Houston Area HIV Services Ryan White Planning Council

Office of Support
2223 West Loop South, Suite 240, Houston, Texas 77027
832 927-7926 telephone; 713 572-3740 fax
http://rwpchouston.org

MEMORANDUM

To: Steering Committee Members:
Crystal R. Starr, Chair
Skeet Boyle, Vice Chair
Josh Mica, Secretary
Rodney Mills, Co-Chair, Affected Community Committee
Diana Morgan, Co-Chair, Affected Community Committee
Allen Murray, Co-Chair, Comprehensive HIV Planning Committee
Steven Vargas, Co-Chair, Comprehensive HIV Planning Committee
Ronnie Galley, Co-Chair, Operations Committee
Cecilia Ligons, Co-Chair, Operations Committee
Bobby Cruz, Co-Chair, Priority and Allocations Committee
Peta-gay Ledbetter, Co-Chair, Priority and Allocations Committee
Tana Pradia, Co-Chair, Quality Improvement Committee
Pete Rodriguez, Co-Chair, Quality Improvement Committee

Copy: Glenn Urbach
Mauricia Chatman
Tiffany Shepherd
Patrick Martin
Mackenzie A. Hudson
Jason Black
Diane Beck
EMAIL ONLY:
Ann Robison
David Williams
Sha'Terra Johnson

From: Tori Williams

Date: Thursday, May 25, 2023

Re: Meeting Announcement

We look forward to seeing you for the following meeting:

Ryan White Steering Committee Meeting
12 noon, Thursday, June 1, 2023

Join the Zoom meeting by clicking on:
https://us02web.zoom.us/j/85782189192?pwd=YmtrcktWcHY5SlV2RE50ZzYraEErQT09
Meeting ID: 857 8218 9192 Passcode: 885832
Or, use your phone to dial in by calling 346 248-7799
Or, join us in the conference room in our old office at 2223 W. Loop South

Please contact Rod to RSVP, even if you cannot attend, and let her know if you prefer to participate virtually or in person. There is room for up to 5 people who are socially distancing in our conference room. Rod can be reached by telephone at: 832 927-7926 or by email at: Rodriga.Avila@cjo.hctx.net. Thank you!

HOUSTON AREA HIV SERVICES RYAN WHITE PLANNING COUNCIL
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STEERING COMMITTEE

AGENDA
12 noon, Thursday, June 1, 2023

Join Zoom Meeting by clicking onto:
https://us02web.zoom.us/j/85782189192?pwd=YmtrcktWcHY5SlV2RE50ZzYraEErQT09
Meeting ID: 857 8218 9192
Passcode: 885832
Or, dial in by calling 346 248-7799

I. Call to Order — Crystal R. Starr, Chair, RW Planning Council
   A. Welcoming Remarks
   B. Moment of Reflection
   C. Select the Committee Co-Chair who will be voting today
   D. Adoption of the Agenda
   E. Adoption of the Minutes

II. Public Comment and Announcements

(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 yourself, 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 Committees

A. Comprehensive HIV Planning Committee — Allen Murray and Steven Vargas, Co-Chairs

Item: 2022 Integrated HIV Prevention and Care Services Plan

Recommended Action: FYI: The Comprehensive HIV Planning Committee will start developing outcome measures for goals in the 2022 Integrated HIV Prevention and Care Services Plan. The process will start **at 2 pm**, after the Council meeting has adjourned, on **Thursday, June 8th**. All are welcome and all will be allowed to vote since this will be the start of the Evaluation Workgroup. The meeting will use the hybrid format. Check the Council website at www.rwpchouston.org for a meeting packet for the June Comprehensive HIV Planning Committee. Or, call Rod or Diane to request a packet. They can be reached at: 832 927-7926.

(continued on next page)

B. Joint Meeting of the Affected Community and Project LEAP/ Proyecto VIDA Advisory Committees — Rodney Mills and Diana Morgan, Co-Chairs

Item: 2022 Project LEAP Evaluation Report
Recommended Action: FYI: Summarize the results of the 2022 Project LEAP and VIDA Evaluation Reports. — Tori Williams and Rod Avila

Item: 2023 Project LEAP and Proyecto VIDA
Recommended Action: **Motion:** Use the same service definition and student selection guidelines in 2023 that were used in 2022.

Item: 2023 Project LEAP
Recommended Action: FYI: If the last two items are approved, 2023 Project LEAP and Proyecto VIDA will begin in August, with the students graduating shortly after Thanksgiving. They will both be taught using a hybrid format. All Ryan White volunteers are encouraged to help recruit student applicants. See the attached flyers and application forms which will be distributed at Ryan White funded clinic sites, special events and more. See the attached list of distribution sites. Please spread the word in person, virtually and more.

C. Quality Improvement Committee — Tana Pradia and Pete Rodriguez, Co-Chairs
Item: Reports from AA – Part A/MAI*
Recommended Action: FYI: See the attached reports.

Item: Reports from the Administrative Agent – Part B/SS
Recommended Action: FYI: See the attached reports.

Item: FY 2024 Service Definitions and Financial Eligibility
Recommended Action: **Motion:** Approve the attached, recommended FY 2024 Service Definitions and Financial Eligibility for the Ryan White Part A/MAI, Part B and State Services funded services. See the attached Summary of How To Best Meet the Need recommendations (neon green paper) and financial eligibility (on the Table of Contents).

Item: Targeting Chart for FY 2024 Service Categories
Recommended Action: **Motion:** Approve the attached FY 2024 Targeting Chart for the Ryan White Part A/MAI, Part B and State Services funded Service categories (neon pink paper).

D. Priority and Allocations Committee — Peta-gay Ledbetter and Bobby Cruz, Co-Chairs
Item: FY 2024 Service Priorities
Recommended Action: FYI: The Committee made recommendations regarding the FY 2024 service priorities, which will be presented to the Steering Committee and Planning Council after the public hearing in late June 2023.

Item: Ryan White FY 2024 Allocations
Recommended Action: FYI: The process for allocating FY 2024 Ryan White Part A/MAI, Part B and State Services funding will begin in early June 2023. See Rod if you wish to receive reminders.

E.	Operations Committee *Item:* Proposed Revisions to the FY 2023 PC Support Budget Recommended Action: Motion: Approve the attached, revised FY 2023 Planning Council Support Budget. *Item:* Proposed FY 2024 Council Support Budget Recommended Action: Motion: Approve the attached, FY 2024 Council Support Budget.	Ronnie Galley and Cecilia Ligons, Co-Chairs
V.	Report from the Office of Support	Tori Williams, Director
VI.	Report from Ryan White Grant Administration	Carin Martin, Manager
VII.	Report from The Resource Group	Sha'Terra Johnson, Health Planner
IX.	Announcements	
X.	Adjournment	

HOUSTON AREA HIV SERVICES RYAN WHITE PLANNING COUNCIL
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STEERING COMMITTEE

MINUTES

12 noon, Thursday, May 4, 2023
Meeting Location: Zoom teleconference

MEMBERS PRESENT	MEMBERS ABSENT	STAFF PRESENT
Crystal Starr, Chair	Rodney Mills, excused	*Ryan White Grant Administration*
Skeet Boyle, Vice Chair	Diana Morgan, excused	Glenn Urbach
Josh Mica, Secretary		Mauricia Chatman
Allen Murray		Jason Black
Steven Vargas		
Ronnie Galley		*The Resource Group*
Cecilia Ligons		Sha'Terra Johnson
Bobby Cruz		Hailey Malcolm
Peta-gay Ledbetter		
Tana Pradia	**OTHERS PRESENT**	*Office of Support*
Pete Rodriguez	Charles Henley	Tori Williams
		Mackenzie Hudson
		Diane Beck

Call to Order: Crystal Starr, Chair, called the meeting to order at 12:02 p.m. During the opening remarks, Starr said that April is usually our busiest time of year because of the How To Best Meet the Need process. She thanked the workgroup co-chairs, the co-chairs of the Quality Improvement Committee and the staff of the Office of Support and Administrative Agencies.

Additional workgroups were dedicated to learning about HIV and Aging and ways to implement some of the activities in the 2022-26 Integrated Plan. These workgroups will continue to meet since they are designed to look at a lot of information before making recommendations to the Council.

On Monday, the HIV and Aging workgroup will host Jules Levin, an HIV activist who has been a driving force behind the development of at least 3 medical clinics in New York City established specifically to meet the needs of Older Adults Living with HIV (OALH). Please attend this hybrid meeting to learn how we can prepare our community to best meet the needs of our aging population.

On Wednesday, May 24th, the Council will work with the Serving the Incarcerated and Recently Released Coalition to explore the pros and cons of distributing condoms in jails and prisons. That hybrid meeting will start at 9:30 am. Reach out to Diane if you need more information about these workgroup meetings. Starr then called for a Moment of Reflection.

Those selected to represent their committee at today's meeting are: Boyle for Affected Community, Murray for Comprehensive HIV Planning, Galley for Operations, Ledbetter for Priority and Allocations and Pradia for Quality Improvement.

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

Approval of the Minutes: ***Motion #2:*** *it was moved and seconded (Boyle, Ligons) to approve the April 6, 2023 minutes.* **Motion carried.**

Public Comment and Announcements: None.

Reports from Committees
Comprehensive HIV Planning Committee: Steven Vargas, Co-Chair, reported on the following: Most Ryan White committees, including the Comprehensive HIV Planning Committee, did not meet in April so that volunteers could attend the FY24 How To Best Meet the Need training and workgroup meetings.

Affected Community Committee: No report.

Quality Improvement Committee: No report.

Operations Committee: No report.

Priority and Allocations Committee: Bobby Cruz, Co-Chair, reported on the following:
Reallocation of FY23 Unallocated Funds*:* ***Motion #3:*** *Allocate $18,000 to increase the FY23 Ryan White Office of Support Budget to pay for a short-term lease on office and meeting space until more permanent space becomes available.* **Motion Carried**.

Reallocation of FY23 Unallocated Funds: ***Motion #4:*** *Allocate $485,889 to Emergency Financial Assistance – Pharmacy based on the high need for this service in FY22.* **Motion Carried**.

Report from Office of Support: Tori Williams, Director, summarized the attached report.

Report from Ryan White Grant Administration: Glenn Urbach, Manager, summarized the attached report.

Report from The Resource Group: Sha'Terra Johnson, Health Planner, submitted the attached report.

Announcements: Vargas asked everyone to keep his partner in your thoughts and prayers. Boyle said this Saturday Bread of Life will be giving out food and household items from 10am -12pm; go to breadoflifeinc.org for the schedule. Next week they will host their first Community Baby Shower for first time mothers, contact Bread of Life for more information. Pradia thanked everyone who participated in HIV Advocacy Day at the Capital in Austin on March 27th.

Adjournment: The meeting was adjourned at 1:07 p.m.

Submitted by: Approved by:

_____ _____
Tori Williams, Director Date Committee Chair Date

2023 Steering Committee Voting Record for Meeting Date 04/06/23

C = Chaired the meeting, ja = Just arrived, lm = Left the meeting

Aff-Affected Community Committee, Comp-Comprehensive HIV Planning Committee, Op-Operations Committee, PA-Priority and Allocations Committee, QI-Quality Improvement Committee

MEMBERS	**Motion #1** Agenda **Carried**				**Motion #2** Minutes **Carried**				**Motion #3** Reallocation of FY23 Unallocated Funds: Office of Support budget **Carried**				**Motion #4** Reallocation of FY23 Unallocated Funds: EFA-Pharmacy **Carried**			
	Absent	**Yes**	**No**	**Abstain**	**Absent**	**Yes**	**No**	**Abstain**	**Absent**	**Yes**	**No**	**Abstain**	**Absent**	**Yes**	**No**	**Abstain**
Crystal Starr, Chair				**C**				**C**				**C**				**C**
Skeet Boyle, Vice Chair		**X**				**X**				**X**				**X**		
Josh Mica, Secretary		**X**				**X**				**X**				**X**		
Allen Murray, Comp		**X**				**X**				**X**				**X**		
Ronnie Galley, Op		**X**				**X**				**X**				**X**		
Peta-gay Ledbetter, PA		**X**				**X**				**X**				**X**		
Tana Pradia, QI		**X**				**X**				**X**				**X**		
Non-voting members at the meeting:																
Steven Vargas, Comp																
Bobby Cruz, PA																
Cecilia Ligons, Op																
Pete Rodriguez, QI																
Absent members:																
Diana Morgan, Aff																
Rodney Mills, Aff																

DRAFT

2023 Project LEAP Student Selection Guidelines

The following guidelines will be used by the Office of Support to select students for the 2023 Project LEAP cohort. They are presented in order of priority:

1. As outlined in the 2023 Service Definition for Project LEAP:

    a. The Office of Support shall enroll 20 to 30 persons who are living with HIV prior to the commencement of the training program. No more than 10 affected individuals are to be included in the training program. Preference will be given to non-aligned (non-conflicted) consumers of Ryan White HIV Program services in the Houston EMA and high risk applicants.

    b. Selected students shall be representative of the demographics of current HIV prevalence in the Houston EMA, with particular attention to sex, race/ethnicity, and the special populations of young adults (age 18 - 24) and people who are transgender and/or gender non-conforming.

2. If the applicant is a prior LEAP graduate, they may be selected for the 2022 cohort if they have not been appointed to the Planning Council following LEAP participation and if space in the class is available.

3. Be available for the 2022 Project LEAP class schedule.

4. Have the ability to commit to Project LEAP expectations in regards to class participation, activities, and homework assignments.

5. Demonstrate an interest in planning HIV services in the Houston EMA. Students should have an understanding of the expected roles of Project LEAP graduates in local HIV prevention and care services planning.

6. Demonstrate an interest in volunteerism, advocacy, and other types of community involvement. If possible, have a history of past volunteerism, advocacy, and/or community involvement.

7. Demonstrated interpersonal skills consistent with successful participation in Project LEAP, such as ability/willingness to work in a team, effective communication skills, etc.

Service Category Title: Grant Administration – 2024 Project LEAP

Unit of Service Definition:
1 unit of service = 1 class hour of training to Project L.E.A.P. participants. No other costs may be billed to the contract issued for Project LEAP.

GOAL: Agency will increase the number and effectiveness of People Living With HIV (PLWH) and the affected community who can participate in organizations, councils and committees dealing with the allocation of public funds for HIV-related prevention and care services, through an effort known as "Project LEAP" (Learning, Empowerment, Advocacy and Participation). Enrollment should include 20 to 30 persons who are living with HIV. No more than 10 individuals are to be enrolled in the training program who are affected by HIV. The race, ethnicity and gender composition of the classes must reflect current local HIV prevalence data to the extent feasible. Agency will prioritize to enroll individuals from groups that are disproportionally affected by HIV disease, including youth and transgender persons living with HIV, in Project LEAP.

Project LEAP will increase the knowledge, participation and efficacy of PLWH and affected participants through a training program specifically developed to provide PLWH and affected persons with the knowledge and skills necessary to become active, informed, and empowered members of HIV planning bodies and other groups responsible for the assessment of HIV-related prevention and service needs in the Houston EMA/HSDA. The primary focus of training is to prepare participants to be productive members of local HIV planning bodies, with an emphasis on planning activities conducted under the auspices of the Houston Ryan White Planning Council (RWPC).

Except under unusual circumstances, such as severe weather or a public health emergency (for example an outbreak of the flu), each class provided during the term of this agreement will include graduation and at least:

A. 44 contact hours of classroom training;

B. 6 hours of participation in Ryan White Planning Council and/or Committee related activities; and

C. 6 hours of participation in HIV-related community activities.

There will be no more than 2 classes at 56 hours per class. The Council-approved minimum outline for the training curriculum includes: HIV funding sources, general and specific operational procedures of HIV-related planning bodies, information regarding assessment of the needs of PLWH in the Houston EMA/HSDA, reviewing and evaluating proposals for HIV-related funding such as serving on an external review panel, organizational case studies and mentoring, presentation skills, knowledge related to accessing services, overview of HIV-related quality assurance (QA) processes and parliamentary procedure/meeting management skills.

Agency will provide reimbursement of eligible expenses to participants during the period of enrollment to reimburse these participants for out of pocket costs related to their in-person classroom participation, limited to transportation, childcare, and meals.

Agency agrees to provide Harris County Public Health (HCPH)/Ryan White Grant Administration (RWGA) and the Houston RWPC with written reports and project summaries as requested by Harris County and in a form acceptable to Harris County, regarding the progress and outcome of the project.

Agency will provide Harris County with a written report summarizing the activities accomplished during the term of the contract within thirty calendar days after the completion of the project. If completed with a noncontract agreement, written report must be submitted at the end, or before the end, of the project calendar year.

Objective 1: Agency will identify and provide training to at least 20 persons who are living with HIV and no more than 10 affected individuals in order for them to receive the necessary skills and knowledge to participate in the decision-making process to fund and allocate public money to HIV-related services in the Houston EMA/HSDA. The following training curriculum shall be provided:

1. Information on PrEP and the sources and purposes of HIV service funds in the Houston EMA/HSDA;
2. The structure, functions, policies and procedures of the Houston HIV Health Services Planning Council (Ryan White Planning Council/RWPC) and the Houston HIV Prevention Community Planning Group (CPG);
3. Specific training and skills building in needs assessments, parliamentary procedures and meeting management procedures, presentation skills, reviewing and evaluating proposals for HIV-related funding such as serving on an external review panel, accessing and utilizing support resources and role models, and competence in organizational participation and conduct; and
4. Specific training on HIV-related Standards of Care, quality assurance methods and HRSA service category definitions.

Objective 2: Agency will enhance the participation of the people living with HIV and affected persons in the decision-making process by the following documented activities:

1. Establishing realistic training schedule(s) which accommodate varying health situations of those selected participants;
2. Conducting a pre-training evaluation of participants to determine their knowledge and beliefs concerning HIV disease and understanding of HIV-related funding processes in the Houston area. Agency must incorporate responses from this pre-training evaluation in the final design of the course curriculum to ensure that, to the extent reasonably possible, the specific training needs of the selected participants are addressed in the curriculum;
3. Conducting a post-training evaluation to measure the change in participants knowledge and beliefs concerning HIV disease and understanding of HIV-related funding processes in the Houston area;
4. Providing reimbursement of allowable expenses to help defray costs of the individual's in-person participation, limited to transportation, child care, and meals; and

5. Providing both lecture and hands-on experiential class activities to enable participants to maximize opportunities for learning, except under unusual circumstances, such as severe weather or a public health emergency when hands-on activities are not feasible.

Objective 3: Agency will encourage cooperation and coordination among entities responsible for administering public funds for HIV-related services by:

1. Involving HCPH/RWGA, The Houston Regional HIV/AIDS Resource Group (TRG) and other administrative agencies for public HIV care and prevention funds in curriculum development and training activities;
2. Ensuring representatives from the RWPC, the Houston Community Planning Group (CPG) and Project LEAP alumni are members of the Project LEAP External Advisory Panel. The responsibility of the Project LEAP External Advisory Panel is to:
   - Assist in curriculum development;
   - Provide input into criteria for selecting Project LEAP participants;
   - Assist with the development of a recruitment strategy;
   - If the agency finds it difficult to find individuals that meet the criteria for participation in the Project, assist with student recruitment; and
   - Review the final report for the Project in order to highlight the successes and brainstorm/problem solve around issues identified in the report. The results of the review will be sent to the Ryan White Operations Committee and the next Advisory Panel.
3. Collaborating with the Project LEAP External Advisory Panel during the initial 60 days of the Contract term. The criteria developed and utilized will, to the maximum extent possible, ensure participants selected represent the groups most affected by HIV disease, consistent with current HIV epidemiological data in the Houston EMA/HSDA, including youth (ages 18-24) and transgender persons living with HIV.

Agency will provide RWGA with the attached matrix and chart 21 and 14 days before the first class and again the day after the first class demonstrating that the criteria established by the Project LEAP External Advisory Panel was met. The matrix must be approved by RWGA 14 days before the first class.

EXAMPLES

Recommended Project LEAP Class of 2021

Candidate	M	F	T	HIV+	Non-Aligned HIV+	W	B	H	Youth Age 18 - 19	Youth Age 20 - 24
1	X			X	X	X				
2		X		X			X		X	
3		X					X			X
4		X		X	X			X		X
5	X					X				
6	X			X	X		X			
7	X			X	X	X				
Totals	4	3		5	4	3	3	1	1	2

	EMA HIV/AIDS prevalence as of 12/31/25*		PC Members as of 09/01/25		Non-Aligned Consumers on PC	
Race/Ethnicity	**No.**	**%**	**No.**	**%**	**No.**	**%**
White, not Hispanic	5,605	26.85%	7	19.44%	4	25.00%
Black, not Hispanic	10,225	48.98%	19	52.78%	8	50.00%
Hispanic	4,712	22.57%	10	27.78%	4	25.00%
Other	333	01.60%	0	00.00%	0	0.00%
Total*	**20,875**	**100%**	**36**	**100%**	**16**	**100%**
Gender	**Number**	**Percentage**	**No.**	**%**	**No.**	**%**
Male	15,413	73.83%	21	58.33%	11	68.75%
Female	5,462	26.17%	15	41.67%	5	31.25%
Total*	**20,875**	**100%**	**36**	**100%**	**16**	**100%**

*Data are estimated cases adjusted for reporting delay. The sum total of estimates for each category may not match the EMA totals due to rounding.

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

FY 2022 Ryan White Part A and MAI
Procurement Report

Priority	Service Category	Original Allocation *RWPC Approved Level Funding Scenario*	Award Reconcilation	July Adjustments (carryover)	October Adjustments	Final Quarter Adjustments (to avoid UOB penalty)	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**	**10,965,788**	**-15,437**	**0**	**84,657**	**-239,401**	**10,795,607**	**44.82%**	**10,795,607**	**0**	3/1/2022	**9,483,782**	**88%**	**100%**
1.a	Primary Care - Public Clinic (a)	3,927,300				-249,250	3,678,050	15.27%	3,678,050	0	3/1/2022	$3,626,349	99%	100%
1.b	Primary Care - CBO Targeted to AA (a) (e) (f)	1,064,576			90,574	9,849	1,164,999	4.84%	1,164,999	0	3/1/2022	$1,344,186	115%	100%
1.c	Primary Care - CBO Targeted to Hispanic (a) (e)	910,551			75,774		986,325	4.09%	986,325	0	3/1/2022	$1,246,718	126%	100%
1.d	Primary Care - CBO Targeted to White/MSM (a) (e)	1,147,924			16,300		1,164,224	4.83%	1,164,224	0	3/1/2022	$717,708	62%	100%
1.e	Primary Care - CBO Targeted to Rural (a) (e)	1,100,000			-97,990		1,002,010	4.16%	1,002,010	0	3/1/2022	$866,195	86%	100%
1.f	Primary Care - Women at Public Clinic (a)	2,100,000					2,100,000	8.72%	2,100,000	0	3/1/2022	$1,249,051	59%	100%
1.g	Primary Care - Pediatric (a.1)	15,437	-15,437				0	0.00%	0	0	3/1/2022	$0	0%	0%
1.h	Vision	500,000					500,000	2.08%	500,000	0	3/1/2022	$404,505	81%	100%
1.x	Primary Care Health Outcome Pilot	200,000					200,000	0.83%	200,000	0	3/1/2022	$29,070	15%	100%
2	**Medical Case Management**	**1,730,000**	**-90,051**	**0**	**-15,000**	**-51,045**	**1,573,904**	**6.53%**	**1,573,904**	**0**	3/1/2022	**1,810,452**	**115%**	**100%**
2.a	Clinical Case Management	488,656					488,656	2.03%	488,656	0	3/1/2022	$557,172	114%	100%
2.b	Med CM - Public Clinic (a)	277,103				53,200	330,303	1.37%	330,303	0	3/1/2022	$432,447	131%	100%
2.c	Med CM - Targeted to AA (a) (e)	169,009				-52,123	116,886	0.49%	116,886	0	3/1/2022	$237,140	203%	100%
2.d	Med CM - Targeted to H/L (a) (e)	169,011				-52,123	116,888	0.49%	116,888	0	3/1/2022	$95,736	82%	100%
2.e	Med CM - Targeted to W/MSM (a) (e)	61,186					61,186	0.25%	61,186	0	3/1/2022	$90,146	147%	100%
2.f	Med CM - Targeted to Rural (a)	273,760					273,760	1.14%	273,760	0	3/1/2022	$120,320	44%	100%
2.g	Med CM - Women at Public Clinic (a)	75,311					75,311	0.31%	75,311	0	3/1/2022	$154,384	205%	100%
2.h	Med CM - Targeted to Pedi (a.1)	90,051	-90,051			0	0	0.00%	0	0	3/1/2022	$0	0%	0%
2.i	Med CM - Targeted to Veterans	80,025			-15,000	0	65,025	0.27%	65,025	0	3/1/2022	$40,737	63%	100%
2.j	Med CM - Targeted to Youth	45,888					45,888	0.19%	45,888	0	3/1/2022	$82,371	180%	100%
3	**Local Pharmacy Assistance Program**	**1,810,360**	**200,000**	**0**	**0**	**177,476**	**2,187,836**	**9.08%**	**2,187,836**	**0**	3/1/2022	**$1,862,214**	**85%**	**100%**
3.a	Local Pharmacy Assistance Program-Public Clinic (a) (e)	310,360				196,050	506,410	2.10%	506,410	0	3/1/2022	$393,778	78%	100%
3.b	Local Pharmacy Assistance Program-Untargeted (a) (e)	1,500,000	200,000			-18,574	1,681,426	6.98%	1,681,426	0	3/1/2022	$1,468,436	87%	100%
4	**Oral Health**	**166,404**	**0**	**0**	**0**	**0**	**166,404**	**0.69%**	**166,404**	**0**	3/1/2022	**166,400**	**100%**	**100%**
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				0	166,404	0.69%	166,404	0	3/1/2022	$166,400	100%	100%
5	**Health Insurance (c)**	**1,383,137**	**431,299**	**138,285**		**0**	**1,952,721**	**8.11%**	**1,952,721**	**0**	3/1/2022	**$1,952,682**	**100%**	**100%**
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	**Medical Nutritional Therapy (supplements)**	**341,395**					**341,395**	**1.42%**	**341,395**	**0**	**3/1/2022**	**$339,519**	**99%**	**100%**
9	**Home and Community-Based Services (c)**	**0**					**0**	**0.00%**	**0**	**0**	**NA**	**$0**	**0%**	**0%**
9.a	In-Home	0					0		0	0	N/A	$0	0%	0%
9.b	Facility Based	0					0		0	0	N/A	$0	0%	0%
10	**Substance Abuse Services - Outpatient (c)**	**45,677**			**-20,667**		**25,010**	**0.10%**	**25,010**	**0**	3/1/2022	**$6,788**	**27%**	**100%**
11	**Hospice Services**	**0**					**0**	**0.00%**	**0**	**0**	**NA**	**$0**	**0%**	**0%**
12	**Referral for Health Care and Support Services (c)**	**0**					**0**	**0.00%**	**0**	**0**	**NA**	**$0**	**0%**	**0%**
13	**Non-Medical Case Management**	**1,267,002**	**0**	**0**	**43,000**	**112,783**	**1,422,785**	**5.91%**	**1,422,785**	**0**	**3/1/2022**	**$1,401,637**	**99%**	**100%**
13.a	Service Linkage targeted to Youth	110,793					110,793	**0.46%**	110,793	0	3/1/2022	$114,491	103%	100%
13.b	Service Linkage targeted to Newly-Diagnosed/Not-in-Care	100,000			**-7,000**		93,000	**0.39%**	93,000	0	3/1/2022	$95,171	102%	100%
13.c	Service Linkage at Public Clinic (a)	370,000				69,960	439,960	**1.83%**	439,960	0	3/1/2022	$508,430	116%	100%
13.d	Service Linkage embedded in CBO Pcare (a) (e)	686,209			50,000	42,823	779,032	**3.23%**	779,032	0	3/1/2022	$683,544	88%	100%
13.e	SLW-Substance Use	0					0	**0.00%**	0	0	NA	$0	0%	0%
14	**Medical Transportation**	**424,911**	**0**	**0**	**0**	**0**	**424,911**	**1.76%**	**424,911**	**0**		**424,383**	**100%**	**100%**
14.a	Medical Transportation services targeted to Urban	252,680					252,680	1.05%	252,680	0	3/1/2022	$269,988	107%	100%
14.b	Medical Transportation services targeted to Rural	97,185					97,185	0.40%	97,185	0	3/1/2022	$79,874	82%	100%
14.c	Transportation vouchering (bus passes & gas cards)	75,046					75,046	0.31%	75,046	0	3/1/2022	$74,521	99%	100%
15	**Emergency Financial Assistance**	**1,545,439**	**189,168**	**750,000**	**-120,000**	**121,903**	**2,486,510**	**10.32%**	**2,486,510**	**0**		**3,344,026**	**134%**	**100%**
15.a	EFA - Pharmacy Assistance	1,305,439	189,168	750,000		121,903	2,366,510	9.82%	2,366,510	0	3/1/2022	$3,267,696	138%	100%
15.b	EFA - Other	240,000			-120,000		120,000	0.50%	120,000	0	3/1/2022	$76,331	64%	100%
16	**Linguistic Services (c)**	**0**	**0**				**0**	**0.00%**	**0**	**0**	**NA**	**$0**	**0%**	**0%**
17	**Outreach**	**420,000**			**30,030**	**-121,717**	**328,313**	**1.36%**	**328,313**	**0**	**3/1/2022**	**$296,700**	**90%**	**100%**
BEU27516	**Total Service Dollars**	**20,100,113**	**714,979**	**888,285**	**2,020**	**-1**	**21,705,396**	**90.11%**	**21,705,396**	**0**		**21,088,583**	**97%**	**100%**

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

FY 2022 Ryan White Part A and MAI
Procurement Report

Priority	Service Category	Original Allocation *RWPC Approved Level Funding Scenario*	Award Reconcilation	July Adjustments (carryover)	October Adjustments	Final Quarter Adjustments (to avoid UOB penalty)	Total Allocation	Percent of Grant Award	Amount Procured (a)	Procure-ment Balance	Original Date Procured	Expended YTD	Percent YTD	Percent Expected YTD
	Grant Administration	**1,795,958**	**169,915**	**0**	**0**	**0**	**1,965,873**	**8.16%**	**1,965,873**	0	**N/A**	**1,556,004**	**79%**	**100%**
BEU27517	HCPH/RWGA Section	1,271,050	169,915	0		0	1,440,965	5.98%	1,440,965	0	N/A	$1,030,811	72%	100%
PC	RWPC Support*	524,908			0	0	524,908	2.18%	524,908	0	N/A	525,193	100%	100%
BEU27521	**Quality Management**	**412,940**		**0**	**0**	**0**	**412,940**	**1.71%**	**412,940**	**0**	**N/A**	**$339,969**	**82%**	**100%**
		22,309,011	**884,894**	**888,285**	**2,020**	**-1**	**24,084,209**	**99.99%**	**24,084,209**	**0**		**22,984,556**	**95.43%**	**100%**
								Unallocated	**Unobligated**			**Unspent**		100%
	Part A Grant Award:	**23,198,771**	***Carry Over:***	**888,285**		***Total Part A:***	**24,087,056**	**2,847**	**0**			**1,102,500**	**4.58%**	100%

		Original Allocation	Award Reconcilation	July Adjustments (carryover)	October Adjustments	Final Quarter Adjustments	Total Allocation	Percent	Total Expended on Services	Percent	
	Core (must not be less than 75% of total service dollars)	**16,442,761**	**525,811**	**138,285**	**48,990**	**-112,970**	**17,155,847**	**79.04%**	**13,669,155**	**72.56%**	**Core Service Waiver needed for FY22**
	Non-Core (may not exceed 25% of total service dollars)	**3,657,352**	**189,168**	**750,000**	**-46,970**	**112,969**	**4,549,550**	**20.96%**	**5,170,046**	**27.44%**	Reasons: Underspent Pcare (Public Clinic); Underspent
	Total Service Dollars (does not include Admin and QM)	**20,100,113**	**714,979**	**888,285**	**2,020**	**0**	**21,705,397**		**18,839,201**		MCM; EFA & SLW higher expenditures than Level alloc
	Total Admin (must be ≤ 10% of total Part A + MAI)	**1,795,958**	**169,915**	**0**	**0**	**0**	**1,965,873**	**7.34%**			
	Total QM (must be ≤ 5% of total Part A + MAI)	**412,940**	**0**	**0**	**0**	**0**	**412,940**	**1.54%**			

MAI Procurement Report

Priority	Service Category	Original Allocation *RWPC Approved Level Funding Scenario*	Award Reconcilation	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**	**2,002,860**	**104,950**	**0**	**0**	**68,030**	**2,175,840**	**80.55%**	**2,175,840**	**0**		**2,173,325**	**100%**	**100%**
1.b (MAI)	Primary Care - CBO Targeted to African American	1,012,700	53,065			34,015	1,099,780	40.71%	1,099,780	0	3/1/2022	$1,143,450	104%	100%
1.c (MAI)	Primary Care - CBO Targeted to Hispanic	990,160	51,884			34,015	1,076,059	39.84%	1,076,059	0	3/1/2022	$1,029,875	96%	100%
2	**Medical Case Management**	**320,100**	**0**	**0**	**0**	**-68,030**	**252,070**	**9.33%**	**252,070**	**0**		**$236,811**	**94%**	100%
2.c (MAI)	MCM - Targeted to African American	160,050				-34,015	126,035	4.67%	126,035	0	3/1/2022	$146,495	116%	100%
2.d (MAI)	MCM - Targeted to Hispanic	160,050				-34,015	126,035	4.67%	126,035	0	3/1/2022	$90,316	72%	100%
3	**DSHS ADAP**	**0**	**0**	**273,335**	**0**	**0**	**273,335**	**10.12%**	**273,335**	**0**	**3/1/2022**	**$276,305**	**101%**	**100%**
	Total MAI Service Funds	**2,322,960**	**104,950**	**273,335**	**0**	**0**	**2,701,245**	**100.00%**	**2,701,245**	**0**		**2,686,441**	**99%**	100%
	Grant Administration	0	0	0	0	0	0	0.00%	0	0		0	0%	0%
	Quality Management	0	0	0	0	0	0	0.00%	0	0		0	0%	0%
	Total MAI Non-service Funds	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**		**0**	**0%**	**0%**
	Total MAI Funds	**2,322,960**	**104,950**	**273,335**	**0**	**0**	**2,701,245**	**100.00%**	**2,701,245**	**0**		**2,686,441**	**99%**	**100%**
								Unallocated	**Unobligated**					
	MAI Grant Award	**2,427,918**	***Carry Over:***	**276,305**		***Total MAI:***	**2,704,223**	***2,978***	0			**Unspent**		100%
												17,783		100%
	Combined Part A and MAI Orginial Allocation Total	**24,631,971**												

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 multiple HRSA service categories. (1) does not include LPAP. Expenditures must be evaluated both by individual service category and by combined service categories.
(c)	Funded under Part B and/or SS
(e)	10% rule reallocations

Prepared by: Ryan White Grant Administration

FY 2022 Ryan White Part A and MAI Service Utilization Report

RW PART A SUR- 4th Quarter (3/1-2/28)																		
Priority	**Service Category**	**Goal**	**Unduplicated Clients Served YTD**	**Male**	**Female**	**Trans gender**	**AA (non-Hispanic)**	**White (non-Hispanic)**	**Other (non-Hispanic)**	**Hispanic**	**0-12**	**13-19**	**20-24**	**25-34**	**35-44**	**45-54**	**55-64**	**65 plus**
1	**Outpatient/Ambulatory Primary Care (excluding Vision)**	**6,467**	**7,946**	**76%**	**22%**	**2%**	**44%**	**12%**	**2%**	**41%**	**0%**	**0%**	**5%**	**28%**	**28%**	**11%**	**26%**	**2%**
1.a	Primary Care - Public Clinic (a)	2,350	2,607	72%	26%	1%	42%	9%	2%	47%	0%	0%	3%	17%	27%	14%	36%	4%
1.b	Primary Care - CBO Targeted to AA (a)	1,060	2,267	71%	27%	3%	98%	0%	1%	0%	0%	0%	7%	37%	27%	10%	18%	2%
1.c	Primary Care - CBO Targeted to Hispanic (a)	960	1,908	82%	14%	4%	0%	0%	0%	100%	0%	0%	6%	32%	30%	11%	19%	1%
1.d	Primary Care - CBO Targeted to White and/or MSM (a)	690	759	87%	11%	2%	0%	85%	15%	0%	0%	0%	2%	29%	26%	8%	32%	3%
1.e	Primary Care - CBO Targeted to Rural (a)	400	614	71%	28%	1%	43%	21%	2%	34%	0%	0%	2%	30%	28%	11%	26%	2%
1.f	Primary Care - Women at Public Clinic (a)	1,000	697	0%	99%	1%	52%	5%	1%	42%	0%	0%	2%	10%	27%	18%	38%	5%
1.g	Primary Care - Pediatric (a)	7	0															
1.h	Vision	1,600	2,251	74%	24%	2%	46%	13%	2%	38%	0%	0%	4%	23%	24%	12%	31%	6%
2	**Medical Case Management (f)**	**3,075**	**4,567**															
2.a	Clinical Case Management	600	753	71%	27%	2%	53%	13%	1%	33%	0%	0%	3%	23%	25%	12%	31%	6%
2.b	Med CM - Targeted to Public Clinic (a)	280	480	91%	7%	2%	50%	13%	1%	35%	0%	0%	1%	23%	28%	10%	32%	5%
2.c	Med CM - Targeted to AA (a)	550	1,404	67%	30%	3%	99%	0%	1%	0%	0%	0%	4%	30%	26%	10%	26%	4%
2.d	Med CM - Targeted to H/L(a)	550	678	79%	15%	6%	0%	0%	0%	100%	0%	0%	6%	29%	30%	11%	22%	2%
2.e	Med CM - Targeted to White and/or MSM (a)	260	449	86%	12%	2%	0%	89%	11%	0%	0%	0%	2%	20%	25%	10%	35%	8%
2.f	Med CM - Targeted to Rural (a)	150	462	66%	33%	1%	44%	30%	3%	24%	0%	0%	3%	24%	26%	10%	32%	6%
2.g	Med CM - Targeted to Women at Public Clinic (a)	240	199	0%	99%	1%	65%	10%	3%	23%	0%	0%	4%	22%	32%	12%	25%	5%
2.h	Med CM - Targeted to Pedi (a)	125	0															
2.i	Med CM - Targeted to Veterans	200	135	97%	3%	0%	70%	20%	1%	10%	0%	0%	0%	0%	3%	4%	44%	49%
2.j	Med CM - Targeted to Youth	120	7	86%	14%	0%	29%	29%	0%	43%	0%	14%	86%	0%	0%	0%	0%	0%
3	**Local Drug Reimbursement Program (a)**	**2,845**	**5,505**	**75%**	**21%**	**3%**	**46%**	**12%**	**2%**	**40%**	**0%**	**0%**	**4%**	**28%**	**28%**	**12%**	**26%**	**2%**
4	**Oral Health**	**200**	**285**	**68%**	**31%**	**1%**	**39%**	**28%**	**1%**	**31%**	**0%**	**0%**	**3%**	**20%**	**24%**	**15%**	**31%**	**7%**
4.a	Oral Health - Untargeted (d)	NA	NA															
4.b	Oral Health - Rural Target	200	285	68%	31%	**1%**	39%	28%	1%	31%	0%	0%	3%	20%	24%	15%	31%	7%
5	**Mental Health Services (d)**	**NA**	**NA**															
6	**Health Insurance**	**1,700**	**1,698**	**79%**	**19%**	**2%**	**43%**	**25%**	**3%**	**29%**	**0%**	**0%**	**1%**	**15%**	**19%**	**10%**	**41%**	**15%**
7	**Home and Community Based Services (d)**	**NA**	**NA**															
8	**Substance Abuse Treatment - Outpatient**	**40**	**9**	**100%**	**0%**	**0%**	**11%**	**44%**	**11%**	**33%**	**0%**	**11%**	**0%**	**44%**	**22%**	**0%**	**22%**	**0%**
9	**Early Medical Intervention Services (d)**	**NA**	**NA**															
10	**Medical Nutritional Therapy/Nutritional Supplements**	**650**	**452**	**75%**	**23%**	**2%**	**43%**	**19%**	**3%**	**35%**	**0%**	**0%**	**1%**	**8%**	**17%**	**8%**	**50%**	**15%**
11	**Hospice Services (d)**	**NA**	**NA**															
12	**Outreach**	**700**	**843**	**77%**	**20%**	**3%**	**58%**	**14%**	**2%**	**26%**	**0%**	**0%**	**5%**	**32%**	**28%**	**9%**	**22%**	**5%**
13	**Non-Medical Case Management**	**7,045**	**7,619**															
13.a	Service Linkage Targeted to Youth	320	165	77%	23%	0%	51%	6%	2%	41%	0%	13%	87%	0%	0%	0%	0%	0%
13.b	Service Linkage at Testing Sites	260	83	73%	24%	2%	54%	6%	4%	36%	0%	0%	0%	46%	33%	10%	12%	0%
13.c	Service Linkage at Public Clinic Primary Care Program (a)	3,700	3,085	68%	30%	1%	50%	9%	1%	39%	0%	0%	0%	18%	25%	13%	38%	6%
13.d	Service Linkage at CBO Primary Care Programs (a)	2,765	4,286	75%	23%	3%	53%	12%	2%	33%	0%	0%	4%	29%	24%	10%	27%	5%
14	**Transportation**	**2,850**	**2,032**															
14.a	Transportation Services - Urban	170	659	69%	30%	2%	59%	7%	3%	31%	0%	0%	5%	26%	24%	10%	30%	6%
14.b	Transportation Services - Rural	130	161	66%	32%	1%	29%	29%	1%	41%	0%	0%	4%	19%	19%	18%	30%	9%
14.c	Transportation vouchering	2,550	1,212															
15	**Linguistic Services (d)**	**NA**	**NA**															
16	**Emergency Financial Assistance (e)**	**NA**	**1,786**	**76%**	**22%**	**2%**	**46%**	**9%**	**2%**	**43%**	**0%**	**0%**	**4%**	**26%**	**28%**	**12%**	**27%**	**3%**
17	**Referral for Health Care - Non Core Service (d)**	**NA**	**NA**															
Net unduplicated clients served - all categories*		**12,941**	**13,745**	**75%**	**23%**	**2%**	**49%**	**14%**	**2%**	**35%**	**0%**	**0%**	**4%**	**25%**	**25%**	**11%**	**29%**	**6%**
Living AIDS cases + estimated Living HIV non-AIDS (from FY19 App) (b)		**NA**	**30,198**	**75%**	**25%**		**48%**	**17%**	**5%**	**30%**	**0%**	**4%**		**21%**	**23%**	**25%**	**20%**	**7%**

Available Data As Of: 4/10/2023

Prepared by: Ryan White Grant Administration

FY 2022 Ryan White Part A and MAI Service Utilization Report

RW MAI Service Utilization Report - 4th Quarter (03/01 - 02/28)																		
Priority	**Service Category MAI unduplicated served includes clients also served under Part A**	**Goal**	**Unduplicated MAI Clients Served YTD**	**Male**	**Female**	**Trans gender**	**AA (non-Hispanic)**	**White (non-Hispanic)**	**Other (non-Hispanic)**	**Hispanic**	**0-12**	**13-19**	**20-24**	**25-34**	**35-44**	**45-49**	**50-64**	**65 plus**
	Outpatient/Ambulatory Primary Care (excluding Vision)																	
1.b	Primary Care - MAI CBO Targeted to AA (g)	1,060	1,819	**71%**	**25%**	**3%**	**99%**	**0%**	**1%**	**0%**	**0%**	**0%**	**6%**	**35%**	**27%**	**10%**	**19%**	**2%**
1.c	Primary Care - MAI CBO Targeted to Hispanic (g)	960	1,627	**82%**	**14%**	**4%**	**0%**	**0%**	**0%**	**100%**	**0%**	**0%**	**5%**	**31%**	**29%**	**13%**	**20%**	**1%**
2	**Medical Case Management (f)**																	
2.c	Med CM - Targeted to AA (a)	1,060	885	**80%**	**17%**	**4%**	**47%**	**13%**	**2%**	**38%**	**0%**	**0%**	**7%**	**37%**	**27%**	**9%**	**17%**	**1%**
2.d	Med CM - Targeted to H/L(a)	960	662	**64%**	**33%**	**3%**	**63%**	**12%**	**1%**	**24%**	**0%**	**1%**	**6%**	**24%**	**28%**	**10%**	**24%**	**6%**
RW Part A New Client Service Utilization Report - 4th Quarter (03/01-02/28) **Report reflects the number & demographics of clients served during the report period who did not receive services during previous 12 months (3/1/22-2/28/23)**																		
Priority	**Service Category**	**Goal**	**Unduplicated New Clients Served YTD**	**Male**	**Female**	**Trans gender**	**AA (non-Hispanic)**	**White (non-Hispanic)**	**Other (non-Hispanic)**	**Hispanic**	**0-12**	**13-19**	**20-24**	**25-34**	**35-44**	**45-49**	**50-64**	**65 plus**
1	**Primary Medical Care**	**2,100**	**1,755**	**81%**	**17%**	**2%**	**47%**	**13%**	**2%**	**38%**	**0%**	**1%**	**9%**	**37%**	**26%**	**9%**	**2%**	**17%**
2	**LPAP**	**1,200**	**791**	**80%**	**17%**	**4%**	**47%**	**13%**	**2%**	**38%**	**0%**	**0%**	**7%**	**37%**	**27%**	**9%**	**1%**	**17%**
3.a	Clinical Case Management	400	67	64%	33%	3%	63%	12%	1%	24%	0%	1%	6%	24%	**28%**	**10%**	6%	**24%**
3.b-3.h	Medical Case Management	1,600	1003	77%	21%	2%	49%	15%	2%	34%	0%	0%	7%	33%	**26%**	**8%**	3%	**21%**
3.i	Medical Case Manangement - Targeted to Veterans	60	20	95%	5%	0%	55%	20%	5%	20%	0%	0%	0%	0%	**5%**	**15%**	35%	**45%**
4	**Oral Health**	**40**	**34**	**76%**	**24%**	0%	**44%**	**26%**	**6%**	**24%**	**0%**	**0%**	**9%**	**32%**	**18%**	**9%**	**6%**	**26%**
12.a. 12.c. 12.d.	**Non-Medical Case Management (Service Linkage)**	**3,700**	**1,753**	**75%**	**23%**	**2%**	**52%**	**13%**	**2%**	**33%**	**0%**	**1%**	**7%**	**30%**	**25%**	**9%**	**23%**	**4%**
12.b	**Service Linkage at Testing Sites**	**260**	**74**	**76%**	**22%**	**3%**	**57%**	**7%**	**3%**	**34%**	**0%**	**4%**	**23%**	**30%**	**27%**	**9%**	**7%**	**0%**
Footnotes:																		
(a)	Bundled Category																	
(b)	Age groups 13-19 and 20-24 combined together; Age groups 55-64 and 65+ combined together.																	
(d)	Funded by Part B and/or State Services																	
(e)	Total MCM served does not include Clinical Case Management																	
(f)	CBO Pcare targeted to AA (1.b) and HL (1.c) goals represent combined Part A and MAI clients served																	

Available Data As Of: 4/10/2023

Priorities and Allocations Committee PC approved

FY23 - Increase Funding Scenario Implemented

April 10, 2023

		Part A	MAI	Part B	State Services	State Rebate	Total	FY 2023 Allocations & Justification
	Remaining Funds to Allocate	**$397,685**	**$0**	**$0**	**$0**	**$0**	**$397,685**	
		Part A	**MAI**	**Part B**	**State Services**	**State Rebate**	**Total**	**FY 2023 Allocations & Justification**
1	**Ambulatory/Outpatient Primary Care**	**$11,465,788**	**$2,068,054**	**$0**	**$0**	**$0**	**$13,533,842**	**$500,000 added to all subcategories except Pilot Project**
1.a	PC-Public Clinic	$4,109,697					$4,109,697	
1.b	PC-AA	$1,114,019	$1,045,669				$2,159,688	
1.c	PC-Hisp - see 1.b above	$952,840	$1,022,386				$1,975,226	
1.d	PC-White - see 1.b above	$1,201,238					$1,201,238	
1.e	PC-Rural	$1,151,088					$1,151,088	
1.f	PC-Women	$2,197,531					$2,197,531	
1.g	PC-Pedi	$16,153					$16,153	**Must zero out for FY24 (no vendor)**
1.h	Vision Care	$523,222					$523,222	
1.j	PC-Pay for Performance Pilot Project	$200,000					$200,000	
2	**Medical Case Management**	**$1,880,000**	**$314,062**	**$0**	**$0**	**$0**	**$2,194,062**	
2.a	CCM-Mental/Substance	$531,025					$531,025	$150,000 overall increase redistributed amoung all subcategories. **Done.**
2.b	MCM-Public Clinic	$301,129					$301,129	
2.c	MCM-AA	$183,663	$157,031				$340,694	
2.d	MCM-Hisp	$183,665	$157,031				$340,696	
2.e	MCM-White	$66,491					$66,491	
2.f	MCM-Rural	$297,496					$297,496	
2.g	MCM-Women	$81,841					$81,841	
2.h	MCM-Pedi	$97,859					$97,859	**Must zero out for FY24 (no vendor)**
2.i	MCM-Veterans	$86,964					$86,964	
2.j	MCM-Youth	$49,867					$49,867	
3	**Local Pharmacy Assistance Program**	**$2,067,104**	**$0**	**$0**	**$0**	**$0**	**$2,067,104**	
3.a	LPAP-Public Clinic	$367,104					$367,104	**FY23 Part A: Increase by $56,744 to address ADAP issues. Done.**
3.b	LPAP-Untargeted	$1,700,000					$1,700,000	
4	**Oral Health**	**$166,404**	**$0**	**$2,218,878**	**$0**		**$2,385,282**	
4.a	General Oral Health			$1,758,878				
4.b	Prosthodontics			$460,000				
4.c	Rural Dental	$166,404					$166,404	
5	**Health Insurance Co-Pays & Co-Ins**	**$1,583,137**	**$0**	**$1,028,433**	**$864,506**	**$0**	**$3,476,076**	**$200,000 added.**
6	**Mental Health Services**	**$0**	**$0**	**$0**	**$300,000**	**$0**	**$300,000**	

Priorities and Allocations Committee PC approved

FY23 - Increase Funding Scenario Implemented

April 10, 2023

		Part A	MAI	Part B	State Services	State Rebate	Total	FY 2023 Allocations & Justification
	Remaining Funds to Allocate	**$397,685**	**$0**	**$0**	**$0**	**$0**	**$397,685**	
7	**Early Intervention Services**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**FY23 SS: Move $175,000 to Referral for Healthcare and Services (RHSS) since the service fits better within RHSS.**
8	**Medical Nutritional Therapy**	**$341,395**	**$0**	**$0**	**$0**	**$0**	**$341,395**	
9	**Home & Community Based Health Services**	**$0**	**$0**	**$113,315**	**$0**	**$0**	**$113,315**	
9.a	In-Home (skilled nursing & health aide)						$0	
9.b	Facility-based (adult day care)			$113,315			$113,315	
10	**Substance Abuse Treatment - Outpatient**	**$45,677**	**$0**	**$0**	**$0**	**$0**	**$45,677**	
11	**Hospice**	**$0**	**$0**	**$0**	**$259,832**	**$0**	**$259,832**	
12	**Referral for Health Care & Support Services**	**$0**	**$0**	**$0**	**$175,000**		**$175,000**	**FY23 SS: Move $175,000 from EIS to Referral to Healthcare & Support Services (RHSS) since service fits better within RHSS.**
13	**Non-Medical Case Management**	**$1,267,002**	**$0**	**$0**	**$350,000**	**$0**	**$1,617,002**	**FY23 Pt A: Per a request from Quality Improvement Committee, increase the average allocation per FTE in order to encourage higher case management salaries and address high turnover. Due to underspending in FY21, Priority & Alloc. Committee feels that level funding will be enough to allow all SLW FTE positions to be increased if agencies wish to make this change.**
13.a	SLW-Youth	$110,793					$110,793	
13.b	SLW-Testing	$100,000					$100,000	
13.c	SLW-Public	$370,000					$370,000	
13.d	SLW-CBO, includes some Rural	$686,209					$686,209	
13.e	SLW-Substance Use	$0			$350,000		$350,000	
14	**Transportation**	**$424,911**	**$0**	**$0**	**$0**	**$0**	**$424,911**	
14.a	Van Based - Urban	$252,680					$252,680	
14.b	Van Based - Rural	$97,185		$0			$97,185	
14.c	Bus Passes & Gas Vouchers	$75,046					$75,046	
15	**Emergency Financial Assistance**	**$1,645,439**	**$0**	**$0**	**$0**	**$0**	**$1,645,439**	
15.a	EFA - Pharmacy Assistance	$1,545,439					$1,545,439	**FY23 Part A: Increase by $240,000 to address ADAP issues.**
15.b	EFA - Other	$100,000					$100,000	**FY23 Part A: Decreased by $140,000 due to underspending in FY21.**
16	**Linguistic Services**	**$0**	**$0**	**$0**	**$68,000**	**$0**	**$68,000**	
17	**Outreach Services**	**$420,000**	**$0**	**$0**	**$0**	**$0**	**$420,000**	

Priorities and Allocations Committee PC approved

FY23 - Increase Funding Scenario Implemented

April 10, 2023

		Part A	MAI	Part B	State Services	State Rebate	Total	FY 2023 Allocations & Justification
	Remaining Funds to Allocate	$397,685	$0	$0	$0	$0	$397,685	
	Total Service Allocation	**$21,306,857**	**$2,382,116**	**$3,360,626**	**$2,017,338**	**$0**	**$29,066,937**	
NA	Quality Management	$428,695					$428,695	
NA	Administration - RWGA + RWPC Support	$2,208,914					$2,208,914	
NA	HCPH Indirect Cost	$0					$0	**Indirect costs are now included in RWGA Admin Budget**
	Total Non-Service Allocation	**$2,637,609**	**$0**	**$0**	**$0**	**$0**	**$2,637,609**	
	Total Grant Funds	**$23,944,466**	**$2,382,116**	**$3,360,626**	**$2,017,338**	**$0**	**$31,704,546**	

Remaining Funds to Allocate (exact same as the yellow row on top)	**$397,685**	**$0**	**$0**	**$0**	**$0**	**$397,685**

Tips:

* Do not make changes to any cells that are underlined. These cells represent running totals. If you make a change to these cells, then the formulas throughout the sheet will become "broken" and the totals will be incorrect.
* It is useful to keep a running track of the changes made to any service allocation. For example, if you want to change an allocation from $42,000 to $40,000, don't just delete the cell contents and type in a new number. Instead, type in "=42000-2000". This shows that you subtracted

Core medical **$17,549,505** **82%**

[For Staff Only]

If needed, use this space to enter base amounts to be used for calculations

	RW/A Amount Actual	MAI Amount Actual	Part B actual	State Service est.	State Rebate est.	
Total Grant Funds	**$24,342,151**	**$2,382,116**	**$3,360,626**	**$2,017,338**	**$0**	**$32,102,231**

Houston Ryan White Health Insurance Assistance Service Utilization Report

Period Reported: 09/01/2022-2/28/2023

Revised: 3/30/2023

	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	337	$35,835.22	170	*0*	*$0.00*	*0*
Medical Deductible	147	$164,576.91	130	*0*	*$0.00*	*0*
Medical Premium	3716	$1,267,800.70	838	*0*	*$0.00*	*0*
Pharmacy Co-Payment	14955	$1,028,232.03	1434	*0*	*$0.00*	*0*
APTC Tax Liability	0	$0.00	0	*0*	*$0.00*	*0*
Out of Network Out of Pocket	0	$0.00	0	*0*	*$0.00*	*0*
ACA Premium Subsidy Repayment	10	$995.87	9	*NA*	*NA*	*NA*
Totals:	19165	$2,495,448.99	2581	0	$0.00	

Comments: This report represents services provided under all grants.

2022 - 2023 DSHS State Services Service Utilization Report
9/1/2022 thru 02/28/2023 Houston HSDA
2nd Quarter

Revised 4/3/2023

Funded Service	UDC		Gender				Race				Age Group							
	Goal	YTD	Male	Female	FTM	MTF	AA	White	Hisp	Other	0-12	13-19	20-24	25-34	35-44	45-49	50-64	65+
Health Insurance Premiums	***925***	1,207	80.00%	18.80%	0.05%	1.15%	38.30%	29.50%	29.80%	2.40%	0.00%	0.00%	1.10%	11.90%	15.40%	23.10%	32.00%	16.50%
Hospice	***35***	11	81.90%	18.10%	0.00%	0.00%	27.20%	45.40%	18.40%	9.00%	0.00%	0.00%	0.00%	0.00%	9.20%	27.20%	3.60%	0.00%
Linguistic Services	***50***	45	49.80%	45.80%	0.00%	4.41%	51.10%	8.80%	4.60%	35.50%	0.00%	0.00%	2.20%	6.90%	26.60%	42.20%	13.30%	8.80%
Mental Health Services	***192***	121	84.20%	15.80%	0.00%	0.20%	42.90%	25.60%	30.50%	0.80%	0.00%	0.85%	1.65%	24.70%	19.80%	20.60%	27.50%	4.90%
Non-Medical Case Management	***315***	75	81.40%	16.00%	0.00%	2.60%	53.30%	17.40%	29.30%	0.00%	0.00%	0.00%	1.30%	13.30%	18.60%	34.60%	25.60%	6.60%
Unduplicated Clients Served By State Services Funds:	*NA*	1,459	75.45%	22.89%	0.01%	1.65%	42.58%	25.34%	22.54%	9.54%	0.00%	0.17%	4.25%	13.36%	19.92%	29.54%	24.40%	8.36%

Completed By: C.Aguries

The Houston Regional HIV/AIDS Resource Group, Inc.

FY 2122 Ryan White Part B

Procurement Report

April 1, 2022 - March 31, 2023

Reflects spending through February 2023

Spending Target: 92%

Revised 4/6/23

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 Service	$1,658,878	48%	$0	$1,658,878	$0	$1,658,878	4/1/2022	$1,425,950	86%
4	Oral Health Service -Prosthodontics	$560,000	16%	$0	$560,000	$0	$560,000	4/1/2022	$600,760	107%
5	Health Insurance Premiums and Cost Sharing (1)	$1,107,702	32%	$0	$1,107,702	$0	$1,107,702	4/1/2022	$1,046,609	94%
9	Home and Community Based Health Services (2)	$113,315	3%	$0	$113,315	$0	$113,315	4/1/2022	$58,960	52%
		$0	0%	$0	$0					
	Total Houston HSDA	3,439,895	100%	0	3,439,895	$0	$3,439,895		3,132,279	91%

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

(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) Service has ended and funds will be reallocated in HSDA 16

*Note TRG reallocated funds to avoid lapse in funds including reallocated funds from rural HSDAs.

Houston Area HIV Services Ryan White Planning Council

FY 2024 How to Best Meet the Need Quality Improvement Committee Service Category Recommendation Summary (as of 05/10/23)

Those services for which no change is recommended include:

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

Hospice Services

Local Pharmacy Assistance Program (LPAP)

Medical Nutritional Therapy/Supplements

Mental Health Services

Oral Health (Untargeted and Targeting the Northern Rural Area)

Outreach

Referral for Health Care (ADAP Enrollment Workers and Incarcerated)

Substance Abuse Treatment

Vision Care

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

Ambulatory Outpatient Medical Care (which includes Emergency Financial Assistance - Pharmacy Assistance)

- Add text to the service definition for EFA-Pharmacy stating that, within a single fiscal year, waivers can be submitted to the Administrative Agent requesting an extension of the 30 day time limit. If multiple waivers are required, they do not need to be submitted consecutively. Keep the financial eligibility the same: Primary Care = 300%, EFA-Pharmacy = 500%

Emergency Financial Assistance – Other

- Keep the service definition and financial eligibility the same at 400%, with the understanding that the Planning Council may add additional services based upon additional information, which is to be provided soon.

Health Insurance Premium and Cost Sharing Assistance

- Keep the service definition and financial eligibility the same: 0 - 400%, ACA plans must have a subsidy, and also request that the Integrated Plan's HIV Education Council increase awareness of this service among private physicians.

Linguistic Services

- Keep the service definition the same and increase the financial eligibility to 500%. Also, explore ways to use virtual technology as much as possible to make this service more accessible and easier for consumers to use. And, ask the Quality Improvement Committee to explore language justice principles in order to make all Ryan White funded services inclusive of people from all cultures.

Transportation

- Add ride sharing to the service definition and keep the financial eligibility the same at 400%.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, prevent, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2022-2026 Integrated Plan, 2021 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Aging adults (50+) f) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. (*Motion approved by QI 03/15/22)*
Part 1: Services offered by Ryan White Part A, Part B, and State Services in the Houston EMA/HSDA as of 03-14-23							
Ambulatory/Outpatient Primary Medical Care (incl. Vision):							
CBO, Adult – Part A, Including LPAP, MCM, EFA-Pharmacy, Outreach & Service Linkage (Includes OB/GYN) *See below for Public Clinic, Rural, and Vision.* ***Workgroup #1*** ***Motion:** (Starr/Murray) Votes: Y=8; N=0; Abstentions = Castillo, Leisher, Rowe, Starr, Valdez*	✔ Yes ___No	☒ EIIHA ☒ Unmet Need ☒ Continuum of Care EIIHA: The purpose of the HRSA EIIHA initiative is to identify the status-*unaware* and facilitate their entry into Primary Care Unmet Need: Facilitating entry/reentry into Primary Care reduces unmet need. Additionally, a criterion for met need is evidence of an ART prescription, and clients cannot access LPAP until they are enrolled in Primary Care. Continuum of Care: Primary	Epi (2019): An estimated 6,825 people in the EMA are living with HIV and unaware of their status. The current estimate of unmet need in the EMA is 7,187, or 25% of all PLWH. Current # of living HIV cases in EMA: 30,149 Need (2020): Rank w/in funded services: *Primary Care: #1* *LPAP/EFA: #2* *Case Management: #3* *Outreach: #14* Service Utilization (2022): # 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 health insurance marketplace	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?	**05/09/23 – the QI committee approved the HTBMN wg recommendation** **Wg Motion 1:** Update the justification chart and keep the service definitions as they are for all services in the bundle, with one exception. Add text to the service definition for EFA-Pharmacy stating that, within a single fiscal year, waivers can be submitted to

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, prevent, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2022-2026 Integrated Plan, 2021 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Aging adults (50+) f) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. (*Motion approved by QI 03/15/22)*
		Care, MCM, and LPAP support maintenance/retention in care and viral suppression for PLWH.	*Primary Care: 9,722* *(3.5% increase v. 2021)* *LPAP: 6,454* *(7% increase v. 2021)* *Medical Case Mgmt: 5,320* *(1% increase v. 2021)* *EFA-Pharmacy: 3,127* *(17.8% increase v. 2021)* *Outreach: 994* *(11% decrease v. 2021)* *Non-Medical Case Mgmt, or Service Linkage: 8,431* *(11.2% increase v. 2021)* Outcomes (FY2020): *Primary Care/LPAP:* 79% of Primary Care clients and 78% of LPAP clients were virally suppressed; *Medical Case Mgmt:* 50% of clients were in continuous HIV 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 from HRSA's Ending the HIV	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		the AA requesting an extension of the 30 day time limit. If multiple waivers are required, they do not need to be submitted consecutively. Keep the financial eligibility the same: PriCare=300%, EFA=500%, MCM/SLW/ Outreach=none, LPAP=500%.

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, prevent, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2022-2026 Integrated Plan, 2021 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Aging adults (50+) f) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. (*Motion approved by QI 03/15/22)*
			care following MCM; 68% of clients who received MCM were virally suppressed; *Outreach:* 34% of clients accessed HIV care w/in 3 mos.; 45% were virally suppressed w/in 12 mos.; *Non-Medical Case Mgmt, or Service Linkage:* 49% of clients were in continuous HIV care following Service Linkage Pops. with difficulty accessing needed services: *Primary Care*: HL, 18-24, 25-49, Rural, OOC, MSM *LPAP/EFA*: Females (sex at birth), HL, 25-49, Homeless, MSM, Rural *Outreach*: Males (sex at birth), White, 18 – 24, Homeless,	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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			MSM, RR, Transgender *Case Management:* Other/multiracial, Black/AA, 18-24, OOC, Transgender, RR, Homeless				
Public Clinic, Adult – Part A, Including LPAP, MCM, EFA-Pharmacy, Outreach & Service Linkage (Includes OB/GYN) *See below for Rural and Vision* ***Workgroup #1*** ***Motion:** (Starr/Murray)* *Votes: Y=8; N=0;* *Abstentions = Castillo, Leisher, Rowe, Starr, Valdez*	✔ Yes ___No	☒ EIIHA ☒ Unmet Need ☒ Continuum of Care EIIHA: The purpose of the HRSA EIIHA initiative is to identify the status-*unaware* and facilitate their entry into Primary Care Unmet Need: Facilitating entry/reentry into Primary Care reduces unmet need. Additionally, a criterion for met need is evidence of an ART prescription, and clients cannot access LPAP until they are	Epi (2019): An estimated 6,825 people in the EMA are living with HIV and unaware of their status. The current estimate of unmet need in the EMA is 7,187, or 25% of all PLWH. Current # of living HIV cases in EMA: 30,149 Need (2020): Rank w/in funded services: *Primary Care: #1* *LPAP/EFA: #2* *Case Management: #3* *Outreach: #14* Service Utilization (2022):	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,	Justify the use of funds: This service category: - Is a HRSA-defined Core Medical Service - Is ranked as the #1 service need by PLWH; and use has increased - Adheres to a medical home model and is bundled with LPAP, Medical Case Management, and Service Linkage - Results in desirable health outcomes for clients who access the service - Referring and linking the	Can we make this service more efficient? No Can we bundle this service? Currently bundled with: EFA, LPAP, Medical Case Management, Outreach and Service Linkage Has a recent capacity issue been identified? No Does this service assist special populations to access primary care?	**05/09/23 – the QI committee approved the HTBMN wg recommendation** **Wg Motion 1:** Update the justification chart and keep the service definitions as they are for all services in the bundle, with one exception. Add text to the service definition for EFA-Pharmacy stating that, within a single fiscal year,

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		enrolled in Primary Care. <u>Continuum of Care</u>: Primary Care, MCM, and LPAP support maintenance/retention in care and viral suppression for PLWH.	# clients served: *Primary Care: 9,722 (3.5% increase v. 2021)* *LPAP: 6,454 (7% increase v. 2021)* *Medical Case Mgmt: 5,320 (1% increase v. 2021)* *EFA-Pharmacy: 3,127 (17.8% increase v. 2021)* *Outreach: 994 (11% decrease v. 2021)* *Non-Medical Case Mgmt, or Service Linkage: 8,431 (11.2% increase v. 2021)* <u>Outcomes (FY2020)</u>: *Primary Care/LPAP:* 79% of Primary Care clients and 78% of LPAP clients were virally suppressed; *Medical Case Mgmt:* 50% of	including federal health insurance marketplace participants <u>Medical Case Management:</u> RW Part C and D <u>Service Linkage:</u> RW Part C and D, HOPWA, and a grant from a private foundation <u>EHE Funding</u>: RWGA received $1,794,295 in HRSA funding for Year 1 implementation of EHE activities. Houston Health Department (HHD) has received funding under PS19-1906 for Accelerating State and Local HIV Planning to End the HIV Epidemic. Several Houston area	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 Is this a duplicative service or activity?		waivers can be submitted to the AA requesting an extension of the 30 day time limit. If multiple waivers are required, they do not need to be submitted consecutively. Keep the financial eligibility the same: PriCare=300%, EFA=500%, MCM/SLW/ Outreach=none, LPAP=500%.

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			clients were in continuous HIV care following MCM; 68% of clients who received MCM were virally suppressed; *Outreach:* 34% of clients accessed HIV care w/in 3 mos.; 45% were virally suppressed w/in 12 mos.; *Non-Medical Case Mgmt, or Service Linkage:* 49% of clients were in continuous HIV care following Service Linkage Pops. with difficulty accessing needed services: *Primary Care*: HL, 18-24, 25-49, Rural, OOC, MSM *LPAP/EFA*: Females (sex at birth), HL, 25-49, Homeless,	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	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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Rural, Adult – Part A, Including LPAP, MCM, EFA-Pharmacy, Outreach & Service Linkage (Includes OB/GYN) *See below for Vision* ***Workgroup #1*** ***Motion:** (Starr/Murray)*	✔ 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 (2019): An estimated 6,825 people in the EMA are living with HIV and unaware of their status. The current estimate of unmet need in the EMA is 7,187, or 25% of all PLWH. Current # of living HIV cases in EMA: 30,149 Need (2020): Rank w/in funded services: *Primary Care: #1*	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	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	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?	**05/09/23 – the QI committee approved the HTBMN wg recommendation** **Wg Motion 1:** Update the justification chart and keep the service definitions as they are for all services in the bundle, with one

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Votes: Y=8; N=0; Abstentions = Castillo, Leisher, Rowe, Starr, Valdez		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.	*LPAP/EFA: #2* *Case Management: #3* *Outreach: #14* Service Utilization (2022): # clients served: *Primary Care: 9,722 (3.5% increase v. 2021)* *LPAP: 6,454 (7% increase v. 2021)* *Medical Case Mgmt: 5,320 (1% increase v. 2021)* *EFA-Pharmacy: 3,127 (17.8% increase v. 2021)* *Outreach: 994 (11% decrease v. 2021)* *Non-Medical Case Mgmt, or Service Linkage: 8,431 (11.2% increase v. 2021)* Outcomes (FY2020): *Primary Care/LPAP:* 79% of	Assistance, the public clinic's pharmacy 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	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	No Does this service assist special populations to access primary care?	exception. Add text to the service definition for EFA-Pharmacy stating that, within a single fiscal year, waivers can be submitted the AA requesting an extension of the 30 day time limit. If multiple waivers are required, they do not need to be submitted consecutively. Keep the financial eligibility the same: PriCare=300%, EFA=500%, MCM/SLW/ Outreach=none, LPAP=500%.

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			Primary Care clients and 78% of LPAP clients were virally suppressed; *Medical Case Mgmt:* 50% of clients were in continuous HIV care following MCM; 68% of clients who received MCM were virally suppressed; *Outreach:* 34% of clients accessed HIV care w/in 3 mos.; 45% were virally suppressed w/in 12 mos.; *Non-Medical Case Mgmt, or Service Linkage:* 49% of clients were in continuous HIV care following Service Linkage Pops. with difficulty accessing	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	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) 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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Vision - Part A ***Workgroup #1*** ***Motion:** (Starr/Murray) Votes: Y=11; N=0; Abstentions= Leisher, Valdez*	✔ Yes ___No	☐ EIIHA ☐ Unmet Need ☒ Continuum of Care Continuum of Care: Vision services support maintenance/ retention in HIV care by increasing access to care and treatment for HIV-related and general ocular diagnoses. Untreated ocular diagnoses may act as logistical or financial barriers to HIV care.	Epi (2019): Current # of living HIV cases in EMA: 30,149 Need (2020): Rank w/in funded services:*#5* Service Utilization (2022): # clients served: 2,659 *(13% decrease v. 2021)* Outcomes (FY2020): 750 diagnoses were reported for HIV-related ocular disorders, 97% of which were managed appropriately Pops. with difficulty accessing needed services: Females (sex at birth), Other/ multiracial, 18-24, Homeless, OOC	No known alternative funding sources exist for this service Covered under QHP?* ___Yes ✔ No *QHPs cover pediatric vision	No known alternative funding sources exist for this service	Can we make this service more efficient? No Can we bundle this service? Currently bundled with Primary Care Has a recent capacity issue been identified? No Does this service assist special populations to access primary care?	**05/09/23 – the QI committee approved the HTBMN wg recommendation** **Wg Motion:** Update the justification chart, keep the service definition and the financial eligibility the same: 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 transmissions by addressing four strategies – diagnose, treat, prevent, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2022-2026 Integrated Plan, 2021 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Aging adults (50+) f) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. (*Motion approved by QI 03/15/22)*
Clinical Case Management - Part A ***Workgroup #1*** ***Motion:** (Starr/Rowe)* *Votes: Y=10; N=0;* *Abstentions= Leisher, Rowe, Valdez*	✔ Yes ___No	☐ EIIHA ☒ Unmet Need ☒ Continuum of Care Unmet Need: Among PLWH with a history of unmet need, substance use is the #2 reason cited for falling out-of-care, making CCM is a strategy for preventing unmet need. CCM also addresses local priorities related to mental health and substance abuse co-morbidities Continuum of Care: CCM supports maintenance/ retention in care and viral suppression for PLWH.	Epi (2019): Current # of living HIV cases in EMA: 30,149 Need (2020): Rank w/in funded services:*#3* Service Utilization (2022): # clients served: 1,012 *(15.5% decrease v. 2021)* Outcomes (FY2020): 56% of clients were in continuous care following receipt of CCM. 73% of clients utilizing CCM were virally suppressed. Pops. with difficulty accessing needed services: Other/multiracial, Black/AA, 18-24, OOC, Transgender, RR, Homeless	RW Part C EHE Funding: RWGA received $1,794,295 in HRSA funding for Year 1 implementation of EHE activities. Houston Health Department (HHD) has received funding under PS19-1906 for Accelerating State and Local HIV Planning to End the HIV Epidemic. Several Houston area FQHCs received a combined total of $1,067,555 from HRSA's Ending the HIV Epidemic-Primary Care HIV Prevention (PCHP) Grant. Covered under QHP? ___Yes ✔ No	Justify the use of funds: This service category: - Is a HRSA-defined Core Medical Service - Is ranked as the #2 service need by PLWH - Results in desirable health outcomes for clients who access the service - Prevents unmet need by addressing co-morbidities related to substance abuse and mental health - Facilitates national, state, and local goals related to continuous HIV care and reducing unmet need - Addresses a system-level objective (#8) from the Comprehensive Plan and addresses certain 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?	**05/09/23 – the QI committee approved the HTBMN wg recommendation** **Wg Motion:** Update the justification chart, keep the service definition and the financial eligibility the same: none.

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, prevent, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2022-2026 Integrated Plan, 2021 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Aging adults (50+) f) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. (*Motion approved by QI 03/15/22)*
					Populations named in the Plan Is this a duplicative service or activity? - This service is funded locally by other RW Parts for specific Special Populations and for clients served by specific funded agencies/programs only		
Case Management – Non-Medical - Part A (Service Linkage at testing sites) ***Workgroup #1*** ***Motion:** (Starr/Rowe)* *Votes: Y=10; N=0;* *Abstentions= Leisher,*	___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	Epi (2019): Current # of living HIV cases in EMA: 30,149 Need (2020): Rank w/in funded services:*#3* Service Utilization (2022): # clients served: 127 *(1.5% increase v. 2021)*	RW Part C and D, HOPWA, and a grant from a private foundation EHE Funding: RWGA received $1,794,295 in HRSA funding for Year 1 implementation of EHE activities. Houston Health Department (HHD) has	Justify the use of funds: This service category: - Is a HRSA-defined 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	Can we make this service more efficient? No Can we bundle this service? No Has a recent capacity issue been identified? No	**05/09/23 – the QI committee approved the HTBMN wg recommendation** **Wg Motion:** Update the justification chart, keep the service definition and the financial eligibility the

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Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, prevent, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2022-2026 Integrated Plan, 2021 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Aging adults (50+) f) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. (*Motion approved by QI 03/15/22)*
Rowe, Valdez		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. Continuum of Care: Service	Outcomes (FY2020): Following Service Linkage, 49% of clients were in continuous HIV care, and 50% accessed HIV primary care for the first time Pops. with difficulty accessing needed services: Other/multiracial, Black/AA, 18-24, OOC, Transgender, RR, Homeless	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	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?	same: none.

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Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, prevent, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2022-2026 Integrated Plan, 2021 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Aging adults (50+) f) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. (*Motion approved by QI 03/15/22)*
		Linkage supports linkage to care, maintenance/retention in care and viral suppression for PLWH.					
Emergency Financial Assistance – Other - Part A ***Workgroup #3*** ***Motion:** (Boyle/Galley)* *Votes: Y=11; N=0;* *Abstention= Leisher, Stacy*	___Yes ✔ No	☐ EIIHA ☐ Unmet Need ☐ Continuum of Care This service started 03/01/21.	Epi (2019): Current # of living HIV cases in EMA: 30,149 Need (2020): N/A Service Utilization (2022): # clients served: 116 *(19.5% increase v. 2021)*	This service was initially provided through a grant during COVID-19 epidemic. Covered under QHP? ___Yes ✔ No		Can we make this service more efficient? No Can we bundle this service? No Has a recent capacity issue been identified? No Does this service assist special populations to access primary care? Yes	**QI Motion:** Update the justification chart, keep the financial eligibility the same at 400%, and keep the service definition the same with the understanding that the Planning Council may add additional services based upon additional information, which is to be provided soon.

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Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, prevent, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2022-2026 Integrated Plan, 2021 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Aging adults (50+) f) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. (*Motion approved by QI 03/15/22)*
Health Insurance Premium and Co-Pay Assistance **- Part A, Part B, and State Services** ***Workgroup #2*** ***Motion:** (Rowe/Murray)* *Votes: Y=10; N=0;*	✔ Yes __No	☐ EIIHA ☒ Unmet Need ☒ Continuum of Care 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	Epi (2019): Current # of living HIV cases in EMA: 30,149 Need (2020): Rank w/in funded services: #7 *% of RW clients with health insurance: 38%* *% of RW clients with Marketplace coverage: 10%* Service Utilization (2021):	No known alternative funding sources exist for this service, though consumers between 100% and 400% FPL may qualify for Advanced Premium Tax Credits (subsidies). COBRA plans seems to have fewer out-of-pocket costs.	Justify the use of funds: This service category: - Is a HRSA-defined Core 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	Can we make this service more efficient? Yes, see attached service definitions for changes. Can we bundle this service? No Has a recent capacity issue been identified? No	**05/09/23 – the QI committee approved the HTBMN wg recommendation** **Wg Motion:** Update the justification chart, keep the service definition the same, keep the financial eligibility the same: 0 - 400%, ACA

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Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, prevent, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2022-2026 Integrated Plan, 2021 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Aging adults (50+) f) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. (*Motion approved by QI 03/15/22)*
Abstention= Palmer		or private health insurance. Currently, 37% of RW clients have some form of health insurance, and 9% 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 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	# clients served: 2,357 *(5.3% increase v. 2021)* Outcomes (FY2020): 73.5% of health insurance assistance clients were virally suppressed Pops. with difficulty accessing needed services: Other / multiracial, HL, 25-49, Transgender, Homeless, MSM, Rural	Covered under QHP? ___Yes ✔ No	- 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	Does this service assist special populations to access primary care?	plans must have a subsidy, and also request that the Integrated Plan's HIV Education Council increase awareness of this service among private physicians.

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Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, prevent, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2022-2026 Integrated Plan, 2021 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Aging adults (50+) f) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. (*Motion approved by QI 03/15/22)*
		funding available to provide other needed services throughout the Continuum of Care.					
Hospice ‡ ***Workgroup #3*** ***Motion:** (Boyle/Galley)* *Votes: Y=12; N=0;* *Abstention=Stacy*	✔ Yes __No	☐ EIIHA ☒ Unmet Need ☒ Continuum of Care Unmet Need: Facilitating entry into/return of the out-of-care into primary care is the intent of reducing unmet need. Hospice contributes to this goal by providing facility-based skilled nursing and palliative care for those with a terminal diagnosis. This, in turn, may prevent PLWH from becoming out-of-care. In 2015, 19% of people with a Stage 3 HIV diagnosis were out-of-care in the EMA.	Epi (2019): Current # of living HIV cases in EMA: 30,149 Need (2020):N/a Service Utilization (2022): # clients served: 29 *(3% decrease v. 2021)* Chart Review (2019): 92% of charts had records of palliative therapy as ordered and 100% had medication administration records on file. Records indicated that bereavement counseling was offered to client's family in	Medicaid, Medicare Covered under QHP? ✔ Yes ___No	Justify the use of funds: This service category: - Is a HRSA-defined Core Medical Service - Prevents unmet need among PWA and those with co-occurring conditions - Facilitates national, state, and local goals related to retention in care and reducing unmet need - Addresses a system-level objective (#8) from the Comprehensive Plan and addresses certain Special	Can we make this service more efficient? No Can we bundle this service? No Has a recent capacity issue been identified? No Does this service assist special populations to access primary care? N/A	**05/09/23 – the QI committee approved the HTBMN wg recommendation** **Wg Motion:** Update the justification chart, keep the service definition and the financial eligibility the same: 300%.

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Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, prevent, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2022-2026 Integrated Plan, 2021 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Aging adults (50+) f) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. (*Motion approved by QI 03/15/22)*
		Hospice 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.	10% of applicable cases. Pops. with difficulty accessing needed services: N/a		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		

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, prevent, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2022-2026 Integrated Plan, 2021 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Aging adults (50+) f) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. (*Motion approved by QI 03/15/22)*
Linguistic Services‡ ***Workgroup #3*** ***Motion:** (Boyle/Galley)* *Votes: Y=12; N=0;* *Abstention=Leisher, Vargas*	___Yes ✔ No	☐ EIIHA ☒ Unmet Need ☒ Continuum of Care Unmet Need: Facilitating entry into/return of the out-of-care into primary care is the intent of reducing unmet need. By eliminating language barriers in RW-funded HIV care, this 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.	Epi (2019): Current # of living HIV cases in EMA: 30,149 Need (2020):N/a Service Utilization (2022): # clients served: 57 *(14% increase v. 2021)* *48% of Linguistics clients were African American / African origin and 36% were Asian American / Asian origin* Pops. with difficulty accessing needed services: N/a	RW providers must have the capacity to serve monolingual Spanish-speakers; Medicaid may provide language translation for *non-Spanish* monolingual clients Covered under QHP? ___Yes ✔ No	Justify the use of funds: This service category: - Is a HRSA-defined Support Service - Has limited or no alternative funding source - Removes potential barriers to entry/retention in HIV care for monolingual PLWH, thereby contributing to EIIHA goals and preventing unmet need - Facilitates national, state, and local goals related to retention in care and reducing unmet need - Linguistic and cultural competence is a Guiding Principle of the Integrated Plan Is this a duplicative service	Can we make this service more efficient? No Can we bundle this service? No Has a recent capacity issue been identified? There is no waiting list at this 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?	**QI Motion:** Update the justification chart, keep the service definition the same, and increase the financial eligibility to 500%. Also, explore ways to use virtual technology as much as possible to make this service more accessible and easier for consumers to use. And, ask the Quality Improvement Committee to explore language justice principles in order to make all Ryan White funded services inclusive of people from all cultures.

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, prevent, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2022-2026 Integrated Plan, 2021 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Aging adults (50+) f) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. (*Motion approved by QI 03/15/22)*
					or activity? - No, there is no known alternative funding for this service as designed		
Medical Nutritional Supplements and Therapy - Part A ***Workgroup #2*** ***Motion:** (Murray/Escamilla)* *Votes: Y=10; N=0;* *Abstention= Palmer*	✔ 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.	Epi (2019): Current # of living HIV cases in EMA: 30,149 Need (2020): Rank w/in funded services: *#10* Service Utilization (2022): # clients served: 518 *(12.6% decrease v. 2021)* Outcomes (FY2020):	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	Can we make this service more efficient? No Can we bundle this service? No Has a recent capacity issue been identified? No	**05/09/23 – the QI committee approved the HTBMN wg recommendation** **Wg Motion:** Update the justification chart, keep the service definition and the financial eligibility the same: 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 transmissions by addressing four strategies – diagnose, treat, prevent, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2022-2026 Integrated Plan, 2021 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Aging adults (50+) f) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. (*Motion approved by QI 03/15/22)*
		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 Nutrition Therapy facilitates viral suppression by allowing PLWH to mitigate HIV medication side effects with supplements, and increasing medication adherence.	83% of medical nutritional therapy clients with wasting syndrome or suboptimal body mass improved or maintained their body mass index. 83% of Medical Nutritional Therapy clients were virally suppressed Pops. with difficulty accessing needed services: Females (sex at birth), Black/AA, 25-49, Homeless		- 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 service may be available through Medicaid.	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 transmissions by addressing four strategies – diagnose, treat, prevent, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2022-2026 Integrated Plan, 2021 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Aging adults (50+) f) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. (*Motion approved by QI 03/15/22)*
Mental Health Services‡ (Professional Counseling) ***Workgroup #2*** ***Motion:** (Galley/Rose)* *Votes: Y=10; N=0;* *Abstention= Palmer*	✔ 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 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	Epi (2019): Current # of living HIV cases in EMA: 30,149 Need (2020): Rank w/in funded services: *#8* Service Utilization (2022): # clients served: 230 *(10% increase v. 2021)* Chart Review (2019): 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 Pops. with difficulty accessing	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 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)	Can we make this service more efficient? No Can we bundle this service? No Has a recent capacity issue been identified? No Does this service assist special populations to access primary care?	**05/09/23 – the QI committee approved the HTBMN wg recommendation** **Wg Motion:** Update the justification chart, keep the service definition and the financial eligibility the same: 500%.

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, prevent, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2022-2026 Integrated Plan, 2021 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Aging adults (50+) f) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. (*Motion approved by QI 03/15/22)*
		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.	needed services: Females (sex at birth), Other / multiracial, White, RR, Rural, Homeless		specific Special Populations (e.g., WICY), (2) those meeting income, disability, and/or age-related eligibility criteria, and (3) those with private sector health insurance.		

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Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, prevent, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2022-2026 Integrated Plan, 2021 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Aging adults (50+) f) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. (*Motion approved by QI 03/15/22)*
Oral Health Untargeted – Part B Rural (North) – Part A ***Workgroup #2*** ***Motion:** (Galley/Rowe)* *Votes: Y=10; N=0;* *Abstention= 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 (2019): Current # of living HIV cases in EMA: 30,149 Need (2020): Rank w/in funded services: *#4* Service Utilization (2022): # clients served: 3,053 *(2.6% decrease v. 2021)* Outcomes (FY2019): Oral Health Care – Rural Target: 99% 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?	**05/09/23 – the QI committee approved the HTBMN wg recommendation** **Wg Motion:** Update the justification chart, keep the service definition and the financial eligibility the same: 300%.

‡ Service Category for Part B/State Services only.

Service Category	**Is this a core service?** If no, how does the service support access to core services & support clients achieving improved outcomes?	**How does this service assist individuals *not in care** to access primary care?** **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, prevent, and respond.	**Documentation of Need** (Sources of Data include: 2020 Needs Assessment, 2022-2026 Integrated Plan, 2021 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	**Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap.** Is this service typically covered under a Qualified Health Plan (QHP)?	**Justify the use of Ryan White Part A, Part B and State Services funds for this service.** **Is this a duplicative service or activity?**	**Service Efficiency** **Can we make this service more efficient? For:** a) Clients b) Providers **Can we bundle this service?** **Has a recent capacity issue been identified?** **Does this service assist special populations to access primary care?** *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Aging adults (50+) f) Other marginalized populations	**Recommendation(s)** As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. (*Motion approved by QI 03/15/22)*
			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				

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Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, prevent, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2022-2026 Integrated Plan, 2021 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Aging adults (50+) f) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. (*Motion approved by QI 03/15/22)*
Program Support: (WITHIN THE ADMINISTRATIVE BUDGET)							
Council Support	___Yes ✔ No						
Project LEAP	___Yes ✔ No						
Blue Book	___Yes ✔ No						
Referral for Health Care – ADAP Enrollment Workers (AEW)‡ ***Workgroup #1*** ***Motion:** (Starr/Murray) Votes: Y=11; N=0; Abstentions= Leisher, Valdez*	___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	☐ 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.	Epi (2019): Current # of living HIV cases in EMA: 30,149 Need (2020): Rank w/in funded services: *#6* Service Utilization (2021*): # clients served: 6,852 **due to issues with the data system, service utilization is not available for 2022.*	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.	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	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?	**05/09/23 – the QI committee approved the HTBMN wg recommendation** **Wg Motion:** Update the justification chart, keep the service definition and the financial eligibility the same: 500%.

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Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, prevent, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2022-2026 Integrated Plan, 2021 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Aging adults (50+) f) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. (*Motion approved by QI 03/15/22)*
	worker will meet with all potential new ADAP enrollees, explain ADAP program benefits and requirements, and assist clients with submission of complete, accurate ADAP applications, as well as appropriate re-certifications and attestations.	Continuum of Care: Increased access to HIV medication coverage supports medication adherence and viral suppression.	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 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	Covered under QHP? ___Yes ✔ No	LPAP funding. Is this a duplicative service or activity? No	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 Does this service assist special populations to access primary care?	

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, prevent, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2022-2026 Integrated Plan, 2021 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Aging adults (50+) f) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. (*Motion approved by QI 03/15/22)*
Referral for Health Care – Incarcerated‡ ***Workgroup #3*** ***Motion:** (Boyle/Escamilla) Votes: Y=11; N=0; Abstention=Rowe, Vargas.*	___Yes ✔ No In 2022, this service transitioned from Early Intervention Services to Referral for Health Care and Support Services to better align with the scope of services provided. No data is available yet.	☒ EIIHA ☒ Unmet Need ☒ Continuum of Care EIIHA: Local jail policy mandates HIV testing within 14 days of incarceration, thereby identifying status-unaware members of this population. From 2016-2018, an estimated 693 PLWH were released from TDCJ into Harris County. During incarceration, 100% are linked to HIV care. This service ensures that the newly diagnosed identified in jail maintain their HIV care post-release by bridging re-entering PLWH into community-based primary care. Unmet Need: PLWH re-entering the community are at risk of	Epi (2019): Current # of living HIV cases in EMA: 30,149	EHE Funding: RWGA received $1,794,295 in HRSA funding for Year 1 implementation of EHE activities. Houston Health Department (HHD) has received funding under PS19-1906 for Accelerating State and Local HIV Planning to End the HIV Epidemic. Several Houston area FQHCs received a combined total of $1,067,555 from HRSA's Ending the HIV Epidemic-Primary Care HIV Prevention (PCHP) Grant. Covered under QHP? ___Yes ✔ No	Justify the use of funds: This service category: - Is a HRSA-defined Support Service - Links those newly diagnosed in a local EMA jail to community-based HIV primary care upon release, thereby maintaining linkage to care for and preventing unmet need in this Special Population - Addresses specific activities from Strategy #3 of the Comprehensive Plan and addresses certain Special Populations named in the Plan Is this a duplicative service or activity? No, there is no known	Can we make this service more efficient? No Can we bundle this service? No Has a recent capacity issue been identified? No Does this service assist special populations to access primary care?	**05/09/23 – the QI committee approved the HTBMN wg recommendation** **Wg Motion:** Update the justification chart, keep the service definition and the financial eligibility the same: none.

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, prevent, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2022-2026 Integrated Plan, 2021 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Aging adults (50+) f) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. (*Motion approved by QI 03/15/22)*
		lapsing their HIV care upon release from incarceration. This service helps to prevent unmet need among this population by bridging re-entering PLWH into community-based primary care post-release. Continuum of Care: This service supports linkage to care, maintenance/retention in care and viral suppression for PLWH.			alternative funding for this service as designed		
Substance Abuse Treatment – Part A ***Workgroup #2*** ***Motion:** (Rowe/Galley)* *Votes: Y=10; N=0;* *Abstention= Palmer*	☑ 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	Epi (2019): Current # of living HIV cases in EMA: 30,149 Need (2020): Rank w/in funded services: *#12* Service Utilization (2022): # clients served: 10	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	Can we make this service more efficient? No Can we bundle this service? No Has a recent capacity issue been identified?	**05/09/23 – the QI committee approved the HTBMN wg recommendation** **Wg Motion:** Update the justification chart, keep the service definition and

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, prevent, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2022-2026 Integrated Plan, 2021 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Aging adults (50+) f) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. (*Motion approved by QI 03/15/22)*
		prevent or reduce unmet need. 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 use that may act as barriers to HIV care.	*(61.5% decrease v. 2021)* Outcomes (FY2019): 50% of clients accessed primary care at least once after receiving Substance Abuse Treatment services and 89% were virally suppressed. Pops. with difficulty accessing needed services: Black/AA, 18-24, RR, Homeless		addressing the #2 cause 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,	No	the financial eligibility the 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? **In care:* EIIHA: Early Identification of Individuals with HIV/AIDS seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, prevent, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2022-2026 Integrated Plan, 2021 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Aging adults (50+) f) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. (*Motion approved by QI 03/15/22)*
					and (2) those with private sector health insurance.		
Case Management – Non-Medical - State Services‡ (Targeting Substance Use Disorders) ***Workgroup #2*** ***Motion:** (Murray/Galley) Votes: Y=7; N=0; Abstentions= Kelly, Palmer, Rowe, Titus.*	___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	Epi (2019): Current # of living HIV cases in EMA: 30,149 Need (2020): Rank of all types of case management w/in funded services: #3 Service Utilization (2022): # clients served: 173 (45% decrease v. 2021) Pops. with difficulty accessing	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,	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	**05/09/23 – the QI committee approved the HTBMN wg recommendation** **Wg Motion:** Update the justification chart, keep the service definition and the financial eligibility the same: none.

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, prevent, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2022-2026 Integrated Plan, 2021 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Aging adults (50+) f) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. (*Motion approved by QI 03/15/22)*
		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 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	needed services: *Case Management:* Other/multiracial, Black/AA, 18-24, OOC, Transgender, RR, Homeless		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	access primary care?	

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, prevent, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2022-2026 Integrated Plan, 2021 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Aging adults (50+) f) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. (*Motion approved by QI 03/15/22)*
		PLWH.					
Transportation – Pt A (Van-based, bus passes & gas vouchers) ***Workgroup #3*** ***Motion:** (Boyle/Galley)* *Votes: Y=11; N=0;* *Abstention= Vargas*	___Yes ✔ No	☐ EIIHA ☒ Unmet Need ☒ Continuum of Care Unmet Need: Lack of transportation is the *fourth* most commonly-cited barrier among PLWH to accessing HIV core medical services. Transportation services eliminate this barrier to care, thereby supporting PLWH in continuous HIV care.	Epi (2019): Current # of living HIV cases in EMA: 30,149 Need (2020): Rank w/in funded services: *#9* Service Utilization (2022): # clients served: *Van-based: 946* *(15% decrease v. 2021)* *Bus pass: 1,334*	Medicaid, RW Part D (small amount of funds for parking and other transportation needs), and by other public sources for (1) specific Special Populations (e.g., WICY), and (2) those meeting income, disability, and/or age-related eligibility criteria. EHE funding provides	Justify the use of funds: This service category: - Is a HRSA-defined Support Service - Is ranked as the #2 need among Support Services by PLWH - Results in clients accessing HIV primary care - Removes potential barriers to entry/retention in HIV	Can we make this service more efficient? No Can we bundle this service? No Has a recent capacity issue been identified? No	**05/09/23 – the QI committee approved the HTBMN wg recommendation** **Wg Motion:** Update the justification chart; add ride sharing to the service definition and the financial eligibility the 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 transmissions by addressing four strategies – diagnose, treat, prevent, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2022-2026 Integrated Plan, 2021 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Aging adults (50+) f) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. (*Motion approved by QI 03/15/22)*
		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.	*(5.9% increase v. 2021)* Outcomes (FY2020): 67% of clients accessed primary care at least once after using van transportation; and 37% of clients accessed primary care after using bus pass services. Pops. with difficulty accessing needed services: Females (sex at birth), Other / multiracial, White, Homeless, OOC, RR	ridesharing with no financial eligibility. Covered under QHP*? ___Yes ✔ No	care, thereby contributing to EIIHA goals and preventing unmet need - Facilitates national, state, and local goals related to continuous HIV care and reducing unmet need Is this a duplicative service or activity? - This service is funded locally by other public sources for (1) specific Special Populations (e.g., WICY), and (2) those meeting income, disability, and/or age-related eligibility criteria.	Does this service assist special populations to access primary care?	

‡ Service Category for Part B/State Services only.

Service Category	Justification for Discontinuing the Service
Part 2: Services *allowed* by HRSA but not offered by Part A, Part B or State Services funding in the Houston EMA/HSDA as of 03-01-23 ***In order for any of the services listed below to be considered for funding, a New Idea Form must be submitted to the Office of Support for the Ryan White Planning Council no later than 5:00 p.m. on May 1, 2023. This form is available by calling the Office of Support: 832 927-7926***	
Ambulatory/Outpatient Primary Medical Care – Pediatric (incl. Medical Case Management and Service Linkage)	Service available from alternative sources.
Buddy Companion/Volunteerism	Low use, need and gap according to the 2002 Needs Assessment (NA).
Childcare Services (In Home Reimbursement; at Primary Care sites)	Primary care sites have alternative funding to provide this service so clients will continue to receive the service through alternative sources.
Food Pantry (Urban)	Service available from alternative sources.
HE/RR	In order to eliminate duplication, eliminate this service but strengthen the patient education component of primary care.
Home and Community-based Health Services (In-home services)	Category unfunded due to difficulty securing vendor.
Home and Community-based Health Services (facility-based)	Category unfunded due to many years of underutilization.
Housing Assistance (Emergency rental assistance) **Housing Related Services** (Housing Coordination)	According to the HOPWA representative, they provide significant funding for emergency rent and utility assistance. (See City Council approved allocations.) But, HOPWA does not give emergency shelter vouchers because they feel there are shelters for this purpose and because it is more prudent to use limited resources to provide long-term housing.
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.

DRAFT

TARGETING FOR FY 2024 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	**Emergency Financial Assistance - Other**
					X	**Emergency Financial Assistance - Pharmacy Assistance**
					X	**Health Insurance**
					X	**Hospice Services**
					X	**Linguistic Services**
					X	**Local Pharmacy Assistance Program**
					X	**Medical Nutritional Therapy**
					X	**Mental Health Treatment**
					X****	**Outreach Services - Primary Care Retention in Care**
			X***		X	**Oral Health**
				X	X‡	**Referral for Health Care -** ADAP Enrollment Workers‡ & Incarcerated
					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 2021 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 HEALTH SERVICES RYAN WHITE PLANNING COUNCIL

EST. JULY 10, 2008 **REV JANUARY 1, 2018** **POLICY No. 400.03**

PROCESS FOR APPROVING THE COUNCIL SUPPORT BUDGET

PURPOSE

This policy is to establish the process used to review and approve the annual budget for the Houston Area HIV Health Services Ryan White Planning Council and the Council Support Staff.

AUTHORITY

The authority given to the Operations Committee by the Council regarding adoption and approval of By-laws Rev. 01/18 and under the order of the Chief Elected Official (CEO) of Harris County, initiate procedures by which day to day business of the Council is to take place. According to the Ryan White HIV/AIDS Treatment Extension Act of 2009, and a letter of guidance issued by the HIV/AIDS Bureau (April 26, 2007) "Section 2604(h) specifies that the chief elected official of an eligible area shall not use in excess of 10 percent of amounts received under a Part A grant for administrative expenses. The amounts may be used for administrative activities that include all activities associated with the grantee's contract award procedures, including activities carried out by the HIV Health Services Planning Council as established under section 2602 (b) of the Act… While Part A Planning Councils may use Ryan White Program funds to support certain activities related to carrying out required functions, the Planning Council must also work with the grantee to agree on a budget for Planning Council support activities. Reasonable and necessary activities include both tasks directly related to legislative functions and the following costs that support multiple functions:

- Staff support (professional and clerical)
- Expenses of Planning Council members as a result of their participation
- Activities publicizing the Planning Council's activities for people living with HIV and efforts to substantively enhance community participation in Planning Council activities
- Developing and implementing Planning Council grievance procedures for decisions related to funding."

INTENT

Create an atmosphere of mutual respect and transparency as the Council works with the CEO and the grantee to agree on the annual Council Support budget.

PROCEDURE

The following describes the steps to be followed in order to secure approval of the Council Support budget:

1. The Director of the Office of Support prepares a proposed budget.

2. The Director distributes the proposed budget to members of the Operations Committee, the liaison to the CEO and the manager of Harris County Public Health/Ryan White Grant Administration Section (the "grantee").
3. The grantee reviews the budget in terms of Ryan White Program guidelines and discusses any concerns with both the Director of the Office of Support and the assigned liaison to the CEO.
4. The Director conveys this input to the Operations Committee when they meet to review and make recommendations on the proposed budget.
5. The Operations Committee reviews the budget to make sure that it supports activities related to carrying out the legislatively mandated role of the Council and prepares a committee recommendation regarding the proposed budget.
6. The Steering Committee and Council review and vote on the recommendations of the Operations Committee regarding the Council Support budget.
7. The Director provides the grantee with the Council approved budget.
8. The grantee reviews the budget and provides written confirmation to the Director of the Office of Support and the liaison with the County Judge's Office stating that the budget is consistent with HRSA requirements and County rules and no changes are necessary. If the budget is not consistent with HRSA requirements and County rules, the budget is returned to the Director of the Office of Support who revises the budget and begins the process at Step 1 as described above.

Houston Ryan White Planning Council
FY 2023 Council Support Budget
March 1, 2023 - February 29, 2024
(Revised 05-23-23)

		Subtotal	Revisions	Total
PERSONNEL		**$267,382**	**($5,000)**	
RWPC Manager (V. Williams) ($6877/mo. X 12 mos. X 100%) Responsible for overall functioning of planning council, supervises all support staff.	$82,525			
RWPC Health Planner (M. Hudson) ($6493/mo. X 12 mos. X 100%) Responsible for coordinating Comprehensive Planning and Needs Assessment activities. Analyzing and presenting data.	$77,918			
RWPC Coordinator (D. Beck) ($4,900/mo x 12 mos. X 100%) Coordinates support activities for the RW Planning Council and committees. Provides routine administrative duties (minutes, scheduling of meetings, mailouts, etc.).	$58,800			
Assistant Coordinator (R. Avila) ($4011/mo x 12 mos. X 100%) Coordinates support activities for assigned committees. Provides routine administrative duties (minutes, scheduling of meetings, mailouts, etc.)	$48,139		**$2,500**	
FRINGE		**$134,687**	**Edit to match changes**	
Social Security @ 7.38%	$19,733			
Health Insurance (4 x $17,252/FTE)	$69,008			
Retirement @ 14.25%	$40,776			
Workers Compensation @ 0.88%	$2,353			
Unemployment Insurance @ 0.10%	$267			
Incentives/allowances	$2,550			
EQUIPMENT				
Replace obsolete computers and tablets and purchase equipment needed to allow Ryan White volunteers and students access to virtual meetings	$1,000	**$1,000**		

Houston Ryan White Planning Council
FY 2023 Council Support Budget
March 1, 2023 - February 29, 2024
(Revised 05-23-23)

		Subtotal	Total
TRAVEL		**$2,800**	
Local Travel: $0.655/mile for Planning Council Support Staff	$800		
Out of EMA travel: Two out of town trips for either Office of Support staff and/or Ryan White volunteers to attend HIV related conferences.	$2,000		
SUPPLIES General consumable office supplies including materials for Council members & public meetings.	$6,109	**$6,109**	
CONTRACTUAL	$0	**$0**	
OTHER		**$128,277**	
Rental Fees for Office & Meeting Rooms Short-term rental agreement for office and meeting space for RW volunteers & staff while County building is being remodeled. ($2,000/mos. X 9 mos. = $18,000)	$18,000		
Moving Costs			**$2,500**
HIV Needs Assessment: Expensies related to gathering needs assessment information from 700 consumers and others in the 6-county service area	$13,685		**($10,000)**
Reimbursement for Volunteer Expenses: Reimbursement for meals, childcare, travel, gift cards/incentives & other eligible expenses resulting from participation in Council approved/HRSA grant required activities.	$19,000		
Meeting Room Rentals (2-3 meetings per month): Off-site room rentals for Council related meetings. Attendance ranges from 18 - 85 people per meeting.	$6,000		
Advertising for PC Activities: For publication of meeting announcements in community papers; invitations to participate in needs assessment activities and focus groups; advertisments for additional volunteers.	$5,000		
Communications (telephone and computer): For local and long distance phone expenses, equipment and internet charges.	$3,500		

Houston Ryan White Planning Council
FY 2023 Council Support Budget
March 1, 2023 - February 29, 2024
(Revised 05-23-23)

		Subtotal	Total
Council Education: For speakers & training costs for ongoing training to insure that key decision-makers receive necessary information. This includes a January Orientation and a mid-year Council meeting to be held off-site in Harris County.	$4,500		
Project LEAP Student Reimbursement: 45 participants for 17-week & 16-week courses including travel, childcare, gift card/incentives & other expenses resulting from participation in required consumer training activities in English and Spanish related to the Ryan White grant.	$7,592		
Project LEAP Education: Training costs for 17 weeks & 16 weeks including facilitation & speaker fees, translators & educational materials in English and Spanish.	$15,000	**$10,000**	
Consumer Education: Training costs for up to 5 seminars including speaker fees, translators and educational materials.	$2,500		
Interpreter Services: For Spanish-speaking & sign-language interpretation services during Council meetings, public hearings, focus groups and more.	$10,000		
Fees and Dues: Registration costs for attending meetings, trainings & conferences related to HIV/AIDS health planning.	$500		
English/Spanish Translation (written): For professional translation of Council, Project LEAP & other educational materials into Spanish.	$5,000		
Storage Unit for HIV Resource Directories: Storage for 30,000 directories @ $250/month	$3,000		
Postal Machine Rental & Postage: For mailouts of Committee and Council agendas, minutes and attachments; HIV/AIDS Resource Guides for those who are unable to pickup in person; other office of support communications.	$6,000		
Copier Rental: For rental, service agreement of high-use Xerox machine used by Council staff.	$9,000		
TOTAL - (NO CHANGE)			**$540,255**

Houston Ryan White Planning Council
FY 2024 Council Support Budget
March 1, 2024 - February 28, 2025
(As of 05-23-23)

		Subtotal	Total
PERSONNEL		**$274,474**	
RWPC Manager (V. Williams) ($6930/mo. X 12 mos. X 100%) Responsible for overall functioning of planning council, supervises all support staff.	$83,158		
RWPC Health Planner (M. Hudson) ($6493/mo. X 12 mos. X 100%) Responsible for coordinating Comprehensive Planning and Needs Assessment activities. Analyzing and presenting data.	$77,918		
RWPC Coordinator (D. Beck) ($4938/mo x 12 mos. X 100%) Coordinates support activities for the RW Planning Council and committees. Provides routine administrative duties (minutes, scheduling of meetings, mailouts, etc.).	$59,259		
Consumer Engagment (R. Avila) ($4512/mo x 12 mos. X 100%) Coordinates support activities for assigned committees. Provides routine administrative duties (minutes, scheduling of meetings, mailouts, etc.)	$54,139		
FRINGE		**$133,616**	
Social Security @ 7.38%	$20,256		
Health Insurance (4 x $17,252/FTE)	$69,008		
Retirement @ 14.25%	$39,113		
Workers Compensation @ 0.88%	$2,415		
Unemployment Insurance @ 0.10%	$274		
Incentives/allowances	$2,550		
EQUIPMENT			
Replace obsolete computers and tablets and purchase equipment needed to allow Ryan White volunteers and students access to virtual meetings	$4,000	**$4,000**	

Houston Ryan White Planning Council
FY 2024 Council Support Budget
March 1, 2024 - February 28, 2025
(As of 05-23-23)

		Subtotal	Total
TRAVEL		**$8,800**	
Local Travel: $0.655/mile for Planning Council Support Staff	$800		
Out of EMA travel: Two out of town trips for either Office of Support staff and/or Ryan White volunteers to attend HIV related conferences.	$8,000		
SUPPLIES General consumable office supplies including materials for Council members & public meetings.	$6,000	**$6,000**	
CONTRACTUAL	$0	**$0**	
OTHER		**$136,029**	
Rental Fees for Office & Meeting Rooms Short-term rental agreement for office and meeting space for RW volunteers & staff while County building is being remodeled. ($2,000/mos. X 12 mos. = $24,000)	$12,000		
Moving Costs	$2,500		
Resource Guide	$31,000		
Reimbursement for Volunteer Expenses: Reimbursement for meals, childcare, travel, gift cards/incentives & other eligible expenses resulting from participation in Council approved/HRSA grant required activities.	$19,000		
Advertising for PC Activities: For publication of meeting announcements in community papers; invitations to participate in needs assessment activities and focus groups; advertisments for additional volunteers.	$5,000		
Communications (telephone and computer): For local and long distance phone expenses, equipment and internet charges.	$3,500		
Council Education: For speakers & training costs for ongoing training to insure that key decision-makers receive necessary information. This includes a January Orientation and a mid-year Council meeting to be held off-site in Harris County.	$4,500		

Houston Ryan White Planning Council
FY 2024 Council Support Budget
March 1, 2024 - February 28, 2025
(As of 05-23-23)

		Subtotal	Total
Project LEAP Student Reimbursement: 45 participants for 17-week & 16-week courses including travel, childcare, gift card/incentives & other expenses resulting from participation in required consumer training activities in English and Spanish related to the Ryan White grant.	$7,592		
Project LEAP Education: Training costs for 17 weeks & 16 weeks including facilitation & speaker fees, translators & educational materials in English and Spanish.	$15,000		
Consumer Education: Training costs for up to 5 seminars including speaker fees, translators and educational materials.	$2,500		
Interpreter Services: For Spanish-speaking & sign-language interpretation services during Council meetings, public hearings, focus groups and more.	$10,000		
Fees and Dues: Registration costs for attending meetings, trainings & conferences related to HIV/AIDS health planning.	$500		
English/Spanish Translation (written): For professional translation of Council, Project LEAP & other educational materials into Spanish.	$5,000		
Storage Unit for HIV Resource Directories: Storage for 30,000 directories @ $250/month	$3,000		
Postal Machine Rental & Postage: For mailouts of Committee and Council agendas, minutes and attachments; HIV/AIDS Resource Guides for those who are unable to pickup in person; other office of support communications.	$6,000		
Copier Rental: For rental, service agreement of high-use Xerox machine used by Council staff.	$9,000		
TOTAL			**$562,919**

REVISED – 05-23-23

MEMO

To: Houston Ryan White Planning Council

From: Members, Operations Committee

Date: Tuesday, May 15, 2023

Re: Proposed FY 2024 Council Support Budget

Attached you will find the proposed FY 2024 Council Support Budget, which is higher than the FY 2023 budget by $~~65,327~~ $22,664.

FY 2024 proposed budget	$562,919
FY 2023 budget	- 540,255
Difference	$ 22,664

The reason for the increase in FY 2024 is because of the following additional activities in FY 2024:

New HIV Resource Guide/Blue Book	$ 31,000
National HRSA Conference (hybrid format), August 2024	8,000
Rental fees at Bering Church for 6 months	12,000

Houston Ryan White Planning Council

Request for Food During Ryan White Meetings or Events

(05-09-23)

In 20_____, I was appointed to serve on the (check all that apply):

Committee(s):

_____ Affected Community

_____ Comprehensive HIV Planning

_____ Operations

_____ Priority & Allocations

_____ Quality Improvement

_____ Steering

Other:

_____ Ryan White Planning Council

_____ Project LEAP Class

_____ Proyecto VIDA Class

_____ Integrated Planning Workgroup(s): _____

_____ Other: _____

When one of my meetings takes place during a mealtime,

I, (print your name) _____

request a meal because I have medication that must be taken with food.

Signature: _____ Date: _____