| Service Category | Is this a core service?<br>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?<br>**EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care<br>**Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months<br>**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.<br>**Ending the HIV Epidemic*: The local plan to end new HIV infections by addressing four strategies – diagnose, treat, protect, and respond. | Documentation of Need<br>(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)<br>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.<br>(i.e., Alternative Funding Sources)<br>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.<br>Is this a duplicative service or activity? | Service Efficiency<br>Can we make this service more efficient? For:<br>a) Clients<br>b) Providers<br>Can we bundle this service?<br>Has a recent capacity issue been identified?<br>Does this service assist special populations to access primary care?<br>*Examples:*<br>a) Youth transitioning into adult care<br>b) Recently released individuals moving into free world care<br>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** | | | | | | | |
| **Early Intervention Services (EIS)‡**<br>(Incarcerated)<br>(Harris County Jail)<br><br>***Workgroup #3***<br>***Motion:** (Vargas/Kelly)*<br>*Votes: Y=12; N=0;*<br>*Abstentions=none* | ✔ Yes ___No | ☒ EIIHA<br>☒ Unmet Need<br>☒ Continuum of Care<br><br>EIIHA: Local jail policy mandates HIV testing within 14 days of incarceration, thereby identifying status-unaware members of this population. From 2016-2018, an estimated 693 PLWH were released from TDCJ into Harris County. During incarceration, 100% are linked to HIV care. EIS ensures that the newly diagnosed identified in jail maintain their HIV care post-release by bridging re-entering PLWH into community-based primary care. | Epi (2018):<br>Current # of living HIV cases in EMA: 29,078<br><br>Need (2020):<br>Rank w/in funded services: *#13*<br><br>Service Utilization (2020):<br># clients served: 572<br>*(15% decrease v. 2019)*<br><br>Chart Review (2019):<br>Of the client records reviewed, 97% of clients had a discharge plan present and 9% of all client records reviewed had documentation that the client accessed HIV care after | RW Part C provides non-targeted EIS<br><br>EHE Funding:<br>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. | Justify the use of funds: This service category:<br>- Is a HRSA-defined Core Medical Service<br>- Results in desirable outcomes for clients who access the service<br>- 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<br>- Addresses specific activities from Strategy #3 of the Comprehensive Plan and | Can we make this service more efficient?<br>No<br><br>Can we bundle this service?<br>No<br><br>Has a recent capacity issue been identified?<br>No<br><br>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?<br>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?<br>**EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care<br>**Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months<br>**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.<br>**Ending the HIV Epidemic*: The local plan to end new HIV infections by addressing four strategies – diagnose, treat, protect, and respond. | Documentation of Need<br>(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)<br>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.<br>(i.e., Alternative Funding Sources)<br>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.<br>Is this a duplicative service or activity? | Service Efficiency<br>Can we make this service more efficient? For:<br>a) Clients<br>b) Providers<br>Can we bundle this service?<br>Has a recent capacity issue been identified?<br>Does this service assist special populations to access primary care?<br>*Examples:*<br>a) Youth transitioning into adult care<br>b) Recently released individuals moving into free world care<br>c) Pregnant women no longer needing OB/GYN care | Recommendation(s) |
|---|---|---|---|---|---|---|---|
| | | This is accomplished through care coordination by EIS staff in partnership with community-based providers/MOUs.<br>Unmet Need: PLWH re-entering the community are at risk of lapsing their HIV care upon release from incarceration. EIS helps to prevent unmet need among this population by bridging re-entering PLWH into community-based primary care post-release. This is accomplished through care coordination by EIS staff in partnership with community-based providers/MOUs.<br>Continuum of Care: EIS supports linkage to care, maintenance/retention in care | release.<br>Pops. with difficulty accessing needed services: Other / multiracial, White, 25-49, RR, Homeless, Transgender, MSM | Covered under QHP?<br>___Yes ✔ No | addresses certain Special Populations named in the Plan<br>Is this a duplicative service or activity?<br>- No, there is no known alternative funding for this service as designed | | |

‡ Service Category for Part B/State Services only.

| Service Category | Is this a core service?<br>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?<br>**EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care<br>**Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months<br>**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.<br>**Ending the HIV Epidemic*: The local plan to end new HIV infections by addressing four strategies – diagnose, treat, protect, and respond. | Documentation of Need<br>(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)<br>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.<br>(i.e., Alternative Funding Sources)<br>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.<br>Is this a duplicative service or activity? | Service Efficiency<br>Can we make this service more efficient? For:<br>a) Clients<br>b) Providers<br>Can we bundle this service?<br>Has a recent capacity issue been identified?<br>Does this service assist special populations to access primary care?<br>*Examples:*<br>a) Youth transitioning into adult care<br>b) Recently released individuals moving into free world care<br>c) Pregnant women no longer needing OB/GYN care | Recommendation(s) |
|---|---|---|---|---|---|---|---|
| | | and viral suppression for PLWH. | | | | | |
| **Emergency Financial Assistance - Other**<br>***Workgroup #3***<br>***Motion:** (Mica/Kelly)*<br>*Votes: Y=11; N=0;*<br>*Abstentions=none* | ___Yes ✔ No | ☐ EIIHA<br>☐ Unmet Need<br>☐ Continuum of Care<br>This is a new service that started 03/01/21. | | Covered under QHP?<br>___Yes ✔ No | | | **Wg Motion:** Update the justification chart; keep the service definition and the financial eligibility the same: 400%. Also ask the Office of Support to highlight in Road 2 Success and ask the AAs to actively promote the service. |
| **Home and Community-Based Services‡**<br>(Facility-based)<br>(Adult Day Treatment)<br>***Workgroup #3*** | ✔ Yes __No | ☐ EIIHA<br>☒ Unmet Need<br>☒ Continuum of Care<br>Unmet Need: Facilitating entry into/return of the out-of-care into primary care is the intent of | Epi (2018):<br>Current # of living HIV cases in EMA: 29,078<br>Need (2020):<br>Rank w/in funded services: *#11* | Medicaid<br>Covered under QHP?<br>___Yes ✔ No | Justify the use of funds: This service category:<br>- Is a HRSA-defined Core Medical Service; and use has increased<br>- Results in desirable health outcomes for clients who | Can we make this service more efficient?<br>No<br>Can we bundle this service?<br>No | **Wg Motion:** Update the justification chart; keep the service definition the same and increase the financial eligibility to 400%. Also ask the Office of Support to |

‡ Service Category for Part B/State Services only.

| Service Category | Is this a core service?<br>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?<br>**EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care<br>**Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months<br>**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.<br>**Ending the HIV Epidemic*: The local plan to end new HIV infections by addressing four strategies – diagnose, treat, protect, and respond. | Documentation of Need<br>(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)<br>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.<br>(i.e., Alternative Funding Sources)<br>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.<br>Is this a duplicative service or activity? | Service Efficiency<br>Can we make this service more efficient? For:<br>a) Clients<br>b) Providers<br>Can we bundle this service?<br>Has a recent capacity issue been identified?<br>Does this service assist special populations to access primary care?<br>*Examples:*<br>a) Youth transitioning into adult care<br>b) Recently released individuals moving into free world care<br>c) Pregnant women no longer needing OB/GYN care | Recommendation(s) |
|---|---|---|---|---|---|---|---|
| ***Motion:** (Mica/Vargas)*<br>*Votes: Y=10; N=0;*<br>*Abstentions=Stacy* | | reducing unmet need. Adult Day Treatment contributes to this goal by providing a community-based alternative to in-patient care facilities for those with advanced HIV-related health concerns. This, in turn, may prevent those with advanced stage illness or complex HIV-related health concerns from becoming out-of-care. In 2015, 19% of people with a Stage 3 HIV diagnosis were out-of-care in the EMA. In addition, the goal of Adult Day Treatment is to return clients to self-sufficient daily functioning, which includes maintenance in HIV care.<br>Continuum of Care: Adult Day Treatment facilitates re-linkage and retention in care for PLWH | Service Utilization (2020):<br># clients served: 21<br>*(22% decrease v. 2019)*<br>Chart Review (2019):<br>82% of clients records had a complete care plan based on the primary medical care provider's order. 90% of records had evaluation of health, psychosocial, functional, and home environment status<br>Pops. with difficulty accessing needed services: Other / multiracial, 25-49, Transgender, Homeless | | access the service<br>- Helps prevent unmet need for those with advanced HIV-related health concerns<br>- Facilitates national, state, and local goals related to retention in care, reducing unmet need, and viral load suppression<br>Is this a duplicative service or activity?<br>- This service is funded locally by one other public source for those meeting income or disability-related eligibility criteria | Has a recent capacity issue been identified?<br>No<br>Does this service assist special populations to access primary care? | highlight in Road 2 Success and ask the AAs to actively promote the service. |

‡ Service Category for Part B/State Services only.

| Service Category | Is this a core service?<br>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?<br>**EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care<br>**Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months<br>**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.<br>**Ending the HIV Epidemic*: The local plan to end new HIV infections by addressing four strategies – diagnose, treat, protect, and respond. | Documentation of Need<br>(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)<br>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.<br>(i.e., Alternative Funding Sources)<br>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.<br>Is this a duplicative service or activity? | Service Efficiency<br>Can we make this service more efficient? For:<br>a) Clients<br>b) Providers<br>Can we bundle this service?<br>Has a recent capacity issue been identified?<br>Does this service assist special populations to access primary care?<br>*Examples:*<br>a) Youth transitioning into adult care<br>b) Recently released individuals moving into free world care<br>c) Pregnant women no longer needing OB/GYN care | Recommendation(s) |
|---|---|---|---|---|---|---|---|
| | | by providing a community-based alternative to in-patient care facilities for those with advanced HIV-related health concerns, and may prevent those with advanced HIV-related health concerns from falling out-of-care. | | | | | |
| **Hospice ‡**<br>***Workgroup #3***<br>***Motion:** (Vargas/Sliepka)*<br>*Votes: Y=9; N=0;*<br>*Abstentions=Stacy* | ✔ Yes ___No | ☐ EIIHA<br>☒ Unmet Need<br>☒ Continuum of Care<br>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 | Epi (2018):<br>Current # of living HIV cases in EMA: 29,078<br>Need (2020):N/a<br>Service Utilization (2020):<br># clients served: 18<br>*(36% decrease v. 2019)*<br>Chart Review (2019):<br>92% of charts had records of palliative therapy as ordered and 100% had medication | Medicaid, Medicare<br>Covered under QHP?<br>✔ Yes ___No | Justify the use of funds: This service category:<br>- Is a HRSA-defined Core Medical Service<br>- Prevents unmet need among PWA and those with co-occurring conditions<br>- Facilitates national, state, and local goals related to retention in care and reducing unmet need<br>- Addresses a system-level | Can we make this service more efficient?<br>No<br>Can we bundle this service?<br>No<br>Has a recent capacity issue been identified?<br>No<br>Does this service assist | **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?<br>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?<br>**EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care<br>**Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months<br>**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.<br>**Ending the HIV Epidemic*: The local plan to end new HIV infections by addressing four strategies – diagnose, treat, protect, and respond. | Documentation of Need<br>(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)<br>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.<br>(i.e., Alternative Funding Sources)<br>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.<br>Is this a duplicative service or activity? | Service Efficiency<br>Can we make this service more efficient? For:<br>a) Clients<br>b) Providers<br>Can we bundle this service?<br>Has a recent capacity issue been identified?<br>Does this service assist special populations to access primary care?<br>*Examples:*<br>a) Youth transitioning into adult care<br>b) Recently released individuals moving into free world care<br>c) Pregnant women no longer needing OB/GYN care | Recommendation(s) |
|---|---|---|---|---|---|---|---|
| | | from becoming out-of-care. In 2015, 19% of people with a Stage 3 HIV diagnosis were out-of-care in the EMA. Hospice ensures clients with co-morbidities remain in HIV care. As a result, this service also addresses local priorities related to mental health and substance abuse co-morbidities.<br>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. | administration records on file. Records indicated that bereavement counseling was offered to client's family in 10% of applicable cases.<br>Pops. with difficulty accessing needed services: N/a | | objective (#8) from the Comprehensive Plan and addresses certain Special Populations named in the Plan<br>Is this a duplicative service or activity?<br>- This service is funded locally by other public sources for those meeting income, disability, and/or age-related eligibility criteria | special populations to access primary care? | |
| **Linguistic Services‡** | ___Yes ✔ No | ☐ EIIHA<br>☒ Unmet Need | Epi (2018):<br>Current # of living HIV cases in | RW providers must have the capacity to serve monolingual | Justify the use of funds: This service category: | Can we make this service more efficient? | **Wg Motion:** Update the justification chart, keep the |

‡ Service Category for Part B/State Services only.

| Service Category | Is this a core service?<br>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?<br>**EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care<br>**Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months<br>**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.<br>**Ending the HIV Epidemic*: The local plan to end new HIV infections by addressing four strategies – diagnose, treat, protect, and respond. | Documentation of Need<br>(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)<br>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.<br>(i.e., Alternative Funding Sources)<br>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.<br>Is this a duplicative service or activity? | Service Efficiency<br>Can we make this service more efficient? For:<br>a) Clients<br>b) Providers<br>Can we bundle this service?<br>Has a recent capacity issue been identified?<br>Does this service assist special populations to access primary care?<br>*Examples:*<br>a) Youth transitioning into adult care<br>b) Recently released individuals moving into free world care<br>c) Pregnant women no longer needing OB/GYN care | Recommendation(s) |
|---|---|---|---|---|---|---|---|
| ***Workgroup #3***<br>***Motion:** (Vargas/Sliepka)*<br>*Votes: Y=10; N=0;*<br>*Abstentions=none* | | ☒ Continuum of Care<br>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.<br>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. | EMA: 29,078<br>Need (2020):N/a<br>Service Utilization (2020):<br># clients served: 52<br>*(4% decrease v. 2019)*<br>*54% of Linguistics clients were African American / African origin and 31% were Asian American / Asian origin*<br>Pops. with difficulty accessing needed services: N/a | Spanish-speakers; Medicaid may provide language translation for *non-Spanish* monolingual clients<br>Covered under QHP?<br>___Yes ✔ No | - Is a HRSA-defined Support Service<br>- Has limited or no alternative funding source<br>- Removes potential barriers to entry/retention in HIV care for monolingual PLWH, thereby contributing to EIIHA goals and preventing unmet need<br>- Facilitates national, state, and local goals related to retention in care and reducing unmet need<br>- Linguistic and cultural competence is a Guiding Principle of the Comprehensive HIV Plan<br>Is this a duplicative service or activity?<br>- No, there is no known | No<br>Can we bundle this service?<br>No<br>Has a recent capacity issue been identified?<br>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<br>Does this service assist special populations to access primary care? | service definition and the financial eligibility the same: 300%. |

‡ Service Category for Part B/State Services only.

| Service Category | Is this a core service?<br>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?<br>**EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care<br>**Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months<br>**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.<br>**Ending the HIV Epidemic*: The local plan to end new HIV infections by addressing four strategies – diagnose, treat, protect, and respond. | Documentation of Need<br>(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)<br>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.<br>(i.e., Alternative Funding Sources)<br>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.<br>Is this a duplicative service or activity? | Service Efficiency<br>Can we make this service more efficient? For:<br>a) Clients<br>b) Providers<br>Can we bundle this service?<br>Has a recent capacity issue been identified?<br>Does this service assist special populations to access primary care?<br>*Examples:*<br>a) Youth transitioning into adult care<br>b) Recently released individuals moving into free world care<br>c) Pregnant women no longer needing OB/GYN care | Recommendation(s) |
|---|---|---|---|---|---|---|---|
| | | | | | alternative funding for this service as designed | | |
| **Transportation – Pt A**<br>(Van-based, bus passes & gas vouchers)<br><br>***Workgroup #3***<br>***Motion:** (Vargas/Sliepka)*<br>*Votes: Y=10; N=0;*<br>*Abstentions=none* | ___Yes ✔ No | ☐ EIIHA<br>☒ Unmet Need<br>☒ Continuum of Care<br>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.<br>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. | Epi (2018):<br>Current # of living HIV cases in EMA: 29,078<br>Need (2020):<br>Rank w/in funded services: *#9*<br>Service Utilization (2020):<br># clients served:<br>*Van-based: 1,273*<br>*(38% increase v. 2019)*<br>*Bus pass: 1,355*<br>*(38% decrease v. 2019)*<br>Outcomes (FY2019):<br>69% of clients accessed primary care at least once after using van transportation; and 37% of clients accessed primary care after using bus | 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.<br>Covered under QHP*?<br>___Yes ✔ No | Justify the use of funds:<br>This service category:<br>- Is a HRSA-defined Support Service<br>- Is ranked as the #2 need among Support Services by PLWH<br>- Results in clients accessing HIV primary care<br>- Removes potential barriers to entry/retention in HIV care, thereby contributing to EIIHA goals and preventing unmet need<br>- Facilitates national, state, and local goals related to continuous HIV care and reducing unmet need | Can we make this service more efficient?<br>No<br>Can we bundle this service?<br>No<br>Has a recent capacity issue been identified?<br>No<br>Does this service assist special populations to access primary care? | **Wg Motion:** Update the justification chart, keep the service definition and the financial eligibility the same: 400%. |

‡ Service Category for Part B/State Services only.

| Service Category | Is this a core service?<br>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?<br>**EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care<br>**Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months<br>**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.<br>**Ending the HIV Epidemic*: The local plan to end new HIV infections by addressing four strategies – diagnose, treat, protect, and respond. | Documentation of Need<br>(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)<br>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.<br>(i.e., Alternative Funding Sources)<br>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.<br>Is this a duplicative service or activity? | Service Efficiency<br>Can we make this service more efficient? For:<br>a) Clients<br>b) Providers<br>Can we bundle this service?<br>Has a recent capacity issue been identified?<br>Does this service assist special populations to access primary care?<br>*Examples:*<br>a) Youth transitioning into adult care<br>b) Recently released individuals moving into free world care<br>c) Pregnant women no longer needing OB/GYN care | Recommendation(s) |
|---|---|---|---|---|---|---|---|
| | | | pass services.<br><u>Pops. with difficulty accessing needed services</u>: Females (sex at birth), Other / multiracial, White, Homeless, OOC, RR | | Is this a duplicative service or activity?<br>- 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. | | |

‡ 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**<br>*(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)<br>**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.