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: Members, Houston Ryan White Planning Council

Copy: Glenn Urbach, Ryan White Grant Administration
Mauricia Chatman, Ryan White Grant Administration
Tiffany Shepherd, The Resource Group
Sha'Terra Johnson, The Resource Group
Diane Beck, Ryan White Office of Support

Email Copy Only:
Lt. Commander Lawrence Momodu, HRSA
Commander Luz Rivera, PACE
Commander Rodrigo Chavez, PACE
Jason Black, Ryan White Grant Administration
Ann Robison, the Montrose Center
Marlene McNeese, Houston Health Department
Charles Henley, Consultant

From: Tori Williams, Director, Ryan White Office of Support
Date: Wednesday, May 25, 2023
Re: Meeting Announcement

Please remember that the Council will be using a hybrid format at all meetings in 2023. That means members can participate by phone, computer or in person. **But, we need 11 people to meet in-person at Bering Church in the Montrose area in order to make quorum.** In an effort to entice you to come in person, we will be providing sandwich trays to those who have a medical need. Others are encouraged to bring a brown bag lunch. Please contact Rod ASAP to RSVP, even if you cannot attend:

Ryan White Planning Council Meeting

12 noon, Thursday, June 8, 2023

Meeting Location: Online or via phone
Click on the following link to join the Zoom meeting:
https://us02web.zoom.us/j/995831210?pwd=UnlNdExMVFFqeVgzQ0NJNkpieXlGQT09
Meeting ID: 995 831 210 Passcode: 577264
Or, use the following telephone number: 346 248-7799

In Person: Bering Church, 1440 Harold St, Houston, Texas 77006. Use parking lot behind the church and ring the bell to be admitted into the building.

Please RSVP to Rod at 832 927-7926 or by responding to her email reminders. Thank you.

HOUSTON AREA HIV SERVICES
RYAN WHITE PLANNING COUNCIL

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We envision an educated community where the needs of all persons living with and/or affected by HIV are met by accessible, effective, and culturally sensitive health and psychosocial services that are part of a fully coordinated system.

The community will continue to intervene responsibly until the end of the epidemic.

The Houston Eligible Metropolitan Area (EMA) Ryan White Planning Council will improve the quality of life and advocate for those living with and/or affected by HIV by taking a leadership role in the planning and assessment of HIV resources.

AGENDA

12 noon, June 8, 2023

Meeting Location: Online or via phone

Click on the following link to join the Zoom meeting:
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In Person: Bering Church, 1440 Harold St, Houston, Texas 77006

I. Call to Order — Crystal R. Starr, Chair, Ryan White Planning Council
   A. Welcome and Moment of Reflection
   B. Adoption of the Agenda
   C. Approval of the Minutes
   D. Results of an Anal Cancer Study — Alan Nyitray, Center for AIDS Intervention Research, Medical College of Wisconsin

II. Public Comments 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 the Council Secretary who would be happy to read the comments on behalf of the individual at this point in the meeting. The Chair of the Council has the authority to limit public comment to 1 minute per person. All information from the public must be provided in this portion of the meeting. Council members please remember that this is a time to hear from the community. It is not a time for dialogue. Council members and staff are asked to refrain from asking questions of the person giving public comment.)

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.

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 — Ronnie Galley and Cecilia Ligons, Co-Chairs
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.

V. Report from the Office of Support — Tori Williams, Director

VI. Report from Ryan White Grant Administration — Glenn Urbach, Manager

VII. Report from The Resource Group — Sha'Terra Johnson, Health Planner

VIII. Medical Updates — Shital Patel, MD, Baylor College of Medicine

IX. New Business (**During Virtual Meetings, Reports Will Be Limited to Written Reports Only**)

A. AIDS Educational Training Centers (AETC) — Shital Patel
B. Ryan White Part C Urban and Part D — Dawn Jenkins
C. HOPWA — Megan Rowe
D. Community Prevention Group (CPG) — Kathryn Fergus
E. Update from Task Forces:
- Sexually Transmitted Infections (STI)
- African American — Sha'Terra Johnson
- Latino — Steven Vargas
- Youth
- MSM
- Hepatitis C — Steven Vargas
- Project PATHH (Protecting our Angels Through Healing Hearts) formerly Urban AIDS Ministry — Skeet Boyle?

F. HIV and Aging Coalition — Skeet Boyle
G. Texas HIV Medication Advisory Committee — Bruce Turner
H. Positive Women's Network — Tana Pradia or Diana M.
I. Texas Black Women's Initiative — Sha'Terra Johnson
J. Texas HIV Syndicate — Steven Vargas
K. END HIV Houston — Jason Black?
L. Texans Living with HIV Network — Steven Vargas?

IX. Announcements

X. Adjournment

* *ADAP = Ryan White Part B AIDS Drug Assistance Program*
** *TDSHS = Texas Department of State Health Services*

HOUSTON AREA HIV SERVICES
RYAN WHITE PLANNING COUNCIL

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The Houston Eligible Metropolitan Area (EMA) Ryan White Planning Council will improve the quality of life and advocate for those living with and/or affected by HIV by taking a leadership role in the planning and assessment of HIV resources.

MINUTES

12 noon, Thursday, May 11, 2023
Meeting Location: St. Philip Presbyterian Church 4807 San Felipe, Houston, Texas 77056
and Zoom teleconference

MEMBERS PRESENT	MEMBERS ABSENT	OTHERS PRESENT
Crystal Starr, Chair	Kevin Aloysius, excused	Charles Henley, Consultant
Ardry "Skeet" Boyle, Vice Chair	Servando Arellano, excused	
Josh Mica, Secretary	Rosalind Belcher	**STAFF PRESENT**
Titan Capri	Caleb Brown, excused	*Ryan White Grant Administration*
Robert "Bobby" Cruz	Johanna Castillo, excused	Glenn Urbach
Kenia Gallardo	Tony Crawford	Mauricia Chatman
Ronnie Galley	Kathryn Fergus, excused	
Dawn Jenkins	Daphne L. Jones, excused	*The Resource Group*
Peta-gay Ledbetter	Roxanne May, excused	Sha'Terra Johnson
Cecilia Ligons	Rodney Mills, excused	
Diana Morgan	Shital Patel, excused	*Office of Support*
Allen Murray	Evelio Salinas Escamilla, excused	Tori Williams
Oscar Perez	Imran Shaikh, excused	Mackenzie Hudson
Tana Pradia	Faye Robinson, excused	Diane Beck
Paul Richards	C. Bruce Turner, excused	Rod Avila
Pete Rodriguez		
Ryan Rose		
Megan Rowe		
Robert Sliepka		
Carol Suazo		
Steven Vargas		

Call to Order: Crystal Starr, Chair, called the meeting to order at 12:14 p.m.

During the opening remarks, Starr said thank you and presented flowers to Lorrie Castle, Operations Manager at St. Philip Presbyterian Church, with the following words of appreciation, "Lorrie has welcomed us and made us feel at home in this lovely church. We extend our deepest thanks to the Pastor

and all of the church members. We have enjoyed working with you and will miss you".

Starr continued by stating that April is usually our busiest time of year because of the How To Best Meet the Need (HTBMN" process. She thanked the HTBMN workgroup co-chairs, the co-chairs of the Quality Improvement Committee and the staff of the Office of Support and Administrative Agencies.

Additional HTBMN 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 hosted 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.

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

Approval of the Minutes: ***Motion #2:*** *it was moved and seconded (Mica, Boyle) to approve the April 13, 2023 minutes.* **Motion carried.** Abstentions: Capri, Ledbetter, Rodriguez, Suazo.

Roles and Responsibilities of Ryan White Part A Stakeholders: Charles Henley, Consultant, presented the attached PowerPoint.

Public Comment and Announcements: None..

Reports from Committees
Comprehensive HIV Planning Committee: Allen Murray, 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**. Abstentions: Jenkins, Perez.

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, summarized the attached report.

Task Force Reports: Starr said that the Council agreed some time ago that they preferred not to have verbal Task Force Reports while meeting on Zoom. The Office of Support is happy to receive and distribute written reports in advance of all Council meetings.

Announcements: Mica announced the opening of the Poz Impact non-profit auto repair shop, services are focused on the LGBTQ and HIV communities as well as women. For information contact Info@pozimpact.org.

Adjournment: ***Motion:*** *it was moved and seconded (Boyle, Ligons) to adjourn the meeting at 1:34 p.m.* **Motion Carried.**

Respectfully submitted,

_____ Date _____
Victoria Williams, Director

Draft Certified by
Council Chair: _____ Date _____

Final Approval by
Council Chair: _____ Date _____

Council Voting Records for May 11, 2023

C = Chaired the meeting ja = Just arrived lm = Left the meeting lr = Left the room VP = Via phone	**Motion #1** Agenda **Carried**				**Motion #2** Minutes **Carried**					**Motion #1** Agenda **Carried**				**Motion #2** Minutes **Carried**			
MEMBERS	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	MEMBERS	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN
Crystal Starr, Chair				C				C	Carol Suazo		X						X
Ardry "Skeet" Boyle, Vice Chair		X				X			Steven Vargas		X				X		
Josh Mica, Secretary		X				X											
Titan Capri		X						X	**MEMBERS ABSENT**								
Robert "Bobby" Cruz		X				X			Kevin Aloysius								
Kenia Gallardo		X				X			Servando Arellano								
Ronnie Galley		X				X			Rosalind Belcher								
Dawn Jenkins		X				X			Caleb Brown								
Peta-gay Ledbetter		X						X	Johanna Castillo								
Cecilia Ligons		X				X			Tony Crawford								
Diana Morgan		X				X			Kathryn Fergus								
Allen Murray		X				X			Daphne L. Jones								
Oscar Perez		X				X			Roxanne May								
Tana Pradia		X				X			Rodney Mills								
Paul Richards		X				X			Shital Patel								
Pete Rodriguez		X						X	Evelio Salinas Escamilla								
Ryan Rose		X				X			Imran Shaikh								
Megan Rowe		X				X			Faye Robinson								
Robert Sliepka		X				X			C. Bruce Turner								

C = Chaired the meeting ja = Just arrived lm = Left the meeting lr = Left the room VP = Via phone	**Motion #3** Reallocation of FY23 Unallocated Funds: Office of Support budget **Carried**				**Motion #4** Reallocation of FY23 Unallocated Funds: EFA-Pharmacy **Carried**					**Motion #3** Reallocation of FY23 Unallocated Funds: Office of Support budget **Carried**				**Motion #4** Reallocation of FY23 Unallocated Funds: EFA-Pharmacy **Carried**			
MEMBERS	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	MEMBERS	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN
Crystal Starr, Chair				C				C	Carol Suazo		X				X		
Ardry "Skeet" Boyle, Vice Chair		X				X			Steven Vargas		X				X		
Josh Mica, Secretary		X				X											
Titan Capri		X				X			**MEMBERS ABSENT**								
Robert "Bobby" Cruz		X				X			Kevin Aloysius								
Kenia Gallardo		X				X			Servando Arellano								
Ronnie Galley		X				X			Rosalind Belcher								
Dawn Jenkins		X						X	Caleb Brown								
Peta-gay Ledbetter		X				X			Johanna Castillo								
Cecilia Ligons		X				X			Tony Crawford								
Diana Morgan		X				X			Kathryn Fergus								
Allen Murray		X				X			Daphne L. Jones								
Oscar Perez		X						X	Roxanne May								
Tana Pradia		X				X			Rodney Mills								
Paul Richards		X				X			Shital Patel								
Pete Rodriguez		X				X			Evelio Salinas Escamilla								
Ryan Rose		X				X			Imran Shaikh								
Megan Rowe		X				X			Faye Robinson								
Robert Sliepka		X				X			C. Bruce Turner								

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

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.

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		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%.

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			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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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)*
			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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			MSM, Rural *Outreach*: Males (sex at birth), White, 18 – 24, Homeless, MSM, RR, Transgender *Case Management:* Other/multiracial, Black/AA, 18-24, OOC, Transgender, RR, Homeless				
Rural, Adult – Part A, Including LPAP, MCM, 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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			needed services: *Primary Care*: HL, 18-24, 25-49, Rural, OOC, MSM *LPAP/EFA*: Females (sex at birth), HL, 25-49, Homeless, MSM, Rural *Outreach*: Males (sex at birth), White, 18 – 24, Homeless, MSM, RR, Transgender *Case Management:* Other/multiracial, Black/AA, 18-24, OOC, Transgender, RR, Homeless				

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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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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.

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					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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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.

‡ 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)*
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

‡ Service Category for Part B/State Services only.

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

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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)*
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.		

‡ 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 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%.

‡ 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)*
	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?	

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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)*
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

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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)*
		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%.

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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? **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.

Prepared by: Ryan White Grant Administration

FY 2023 Ryan White Part A and MAI Service Utilization Report

RW PART A SUR- 1st Quarter (3/1-5/31)																		
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**	**2,458**	**75%**	**23%**	**3%**	**40%**	**12%**	**2%**	**46%**	**0%**	**0%**	**4%**	**26%**	26%	13%	29%	3%
1.a	Primary Care - Public Clinic (a)	2,350	1,017	73%	25%	2%	38%	9%	1%	52%	0%	0%	2%	17%	24%	16%	36%	4%
1.b	Primary Care - CBO Targeted to AA (a)	1,060	570	69%	27%	4%	98%	0%	1%	0%	0%	0%	7%	35%	25%	10%	20%	3%
1.c	Primary Care - CBO Targeted to Hispanic (a)	960	552	80%	16%	4%	0%	0%	0%	100%	0%	1%	5%	33%	29%	12%	20%	1%
1.d	Primary Care - CBO Targeted to White and/or MSM (a)	690	223	85%	14%	1%	1%	83%	15%	1%	0%	0%	2%	24%	26%	11%	35%	3%
1.e	Primary Care - CBO Targeted to Rural (a)	400	100	71%	29%	0%	31%	27%	2%	40%	0%	0%	4%	28%	23%	11%	29%	5%
1.f	Primary Care - Women at Public Clinic (a)	1,000	258	0%	99%	0%	39%	7%	1%	53%	0%	0%	1%	9%	26%	20%	39%	5%
1.g	Primary Care - Pediatric (a)	7	0															
1.h	Vision	1,600	384	77%	22%	2%	38%	13%	1%	48%	0%	0%	3%	19%	25%	11%	38%	5%
2	**Medical Case Management (f)**	**3,075**	**1,015**															
2.a	Clinical Case Management	600	240	67%	30%	3%	56%	16%	2%	26%	0%	0%	2%	20%	21%	13%	37%	8%
2.b	Med CM - Targeted to Public Clinic (a)	280	245	93%	4%	2%	53%	10%	2%	36%	0%	0%	0%	23%	26%	11%	35%	4%
2.c	Med CM - Targeted to AA (a)	550	199	69%	25%	6%	98%	0%	2%	0%	0%	1%	6%	29%	28%	8%	23%	6%
2.d	Med CM - Targeted to H/L(a)	550	62	74%	19%	6%	2%	0%	2%	97%	0%	0%	2%	32%	35%	6%	16%	8%
2.e	Med CM - Targeted to White and/or MSM (a)	260	86	88%	9%	2%	0%	94%	6%	0%	0%	0%	1%	17%	26%	6%	40%	10%
2.f	Med CM - Targeted to Rural (a)	150	41	61%	39%	0%	61%	22%	2%	15%	0%	0%	0%	12%	20%	7%	49%	12%
2.g	Med CM - Targeted to Women at Public Clinic (a)	240	111	0%	100%	0%	69%	6%	2%	23%	0%	0%	2%	16%	38%	13%	26%	5%
2.h	Med CM - Targeted to Pedi (a)	125	0															
2.i	Med CM - Targeted to Veterans	200	31	94%	6%	0%	74%	19%	0%	6%	0%	0%	0%	0%	0%	3%	45%	52%
2.j	Med CM - Targeted to Youth	120	0	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
3	**Local Drug Reimbursement Program (a)**	**2,845**	**1,940**	**74%**	**22%**	**4%**	**41%**	**12%**	**2%**	**45%**	**0%**	**0%**	**3%**	**22%**	**27%**	**12%**	**33%**	**3%**
4	**Oral Health**	**200**	**121**	**66%**	**33%**	**1%**	**34%**	**31%**	**1%**	**34%**	**0%**	**0%**	**2%**	**12%**	**22%**	**18%**	**37%**	**9%**
4.a	Oral Health - Untargeted (d)	NA	NA															
4.b	Oral Health - Rural Target	200	121	66%	33%	**1%**	34%	31%	1%	34%	0%	0%	2%	12%	22%	18%	37%	9%
5	**Mental Health Services (d)**	**NA**	**NA**															
6	**Health Insurance**	**1,700**	**532**	**79%**	**19%**	**2%**	**35%**	**27%**	**4%**	**34%**	**0%**	**0%**	**1%**	**11%**	**17%**	**10%**	**50%**	**11%**
7	**Home and Community Based Services (d)**	**NA**	**NA**															
8	**Substance Abuse Treatment - Outpatient**	**40**	**5**	**100%**	**0%**	**0%**	**0%**	**40%**	**20%**	**40%**	**0%**	**0%**	**0%**	**80%**	**0%**	**0%**	**20%**	**0%**
9	**Early Medical Intervention Services (d)**	**NA**	**NA**															
10	**Medical Nutritional Therapy/Nutritional Supplements**	**650**	**171**	**74%**	**24%**	**2%**	**44%**	**15%**	**4%**	**37%**	**0%**	**1%**	**2%**	**7%**	**8%**	**6%**	**57%**	**19%**
11	**Hospice Services (d)**	**NA**	**NA**															
12	**Outreach**	**700**	**150**	**73%**	**25%**	**3%**	**67%**	**15%**	**0%**	**17%**	**0%**	**0%**	**8%**	**31%**	**23%**	**7%**	**25%**	**6%**
13	**Non-Medical Case Management**	**7,045**	**1,804**															
13.a	Service Linkage Targeted to Youth	320	69	70%	29%	1%	52%	9%	3%	36%	0%	9%	91%	0%	0%	0%	0%	0%
13.b	Service Linkage at Testing Sites	260	27	85%	15%	0%	59%	4%	0%	37%	0%	0%	0%	63%	22%	7%	4%	4%
13.c	Service Linkage at Public Clinic Primary Care Program (a)	3,700	1,046	69%	29%	2%	52%	9%	2%	38%	0%	0%	0%	20%	24%	12%	39%	6%
13.d	Service Linkage at CBO Primary Care Programs (a)	2,765	662	76%	20%	4%	45%	15%	1%	39%	0%	0%	3%	26%	25%	11%	29%	5%
14	**Transportation**	**2,850**	**408**															
14.a	Transportation Services - Urban	170	73	63%	36%	1%	45%	12%	4%	38%	0%	0%	5%	27%	18%	11%	22%	16%
14.b	Transportation Services - Rural	130	26	58%	42%	0%	38%	35%	0%	27%	0%	0%	0%	15%	15%	8%	42%	19%
14.c	Transportation vouchering	2,550	309	76%	22%	2%	63%	10%	2%	25%	0%	0%	2%	12%	18%	11%	50%	6%
15	**Linguistic Services (d)**	**NA**	**NA**															
16	**Emergency Financial Assistance (e)**	**NA**	**190**	**73%**	**24%**	**3%**	**60%**	**7%**	**3%**	**31%**	**0%**	**0%**	**6%**	**28%**	**26%**	**8%**	**31%**	**1%**
17	**Referral for Health Care - Non Core Service (d)**	**NA**	**NA**															
Net unduplicated clients served - all categories*		**12,941**	**6,234**	**74%**	**24%**	**3%**	**45%**	**14%**	**2%**	**39%**	**0%**	**0%**	**4%**	**22%**	**24%**	**11%**	**33%**	**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: 5/22/2023

Prepared by: Ryan White Grant Administration

FY 2023 Ryan White Part A and MAI Service Utilization Report

RW MAI Service Utilization Report - 1st Quarter (03/01 -05/31)																		
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	267	**72%**	**25%**	**4%**	**100%**	**0%**	**0%**	**0%**	**0%**	**0%**	**6%**	**36%**	**27%**	**8%**	**21%**	**1%**
1.c	Primary Care - MAI CBO Targeted to Hispanic (g)	960	286	**85%**	**10%**	**4%**	**0%**	**0%**	**0%**	**100%**	**0%**	**0%**	**6%**	**36%**	**24%**	**9%**	**21%**	**2%**
2	**Medical Case Management (f)**																	
2.c	Med CM - Targeted to AA (a)	1,060	193	**80%**	**17%**	**3%**	**53%**	**6%**	**2%**	**39%**	**0%**	**2%**	**8%**	**38%**	**26%**	**6%**	**20%**	**2%**
2.d	Med CM - Targeted to H/L(a)	960	128	**83%**	**17%**	**0%**	**75%**	**8%**	**0%**	**17%**	**0%**	**0%**	**0%**	**0%**	**33%**	**17%**	**50%**	**0%**

RW Part A New Client Service Utilization Report - 1st Quarter (03/01-05/31) Report reflects the number & demographics of clients served during the report period who did not receive services during previous 12 months (3/1/22 - 5/31/22)																		
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**	**253**	80%	17%	3%	49%	9%	2%	41%	0%	2%	9%	43%	21%	8%	4%	13%
2	**LPAP**	**1,200**	**66**	80%	17%	3%	53%	6%	2%	39%	0%	2%	8%	38%	26%	6%	2%	20%
3.a	Clinical Case Management	400	**12**	83%	17%	0%	75%	8%	0%	17%	0%	0%	0%	0%	33%	17%	0%	50%
3.b-3.h	Medical Case Management	1,600	**140**	71%	26%	2%	51%	11%	1%	36%	0%	1%	4%	34%	22%	14%	6%	19%
3.i	Medical Case Manangement - Targeted to Veterans	60	**3**	67%	33%	0%	100%	0%	0%	0%	0%	0%	0%	0%	0%	33%	67%	0%
4	**Oral Health**	**40**	**4**	50%	50%	0%	25%	25%	0%	50%	0%	0%	0%	0%	0%	25%	0%	75%
12.a. 12.c. 12.d.	**Non-Medical Case Management (Service Linkage)**	**3,700**	**357**	73%	25%	2%	52%	14%	1%	33%	0%	0%	4%	25%	23%	10%	28%	9%
12.b	**Service Linkage at Testing Sites**	**260**	**20**	70%	25%	5%	55%	5%	0%	40%	**0%**	**10%**	**10%**	**40%**	**20%**	**10%**	**5%**	**5%**

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: 5/22/2023

Part A Reflects "TBD" Funding Scenario
MAI Reflects "TBD" Funding Scenario

FY 2023 Ryan White Part A and MAI
Procurement Report

Priority	Service Category	Original Allocation *RWPC Approved Level Funding Scenario*	Award Reconcilation	July Adjustments (carryover)	August 10% Rule Adjustments (f)	October Adjustments	Final Quarter Adjustments	Total Allocation	Percent of Grant Award	Amount Procured (a)	Procure-ment Balance	Original Date Procured	Expended YTD	Percent YTD	Percent Expected YTD
1	**Outpatient/Ambulatory Primary Care**	**10,965,788**	**460,625**	**0**	**0**	**0**	**0**	**11,426,413**	**46.94%**	**11,426,413**	**0**		**304,572**	**3%**	**8%**
1.a	Primary Care - Public Clinic (a)	3,927,300	182,397					4,109,697	16.88%	4,109,697	0	3/1/2023	$0	0%	8%
1.b	Primary Care - CBO Targeted to AA (a) (e) (f)	1,064,576	49,443					1,114,019	4.58%	1,114,019	0	3/1/2023	$104,427	9%	8%
1.c	Primary Care - CBO Targeted to Hispanic (a) (e)	910,551	42,289					952,840	3.91%	952,840	0	3/1/2023	$89,590	9%	8%
1.d	Primary Care - CBO Targeted to White/MSM (a) (e)	1,147,924	53,314					1,201,238	4.93%	1,201,238	0	3/1/2023	$53,540	4%	8%
1.e	Primary Care - CBO Targeted to Rural (a) (e)	1,100,000	51,088					1,151,088	4.73%	1,151,088	0	3/1/2023	$27,205	2%	8%
1.f	Primary Care - Women at Public Clinic (a)	2,100,000	97,531					2,197,531	9.03%	2,197,531	0	3/1/2023	$0	0%	8%
1.g	Primary Care - Pediatric (a.1)	15,437	-15,437					0	0.00%	0	0	3/1/2023	$0	0%	0%
1.h	Vision	500,000	0					500,000	2.05%	500,000	0	3/1/2023	$29,810	6%	8%
1.x	Primary Care Health Outcome Pilot	200,000	0					200,000	0.82%	200,000	0	3/1/2023	$0	0%	8%
2	**Medical Case Management**	**1,880,000**	**-97,859**	**0**	**0**	**0**	**0**	**1,782,141**	**7.32%**	**1,782,141**	**0**		**105,492**	**6%**	**8%**
2.a	Clinical Case Management	531,025	0					531,025	2.18%	531,025	0	3/1/2023	$64,803	12%	8%
2.b	Med CM - Public Clinic (a)	301,129	0					301,129	1.24%	301,129	0	3/1/2023	0	0%	8%
2.c	Med CM - Targeted to AA (a) (e)	183,663	0					183,663	0.75%	183,663	0	3/1/2023	$19,904	11%	8%
2.d	Med CM - Targeted to H/L (a) (e)	183,665	0					183,665	0.75%	183,665	0	3/1/2023	$4,323	2%	8%
2.e	Med CM - Targeted to W/MSM (a) (e)	66,491	0					66,491	0.27%	66,491	0	3/1/2023	$10,150	15%	8%
2.f	Med CM - Targeted to Rural (a)	297,496	0					297,496	1.22%	297,496	0	3/1/2023	$4,804	2%	8%
2.g	Med CM - Women at Public Clinic (a)	81,841	0					81,841	0.34%	81,841	0	3/1/2023	$0	0%	8%
2.h	Med CM - Targeted to Pedi (a.1)	97,859	-97,859					0	0.00%	0	0	3/1/2023	$0	0%	0%
2.i	Med CM - Targeted to Veterans	86,964	0					86,964	0.36%	86,964	0	3/1/2023	$1,509	2%	8%
2.j	Med CM - Targeted to Youth	49,867	0					49,867	0.20%	49,867	0	3/1/2023	$0	0%	8%
3	**Local Pharmacy Assistance Program**	**2,067,104**	**0**	**0**	**0**	**0**	**0**	**2,067,104**	**8.49%**	**2,067,104**	**0**	3/1/2023	**$68,261**	**3%**	**8%**
3.a	Local Pharmacy Assistance Program-Public Clinic (a) (e)	367,104	0					367,104	1.51%	367,104	0	3/1/2023	$0	0%	8%
3.b	Local Pharmacy Assistance Program-Untargeted (a) (e)	1,700,000	0					1,700,000	6.98%	1,700,000	0	3/1/2023	$68,261	4%	8%
4	**Oral Health**	**166,404**	**0**	**0**	**0**	**0**	**0**	**166,404**	**0.68%**	**166,404**	**0**	3/1/2023	**27,650**	**17%**	**8%**
4.b	Oral Health - Targeted to Rural	166,404	0					166,404	0.68%	166,404	0	3/1/2023	$27,650	17%	8%
5	**Health Insurance (c)**	**1,383,137**	**223,222**		**0**	**0**	**0**	**1,606,359**	**6.60%**	**1,606,359**	**0**	3/1/2023	**$0**	**0%**	**8%**
8	**Medical Nutritional Therapy (supplements)**	**341,395**	**0**					**341,395**	**1.40%**	**341,395**	**0**	**3/1/2023**	**$26,413**	**8%**	**8%**
10	**Substance Abuse Services - Outpatient (c)**	**45,677**	**0**	**0**	**0**	**0**	**0**	**45,677**	**0.19%**	**45,677**	**0**	3/1/2023	**$450**	**1%**	**8%**
13	**Non-Medical Case Management**	**1,267,002**	**0**	**0**	**0**	**0**	**0**	**1,267,002**	**5.20%**	**1,267,002**	**0**	**3/1/2023**	**$71,687**	**6%**	**8%**
13.a	Service Linkage targeted to Youth	110,793	0					110,793	**0.46%**	110,793	0	3/1/2023	$4,338	4%	8%
13.b	Service Linkage targeted to Newly-Diagnosed/Not-in-Care	100,000	0					100,000	**0.41%**	100,000	0	3/1/2023	$13,015	13%	8%
13.c	Service Linkage at Public Clinic (a)	370,000	0					370,000	**1.52%**	370,000	0	3/1/2023	$0	0%	8%
13.d	Service Linkage embedded in CBO Pcare (a) (e)	686,209	0					686,209	**2.82%**	686,209	0	3/1/2023	$54,333	8%	8%
14	**Medical Transportation**	**424,911**	**0**	**0**	**0**	**0**	**0**	**424,911**	**1.75%**	**424,911**	**0**		**9,736**	**2%**	**8%**
14.a	Medical Transportation services targeted to Urban	252,680	0					252,680	1.04%	252,680	0	3/1/2023	$6,180	2%	8%
14.b	Medical Transportation services targeted to Rural	97,185	0					97,185	0.40%	97,185	0	3/1/2023	$3,556	4%	8%
14.c	Transportation vouchering (bus passes & gas cards)	75,046	0					75,046	0.31%	75,046	0	3/1/2023	$0	0%	8%
15	**Emergency Financial Assistance**	**1,653,247**	**485,889**	**0**	**0**	**0**	**0**	**2,139,136**	**8.79%**	**2,139,136**	**0**		**63,702**	**3%**	**8%**
16.a	EFA - Pharmacy Assistance	1,553,247	485,889					2,039,136	8.38%	2,039,136	0	3/1/2023	$57,545	3%	8%
16.b	EFA - Other	100,000	0					100,000	0.41%	100,000	0	3/1/2023	$6,157	6%	8%
17	**Outreach**	**420,000**	0					**420,000**	**1.73%**	**420,000**	**0**	**3/1/2023**	**$12,845**	**3%**	**8%**
FY23_RW_DIR	**Total Service Dollars**	**20,614,665**	**1,071,877**	**0**	**0**	**0**	**0**	**21,686,542**	**89.09%**	**21,686,542**	**0**		**690,808**	**3%**	**8%**
	Grant Administration	**2,208,914**	**18,000**	**0**	**0**	**0**	**0**	**2,226,914**	**9.15%**	**2,226,914**	0	**N/A**	**181,048**	**8%**	**8%**
FY23_RW_ADMIN	HCPH/RWGA Section (including indirect $169,915)	1,686,659	0	0	0		0	1,686,659	6.93%	1,686,659	0	N/A	$116,058	7%	8%
FY23_RW_ADMIN	RWPC Support	522,255	18,000		0	0	0	540,255	2.22%	540,255	0	N/A	64,990	12%	8%
FY23_RW_QM	**Quality Management**	**428,695**	**0**	**0**	**0**	**0**	**0**	**428,695**	**1.76%**	428,695	**0**	**N/A**	**$16,338**	**4%**	**8%**
		23,252,274	**1,089,877**	**0**	**0**	**0**	**0**	**24,342,151**	**100.00%**	**24,342,151**	**0**		**888,194**	**4%**	**8%**

Part A Reflects "TBD" Funding Scenario
MAI Reflects "TBD" Funding Scenario

FY 2023 Ryan White Part A and MAI
Procurement Report

Priority	Service Category	Original Allocation *RWPC Approved Level Funding Scenario*	Award Reconcilation	July Adjustments (carryover)	August 10% Rule Adjustments (f)	October Adjustments	Final Quarter Adjustments	Total Allocation	Percent of Grant Award	Amount Procured (a)	Procure-ment Balance	Original Date Procured	Expended YTD	Percent YTD	Percent Expected YTD
									Unallocated	Unobligated					8%
	Part A Grant Award:	**24,342,151**	***Carryover:***	**0**			***Total Part A:***	**24,342,151**	**0**	**0**					8%

		Original Allocation	Award Reconcilation	July Adjusments (carryover)	August 10% Rule Adjustments	October Adjustments	Final Quarter Adjustments	Total Allocation	Percent	Total Expended on Services	Percent	Award Category	Award Amount	Amount Spent	Balance
	Core (must not be less than 75% of total service dollars)	**16,849,505**	**585,988**	**0**	**0**	**0**	**0**	**17,435,493**	**80.40%**	**532,838**	**78.59%**	Formula			0
	Non-Core (may not exceed 25% of total service dollars)	**3,765,160**	**485,889**	**0**	**0**	**0**	**0**	**4,251,049**	**19.60%**	**145,125**	**21.41%**	Supplemen			0
	Total Service Dollars (does not include Admin and QM)	**20,614,665**	**1,071,877**	**0**	**0**	**0**	**0**	**21,686,542**		**677,963**		Carry Over	0		0
												Totals	0	0	0
	Total Admin (must be ≤ 10% of total Part A + MAI)	**2,208,914**	**18,000**	**0**	**0**	**0**	**0**	**2,226,914**	**8.33%**						
	Total QM (must be ≤ 5% of total Part A + MAI)	**428,695**	**0**	**0**	**0**	**0**	**0**	**428,695**	**1.60%**						

MAI Procurement Report

Priority	Service Category	Original Allocation *RWPC Approved Level Funding Scenario*	Award Reconcilation	July Adjustments (carryover)	August 10% Rule Adjustments (f)	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**	**2,107,819**	**-39,764**	**0**	**0**	**0**	**0**	**2,068,055**	**86.82%**	**2,068,055**	**0**		**152,750**	**7%**	**8%**
1.b (MAI)	Primary Care - CBO Targeted to African American	1,065,775	-20,106		0			1,045,669	43.90%	1,045,669	0	3/1/2023	$73,775	7%	8%
1.c (MAI)	Primary Care - CBO Targeted to Hispanic	1,042,044	-19,658		0			1,022,386	42.92%	1,022,386	0	3/1/2023	$78,975	8%	8%
2	**Medical Case Management**	**320,099**	**-6,038**	**0**	**0**	**0**	**0**	**314,061**	**13.18%**	**314,061**	**0**		**$23,881**	**8%**	8%
2.c (MAI)	MCM - Targeted to African American	160,050	-3,019					157,031	6.59%	157,031	0	3/1/2023	$14,110	9%	8%
2.d (MAI)	MCM - Targeted to Hispanic	160,049	-3,019					157,030	6.59%	157,030	0	3/1/2023	$9,771	6%	8%
	Total MAI Service Funds	**2,427,918**	**-45,802**	**0**	**0**	**0**	**0**	**2,382,116**	**100.00%**	**2,382,116**	**0**		**176,631**	**7%**	**8%**
	Grant Administration	0	0	0	0	0	0	0	0.00%	0	0		0	0%	0%
	Quality Management	0	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**	**0.00%**	**0**	**0**		**0**	**0%**	**0%**
	Total MAI Funds	**2,427,918**	**-45,802**	**0**	**0**	**0**	**0**	**2,382,116**	**100.00%**	**2,382,116**	**0**		**176,631**	**7%**	**8%**
	MAI Grant Award	**2,382,116**	***Carry Over:***	**0**			***Total MAI:***	**2,382,116**							8%
	Combined Part A and MAI Orginial Allocation Total	**25,680,192**							Unallocated	Unobligated					
									0	**0**		***MAI Award***	**2,382,116**		
Footnotes:							**Total Part A & MAI**	**26,724,267**							
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														

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.

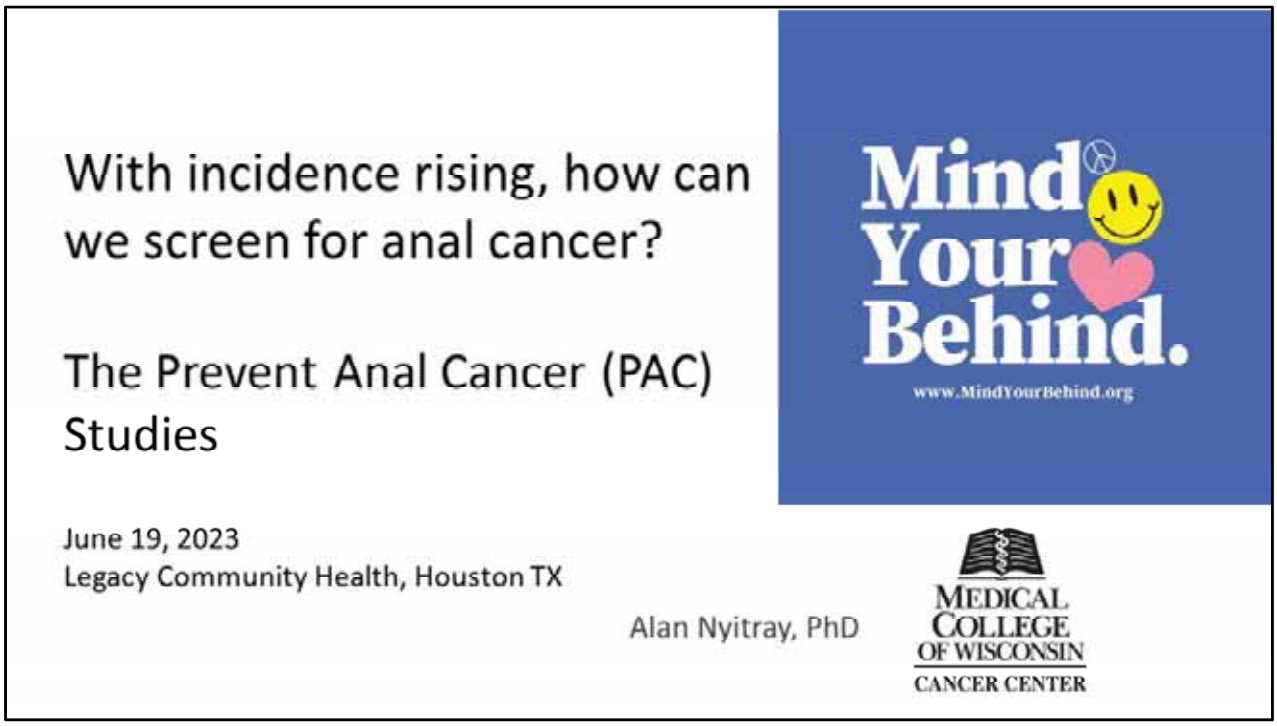
Signature: _____ Date: _____

June 8, 2023

Council Handouts

ITEM	DOCUMENTS
PAC Presentation from Dr. A. Nytray	1
Table of Contents with Proposed FY24 Income Eligibility	2
Director's Report: Ryan White Office of Support	3
Manager's Report: Ryan White Grant Administration	4
Manager's Report: The Resource Group	5

* National AIDS Treatment Advocacy Project (NATAP)



We gathered here clinicians in Milwaukee who are supporting the PAC Study.

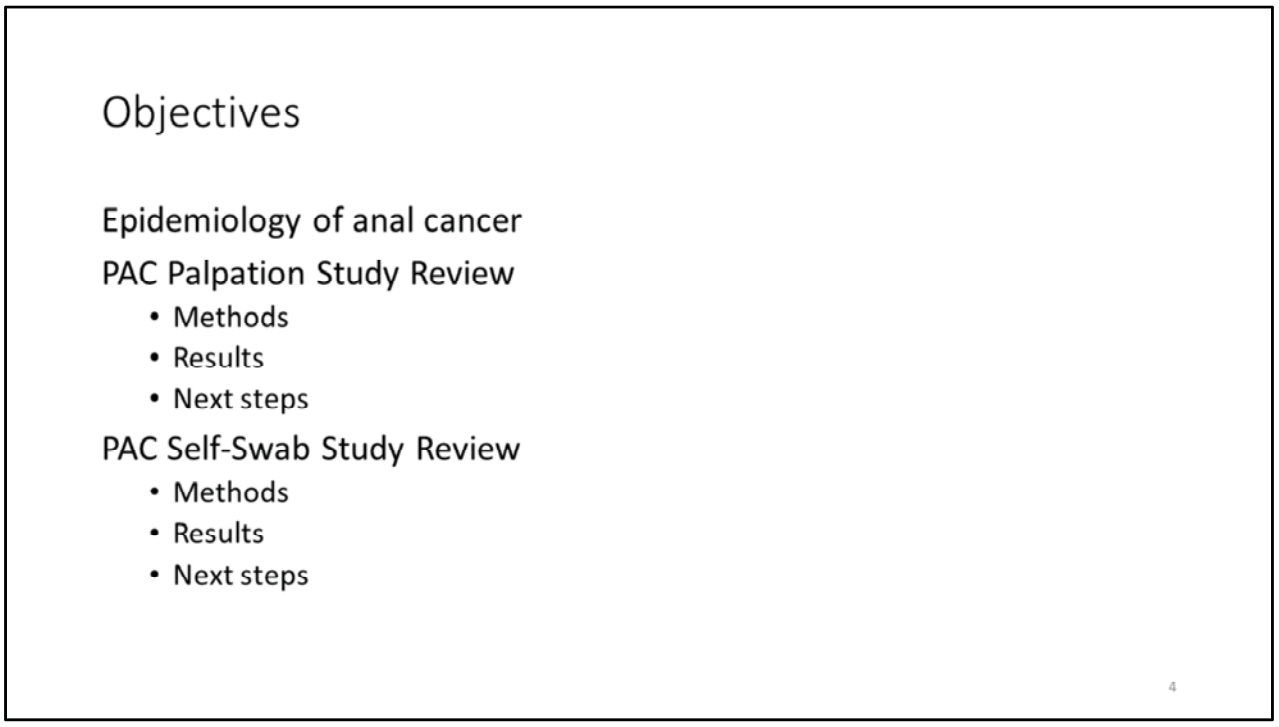
1) I understand all of you are very busy and thank you, thank you, thank you for supporting PAC Study
2) Cancer risk scale – Why we have the current focus
3) So far we've detected X number of high-grade lesions at the anal canal through your efforts.
    1) These are all persons who are getting follow-up clinical advice, including from Sarah Lundeen, our HRA
4) So, how did we discover these X lesions?
5) recruitment
6) Enrollment
7) Randomization

Financial disclosures

- National Institutes of Health, National Cancer Insitute – Research funding
- Medical College of Wisconsin – Research funding and salary
- EUROGIN – Conference fees and travel costs
- COPAN Italia SPA, Brescia, Italy – Donated swabs and supplies

Presenter: Alan G. Nyitray, PhD

Clinical Cancer Center and Center for AIDS Intervention Research
Medical College of Wisconsin
2071 North Summit Avenue
Milwaukee, WI 53202
Email: anyitray@mcw.edu
Ph: 414-805-3312
Fax: 414-287-4209



And finally Next steps which I believe, given our results, strongly call for the development of biomarkers within an equity framework, developed not in isolation from their use in diverse communities.

Why is cancer in LGBTQ communities important?

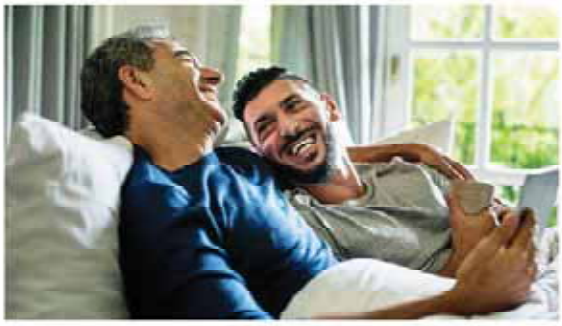
Why is cancer in LGBTQ people important?

As the LGBTQ communities age, *chronic diseases like cancer* become a high priority.

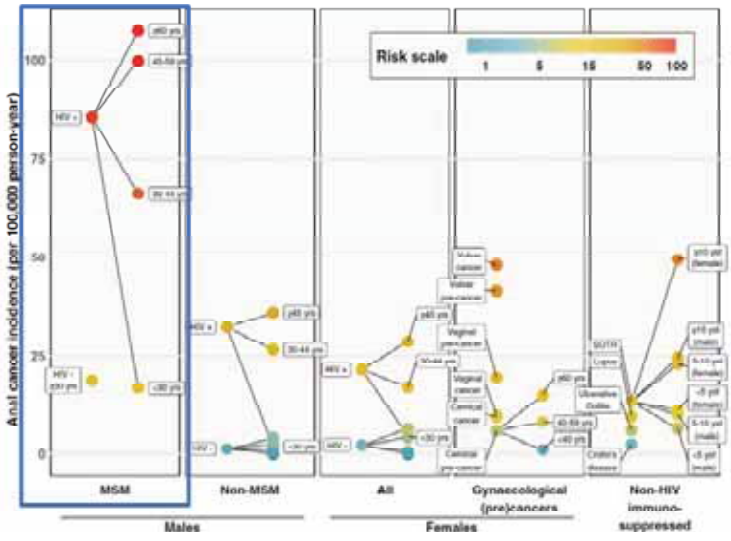
Why is cancer in GBM important?

In the age of effective HIV treatment….

Any holistic approach to gay and bisexual men's health needs to address the most common chronic diseases GBM will experience.



Anal cancer risk scale



Clifford et al., International Journal of Cancer 2020, 148(1):38-47

FIGURE 5 Anal cancer risk scale. 95% CIs around the point estimates can be found in the relevant Figures 1-4 and Tables S1 and S2. Estimates for HIV-negative men and men are shown, without labels, for age-groups <20, 20 to 44, 45 to 59, and ≥60 years (see Section 2). CI, confidence interval; MSM, men who have sex with men; MSW, men who have sex with women; yrs, years old; yst, years since transplant

Risk for anal cancer is not evenly distributed with anal cancer with risk being much higher in some populations. MSM-Negative MSM and MSM with HIV

MSM with HIV - 8 studies (US HIV/AIDS Cancer match provided most data)
Non-MSM males with HIV – 5 studies
Females with HIV – 6 studies

HIV-negative MSM – only 2 studies

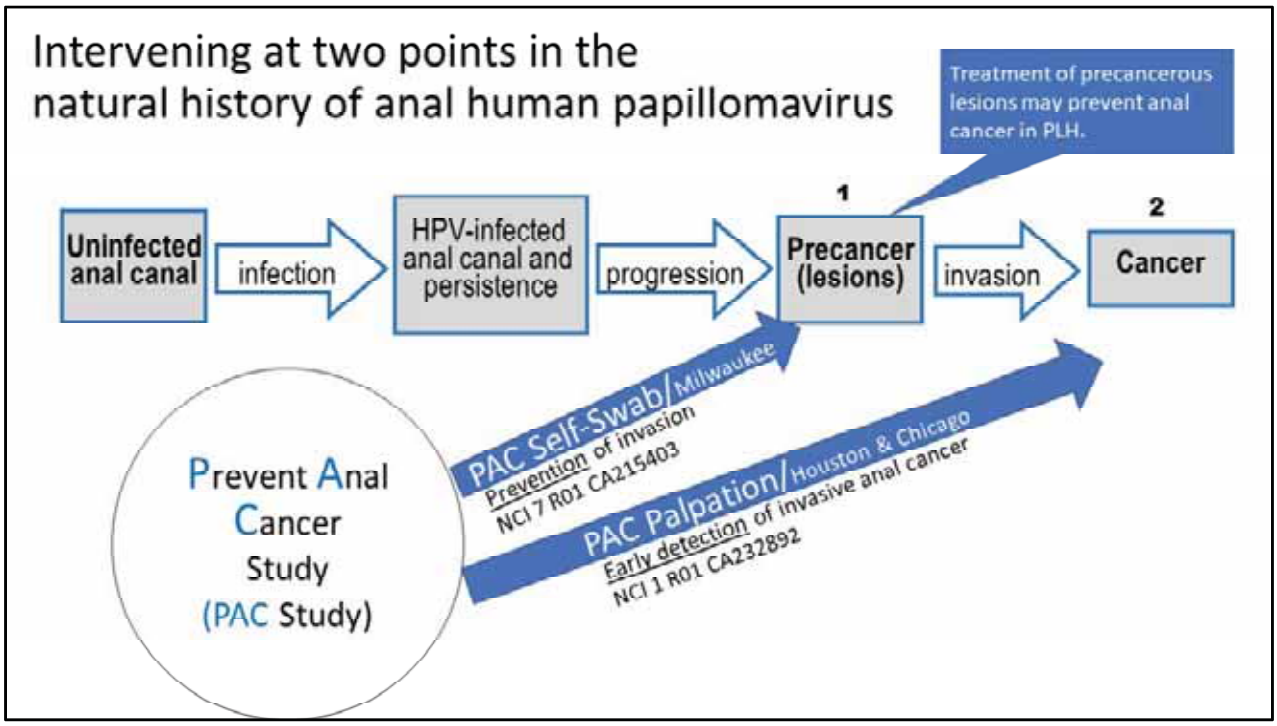
HIV-negative Females with prior cervical cancers– 4 studies
HIV-negative Females with prior cervical precancers – 8 studies

HIV-negative Females with prior vulvar cancers– 4 studies
HIV-negative Females with prior vaginal cancers – 4 studies

Solid organ transplants – 5 studies
Autoimmune diseases – 4 studies.

No uniform anal cancer screening recommendations exist.

Rating System for Prevention and Treatment Recommendations
Strength of Recommendation Quality of Evidence for the Recommendation
A: Strong recommendation for the statement **I:** One or more randomized trials with clinical outcomes and/or validated
laboratory endpoints
B: Moderate recommendation for the statement **II:** One or more well-designed, non-randomized trials or observational cohort
studies with long-term clinical outcomes
C: Optional recommendation for the statement **III:** Expert opinion



Here's some text to help explain this slide

Human papillomavirus is the cause of the large majority of anal cancers. The natural history of anal HPV infection is thought to be very similar to the natural history of cervical HPV infection. Persistent anal HPV lesions may progress to precancerous lesions and then invasion. The Prevent Anal Cancer or PAC Study is funded by two NCI R01's with each R01 intervening at a different point in the natural history of anal HPV.

The Milwaukee arm of the PAC Study seeks to prevent anal cancer through detection of high-grade lesions at the anal canal (i.e., a cervical cancer screening model). 400 gay/bi men and transgender persons will be randomized to either home-based self-swabbing or clinic-based clinician swabbing. This translational research will assess adherence to each condition and the utility of two molecular biomarkers, HPV persistence and host/viral methylation, to identify persons at increased risk for anal cancer.

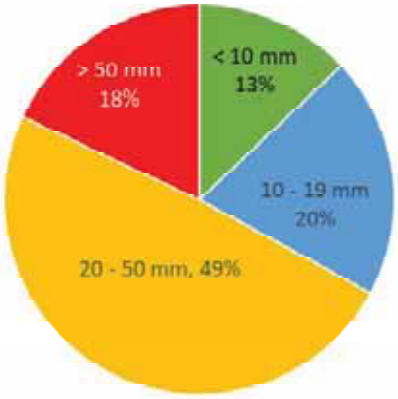
The Chicago/Houston arm of the PAC Study seeks early detection of anal cancer through self-palpation. The study will recruit 800 gay/bi men and transpersons in these two cities to test the sensitivity and specificity of anal self-exams and anal companion exams. Detection of small malignant tumors can result in very low morbidity and mortality and may be important in geographic regions that have neither the expertise nor resources to follow a

cervical cancer screening model.

Both arms of the PAC Study are currently recruiting.

Mean anal canal tumor size at presentation 36 mm in diameter

n = 1,622 Texas Cancer Registry, 2000-2010



Overall 5-year survival

Stage I	85.5% (tumor ≤ 20 mm)
Stage IIA	78.5% (tumor 21 - 50 mm)
Stage IIB	73.7%
Stage IIIA	62.2% (tumor > 50 mm)
Stage IIIB	59.3%
Stage IIIC	57.2%
Stage IV	22.1%

AJCC Cancer Staging System, 2023

66 French women and men with early invasive anal cancer (≤10 mm tumors):
5-year disease-specific survival was 100%

Orthofan et al., 2005

15 PLWH with T1N0M0 cancer of the anal verge (below the dentate line):
4-year disease-specific survival was 100%

Alfa Wali et al., 2016

11

Also for size of tumor.
Current survival for anal cancer by stage is what?

Epidermoid anal cancer: results from the UKCCCR randomised trial of radiotherapy alone versus radiotherapy, 5-fluorouracil, and mitomycin. UKCCCR Anal Cancer Trial Working Party. UK Co-ordinating Committee on Cancer Research

Lancet 1996 Vol. 348 Issue 9034 Pages 1049-54

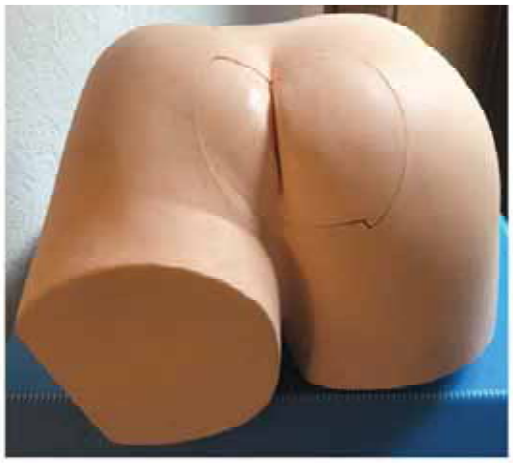
PAC Palpation Study assesses the ability of individuals to recognize an anal abnormality

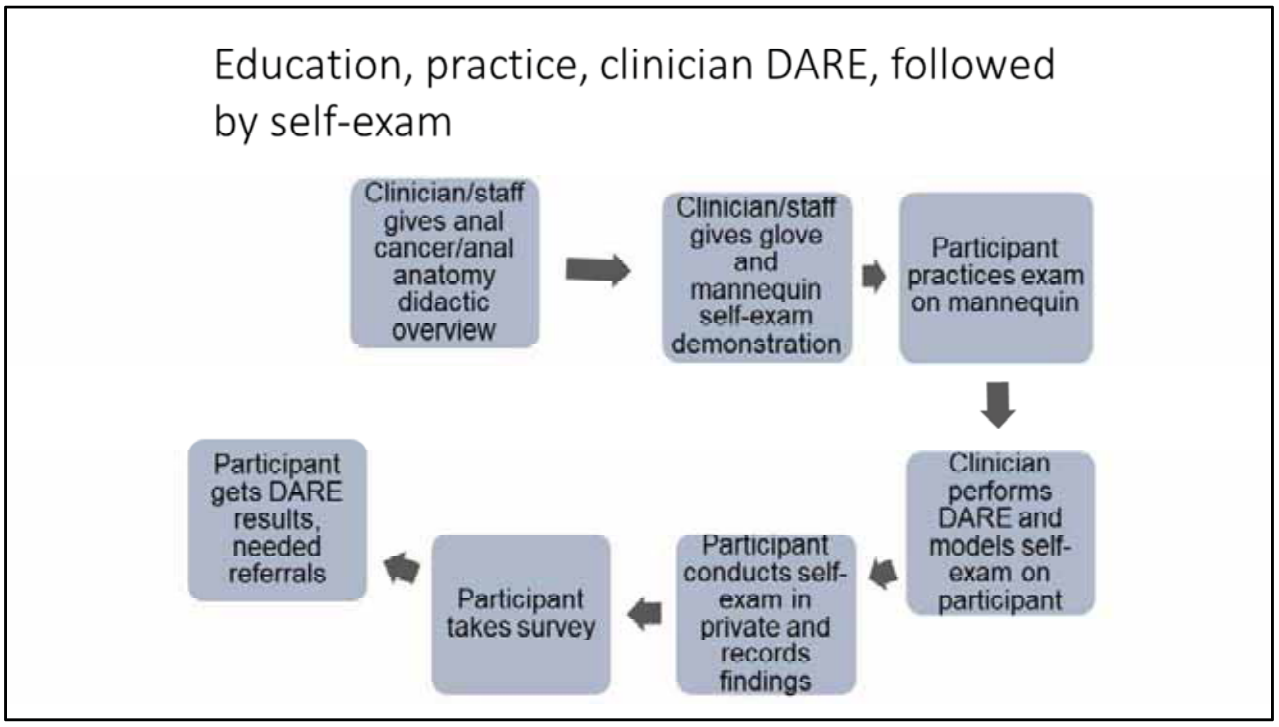
Since most anal cancers have a tumor that can be felt with a finger…

Can MSM and trans individuals recognize an anal abnormality ?

NCI 1 R01 CA232892 01

Mannequin (Kyoto Kagaku)





Once a participant enrolls, this is what happens in the clinic….

We also had

- Physician observations
- Standard anoscopy

Focus groups (3)

- Learn more about the experience of the men doing a SAE

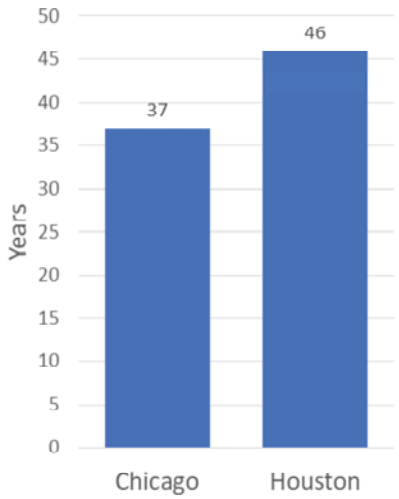
Healthy anal canal vs. one with a tumor <10 mm in diameter

This is the practice model. One has a normal anal canal and one has an anal canal with a tumor of less than 1 cm in diameter.

Enrollment

	# persons randomized
Chicago	371
Houston	346
Total	717

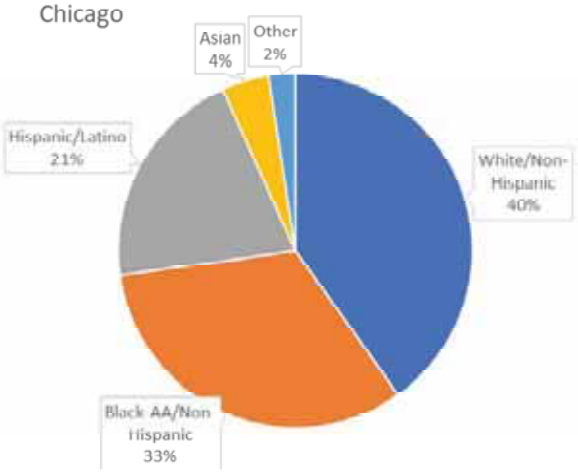
Median age, years



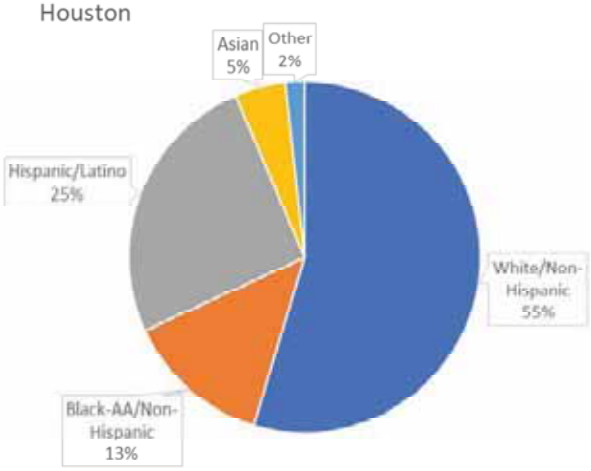
N=717

Race/ethnicity

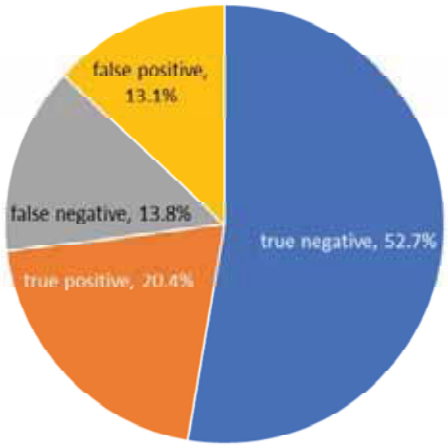
Chicago



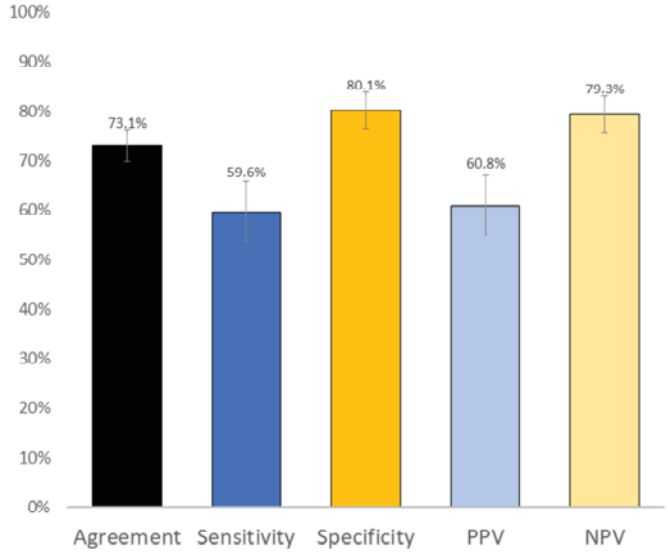
Houston



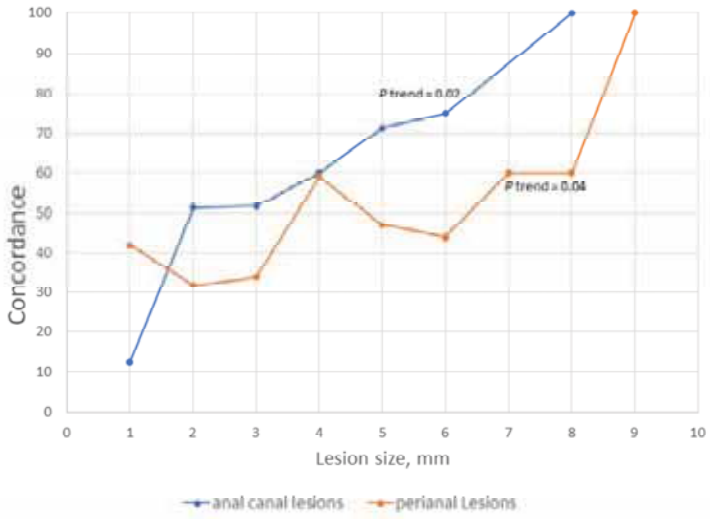
ASE/ACE results

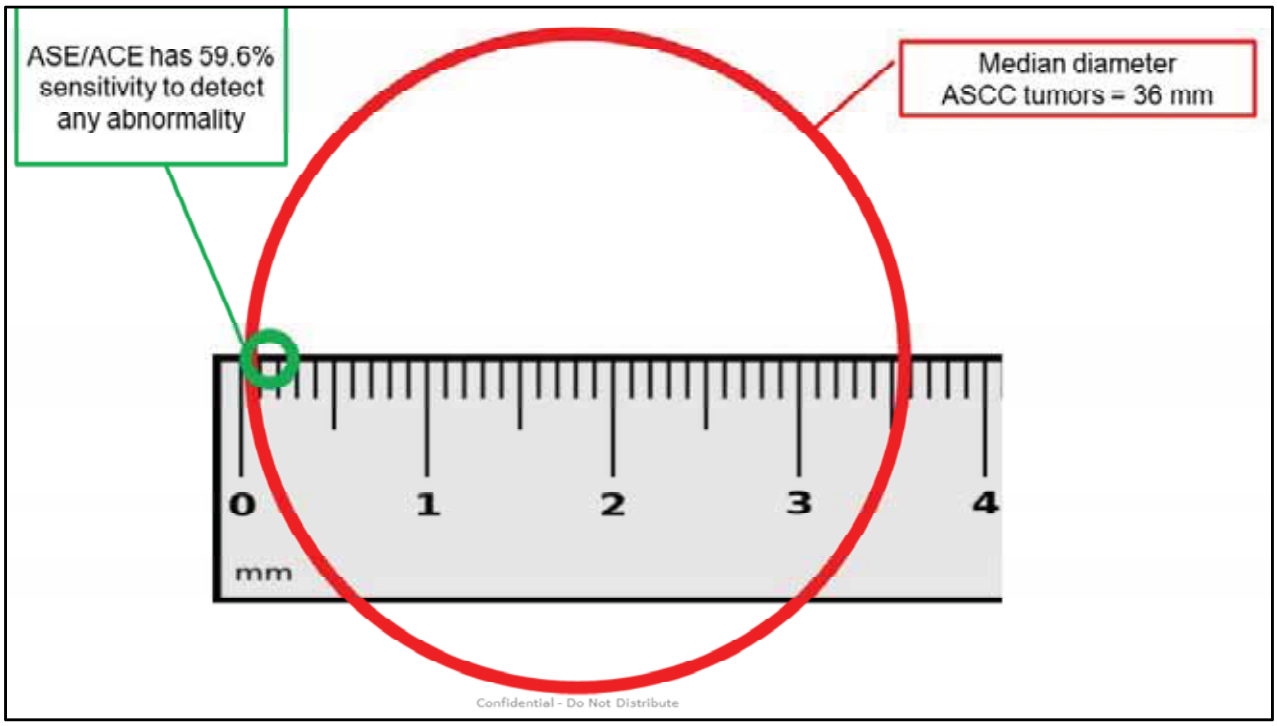


ASE/ACE Accuracy



Concordance between participant ASE/ACE and clinician DARE by lesion location and size




ASE/ACE has 59.6% sensitivity to detect any abnormality
Median diameter ASCC tumors = 36 mm
0
1
2
3
4
mm
Confidential - Do Not Distribute

Take away points

- Anal cancer incidence is increasing in many countries.
- People with HIV have the highest incidence of anal cancer and its precancer HSIL.
- It is now known that treatment of HSIL is proven to reduce anal cancer incidence in HIV+ people. Treatment needs to be better.
- People can detect much smaller abnormalities at the perianus and anal canal than the current size of anal cancer tumors at presentation.

The highest prevalence and incidence of HSIL is in persons with HIV, HIV-negative men who have sex with men, women with prior HPV-associated disease, and persons with other immunosuppression, for example, solid organ transplants. HSIL is detected by high-resolution anoscopy (HRA) and confirmed by HRA-directed biopsies. Cytology may be used to stratify screening populations by risk however it has shortcomings. Other screening algorithms and other biomarkers are understudy.
Sampling error is important to keep in mind. For example, did the biopsy of a high-grade lesion contain HSIL or did it miss the HSIL. Sometimes multiple biopsies of the lesion may be taken. Gaisa

Farrah Fawcett

http://www.thefarrahfawcettfoundation.org

Born in Corpus Christi, February 2, 1947.
Attended John J. Pershing Middle School in Houston.
Died June 25, 2009 from anal cancer.

Table of Contents

FY 2024 Houston EMA/HSDA Service Categories Definitions
Ryan White Part A, Part B and State Services

Barbie Robinson, MPP, JD, CHC
Executive Director
1111 Fannin
Houston, Texas 77002

Harris County Public Health
Building a Healthy Community

Ericka Brown, MD, MBA, FACHE
Director Community Health and Wellness Division
1111 Fannin
Houston, Texas 77002

Houston EMA Ryan White Part A, MAI & EHE
Administrative Agency Report
June 1, 2023

FY 2023 Contract Status

- All initial award contracts have been approved by Harris County Commissioners Court (CC)
- The Grants Management section has submitted the 1st Amendment Contracts reflecting FY 23 notice of full award. Agency contracts will be placed on the June 27th CC agenda
- Rural Primary Care Bundle (formerly Part B-funded Primary Care Bundle) will be put out to the bid in June with funding for the remaining six months of FY23 and will include 4-one year renewal options beginning on 3/1/2024
    - The current RFP does not apply to the Rural Primary Bundle just awarded under RFP22-0352
    - When RFP22-0352 goes out to bid again in 2027, both RFPs will be combined into one

FY 2022 Contract Status

- RWGA has processed all the final expenditure reports from sub-recipients
- Sub-recipients will be notified of carryover availability allocation requests in June

EHE Update

- RWGA will be issuing an RFP to solicit bids to provide six-month housing assistance (EFA-Other) using carryover funds—currently, the EHE grant funds three months of housing assistance.
- We will also be issuing a second RFP to secure more Rapid Start providers and to build a robust social media campaign around EHE initiatives

Quality Management & Improvement Updates

- RWGA is hosting a Cultural Competency training with case management and frontline staff. Topics to align with the efforts of the RWPC around HIV and Aging and HIV and Cisgender Black women, as well as capacity building and mobilization of unique service delivery per population.

Glenn Urbach, Manager
HCPH/Ryan White Grant Administration Section
1111 Fannin, Houston, TX 77002
(713) 274-5790/glenn.urbach@phs.hctx.net

- The QM team is collaborating with RWGA's QA team to assess data collection and quality improvement needs of subrecipients
- A TA calendar has been established regarding SOC knowledge and understanding, as well as onboard training for subrecipients

RWGA Vacancies

- Clinical Quality Improvement Project Coordinator-continuing to interview for the position. However, RWGA will be contracting with a healthcare consulting firm to fulfill the duties of the position, train and mentor the new hire, and provide technical assistance and training regarding our QM and QI activities
- Financial Analyst position-RWGA is in the process of contracting with a temp agency to fulfill the position's duties with an option to hire or until a permanent hire is made
- Assistant Program Manager position (new)-RWGA has been approved to hire its first Assistant Program Manager as recommended by HRSA and in alignment with HCPH's goal of succession planning

Other Items

- **AA & Planning Council Roles & Responsibilities Technical Assistance Training:** On May 8th, RWGA consultant, Charles Henley, conducted a TA outlining the roles and responsibilities of RWGA and RWPC. All RWGA staff and Harris County Public Health's upper management attended the training.

The Houston EMA Ryan White Planning Council Report
May 2023

Submitted by Tori Williams on 06-06-23

- The lease with Bering Church is being held up in the County Attorney's office. Hopefully, it will be approved in time for the Judge to put it on the June 27th Commissioners Court agenda. If that is the case, than staff will close down the current offices and move to Bering Church on Thursday or Friday, June 29th or 30th. In the meantime, the Council is renting meeting rooms on an hourly basis from the Church. And, after staff has settled into the new office space, the copier and postage machines will be moved to a room downtown where Rod can go once a week to make all of our meeting packets for the following week.
- **Please note that we will continue to have Council meetings at Bering Church. The location of other meetings will be determined on a meeting by meeting basis depending upon the activities related to the meeting.** And, Ryan White meetings will continue to be provided in a hybrid format.
- As soon as the move is accomplished, the August start date for Project LEAP and Proyecto VIDA will be announced. They will run simultaneously and graduation will take place after Thanksgiving. Please see Robert or Kenia if you wish to help recruit students. And, see Diane or Tori if you want fliers and application forms.
- In an effort to diversify Project LEAP, there will be four co-facilitators for Project LEAP 2023. The Council Coordinator and one of the new co-facilitators will staff the morning Project LEAP class. The Director and the second new co-facilitator will staff the evening class. The individuals who are hired for these temporary contract positions will be announced next week and have been recruited based upon their extensive networks of friends and colleagues within the 10-county, Greater Houston area.
- The Manager of Ryan White Grant Administration and the Director of the Office of Support received the critique of the 2022 Integrated HIV Prevention and Care Plan. We are pleased to say that no weaknesses were sited. Soon, there will be a conference call with our HRSA and CDC representatives to discuss the review. In the meantime, see Tori if you wish to see the written critique.
- The Director is also setting up a meeting to align the Integrated Planning Leadership structure with partners from other planning bodies.
- The Health Planner and the Director of the Office of Support submitted the Council portion of the FY 2022 Progress Report. The Director also prepared the FY 2023 Program Report.
- Staff turned in all receipts from FY 2022 so that the County can close the books on last year's grant.
- Please note the form in your meeting packet that invites volunteers who must take food with medication to please fill out and submit this form to staff before you leave today, or scan and send it to us.
- Mackenzie will be working half time for the next 2 – 3 months due to a chronic health condition which requires treatment. Please join me in wishing her well.

Houston RWPC Steering Committee & Council Report

June 2023

Administrative Agency Update

TRG Reports Submission:

Procurement Monthly Report

a. **Ryan White B (April 1 – March 31)**
- FY 22-23 spending through March 2023 CLOSEOUT **provided 6/5/2023**

b. **State Services (April – August 31):**
- FY 22-23 SS spending through April 2023 **provided 6/5/2023**

Service Utilization Quarterly Report

a. **State Services (September 1-August 31):**
- FY 22-23 1st Quarter (Sept-Nov) provided 2/9/2023
- FY 22-23 2nd Quarter (Dec-Feb) provided 4/6/2023
- FY 22-23 3rd Quarter (Mar-May)
- FY 22-23 4th Quarter FINAL (Jun-Aug)

b. **Ryan White Part B (April 1-March 31):**
- FY 22-23 1st Quarter (Apr-Jun)
- FY 22-23 2nd Quarter (Jul-Sept)
- FY 22-23 3rd Quarter (Oct-Dec) provided 2/9/2023
- FY 22-23 4th Quarter FINAL (Jan-Mar) provided 5/4/2023

Health Insurance Assistances Service Utilization Quarterly Report
- FY 22-2023 April 2023 **provided 6/5/2023**

All reports provided to RWPC OOS

Address: 3700 Buffalo Speedway, Suite 250, Houston Texas 77098-3799
Phone: 713-526-1016
Website: www.hivtrg.org

DSHS Funding Ryan White Part B, State-R, State Services & HOPWA Updates

a. **Grant Updates**

b. **Service Categories Updates**

- **Referral for Healthcare Targeting the Incarcerated and Recently Released:** Contract issued. County system for approval in process. TRG will be establishing a monthly coordination webinar with HHS to provide technical assistance and training for the contract start-up.

c. **Houston ADAP Enrollment Workers:**

- Regional ADAP/Eligibility Liaison Hailey Malcolm Contact email hmalcolm@hivtrg.org
- All THMP processing dates are current
- Regional AEWs will attend in service training with ADAP Liaison June 13-14
- THMP continues to encourage the use of expedite applications
- All Regions call for Houston and East Tx will be held on July 25th and July 26th

d. **Rural HOPWA**

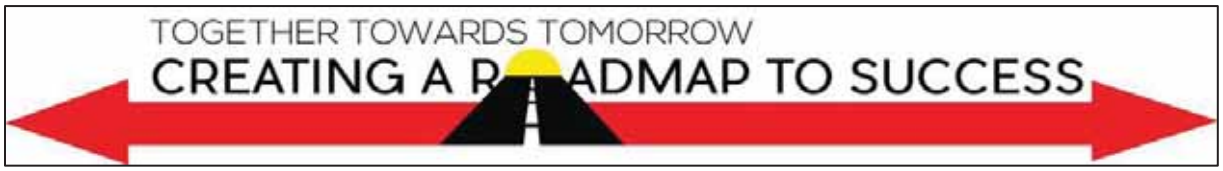
- Rural HOPWA RFP released May, 30, 2023; **Houston (only specific to Wharton, Colorado, and Matagorda counties).**
- **HOPWA Bridge Re-Entry Initiative (BRI) Project:** This service will be part of the HOPWA RFP process.

Ryan White Part D: The Positive VIBE Project (PVP) of Houston Galveston Update

- HRSA Site Visit: HRSA will be conducting a site review of the PVP in August. TRG has met with the site visit team.
- Youth Transition Summit: The Positive Vibe Project conducted a youth transition summit on 4/21/23 at 9:30 a.m. to 4 p.m. at The Montrose Center on the 2nd Floor. The morning session focused on training and TA for service linkage workers, non-medical and medical case managers to improve the connection of youth into adult care. The afternoon session focused on providing skills building for youth who will be transitioning to adult care in the next six months or less. Several adult RW medical clinics were present to allow the youth to meet with prospective providers. The formal debrief has been delayed but should be available in July.
- Youth Transitioning Initiative: TRG's Positive VIBE Network is funding a new initiative to provide counselor facilitated support groups for youths transitioning from pediatric care to adult care providers. These support groups will be available for youth regardless of whether the pediatric provider is funded by TRG's Part D grant. The Montrose Center has created a referral process.
- Parental Support Network: As a QI initiative, TRG's Positive VIBE Network is using the Postpartum Support International (PSI) model to create a (pre- and post-delivery) parental support network to assist parents in address the stress, anxiety, and needs of adding another member to their household. The support groups will be developed in Houston and Galveston HSDAs as pilot projects. PVP Partners are helping map out the services and providers that will be recruited into the support network. Additionally, TRG will be working with the PVP to increase screening and connection to treatment for postpartum depression (PPD).

Address: 3700 Buffalo Speedway, Suite 250, Houston Texas 77098-3799
Phone: 713-526-1016
Website: www.hivtrg.org

RYAN WHITE HIV/AIDS PROGRAM PART B



TRG Community Initiatives

Trauma-Informed Care Initiative

- The Change Team continues implementing the trauma principles based on TRG staff feedback.
- The Change Team created a grant update and presented it to TRG staff to Sho the progress and work happening during the implementation from January 2023- May 2023
- The Executive Director and Quality Manager participated in the 3-hour grant strategic meeting with the Change Team and Grant consultants/ coaches. On May 15, 2023
- Please contact Reachelian Ellison rellison@hivtrg.org, project lead, with questions.

Serving the Recently Released and Incarcerated

- SIRR met on May 24th. The meeting was a hybrid meeting which included in-person attendance at The Montrose Center Community Center. SIRR partnered with the Office of Support and the Planning Council to host a community dialogue on the prohibition of condoms in Texas jails and prisons. There was some technical difficulties that were overcome. Two presenters did not show up, so the agenda had to be modified on the fly. The remaining presenter provided information on the Prison Rape Elimination Act (PREA) and the existing Texas State Code that prohibits sexual contact in all correctional facilities in Texas (making it a felony). This laid the foundation for discussion. The 20+ participants engaged in lively dialogue. There were some follow-up action steps that were proposed moving forward. More information will be provided at the June SIRR meeting.
- To be added to the distribution list for meeting announcements, contact Felicia Booker fbooker@hivtrg.org

Texas Black Women's Health Initiative (TxBWHI) Houston Team

- June meeting with AASOETF 6/9/2023 @ 12:30 pm @ TRG. Contact Sha'Terra Johnson tbwihouston@gmail.com

Other: TRG and staff participates in many EMA and HSDA community groups, initiatives and programs that impacts the HIV workforce in prevention, care and support on the national, state and local levels.

Address: 3700 Buffalo Speedway, Suite 250, Houston Texas 77098-3799
Phone: 713-526-1016
Website: www.hivtrg.org