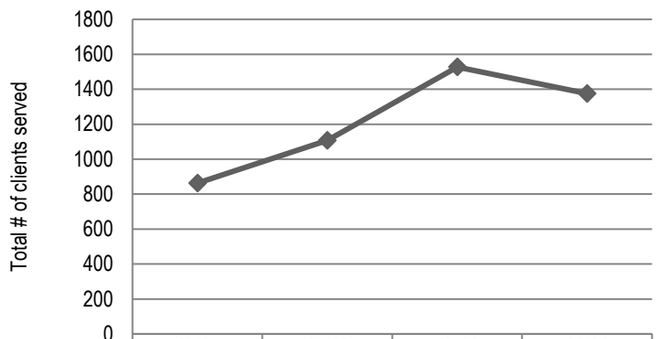
Service	Allocation	Client Utilization	Outcomes	Needs Assessment Data	National, State, and Local Priorities
Emergency Financial Assistance (Pharmacy Assistance)	Part A: FY18: $450,000 FY19: $450,000 FY20: $525,000 Source: FY 2020 Allocations - Level Funding Scenario Based - Approved 07/11/19	 CY17 CY18 CY19 CY20 EFA 863 1,108 1,527 1,375 Source: RWGA, 4/6/21	Emergency financial assistance outcomes data are not available for this service category at this time.	Needs Assessment Rankings: As EFA is currently used for rapid medication access in the Houston area, it was not evaluated as a separate service from HIV Medication Assistance/Local Pharmacy Assistance Program (LPAP) in the 2020 Needs Assessment. See also: LPAP	This service aligns with the following goals: EHE • Treat HIV rapidly and effectively to achieve sustained viral suppression NHAS • ↑ virally suppressed diagnosed PLWH to least 80%. Early Identification of Individuals with HIV/AIDS (EIIHA) • Refer and link newly diagnosed PLWH to medical care and services HIV Care Continuum • ↑ percentage of diagnosed PLWH on antiretroviral therapy (ART), retained in HIV care, and virally suppressed The Texas HIV Plan (2017-2021): • ↑timely linkage to HIV-related care and treatment • ↑ viral suppression Achieving Together Plan (Texas, by 2030): • ↑ diagnosed PLWH on ART to 90% • ↑ diagnosed PLWH on ART who are virally suppressed to 90% • ↓ annual new diagnoses by 50% Comprehensive HIV Plan (2017-2021): • ↑ RW clients who are virally suppressed to ≥ 90% • ↑PLWH who are virally suppressed ≥80% END Plan (2017-2021) Support 90% of diagnosed PLWH in Houston/Harris County to achieve viral suppression

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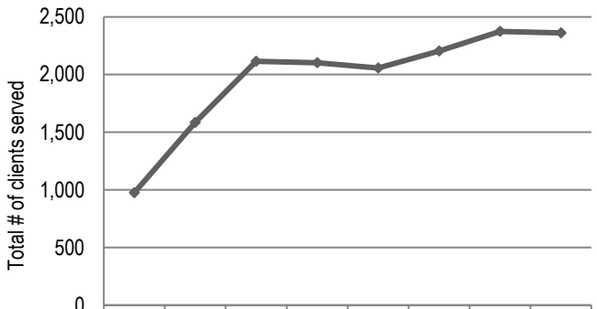
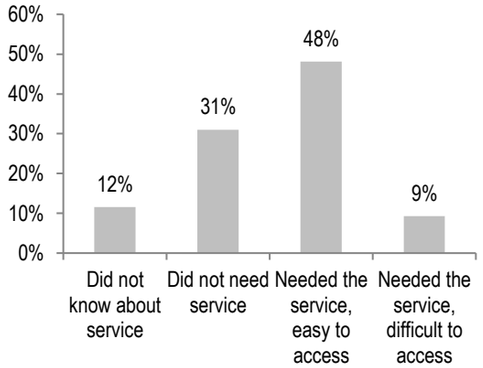
Service	Allocation	Client Utilization	Outcomes	Needs Assessment Data	National, State, and Local Priorities
Health Insurance Premium and Cost Sharing Assistance	Part A: FY99: $0 FY00: $75,917 FY01: $50,917 FY02: $51,295 FY03: $81,303 FY04: $82,151 FY05: $177,852 FY06: $200,000 FY07: $400,000 FY08: $1,238,590 FY09: $573,135 FY10: $573,135 Part B/SS: FY11: $1,356,658 FY12: $1,406,658 FY13: $1,578,402 FY14: $2,068,402 Part A/B/SS: FY15: $3,442,297 FY16: $3,049,619 FY17: $3,049,619 FY18: $2,951,969 FY19: $3,210,400 FY20: $3,376,569 Source: FY 2020 Allocations - Level Funding Scenario Based - Approved 07/11/19	 CY13 CY14 CY15 CY16 CY17 CY18 CY19 CY20 HIA 975 1,584 2,116 2,102 2,057 2,203 2,374 2361 Source: RWGA and The Resource Group, 4/8/21	• 81% of health insurance assistance clients were virally suppressed Source: RWGA FY 2018 Highlights from Performance Measures	Needs Assessment Rankings: Health Insurance Assistance (HIA) was defined as: *"this is when you have private health insurance or Medicare and you get help paying for your co-pays, deductibles, or premiums for medications or medical visits"* in the 2020 Needs Assessment. Results as defined are below:  • 57% of respondents reported a need for HIA, placing this service as the 7th highest need. • The most common barriers reported were eligibility and financial issues (each 23% of all reported barriers to this service). • White PLWH and PLWH age 18 to 24 reported the least difficulty accessing HIA • Transgender, homeless, MSM and rural PLWH reported more difficulty accessing HIA than the sample as a whole. Sources: 2020 Houston Area HIV Needs Assessment.	This service aligns with the following goals: EHE • Treat HIV rapidly and effectively to achieve sustained viral suppression NHAS • ↑ diagnosed PLWH retained in HIV medical care to at least 90%. • ↑ virally suppressed diagnosed PLWH to least 80%. HIV Care Continuum • ↑ percentage of diagnosed PLWH retained in HIV care The Texas HIV Plan (2017-2021): • ↑ continuous participation in systems of care and treatment • ↑ viral suppression Achieving Together Plan (Texas, by 2030): • ↑ diagnosed PLWH on ART to 90% • ↑ diagnosed PLWH on ART who are virally suppressed to 90% Comprehensive HIV Plan (2017-2021): • ↑ RW clients in continuous HIV care to ≥ 90% • ↑ PLWH who are retained in care to ≥ 90%. • ↑ RW clients who are virally suppressed to ≥ 90% • ↑ who are virally suppressed ≥80% END Plan (2017-2021) • Foster 90% retention in care • Support 90% of diagnosed PLWH in Houston/Harris County to achieve viral suppression

FY2021 HTBMN - Service Category Information Summary – Part A, MAI, Part B, SS

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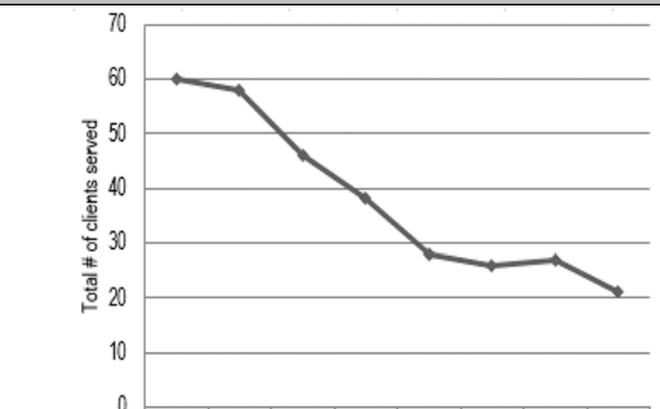
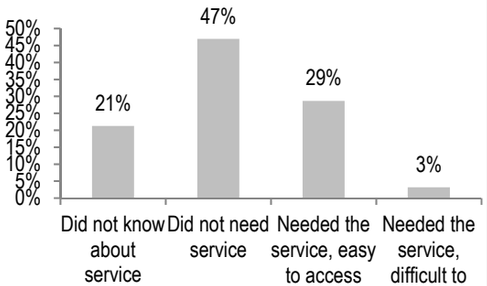
Service	Allocation	Client Utilization	Outcomes	Needs Assessment Data	National, State, and Local Priorities
Home & Community-Based Health Services (Adult Day Treatment)	Part A: FY99: $0 FY00: $0 FY01: $0 FY02: $0 FY03: $83,577 FY04: $60,588 FY05: $72,289 FY06: $72,000 FY07: $72,000 FY08: $222,000 FY09:$148,972 Part B: FY10: $242,000 FY11: $232,000 FY12: $242,000 FY13: $232,000 FY14: $232,000 FY15: $232,000 FY16: $232,000 FY17: $232,000 FY18: $203,315 FY19: $113,315 FY20: $113,315 Source: FY 2020 Allocations - Level Funding Scenario Based - Approved 07/11/19	 CY13 CY14 CY15 CY16 CY17 CY18 CY19 CY20 Adult Day 60 58 46 38 28 26 27 21 Source: The Resource Group, 4/8/21	• 82% of clients records reviewed for Home & Community Based Health Services (Adult Day Treatment) had documentation of a care plan completed • 90% of client records reviewed had an evaluation of client's health, psychosocial status, functional status, and home environment • A nursing/medical record assessment was not conducted Source: TRG 2019 Chart Review Report	Needs Assessment Rankings: Home & Community Based Health Services (Adult Day Treatment) was surveyed as "*Day Treatment,*" defined as: "*this is a place you go during the day for help with your HIV medical care from a nurse or PA. It is not a place you live*" in the 2020 Needs Assessment. Results as defined are below:  • 32% of respondents reported a need for Home & Community Based Health Services (Adult Day Treatment), placing this service as the 4th lowest ranked need. • The most common barrier reported was education and awareness (25% of all reported barriers to this service). • Females, other/multiracial PLWH, and PLWH age 18 to 24 reported the least difficulty accessing Home & Community Based Health Services (Adult Day Treatment). • Transgender and homeless PLWH reported more difficulty accessing Home & Community Based Health Services (Adult Day Treatment) than the sample as whole Source: 2020 Houston Area HIV Needs Assessment	This service aligns with the following goals: EHE • Treat HIV rapidly and effectively to achieve sustained viral suppression NHAS • ↑ diagnosed PLWH retained in HIV medical care to at least 90%. • ↑ virally suppressed diagnosed PLWH to least 80%. HIV Care Continuum • ↑ percentage of diagnosed PLWH retained in HIV care • ↑ percentage of diagnosed PLWH with a suppressed viral load The Texas HIV Plan (2017-2021): • ↑ viral suppression Increase continuous participation in systems of care and treatment • ↑ viral suppression Achieving Together Plan (Texas, by 2030): • ↑ diagnosed PLWH on ART to 90% • ↑ diagnosed PLWH on ART who are virally suppressed to 90% Comprehensive HIV Plan (2017-2021): • ↑ RW clients in continuous HIV care to ≥ 90% • ↑ PLWH retained in care to ≥ 90%. • ↑ RW clients who are virally suppressed to ≥ 90% • ↑ PLWH who are virally suppressed ≥80% END Plan (2017-2021) • Foster 90% retention in care • Support 90% of diagnosed PLWH in Houston/Harris County to achieve viral suppression

FY2021 HTBMN - Service Category Information Summary – Part A, MAI, Part B, SS

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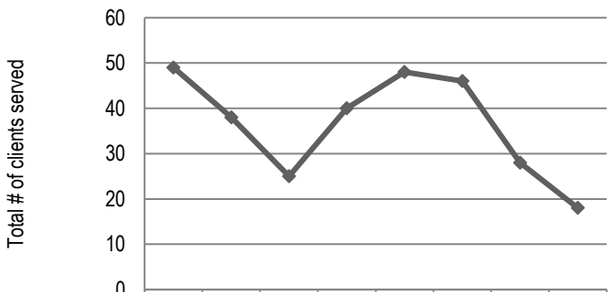
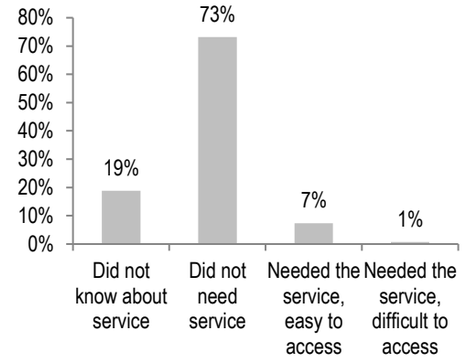
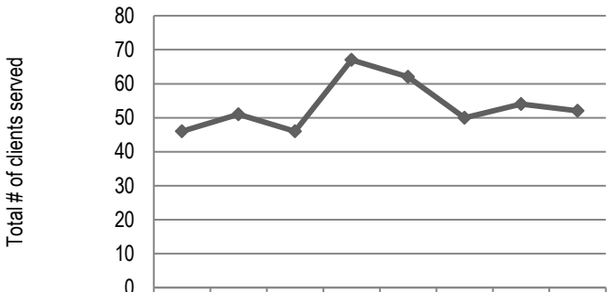
Service	Allocation	Client Utilization	Outcomes	Needs Assessment Data	National, State, and Local Priorities
Hospice	Part A: FY99: $123,530 FY00: $147,889 FY01: $166,678 FY02: $167,914 FY03: $190,553 FY04: $203,039 FY05: $264,643 FY06: $283,600 FY07: $283,600 FY08: $422,915 Part A/SS: FY09: $422,915 FY10: $422,915 FY11: $419,916 FY12: $416,326 SS: FY13: $414,832 FY14: $414,832 FY15: $414,832 FY16: $414,832 FY17: $414,832 FY18: $359,832 FY19: $259,832 FY20: $259,832 Source: FY 2020 Allocations - Level Funding Scenario Based - Approved 07/11/19	 CY13 CY14 CY15 CY16 CY17 CY18 CY19 CY20 Hospice 49 38 25 40 48 46 28 18 Source: The Resource Group, 4/3/20	• According to chart review, 100% of clients receiving Hospice services had a documented multidisciplinary care plan with monthly updates. • 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. Source: TRG 2019 Chart Review Report	Needs Assessment Rankings: Hospice was defined as: "*a program for people in a terminal stage of illness to get end-of-life care*" in the 2020 Needs Assessment. Results as defined are below:  • Hospice care is not a ranked service, as historically those receiving or are in greatest need of hospice care are not representatively sampled. • The most common barrier reported was education and awareness and transportation issues. • Females, White, Hispanic/Latinx, and other/multiracial PLWH, and PLWH age 50+ reported the least difficulty accessing Hospice care. • MSM reported greater difficulty accessing Hospice care than the sample as a whole. Source: 2020 Houston Area HIV Needs Assessment	This service aligns with the following goals: EHE • Treat HIV rapidly and effectively to achieve sustained viral suppression NHAS • ↑ diagnosed PLWH retained in HIV medical care to at least 90%. • ↑ virally suppressed diagnosed PLWH to least 80%. HIV Care Continuum • ↑ percentage of diagnosed PLWH retained in HIV care The Texas HIV Plan (2017-2021): • ↑ continuous participation in systems of care and treatment • ↑ viral suppression Comprehensive HIV Plan (2017-2021): • ↑ RW clients in continuous HIV care to ≥ 90% • ↑ PLWH retained in care to ≥ 90%. The following Special Populations are also specifically addressed by this service: • Homeless • PWIDU END Plan (2017-2021) • Foster 90% retention in care • Support 90% of diagnosed PLWH in Houston/Harris County to achieve viral suppression

FY2021 HTBMN - Service Category Information Summary – Part A, MAI, Part B, SS

Last Updated: 4/13/21

Service	Allocation	Client Utilization	Outcomes	Needs Assessment Data	National, State, and Local Priorities
Linguistic Services	SS: FY09: $28,000 FY10: $28,000 FY11: $28,000 FY12: $28,000 FY13: $35,000 FY14: $35,000 FY15: $35,000 FY16: $48,000 FY17: $48,000 FY18: $68,000 FY19: $68,000 FY20: $68,000 Source: FY 2020 Allocations - Level Funding Scenario Based - Approved 07/11/19	 CY13 CY14 CY15 CY16 CY17 CY18 CY19 CY20 Linguistic 46 51 46 67 62 50 54 52 Source: The Resource Group, 4/8/21	Linguistics outcome data are not available for this service category at this time. However, utilization data for CY19 show that: • 54% of Linguistics clients were African American / African origin • 31% were Asian American / Asian origin	Needs Assessment Rankings: Linguistic Services are provided to *non*-Spanish-speaking monolingual RW clients. However, needs assessment surveys are conducted in English and Spanish only; therefore, the need for Linguistic Services *as designed* may not be fully known. For this reason, Linguistic Services is not assigned a need ranking.	This service aligns with the following goals: EHE • Treat HIV rapidly and effectively to achieve sustained viral suppression National HIV/AIDS Strategy (NHAS) Updated for 2020 (2015) • ↑ diagnosed PLWH retained in HIV medical care to at least 90%. • ↑ virally suppressed diagnosed PLWH to least 80%. HIV Care Continuum • ↑ percentage of diagnosed PLWH retained in HIV care The Texas HIV Plan (2017-2021): • ↑ continuous participation in systems of care and treatment Achieving Together Plan (Texas, by 2030): • ↑ diagnosed PLWH on ART to 90% Comprehensive HIV Plan (2017-2021): • ↑ newly diagnosed individuals linked to care w/in 1 month diagnosis to ≥85% • ↓ new HIV diagnoses with an HIV stage 3 (AIDS) diagnosis w/in 1 year by 25% • ↑ clients in continuous HIV care to ≥ 90% • ↑ PLWH who are retained in care to ≥ 90%. END Plan (2017-2021) • Foster 90% retention in care

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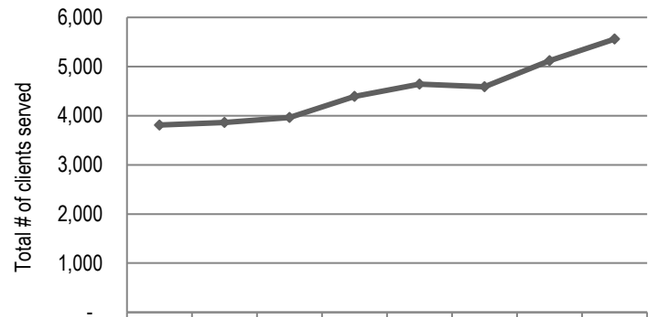
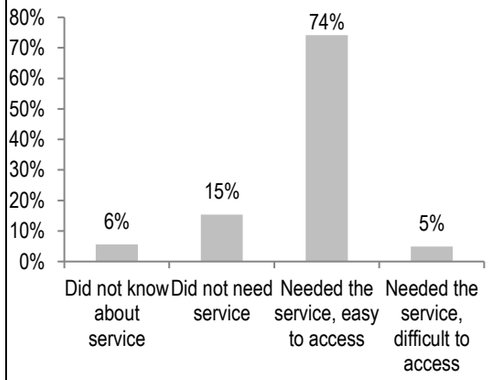
Service	Allocation	Client Utilization	Outcomes	Needs Assessment Data	National, State, and Local Priorities
Local Pharmacy Assistance Program (LPAP)	Part A: FY99: $1,414,401 FY00: $1,545,043 FY01: $2,130,863 FY02: $2,014,178 FY03: $2,280,942 FY04: $2,862,518 FY05: $3,038,662 FY06: $2,496,000 FY07: $2.424,450 FY08: $3,288,420 FY09: $3,552,061 FY10: $3,452,061 FY11: $3,679,361 FY12: $3,582,046 FY13: $2,793,717 FY14: $2,544,176 FY15: $2,219,276 FY16: $2,581,440 FY17: $2,384,796 FY18: $1,934,796 FY19: $2,657,166 FY20: $3,157,166 Source: FY 2020 Allocations - Level Funding Scenario Based - Approved 07/11/19	 CY13 CY14 CY15 CY16 CY17 CY18 CY19 CY20 LPAP 3,811 3,863 3,961 4,392 4,641 4,591 5,119 5,559 Source: RWGA, 4/6/21	• 79% of LPAP clients were virally suppressed Source: RWGA FY 2019 Highlights from Performance Measures	Needs Assessment Rankings: HIV Medication Assistance (LPAP and EFA) was defined as: "*help paying for HIV medications in addition to or instead of assistance from the state/ADAP"* in the 2020 Needs Assessment. Results as defined are below. Results as defined are below:  • 79% of respondents reported a need for LPAP, placing this service as the 2nd highest ranked need. • The most common barrier reported was eligibility issues (25% of all reported barriers to this service). • Males, white PLWH, and PLWH age 50+ reported the least difficulty accessing LPAP. • Homeless, MSM, rural, and transgender PLWH reported the more difficulty accessing LPAP than the sample as a whole. See also: EFA Source: 2020 Houston Area HIV Needs Assessment.	This service aligns with the following goals: EHE • Treat HIV rapidly and effectively to achieve sustained viral suppression NHAS • ↑ diagnosed PLWH retained in HIV medical care to at least 90%. • ↑ virally suppressed diagnosed PLWH to least 80%. HIV Care Continuum • ↑ percentage of diagnosed PLWH with a suppressed viral load The Texas HIV Plan (2017-2021): • ↑ continuous participation in systems of care and treatment • ↑ viral suppression Achieving Together Plan (Texas, by 2030): • ↑ diagnosed PLWH on ART to 90% • ↑ diagnosed PLWH on ART who are virally suppressed to 90% • ↓ annual new diagnoses by 50% Comprehensive HIV Plan (2017-2021): • ↓new HIV diagnoses with an HIV Stage 3 diagnosis w/in 1 year by 25% • ↓ new HIV diagnoses with an HIV stage 3 diagnosis w/in 1 year among Hispanic and Latino men age 35+ by 25% • ↑ RW clients who are virally suppressed to ≥ 90% • ↑ PLWH who are virally suppressed ≥80% END Plan (2017-2021) • Foster 90% retention in care • Support 90% of diagnosed PLWH in Houston/Harris County to achieve viral suppression

FY2021 HTBMN - Service Category Information Summary – Part A, MAI, Part B, SS

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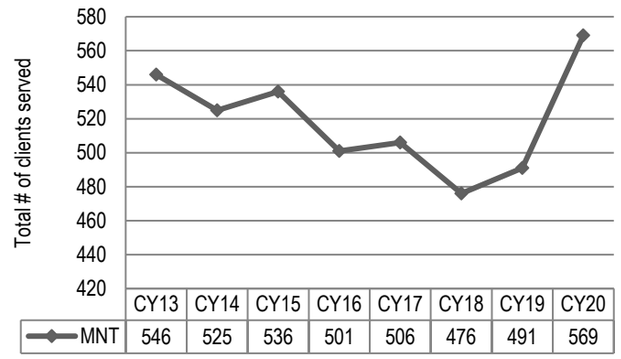
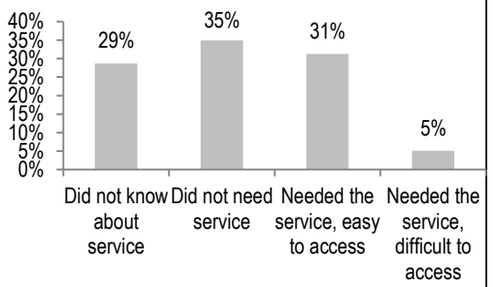
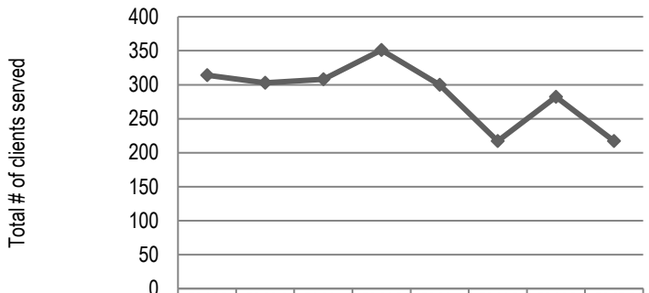
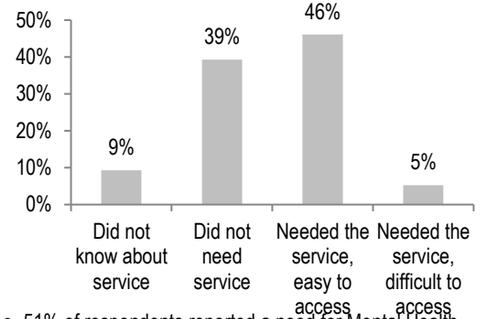
Service	Allocation	Client Utilization	Outcomes	Needs Assessment Data	National, State, and Local Priorities
Medical Nutritional Therapy (MNT) (incl. nutritional supplements)	Part A: FY07:$144,148 FY08:$301,325 Part A/B: FY09: $301,325 FY10: $301,325 Part A: FY11: $351,285 FY12: $341,994 FY13: $341,994 FY14: $341,395 FY15: $341,395 FY16: $341,395 FY17: $341,395 FY18: $341,395 FY19: $341,395 FY20: $341,395 Source: FY 2020 Allocations - Level Funding Scenario Based - Approved 07/11/19	 CY13 CY14 CY15 CY16 CY17 CY18 CY19 CY20 MNT 546 525 536 501 506 476 491 569 Source: RWGA, 4/6/21	• 50% of medical nutritional therapy clients with wasting syndrome or suboptimal body mass improved or maintained their body mass index • 81% of medical nutritional therapy clients were virally suppressed Source: RWGA FY 2019 Highlights from Performance Measures	Needs Assessment Rankings:[a] Medical Nutrition Therapy was surveyed as "*Nutritional Supplements,"* defined as: "*like Ensure, fish oil, protein powder, etc., and/or nutritional counseling from a professional dietician"* in the 2020 Needs Assessment. Results as defined are below:  • 36% of respondents reported a need for Medical Nutrition Therapy, placing this service as the 5th lowest ranked need. • The most common barrier reported was education and awareness (35% of all reported barriers to this service). • Females, Hispanic/Latinx PLWH, and PLWH age 18 to 24 reported the least difficulty accessing Medical Nutrition Therapy. • Homeless PLWH reported more difficulty accessing Medical Nutrition Therapy than the sample as a whole. Source: 2020 Houston Area HIV Needs Assessment.	This service aligns with the following goals: EHE • Treat HIV rapidly and effectively to achieve sustained viral suppression NHAS • ↑ diagnosed PLWH retained in HIV medical care to at least 90%. • ↑ virally suppressed diagnosed PLWH to least 80%. HIV Care Continuum • ↑ percentage of diagnosed PLWH with a suppressed viral load The Texas HIV Plan (2017-2021): • ↑ continuous participation in systems of care and treatment • ↑ viral suppression Achieving Together Plan (Texas, by 2030): • ↑ diagnosed PLWH on ART to 90% • ↑ diagnosed PLWH on ART who are virally suppressed to 90% Comprehensive HIV Plan (2017-2021): • ↑ RW clients who are virally suppressed to ≥ 90% • ↑ PLWH who are virally suppressed ≥80% END Plan (2017-2021) • Foster 90% retention in care • Support 90% of diagnosed PLWH in Houston/Harris County to achieve viral suppression

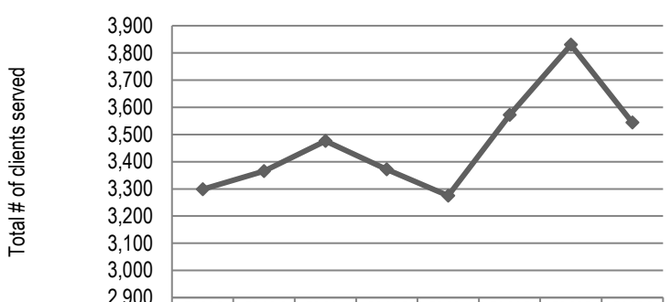
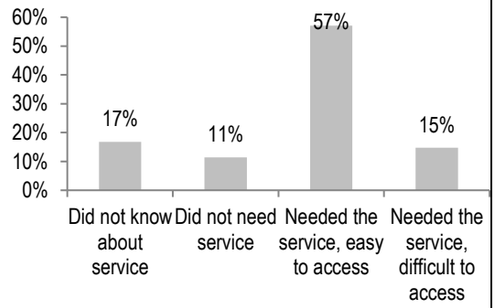
FY2021 HTBMN - Service Category Information Summary – Part A, MAI, Part B, SS

Last Updated: 4/13/21

Service	Allocation	Client Utilization	Outcomes	Needs Assessment Data	National, State, and Local Priorities
Mental Health (Professional Counseling)	Part A: FY99: $774,176 FY00: $445,344 FY01: $329,112 FY02: $174,719 FY03: $268,764 FY04: $194,834 FY05: $224,000 FY06: $234,000 FY07: $214,000 FY08: $365,798 SS: FY09: $252,200 FY10: $252,200 FY11: $252,200 FY12: $252,200 FY13: $252,200 FY14: $252,200 FY15: $300,000 FY16: $300,000 FY17: $300,000 FY18: $300,000 FY19: $300,000 FY20: $300,000 Source: FY 2020 Allocations - Level Funding Scenario Based - Approved 07/11/19	 CY13 CY14 CY15 CY16 CY17 CY18 CY19 CY20 Ment Health 314 303 308 351 300 217 282 217 Source: The Resource Group, 4/8/21	• By the third appointment, all clients had a psychosocial assessment with all elements of the Mental Health SOC and a treatment plan. • Progress notes were completed for each counseling session. • 96% of clients had treatment plans reviewed and/or modified at least every 90 days. • 100% of charts reviewed contained evidence of appropriate coordination across all medical care team members Source: TRG 2019 Chart Review Report	Needs Assessment Rankings: Mental Health was surveyed as "*Professional Mental Health Counseling,"* defined as: "*by a licensed professional counselor or therapist either individually or as part of a therapy group"* in the 2020 Needs Assessment. Results as defined are below:  • 51% of respondents reported a need for Mental Health services, placing it as the 7th lowest ranked need. • The most common barrier reported were administrative and education and awareness issues (22% of all reported barriers, respectively). • Males, Hispanic/Latinx PLWH, and PLWH age 18 to 24 reported the least difficulty accessing Mental Health services • Recently released, rural, and homeless PLWH reported more difficulty accessing Mental Health Services than the sample as a whole Source: 2020 Houston Area HIV Needs Assessment	This service aligns with the following goals: EHE • Treat HIV rapidly and effectively to achieve sustained viral suppression NHAS • ↑ diagnosed PLWH retained in HIV medical care to at least 90%. • ↑ virally suppressed diagnosed PLWH to least 80%. HIV Care Continuum • ↑ percentage of diagnosed PLWH retained in HIV care The Texas HIV Plan (2017-2021): • ↑ continuous participation in systems of care and treatment • ↑ viral suppression Focus on Addressing mental health, substance use, housing and criminal justice from Achieving Together Plan (Texas, by 2030): • ↑ access to mental health services and substance use disorder treatment. • Promote a recovery model for mental health disorders, including broadening the base of trained mental health recovery coaches. • Establish collaborations between HIV organizations and mental health providers. •Adopt models for co-location of services. Comprehensive HIV Plan (2017-2021): • ↑ RW clients in continuous HIV care to ≥ 90% • ↑ PLWH who are retained in care to ≥ 90%. END Plan (2017-2021) • Foster 90% retention in care • Support 90% of diagnosed PLWH in Houston/Harris County to achieve viral suppression

FY2021 HTBMN - Service Category Information Summary – Part A, MAI, Part B, SS

Last Updated: 4/13/21

Service	Allocation	Client Utilization	Outcomes	Needs Assessment Data	National, State, and Local Priorities
Oral Health (Untargeted & Rural)	Part A: FY99: $722,299 FY00: $620,240 FY01: $772,480 FY02: $776,585 FY03: $903,017 FY04: $884,176 FY05: $1,014,124 FY06: $1,060,000 FY07: $1,060,000 FY08: $1,455,678 Part A/B: FY09: $1,550,678 FY10: $1,700,325 FY11: $1,835,346 FY12: $2,146,063 FY13: $1,951,776 FY14: $1,951,546 FY15: $2,083,999 FY16: $2,286,750 FY17: $2,536,750 FY18: $2,251,969 FY19: $2,353,309 FY20:$2,377,809 Source: FY 2020 Allocations - Level Funding Scenario Based - Approved 07/11/19	 CY13 CY14 CY15 CY16 CY17 CY18 CY19 CY20 Oral Health 3,298 3,365 3,476 3,372 3,275 3,572 3,830 3,544 Source: RWGA and The Resource Group, 4/8/21	Untargeted: [a] • According to client charts reviewed for untargeted oral health services, 99% had chart evidence for vital signs assessment at initial visit, 99% had updated health histories in their chart, 89% had a signed dental treatment plan established or updated within the last year, and 75% had chart evidence of receipt of oral health education including smoking cessation. Rural: [b] • According to client charts reviewed for rural oral health services, 100% of client charts had evidence of viatal signs assessment, 92% had evidence of hard and soft tissue examinations, 94% had evidence of receipt of periodontal screening, and 99% had evidence of oral health education. Source: [a] TRG 2019 Chart Review Report [b] RWGA Oral Health Care – Rural Target Chart Review FY 2019	Needs Assessment Rankings: Oral Health was defined as: "*Oral health care visits with a dentist or hygienist,"* in the 2020 Needs Assessment. Results as defined are below:  • 72% of respondents reported a need for Oral Health services, placing this service as the 4th highest ranked need. • The most common barrier reported was wait-related issues (22% of all reported barriers to this service). • Males, Hispanic/Latinx PLWH, and PLWH age 18 to 24 reported the least difficulty accessing Oral Health services. • Out of care, recently released, and MSM PLWH reported more difficulty accessing Oral Health Services than the sample as a whole. Source: 2020 Houston Area HIV Needs Assessment.	This service aligns with the following goals: EHE • Treat HIV rapidly and effectively to achieve sustained viral suppression NHAS • ↑ diagnosed PLWH retained in HIV medical care to at least 90%. • ↑ virally suppressed diagnosed PLWH to least 80%. HIV Care Continuum • ↑ percentage of diagnosed PLWH retained in HIV care The Texas HIV Plan (2017-2021): • ↑ continuous participation in systems of care and treatment Comprehensive HIV Plan (2017-2021): • ↑RW clients in continuous HIV care to ≥ 90% • ↑ PLWH who are retained in care to ≥ 90%. END Plan (2017-2021) • Reach 90% retention in care • Support 90% of diagnosed PLWH in Houston/Harris County to achieve viral suppression

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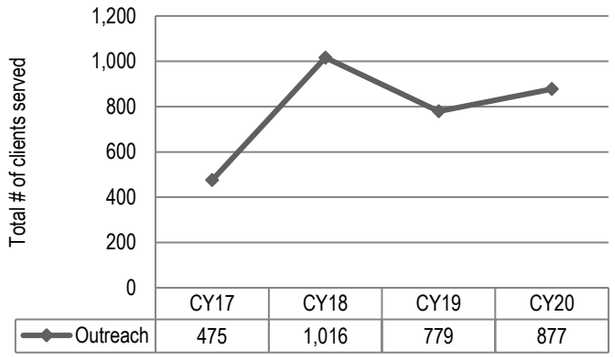
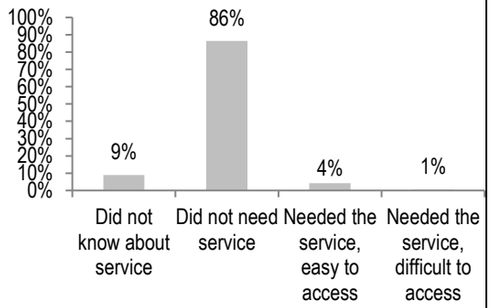
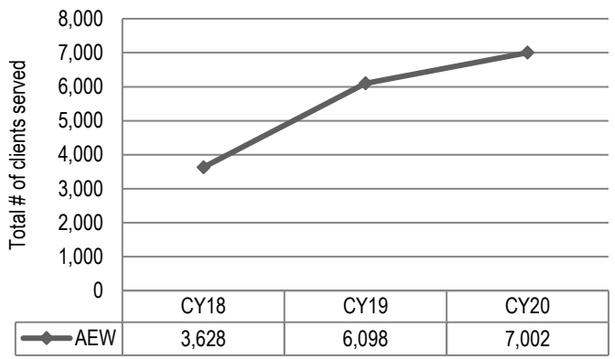
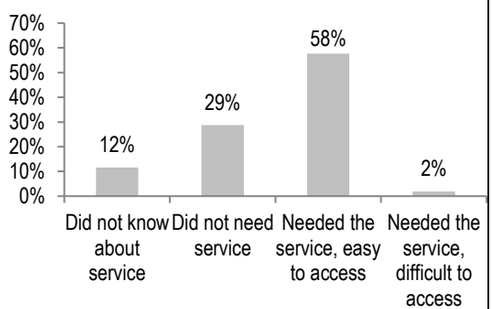
Last Updated: 4/13/21

Service	Allocation	Client Utilization	Outcomes	Needs Assessment Data	National, State, and Local Priorities
Outreach Services	Part A: FY17: $490,000 FY18: $420,000 FY19: $420,000 FY20: $420,000 Source: FY 2020 Allocations - Level Funding Scenario Based - Approved 07/11/19	 CY17 CY18 CY19 CY20 Outreach 475 1,016 779 877 Source: RWGA, 4/6/21	• 34% of outreach clients accessed primary care within three months of their first outreach visit • 66% of clients moved from unsuppressed to suppressed viral load status within three months of their first outreach visit Source: RWGA FY 2019 Highlights from Performance Measures	Needs Assessment Rankings: Outreach Service workers were defined as: "*people at your clinic or program who contact you to help you get HIV medical care when you have a couple of missed appointments"* in the 2020 Needs Assessment. Results as defined are below:  • 5% of respondents reported a need for Outreach Services, placing this service as the lowest ranked need. • The most common barrier reported was interactions with staff (71% of all reported barriers to this service). • Males, Black/African American and Hispanic/Latinx PLWH, and PLWH age 18 to 24 reported the least difficulty accessing Outreach Services. • Homeless, MSM, recently released, and transgender PLWH reported more difficulty accessing Outreach Services than the sample as a whole. Source: 2020 Houston Area HIV Needs Assessment.	This service aligns with the following goals: EHE • Treat HIV rapidly and effectively to achieve sustained viral suppression NHAS • ↑ diagnosed PLWH retained in HIV medical care to at least 90%. • ↑ virally suppressed diagnosed PLWH to least 80%. HIV Care Continuum • ↑ percentage of diagnosed PLWH retained in HIV care • ↑ percentage of diagnosed PLWH with a suppressed viral load The Texas HIV Plan (2017-2021): • ↑ continuous participation in systems of care and treatment • ↑ viral suppression Achieving Together Plan (Texas, by 2030): • ↑ diagnosed PLWH on ART to 90% • ↑ diagnosed PLWH on ART who are virally suppressed to 90% Comprehensive HIV Plan (2017-2021): • ↑ clients in continuous HIV care to ≥ 90% • ↑ PLWH who are retained in care to ≥ 90%. • ↑ RW clients who are virally suppressed to ≥ 90% • ↑ PLWH who are virally suppressed ≥80% END Plan (2017-2021) • Reach 90% retention in care • Support 90% of diagnosed PLWH in Houston/Harris County to achieve viral suppression

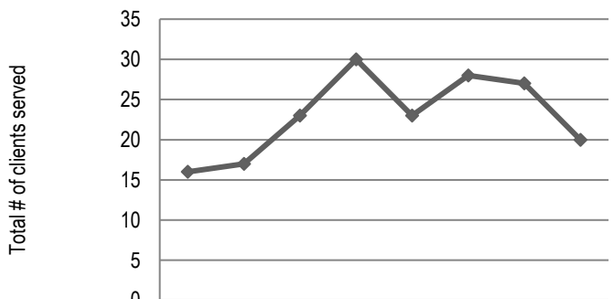
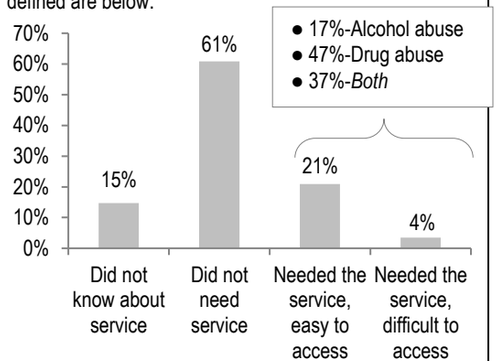
FY2021 HTBMN - Service Category Information Summary – Part A, MAI, Part B, SS

Last Updated: 4/13/21

Service	Allocation	Client Utilization	Outcomes	Needs Assessment Data	National, State, and Local Priorities
Referral for Health Care & Support Services (ADAP Enrollment Workers)	SS-R: FY18: $375,000 FY19: $375,000 FY20: $375,000 Source: FY 2020 Allocations - Level Funding Scenario Based - Approved 07/11/19	 CY18 CY19 CY20 AEW 3,628 6,098 7,002 Source: The Resource Group, 4/8/21	• 59% of AEW client had charts documented evidence of benefit applications completed as appropriate within two weeks the eligibility determination date • 59% had evidence of assistance provided to access health insurance or Marketplace plans • 73% had evidence of completed secondary reviews of ADAP applications before submission to THMP Source: TRG 2019 Chart Review Report	Needs Assessment Rankings: ADAP Enrollment Workers (AEW) were defined as: "*people at your clinic or program who help you complete an application for ADAP medication assistance from the state"* in the 2020 Needs Assessment. Results as defined are below:  • 60% of respondents reported a need for AEW services, placing this service as the lowest ranked need. • The most common barrier reported was education and awareness (30% of all reported barriers to this service). • Females, Hispanic/Latinx, and PLWH age 18 to 24 reported the least difficulty accessing AEW. • Out of care, rural, and homeless PLWH reported more difficulty accessing Outreach Services than the sample as a whole. Source: 2020 Houston Area HIV Needs Assessment.	This service aligns with the following goals: EHE • Treat HIV rapidly and effectively to achieve sustained viral suppression NHAS • ↑ virally suppressed diagnosed PLWH to least 80%. Early Identification of Individuals with HIV/AIDS (EIIHA) • Refer and link newly diagnosed PLWH to medical care and services HIV Care Continuum • ↑ percentage of diagnosed PLWH on antiretroviral therapy (ART), retained in HIV care, and virally suppressed The Texas HIV Plan (2017-2021): • ↑ timely linkage to HIV-related care and treatment • ↑ viral suppression Achieving Together Plan (Texas, by 2030): • ↑ diagnosed PLWH on ART to 90% • ↑ diagnosed PLWH on ART who are virally suppressed to 90% Comprehensive HIV Plan (2017-2021): • ↑ RW clients who are virally suppressed to ≥ 90% • ↑ PLWH who are virally suppressed ≥80% END Plan (2017-2021) • Support 90% of diagnosed PLWH in Houston/Harris County to achieve viral suppression

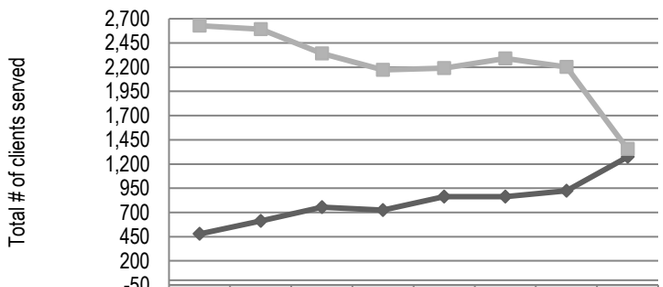
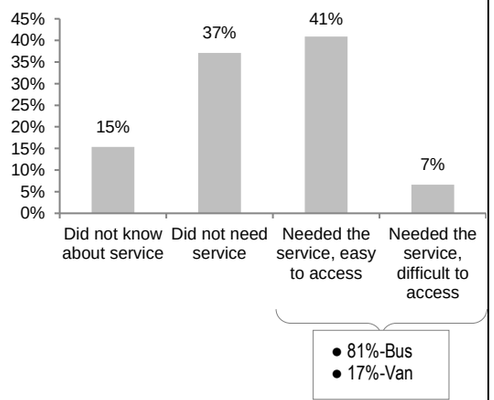
FY2021 HTBMN - Service Category Information Summary – Part A, MAI, Part B, SS

Last Updated: 4/13/21

Service	Allocation	Client Utilization	Outcomes	Needs Assessment Data	National, State, and Local Priorities
Substance Abuse Treatment	Part A: FY99: $247,077 FY00: $207,639 FY01: $41,368 FY02: $56,786 FY03: $59,110 FY04: $85,745 FY05: $42,850 FY06: $45,000 FY07: $35,000 FY08: $25,051 FY09: $66,051 FY10: $72,000 FY11: $47,000 FY12: $45,757 FY13: $45,757 FY14: $45,677 FY15: $45,677 FY16: $45,677 FY17: $45,677 FY18: $45,677 FY19: $45,677 FY20: $45,677 Source: FY 2020 Allocations - Level Funding Scenario Based - Approved 07/11/19	 CY13 CY14 CY15 CY16 CY17 CY18 CY19 CY20 Sub Abuse 16 17 23 30 23 28 27 20 Source: RWGA, 4/3/20	• 50% of substance abuse treatment services clients completed a treatment program during the reporting period. • Following receipt of substance abuse treatment services, 71% of clients accessed HIV primary at least once and 83% were virally suppressed. Source: RWGA FY 2019 Highlights from Performance Measures	Needs Assessment Rankings: Substance Abuse Treatment was surveyed as "*alcohol or drug abuse treatment or counseling (in an outpatient setting only)*" in the 2020 Needs Assessment. Results as defined are below:  • 24% of respondents reported a need for Substance Abuse Treatment, placing this service as the 3rd lowest ranked need. • The most common barrier reported was education and awareness (46% of all reported barriers to this service). • Females, other/multiracial PLWH, and PLWH age 50+ reported the least difficulty accessing Substance Abuse Treatment • Recently released and homeless PLWH reported more difficulty accessing Substance Abuse Treatment than the sample as a whole Source: 2020 Houston Area HIV Needs Assessment.	This service aligns with the following goals: EHE • Treat HIV rapidly and effectively to achieve sustained viral suppression NHAS • ↑ diagnosed PLWH retained in HIV medical care to at least 90%. • ↑ virally suppressed diagnosed PLWH to least 80%. HIV Care Continuum • ↑ percentage of diagnosed PLWH retained in HIV care The Texas HIV Plan (2017-2021): • ↑ continuous participation in systems of care and treatment • ↑ viral suppression Focus on Addressing mental health, substance use, housing and criminal justice from Achieving Together Plan (Texas, by 2030): • ↑ access to mental health services and substance use disorder treatment. • Promote a recovery model for substance use disorders, including broadening the base of trained substance use recovery coaches. Comprehensive HIV Plan (2017-2021): • ↑ RW clients in continuous HIV care to ≥ 90% • ↑ PLWH who are retained in care to ≥ 90%. The following Special Populations are also specifically addressed by this service: • PWIDU END Plan (2017-2021) • Foster 90% retention in care • Support 90% of diagnosed PLWH in Houston/Harris County to achieve viral suppression

FY2021 HTBMN - Service Category Information Summary – Part A, MAI, Part B, SS

Last Updated: 4/13/21

Service	Allocation	Client Utilization	Outcomes	Needs Assessment Data	National, State, and Local Priorities
Transportation (Untargeted & Rural) (Van & Bus Pass)	Part A: FY99: $580,909 FY00: $838,460 FY01: $912,947 FY02: $1,015,666 FY03: $945,743 FY04: $598,816 FY05: $570,000 FY06: $570,000 FY07: $512,000 FY08: $654,539 Part A/B: FY09: $654,539 FY10: $595,366 Part A: FY11: $625,366 FY12: $543,459 FY13: $543,459 FY14: $527,361 FY15: $527,362 FY16: $527,362 FY17: $527,362 FY18: $482,087 FY19: $424,911 FY20: $424,911 Source: FY 2020 Allocations - Level Funding Scenario Based - Approved 07/11/19	 Source: RWGA, 4/6/21	Van Based: • Following van based transportation services: 69% of clients accessed RW HIV primary care at least once and 57% accessed LPAP at least once. Bus Pass: • Following bus pass transportation services: – 78% of clients accessed a RW service of some kind at least once. – 37% accessed RW HIV primary care at least once. – 22% accessed LPAP at least once. Source: RWGA FY 2019 Highlights from Performance Measures	Needs Assessment Rankings: Transportation was defined *as "Transportation to/from your HIV medical appointments on a van or with a Metro bus card"* in the 2020 Needs Assessment. Results as defined are below:  • 48% of respondents reported a need for Transportation services, placing it as the 6th lowest ranked need. • The most common barrier reported for Transportation Services was lack of education and awareness (24% of all reported barriers to this service). • Males, Hispanic/Latino PLWH, and PLWH age 18 to 24 reported the least difficulty accessing Transportation services • Homeless, out of care, and recently released PLWH reported more difficulty accessing Transportation services than the sample as a whole. Source: 2020 Houston Area HIV Needs Assessment	This service aligns with the following goals: EHE • Treat HIV rapidly and effectively to achieve sustained viral suppression NHAS • ↑ diagnosed PLWH retained in HIV medical care to at least 90%. • ↑ virally suppressed diagnosed PLWH to least 80%. HIV Care Continuum • ↑ percentage of diagnosed PLWH retained in HIV care • ↑ percentage of diagnosed PLWH with a suppressed viral load The Texas HIV Plan (2017-2021): • ↑ continuous participation in systems of care and treatment • ↑ viral suppression Comprehensive HIV Plan (2017-2021): • ↑ newly diagnosed individuals linked to care w/in 1 month diagnosis to ≥85% • ↑ RW clients in continuous HIV care to ≥ 90% • ↑ PLWH who are retained in care to ≥ 90%. • ↑ RW clients who are virally suppressed to ≥ 90% • ↑ PLWH who are virally suppressed ≥80% END Plan (2017-2021) • Foster 90% retention in care • Support 90% of diagnosed PLWH in Houston/Harris County to achieve viral suppression

	CY13	CY14	CY15	CY16	CY17	CY18	CY19	CY20
Van Based	478	611	754	723	864	863	923	1,273
Bus Pass	2,628	2,592	2,342	2,171	2,189	2,291	2,203	1,355

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TARGETING FOR FY 2022 SERVICE CATEGORIES FOR RYAN WHITE PART A, B, MAI AND STATE SERVICES FUNDING

HIV Prevalence	AIDS Prevalence	HIV & AIDS Prevalence	Geographic Targeting	Other Targeting	N/A or No Targeting	Service Category
			X*	X**		Ambulatory/Outpatient Medical Care
			X*	X		Case Management Services - Core
				X		Case Management Services - Non-Core
				X		Early Medical Intervention
					X	Emergency Financial Assistance - Pharmacy Assistance
					X	Health Insurance
					X	Home and Community Based Services
					X	Hospice Services
					X	Linguistic Services
					X	Local Pharmacy Assistance Program
					X	Medical Nutritional Therapy
					X	Mental Health Treatment
					X	Other Professional Services
					X****	Outreach Services - Primary Care Retention in Care
			X***		X	Oral Health
					X	Referral for Health Care & Support Services - ADAP Enrollment Worker
					X	Substance Abuse Treatment
			X	X		Transportation Services
					X	Vision

* Geographic targeting in rural area only.

** In an effort to provide a base line that reflects actual client utilization, for community based organizations base this percentage on the FY 2020 final expenditures that targeted African Americans, Whites and Hispanics.

*** Geographic targeting in the north only.

**** Pay particular attention to youth who are transitioning into adult care.

Houston Area HIV Services Ryan White Planning Council
Assessment of the Local Ryan White HIV/AIDS Program Administrative Mechanism
Assessment Checklist

(Quality Improvement Committee approved 05/07/20)

Background

The Ryan White CARE Act requires local Planning Councils to "[a]ssess the efficiency of the administrative mechanism in rapidly allocating funds to the areas of greatest need within the eligible area" (Ryan White Part A [formerly Title I] *Manual*, Section V, Chapter 1, Page 4). To meet this mandate, a time-specific documented observation of the local procurement, expenditure, and reimbursement process for Ryan White funds is conducted by the local Planning Councils (*Manual*, Section VI, Chapter 1, Page 7). The observation process is not intended to evaluate either the local administrative agencies for Ryan White funds or the individual service providers funded by Ryan White (*Manual*, Section VI, Chapter 1, Page 8). Instead, it produces information about the procurement, expenditure, and reimbursement process for the local *system* of Ryan White funding that can be used for overall quality improvement purposes.

Process

In the Houston eligible area, an assessment of the local administrative mechanism is performed for each Fiscal Year of Ryan White funding using a written checklist of specific data points. Taken together, the information generated by the checklist is intended to measure the overall efficacy of the local procurement, reimbursement, and contract monitoring processes of the administrative agents for (1) Ryan White Part A and Minority AIDS Initiative (MAI) funds; and (2) Ryan White Part B and State Services (SS) funds. The checklist is reviewed and approved annually by the Quality Improvement Committee of the Houston Area HIV Services Ryan White Planning Council, and application of the checklist, including data collection, review, analysis and reporting, is performed by the Ryan White Planning Council Office of Support in collaboration with the administrative agents for the funds. All data and documents reviewed in the process are publicly available.

Checklist

The checklist for the assessment of the administrative mechanism for the Houston eligible area is attached below. The following acronyms are used in the checklist:

AA:	Administrative Agent
DSHS:	Texas Department of State Health Services
FY:	Fiscal Year (The FY to be assessed for Part A, B, and MAI will be the immediate prior FY, ending February 28 [Part A and MAI] and March 31 [Part B]; the FY to be assessed for SS will be the most recent completed FY.
MAI:	Minority AIDS Initiative
MOU:	Memorandum of Understanding (between the AAs and the Planning Council)
NGA:	Notice of Grant Award
PC:	Ryan White Planning Council
RFP:	Request for Proposals
SOC:	Standards of Care
SS:	State Services

Checklist for the Assessment of the Ryan White Administrative Mechanism in the Houston Area (Quality Improvement Committee approved 05-07-20)

Intent of the Measure	Data Point to Measure	Method of Measurement	Data Source
Section I: Procurement/Request for Proposals Process			
• To assess the timeliness of the AA in authorizing contracted agencies to provide services	Time between receipt of NGA or funding contract by the AA and when contracts are executed with funded service providers	a) How much time elapsed between receipt of the NGA or funding contract by the AA and contract execution with funded service providers (i.e., 30, 60, 90 days)?	Part A/MAI: (1) NGA; and (2) Commissioner's Court Agendas Part B/SS: (1) DSHS Contract Face Sheet; and (2) Contract Tracking Sheet
• To assess the timeliness of the AA in procuring funds to contracted agencies to provide services	Time between receipt of NGA or funding contract by the AA and when funds are procured to contracted service providers	b) What percentage of the grant award was procured by the: ☐ 1st quarter? ☐ 2nd quarter? ☐ 3rd quarter?	Year-to-date and year-end FY Procurement Reports provided by AA to PC
• To assess if the AA awarded funds to service categories as designed by the PC	Comparison of the list of service categories awarded funds by the AA to the list of allocations made by the PC	c) Did the awarding of funds in specific categories match the allocations established by the PC at the: ☐ 1st quarter? ☐ 2nd quarter? ☐ 3rd quarter?	Year-to-date and year-end FY Procurement Reports provided by AA to PC Final PC Allocations Worksheet
• To assess if the AAs make potential bidders aware of the grant award process	Confirmation of communication by the AAs to potential bidders specific to the grant award process	d) Does the AA have a grant award process which: ☐ Provides bidders with information on applying for grants? ☐ Offers a bidder's conference?	RFP Courtesy Notices for Pre-Bid Conferences
• To assess if the AAs are requesting bids for service category definitions approved by the PC	Confirmation of communication by the AAs to potential bidders specific to PC products	e) Does the RFP incorporate service category definitions that are consistent with those defined by the PC?	RFP
• To assess if the AAs are procuring funds in alignment with allocations	Comparison of final amounts procured and total amounts allocated in each service category	f) At the end of the award process, were there still unobligated funds?	Year-end FY Procurement Reports provided by AA to PC
• To assess if the AAs are dispersing all available funds for services and, if not, are unspent funds within the limits allowed by the funder	Review of final spending amounts for each service category	g) At the end of the year, were there unspent funds? If so, in which service categories?	Year-end FY Procurement Reports provided by AA to PC

Checklist for the Assessment of the Ryan White Administrative Mechanism in the Houston Area (Quality Improvement Committee approved 05-07-20)

Intent of the Measure	Data Point to Measure	Method of Measurement	Data Source
Section I: Procurement/Request for Proposals Process (con't)			
• To assess if the AAs are making the PC aware of the procurement process	Confirmation of communication by the AAs to the PC specific to procurement results	h) Does the AA have a method of communicating back to the PC the results of the procurement process?	MOU PC Agendas
Section II: Reimbursement Process			
• To assess the timeliness of the AA in reimbursing contracted agencies for services provided	Time elapsed between receipt of an accurate contractor reimbursement request or invoice and the issuance of payment by the AA	a) What is the average number of days that elapsed between receipt of an accurate contractor reimbursement request or invoice and the issuance of payment by the AA? b) What percent of contractors were paid by the AA after submission of an accurate contractor reimbursement request or invoice: ☐ Within 20 days? ☐ Within 35 days? ☐ Within 50 days?	Annual Contractor Reimbursement Report
Section III: Contract Monitoring Process			
• To assess if the AA is monitoring adherence by contracted agencies to PC quality standards	Confirmation of use of adopted SOC in contract monitoring activities	a) Does the AA use the SOC as part of the contract monitoring process?	RFP Policy and Procedure for Performing Site Visits Quality Management Plan

DRAFT
2021 Quarterly Report
Quality Improvement Committee
(May 2021)

Status of Committee Goals and Responsibilities (*means mandated by HRSA)

1. Conduct the "How to Best Meet the Needs" (HTBMN) process, with particular attention to the continuum of care with respect to HRSA identified core services.

2. Develop a process for including consumer input that is proactive and consumer friendly for the Standards of Care and Performance Measures review process.

3. Continue to improve the information, processes and reporting (within the committee and also thru collaboration with other Planning Council committees) needed to:
   a. Identify "The Un-met Need";
   b. Determine "How to Best Meet the Needs";
   c. *Strengthen and improve the description and measurement of medical and health related outcomes.

4. *Identify and review the required information, processes and reporting needed to assess the "Efficiency of the Administrative Mechanism". Focus on the status of specific actions and related time-framed based information concerning the efficiency of the administrative mechanism operation in the areas of:
   a. Planning fund use (meeting RWPC identified needs, services and priorities);
   b. Allocating funds (reporting the existence/use of contract solicitation, contract award and contract monitoring processes including any time-frame related activity);
   c. Distributing funds (reporting contract/service/re-imbursement expenditures and status, as well as, reporting contract/service utilization information).

5. Annually, review the status of committee activities identified in the current Comprehensive Plan.

Status of Tasks on the Timeline:

_____ _____

Committee Chairperson Date

HOUSTON AREA HIV MEDICATION ASSISTANCE PROGRAMS

Every resource has their own eligibility and usage requirements.

Every Ryan White funded clinic has ADAP Enrollment Workers (AEW's) and Case Managers that can help with accessing all medication options.

1 HABORPATH / COMPASSIONATE CARE PROGRAM

- A non-profit that provides medications assistance.
- https://www.harborpath.org/

2 GILEAD PATIENT ASSISTANCE PROGRAM

- A Gilead program that helps individuals with their medications, regardless of insurance status.
- https://www.gileadadvancingaccess.com/

3 LOCAL PHARMACY ASSISTANCE PROGRAM (LPAP)

- An LPAP is a program to ensure that clients obtain medications when other means to get medications are unavailable or insufficient.
- Contact your local Ryan White provider.

4 EMERGENCY FINANCIAL ASSISTANCE FOR MEDICATION

- Provides short-term medication assistance to individuals with an urgent need.
- Generally used while waiting on ADAP approval or denial.
- Contact your local Ryan White provider.

5 AIDS DRUG ASSISTANCE PROGRAM (ADAP)

- Texas HIV Medication Program that provides HIV medication long term for individuals with limited or no health insurance.
- Contact your local Ryan White provider.

6 HEALTH INSURANCE ASSISTANCE

- A Ryan White funded service that helps people living with HIV pay for costs associated with public and private health insurance.
- Contact: (832) 548-5111

THE RESOURCE GROUP

Ryan White Planning Council

Harris County Public Health
Building a Healthy Community