Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV infections by addressing four strategies – diagnose, treat, protect, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2019 Outcome Measures, 2019 Chart Reviews, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate funding or the need to fill in a gap. (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals moving into free world care c) Pregnant women no longer needing OB/GYN care	Recommendation(s)
Part 1: Services offered by Ryan White Part A, Part B, and State Services in the Houston EMA/HSDA as of 03-16-21							
Ambulatory/Outpatient Primary Medical Care (incl. Vision):							
CBO, Adult – Part A, Including LPAP, MCM & Svc Linkage (Includes OB/GYN) *See below for Public Clinic, Rural, Pediatric, Vision* ***Workgroup #1*** ***Motion:** (Pradia/Sierra) Votes: Y=8; N=0; Abstentions= Aloysius, Leonard, Kelly, Padilla*	✔ Yes ___No	☒ EIIHA ☒ Unmet Need ☒ Continuum of Care EIIHA: The purpose of the HRSA EIIHA initiative is to identify the status-*unaware* and facilitate their entry into Primary Care Unmet Need: Facilitating entry/reentry into Primary Care reduces unmet need. Additionally, a criterion for met need is evidence of an ART prescription, and clients cannot access LPAP until they are enrolled in Primary Care.	Epi (2018): An estimated 6,825 people in the EMA are living with HIV and unaware of their status. The current estimate of unmet need in the EMA is 7,187, or 25% of all PLWH. Current # of living HIV cases in EMA: 29,078 Need (2020): Rank w/in funded services: *Primary Care: #1* *LPAP/EFA: #2* *Case Management: #3* *Outreach: #14* Service Utilization (2020): # clients served:	Primary Care: Medicaid, Medicare, RW Part D, and private providers, including federal health insurance marketplace participants LPAP: ADAP, State Pharmacy Assistance Program, Medicaid, Medicare Part D, RW Health Insurance Assistance, the public clinic's pharmacy program, private sector Patient Assistance Programs, and private pharmacy benefit programs, including federal	Justify the use of funds: This service category: - Is a HRSA-defined Core Medical Service - Is ranked as the #1 service need by PLWH; and use has increased - Adheres to a medical home model and is bundled with LPAP, Medical Case Management, and Service Linkage - Results in desirable health outcomes for clients who access the service - Referring and linking the status-unaware to Primary	Can we make this service more efficient? No Can we bundle this service? Currently bundled with: EFA, LPAP, Medical Case Management, Outreach and Service Linkage Has a recent capacity issue been identified? No Does this service assist special populations to access primary care?	**Wg Motion:** Update the justification chart, keep the service definition and the financial eligibility the same: PriCare=300%, EFA=500%, LPAP=400% +500%, MCM=none, SLW=none, Outreach=none.

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV infections by addressing four strategies – diagnose, treat, protect, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2019 Outcome Measures, 2019 Chart Reviews, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate funding or the need to fill in a gap. (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals moving into free world care c) Pregnant women no longer needing OB/GYN care	Recommendation(s)
		Continuum of Care: Primary Care, MCM, and LPAP support maintenance/retention in care and viral suppression for PLWH.	*Primary Care: 9,357 (slight decrease v. 2019)* *LPAP: 5,559 (8.6% increase v. 2019)* *Medical Case Mgmt: 5,396 (1.5% increase v. 2019)* *EFA: 1,375 (10% decrease v. 2019)* *Outreach: 877 (12.6% increase v. 2019)* *Non-Medical Case Mgmt, or Service Linkage: 8,328 (8.9% decrease v. 2019)* Outcomes (FY2019): *Primary Care/LPAP:* 82% of Primary Care clients and 77% of LPAP clients were virally suppressed; *Medical Case Mgmt:* 50% of clients were in continuous HIV	health insurance marketplace participants Medical Case Management: RW Part C and D Service Linkage: RW Part C and D, HOPWA, and a grant from a private foundation EHE Funding: RWGA received $1,794,295 in HRSA funding for Year 1 implementation of EHE activities. Houston Health Department (HHD) has received funding under PS19-1906 for Accelerating State and Local HIV Planning to End the HIV Epidemic. Several Houston area FQHCs received a combined total of $1,067,555	Care is the goal of the national and local EIIHA initiative - Referring and linking the out-of-care to Primary Care is the goal of reducing unmet need - Facilitates national, state, and local goals related to continuous HIV care, reducing unmet need, and viral load suppression - Addresses specific activities from Strategy #3 of the Comprehensive Plan and addresses certain Special Populations named in the Plan Is this a duplicative service or activity? - This service is funded locally		

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			care following MCM; 73% of clients who received MCM were virally suppressed; *Outreach:* 34% of clients accessed HIV care w/in 3 mos.; 66% were virally suppressed w/in 3 mos.; *Non-Medical Case Mgmt, or Service Linkage:* 48% of clients were in continuous HIV care following Service Linkage Pops. with difficulty accessing needed services: *Primary Care*: HL, 18-24, 25-49, Rural, OOC, MSM *LPAP/EFA*: Females (sex at birth), HL, 25-49, Homeless, MSM, Rural *Outreach*: Males (sex at birth),	from HRSA's Ending the HIV Epidemic-Primary Care HIV Prevention (PCHP) Grant. Covered under QHP? ✔ Yes ___No	by other public and private sources for (1) specific Special Populations (e.g., WICY), (2) those meeting income, disability, and/or age-related eligibility criteria, and (3) those with private sector health insurance.		

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Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV infections by addressing four strategies – diagnose, treat, protect, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2019 Outcome Measures, 2019 Chart Reviews, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate funding or the need to fill in a gap. (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals moving into free world care c) Pregnant women no longer needing OB/GYN care	Recommendation(s)
			White, 18 – 24, Homeless, MSM, RR, Transgender *Case Management:* Other/multiracial, Black/AA, 18-24, OOC, Transgender, RR, Homeless				
Public Clinic, Adult – Part A, Including LPAP, MCM & Svc Linkage (Includes OB/GYN) *See below for Rural, Pediatric, Vision* ***Workgroup #1*** ***Motion:** (Pradia/Sierra) Votes: Y=8; N=0; Abstentions= Aloysius, Leonard, Kelly, Padilla*	✔ Yes ___No	☒ EIIHA ☒ Unmet Need ☒ Continuum of Care EIIHA: The purpose of the HRSA EIIHA initiative is to identify the status-*unaware* and facilitate their entry into Primary Care Unmet Need: Facilitating entry/reentry into Primary Care reduces unmet need. Additionally, a criterion for met need is evidence of an ART	Epi (2018): An estimated 6,825 people in the EMA are living with HIV and unaware of their status. The current estimate of unmet need in the EMA is 7,187, or 25% of all PLWH. Current # of living HIV cases in EMA: 29,078 Need (2020): Rank w/in funded services: *Primary Care: #1* *LPAP/EFA: #2* *Case Management: #3* *Outreach: #14*	Primary Care: Medicaid, Medicare, RW Part D, and private providers, including federal health insurance marketplace participants LPAP: ADAP, State Pharmacy Assistance Program, Medicaid, Medicare Part D, RW Health Insurance Assistance, the public clinic's pharmacy program, private sector Patient Assistance Programs, and	Justify the use of funds: This service category: - Is a HRSA-defined Core Medical Service - Is ranked as the #1 service need by PLWH; and use has increased - Adheres to a medical home model and is bundled with LPAP, Medical Case Management, and Service Linkage - Results in desirable health outcomes for clients who	Can we make this service more efficient? No Can we bundle this service? Currently bundled with: EFA, LPAP, Medical Case Management, Outreach and Service Linkage Has a recent capacity issue been identified? No Does this service assist	**Wg Motion:** Update the justification chart, keep the service definition and the financial eligibility the same: PriCare=300%, EFA=500%, LPAP=400% +500%, MCM=none, SLW=none, Outreach=none.

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Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? *EIIHA: Early Identification of Individuals with HIV/AIDS seeks to identify the status-unaware and link them into care *Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months *Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV infections by addressing four strategies – diagnose, treat, protect, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2019 Outcome Measures, 2019 Chart Reviews, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate funding or the need to fill in a gap. (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals moving into free world care c) Pregnant women no longer needing OB/GYN care	Recommendation(s)
		prescription, and clients cannot access LPAP until they are enrolled in Primary Care. Continuum of Care: Primary Care, MCM, and LPAP support maintenance/retention in care and viral suppression for PLWH.	Service Utilization (2020): # clients served: *Primary Care: 9,357 (slight decrease v. 2019) LPAP: 5,559 (8.6% increase v. 2019) Medical Case Mgmt: 5,396 (1.5% increase v. 2019) EFA: 1,375 (10% decrease v. 2019) Outreach: 877 (12.6% increase v. 2019) Non-Medical Case Mgmt, or Service Linkage: 8,328 (8.9% decrease v. 2018)* Outcomes (FY2019): *Primary Care/LPAP:* 82% of Primary Care clients and 77% of LPAP clients were virally suppressed;	private pharmacy benefit programs, including federal health insurance marketplace participants Medical Case Management: RW Part C and D Service Linkage: RW Part C and D, HOPWA, and a grant from a private foundation EHE Funding: RWGA received $1,794,295 in HRSA funding for Year 1 implementation of EHE activities. Houston Health Department (HHD) has received funding under PS19-1906 for Accelerating State and Local HIV Planning to End the HIV Epidemic. Several	access the service - Referring and linking the status-unaware to Primary Care is the goal of the national and local EIIHA initiative - Referring and linking the out-of-care to Primary Care is the goal of reducing unmet need - Facilitates national, state, and local goals related to continuous HIV care, reducing unmet need, and viral load suppression - Addresses specific activities from Strategy #3 of the Comprehensive Plan and addresses certain Special Populations named in the Plan	special populations to access primary care?	

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			Medical Case Mgmt: 50% of clients were in continuous HIV care following MCM; 73% of clients who received MCM were virally suppressed; *Outreach:* 34% of clients accessed HIV care w/in 3 mos.; 66% were virally suppressed w/in 3 mos.; *Non-Medical Case Mgmt, or Service Linkage:* 48% of clients were in continuous HIV care following Service Linkage Pops. with difficulty accessing needed services: *Primary Care*: HL, 18-24, 25-49, Rural, OOC, MSM *LPAP/EFA*: Females (sex at birth), HL, 25-49, Homeless,	Houston area FQHCs received a combined total of $1,067,555 from HRSA's Ending the HIV Epidemic-Primary Care HIV Prevention (PCHP) Grant. Covered under QHP? ✔ Yes ___No	Is this a duplicative service or activity? - This service is funded locally by other public and private sources for (1) specific Special Populations (e.g., WICY), (2) those meeting income, disability, and/or age-related eligibility criteria, and (3) those with private sector health insurance.		

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			MSM, Rural *Outreach*: Males (sex at birth), White, 18 – 24, Homeless, MSM, RR, Transgender *Case Management:* Other/multiracial, Black/AA, 18-24, OOC, Transgender, RR, Homeless				
Rural, Adult – Part A, Including LPAP, MCM & Svc Linkage (Includes OB/GYN) *See below for Pediatric, Vision* ***Workgroup #1*** ***Motion:** (Pradia/Sierra)* *Votes: Y=8; N=0;* *Abstentions= Aloysius,*	✔ Yes ___No	☒ EIIHA ☒ Unmet Need ☒ Continuum of Care EIIHA: The purpose of the HRSA EIIHA initiative is to identify the status-*unaware* and facilitate their entry into Primary Care Unmet Need: Facilitating entry/reentry into Primary Care reduces unmet need.	Epi (2018): An estimated 6,825 people in the EMA are living with HIV and unaware of their status. The current estimate of unmet need in the EMA is 7,187, or 25% of all PLWH. Current # of living HIV cases in EMA: 29,078 Need (2020): Rank w/in funded services: *Primary Care: #1* *LPAP/EFA: #2*	Primary Care: Medicaid, Medicare, RW Part D, and private providers, including federal health insurance marketplace participants LPAP: ADAP, State Pharmacy Assistance Program, Medicaid, Medicare Part D, RW Health Insurance Assistance, the public clinic's pharmacy	Justify the use of funds: This service category: - Is a HRSA-defined Core Medical Service - Is ranked as the #1 service need by PLWH; and use has increased - Adheres to a medical home model and is bundled with LPAP, Medical Case Management, and Service Linkage	Can we make this service more efficient? No Can we bundle this service? Currently bundled with: EFA, LPAP, Medical Case Management, Outreach and Service Linkage Has a recent capacity issue been identified? No	**Wg Motion:** Update the justification chart, keep the service definition and the financial eligibility the same: PriCare=300%, EFA=500%, LPAP=400% +500%, MCM=none, SLW=none, Outreach=none.

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Leonard, Kelly, Padilla		Additionally, a criterion for met need is evidence of an ART prescription, and clients cannot access LPAP until they are enrolled in Primary Care. Continuum of Care: Primary Care, MCM, and LPAP support maintenance/retention in care and viral suppression for PLWH.	*Case Management: #3* *Outreach: #14* Service Utilization (2020): # clients served: *Primary Care: 9,357 (slight decrease v. 2019)* *LPAP: 5,559 (8.6% increase v. 2019)* *Medical Case Mgmt: 5,396 (1.5% increase v. 2018)* *EFA: 1,375 (10% decrease v. 2019)* *Outreach: 877 (12.6% increase v. 2019)* *Non-Medical Case Mgmt, or Service Linkage: 8,328 (8.9% decrease v. 2019)* Outcomes (FY2019): *Primary Care/LPAP:* 82% of Primary Care clients and 77%	program, private sector Patient Assistance Programs, and private pharmacy benefit programs, including federal health insurance marketplace participants Medical Case Management: RW Part C and D Service Linkage: RW Part C and D, HOPWA, and a grant from a private foundation EHE Funding: RWGA received $1,794,295 in HRSA funding for Year 1 implementation of EHE activities. Houston Health Department (HHD) has received funding under PS19-1906 for Accelerating State	- Results in desirable health outcomes for clients who access the service - Referring and linking the status-unaware to Primary Care is the goal of the national and local EIIHA initiative - Referring and linking the out-of-care to Primary Care is the goal of reducing unmet need - Facilitates national, state, and local goals related to continuous HIV care, reducing unmet need, and viral load suppression - Addresses specific activities from Strategy #3 of the Comprehensive Plan and addresses certain Special	Does this service assist special populations to access primary care?	

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			of LPAP clients were virally suppressed; *Medical Case Mgmt:* 50% of clients were in continuous HIV care following MCM; 73% of clients who received MCM were virally suppressed; *Outreach:* 34% of clients accessed HIV care w/in 3 mos.; 66% were virally suppressed w/in 3 mos.; *Non-Medical Case Mgmt, or Service Linkage:* 48% of clients were in continuous HIV care following Service Linkage Pops. with difficulty accessing needed services: *Primary Care*: HL, 18-24, 25-49, Rural, OOC, MSM	and Local HIV Planning to End the HIV Epidemic. Several Houston area FQHCs received a combined total of $1,067,555 from HRSA's Ending the HIV Epidemic-Primary Care HIV Prevention (PCHP) Grant. Covered under QHP? ✔ Yes ___No	Populations named in the Plan Is this a duplicative service or activity? - This service is funded locally by other public and private sources for (1) specific Special Populations (e.g., WICY), (2) those meeting income, disability, and/or age-related eligibility criteria, and (3) those with private sector health insurance.		

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Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV infections by addressing four strategies – diagnose, treat, protect, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2019 Outcome Measures, 2019 Chart Reviews, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate funding or the need to fill in a gap. (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals moving into free world care c) Pregnant women no longer needing OB/GYN care	Recommendation(s)
			LPAP/EFA: Females (sex at birth), HL, 25-49, Homeless, MSM, Rural *Outreach*: Males (sex at birth), White, 18 – 24, Homeless, MSM, RR, Transgender *Case Management:* Other/multiracial, Black/AA, 18-24, OOC, Transgender, RR, Homeless				
Pediatric – Part A ***Workgroup #1*** ***Motion:** (Pradia/Sierra) Votes: Y=8; N=0; Abstentions= Aloysius, Leonard, Kelly, Padilla*	✔ Yes ___No	☒ EIIHA ☒ Unmet Need ☒ Continuum of Care EIIHA: The purpose of the HRSA EIIHA initiative is to identify the status-*unaware* and facilitate their entry into Primary Care Unmet Need: Facilitating	Epi (2018): An estimated 6,825 people in the EMA are living with HIV and unaware of their status. The current estimate of unmet need in the EMA is 7,187, or 25% of all PLWH. Current # of living HIV cases in EMA: 29,078 Need (2020): Rank w/in funded services:	Primary Care: Medicaid, Medicare, RW Part D, and private providers, including federal health insurance marketplace participants Medical Case Management: RW Part C and D Service Linkage:	Justify the use of funds: This service category: - Is a HRSA-defined Core Medical Service - Is ranked as the #1 service need by PLWH; and use has increased - Adheres to a medical home model and is bundled with Medical Case Management	Can we make this service more efficient? No Can we bundle this service? Currently bundled with: Medical Case Management and Service Linkage Has a recent capacity issue been identified?	**Wg Motion:** Update the justification chart, keep the service definition and the financial eligibility the same: PriCare=300%, EFA=500%, LPAP=400% +500%, MCM=none, SLW=none, Outreach=none.

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV infections by addressing four strategies – diagnose, treat, protect, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2019 Outcome Measures, 2019 Chart Reviews, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate funding or the need to fill in a gap. (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals moving into free world care c) Pregnant women no longer needing OB/GYN care	Recommendation(s)
		entry/reentry into Primary Care reduces unmet need. Continuum of Care: Primary Care, MCM, and Service Linkage support maintenance/retention in care and viral suppression for PLWH.	*Primary Care: #1* *Case Management: #3* Service Utilization (2020): # clients served: *Primary Care: 9,357 (slight decrease v. 2019)* *Medical Case Mgmt: 5,396 (1.5% increase v. 2019)* *Non-Medical Case Mgmt, or Service Linkage: 8,328 (8.9% decrease v. 2019)* Outcomes (FY2019): *Primary Care/LPAP:* 82% of Primary Care clients and 77% of LPAP clients were virally suppressed; *Medical Case Mgmt:* 50% of clients were in continuous HIV care following MCM; 73% of clients who received MCM	RW Part C and D, HOPWA, and a grant from a private foundation EHE Funding: RWGA received $1,794,295 in HRSA funding for Year 1 implementation of EHE activities. Houston Health Department (HHD) has received funding under PS19-1906 for Accelerating State and Local HIV Planning to End the HIV Epidemic. Several Houston area FQHCs received a combined total of $1,067,555 from HRSA's Ending the HIV Epidemic-Primary Care HIV Prevention (PCHP) Grant. Covered under QHP?	and Service Linkage - Results in desirable health outcomes for clients who access the service - Referring and linking the status-unaware to Primary Care is the goal of the national and local EIIHA initiative - Referring and linking the out-of-care to Primary Care is the goal of reducing unmet need - Facilitates national, state, and local goals related to continuous HIV care, reducing unmet need, and viral load suppression - Addresses specific activities from Strategy #3 of the Comprehensive Plan and	No Does this service assist special populations to access primary care?	

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Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV infections by addressing four strategies – diagnose, treat, protect, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2019 Outcome Measures, 2019 Chart Reviews, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate funding or the need to fill in a gap. (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals moving into free world care c) Pregnant women no longer needing OB/GYN care	Recommendation(s)
			were virally suppressed; *Non-Medical Case Mgmt, or Service Linkage:* 48% of clients were in continuous HIV care following Service Linkage Pops. with difficulty accessing needed services: *Primary Care*: HL, 18-24, 25-49, Rural, OOC, MSM *LPAP/EFA*: Females (sex at birth), HL, 25-49, Homeless, MSM, Rural *Outreach*: Males (sex at birth), White, 18 – 24, Homeless, MSM, RR, Transgender *Case Management:* Other/multiracial, Black/AA, 18-24, OOC, Transgender, RR, Homeless	✔ Yes ___No	addresses certain Special Populations named in the Plan Is this a duplicative service or activity? - This service is funded locally by other public and private sources for (1) specific Special Populations (e.g., WICY), (2) those meeting income, disability, and/or age-related eligibility criteria, and (3) those with private sector health insurance.		

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Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV infections by addressing four strategies – diagnose, treat, protect, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2019 Outcome Measures, 2019 Chart Reviews, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate funding or the need to fill in a gap. (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals moving into free world care c) Pregnant women no longer needing OB/GYN care	Recommendation(s)
Clinical Case Management - Part A ***Workgroup #1*** ***Motion:** (Vargas/Galley)* *Votes: Y=8; N=0;* *Abstentions= Aloysius, Kelly, Leonard, Padilla*	✔ 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 (2018): Current # of living HIV cases in EMA: 29,078 Need (2020): Rank w/in funded services:*#3* Service Utilization (2019): # clients served: 1,316 *(15% increase v. 2018)* Outcomes (FY2018): 50% of clients were in continuous care following receipt of CCM. 79% of clients utilizing CCM were virally suppressed. Pops. with difficulty accessing needed services: Other/multiracial, Black/AA, 18-24, OOC, Transgender,	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?	**Wg Motion:** Update the justification chart, keep the service definition and the financial eligibility the same: none.

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV infections by addressing four strategies – diagnose, treat, protect, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2019 Outcome Measures, 2019 Chart Reviews, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate funding or the need to fill in a gap. (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals moving into free world care c) Pregnant women no longer needing OB/GYN care	Recommendation(s)
			RR, Homeless		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:** (Pradia/Kelly)*	___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.	Epi (2018): Current # of living HIV cases in EMA: 29,078 Need (2020): Rank w/in funded services:#3 Service Utilization (2020): # clients served: 135	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	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	Can we make this service more efficient? No Can we bundle this service? No Has a recent capacity issue been identified?	**Wg Motion:** Update the justification chart, keep the service definition and the financial eligibility the same: none.

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV infections by addressing four strategies – diagnose, treat, protect, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2019 Outcome Measures, 2019 Chart Reviews, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate funding or the need to fill in a gap. (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals moving into free world care c) Pregnant women no longer needing OB/GYN care	Recommendation(s)
Votes: Y=8; N=0; Abstentions= Aloysius, Kelly, Leonard, Padilla		Additionally, linking the newly diagnosed into HIV care via strategies such as Service Linkage fulfills the national, state, and local goal of linkage to HIV medical care ≤ 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.	*(23% decrease v. 2019)* Outcomes (FY2019): Following Service Linkage, 48% of clients were in continuous HIV care, and 50% accessed HIV primary care for the first time Pops. with difficulty accessing needed services: Other/multiracial, Black/AA, 18-24, OOC, Transgender, RR, Homeless	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	national EIIHA goals locally - Prevents the newly diagnosed from having unmet need - Facilitates national, state, and local goals related to linkage to care Is this a duplicative service or activity? - This service is funded locally by other RW Parts for specific Special Populations and for clients served by specific funded agencies/programs only	No Does this service assist special populations to access primary care?	

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV infections by addressing four strategies – diagnose, treat, protect, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2019 Outcome Measures, 2019 Chart Reviews, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate funding or the need to fill in a gap. (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals moving into free world care c) Pregnant women no longer needing OB/GYN care	Recommendation(s)
		Continuum of Care: Service Linkage supports linkage to care, maintenance/retention in care and viral suppression for PLWH.					
Referral for Health Care and Support Services‡ ***Workgroup #1*** ***Motion:** (Mica/Vargas) Votes: Y=7; N=0; Abstentions= Aloysius, Kelly, Padilla.*	___Yes ✔ No Referral For Health Care/Support Services – AIDS Drug Assistance Program Enrollment Worker at Ryan White Care Sites will fund one FTE ADAP enrollment worker per Ryan White Part A primary care site. Each ADAP enrollment worker will meet with all	☐ 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 (2018): Current # of living HIV cases in EMA: 29,078 Need (2020): Rank w/in funded services: *#6* Service Utilization (2020): # clients served: 7,002 *(15% increase v. 2019)* Chart Review (2019): 59% of AEW client had charts documented evidence of benefit applications completed	Beyond assistance offered in the provision of case management care coordination, there is currently no funding to support dedicated ADAP Enrollment Workers at Ryan White primary care sites. Covered under QHP?	Justify the use of funds: This service category: - Is a HRSA-defined Support Service - State Services-Rebate (SS-R) funding is intended to ensure service continuation or bridge service gaps. - ADAP medication coverage reduces use of LPAP funding. Is this a duplicative service	Can we make this service more efficient? Placement of ADAP Enrollment Workers at each Ryan White primary care site will make this service more efficient and accessible than placement at a single site. Can we bundle this service? N/a – this would be the only	**Wg Motion:** Update the justification chart, keep the service definition the same and increase the financial eligibility to 500% to be in line with HIV medications in LPAP.

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Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV infections by addressing four strategies – diagnose, treat, protect, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2019 Outcome Measures, 2019 Chart Reviews, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate funding or the need to fill in a gap. (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals moving into free world care c) Pregnant women no longer needing OB/GYN care	Recommendation(s)
	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.	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	___Yes ✔ No	or activity? No	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?	
Vision – Part A ***Workgroup #1*** ***Motion:** (Pradia/Mica)*	✔ Yes ___No	☐ EIIHA ☐ Unmet Need ☒ Continuum of Care Continuum of Care: Vision	Epi (2018): Current # of living HIV cases in EMA: 29,078 Need (2020):	No known alternative funding sources exist for this service	No known alternative funding sources exist for this service	Can we make this service more efficient? No Can we bundle this service?	**Wg Motion:** Update the justification chart, keep the service definition the same and increase the financial

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Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV infections by addressing four strategies – diagnose, treat, protect, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2019 Outcome Measures, 2019 Chart Reviews, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate funding or the need to fill in a gap. (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals moving into free world care c) Pregnant women no longer needing OB/GYN care	Recommendation(s)
Votes: Y=10; N=0; Abstentions= Aloysius, Padilla		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.	Rank w/in funded services:#5 Service Utilization (2020): # clients served: 3,109 *(8.5% increase v. 2019)* Outcomes (FY2019): 11 diagnoses were reported for HIV-related ocular disorders, all of which were managed appropriately Pops. with difficulty accessing needed services: Females (sex at birth), Other/multiracial, 18-24, Homeless, OOC	Covered under QHP?* ___Yes ✔ No *QHPs cover pediatric vision		Currently bundled with Primary Care Has a recent capacity issue been identified? No Does this service assist special populations to access primary care?	eligibility to 400%.

‡ Service Category for Part B/State Services only.

Service Category	Justification for Discontinuing the Service
Part 2: Services *allowed* by HRSA but not offered by Part A, Part B or State Services funding in the Houston EMA/HSDA as of 03-01-21 *(In order for any of the services listed below to be considered for funding, a New Idea Form must be submitted to the Office of Support for the Ryan White Planning Council no later than **5 p.m. on May 3, 2021**. This form is available by calling the Office of Support: 832 927-7926)*	
Buddy Companion/Volunteerism	Low use, need and gap according to the 2002 Needs Assessment (NA).
Childcare Services (In Home Reimbursement; at Primary Care sites)	Primary care sites have alternative funding to provide this service so clients will continue to receive the service through alternative sources.
Food Pantry (Urban)	Service available from alternative sources.
HE/RR	In order to eliminate duplication, eliminate this service but strengthen the patient education component of primary care.
Home and Community-based Health Services (In-home services)	Category unfunded due to difficulty securing vendor.
Housing Assistance (Emergency rental assistance) **Housing Related Services** (Housing Coordination)	According to the HOPWA representative, they provide significant funding for emergency rent and utility assistance. (See City Council approved allocations.) But, HOPWA does not give emergency shelter vouchers because they feel there are shelters for this purpose and because it is more prudent to use limited resources to provide long-term housing.
Minority Capacity Building Program	The Capacity Building program targeted to minority substance abuse providers was a one-year program in FY2004.
Outreach Services	Significant alternative funding.
Psychosocial Support Services (Counseling/Peer)	Duplicates patient education program in primary care and case management. The boundary between peer and client gets confusing and difficult to supervise. Not cost effective, costs almost as much per client as medical services.
Rehabilitation	Service available from alternative sources.

‡ Service Category for Part B/State Services only.