Ending the HIV Epidemic/Integrated HIV Prevention and Care Planning Body
Ryan White Office of Support
1310 Prairie Street, Suite 800, Houston, Texas 77002
832 927-7926 | www.rwpchouston.org

TREAT COMMITTEE

AGENDA

Noon, Friday, May 10, 2024 — *This is a virtual meeting*

Join Zoom Meeting: https://us02web.zoom.us/j/8899837982
Meeting ID: 889 983 7982
Or, join by telephone at: 346 248-7799

I.	Welcome A. Identification of facilitator	Co-Chairs Pete Rodriguez and Paul "Conlee" Stone
II.	Old Business A. Review goals vs. SMART goals B. Can we simplify tasks to meet the goals? C. See below for summary of March meeting D. Review subcommittee activities, see March Summary of Activities – Interface regularly with workgroups?	
III.	Moving Forward A. Document task assignments B. Set date for next meeting	Co-Chairs Pete Rodriguez and Paul "Conlee" Stone
IV.	Adjourn	

Summary of Treat Committee Discussion, 03/08/2024, Tori Williams, RWOoS
Members of the Treat Committee reviewed Integrated Planning goals more thoroughly, identified community leaders they wish to recruit for membership and identified groups that may be already engaged in efforts that relate to the committee's assigned goals. To meet goals, the co-chairs expressed interest in surveying case managers who work with people living with HIV and those who are homeless to find out what barriers individuals face in securing and maintaining identification documents and how the committee can help them replace documents needed to access care; determine if Harris County Centralized Patient Care Data Management System (CPCDMS) can be used to provide proof of residency, income and other essential data to make it easier for clients to go through eligibility screenings. Other actions included seeking clarification of Goal 2D by sending it back to the SMART Committee that wrote it; creating a list of agencies providing after-hours care; learning more about the Ryan White–funded position of retention nurse at Cambridge Health Alliance (Cambridge, MA), which helps ensure care, treatment adherence and more. **Next Meeting: Noon, Friday, May 10, 2024.**

(Over for Report Back Form)

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Ryan White Office of Support

Documentation of Progress for Treat Committee—Page 2
Noon, Friday, May 10, 2024

SUMMARY OF MEETING: NEXT MEETING DATE: _____

DECISIONS MADE & TASK ASSIGNMENTS:

Submitted by: _____ Date: _____
Tori Williams, Staff

SMART goals for 2022 Integrated HIV Prevention and Care Plan – Updated 11/14/23

(All SMART Goals Approved by Ryan White Comp HIV Planning Committee 11/09/23)

The SMART method provides a way to measure your progress and be accountable for your success. Setting SMART goals allow you to realistically evaluate what you are trying to achieve by assessing what actions to take to reach your goal. For example, you might set a goal to "get better" at typing. However, upon evaluating this goal using the SMART method, you see that your goal is quite vague. By restating your goal in quantifiable terms, such as "be able to type more words per minute," you have a SMART goal that can be obtained. The characteristics of this goal can then be further detailed to reflect the remaining traits of the SMART goal process.

GOAL & ACTIVITY	**Specific** Narrow for more long-term planning	**M**easurable What evidence will prove you are making progress	**A**ttainable Make sure you can reasonably accomplish your goal	**R**elevant align with your values & long-term objectives	**T**ime-Based Set a realistic end-date	How will the Houston Area Evaluation Team measure the success of the goal?
EXAMPLE 1 (HHD): Goal 1A: Increase individual knowledge of HIV status by diagnosing at least 90% of the estimated individuals who are unaware of their status within five (5) years.	Increase individual knowledge of HIV status	by diagnosing at least 90%	of the estimated individuals who are unaware of their status		within three (3) years.	
EXAMPLE 2 (NHAS): Goal 5C: Decrease by 50% the proportion of people with diagnosed HIV who report an unmet need for services from a mental health professional from a 2017 baseline of 24.2%.	who report an unmet need for services from a mental health professional	Decrease by 50%	the proportion of people with diagnosed HIV		from a 2017 baseline of 24.2%.	
Pillar 1: Diagnose						
Goal 1B: Improve HIV-Related Health Outcomes of All People Being Tested for HIV Goal 1B REV.: Using the status neutral approach, develop X number of Rapid Start programs in order to increase the capacity of the public health healthcare delivery systems and healthcare workforce in order to improve HIV-	Ensure all Ryan White-funded medical care and treatment programs have Rapid Start		By using lessons learned during pilot phase and funding similar efforts	And prioritizing populations that least benefitted, accessed	Within three (3) years.	

GOAL & ACTIVITY	**Specific** Narrow for more long-term planning	**M**easurable What evidence will prove you are making progress	**A**ttainable Make sure you can reasonably accomplish your goal	**R**elevant align with your values & long-term objectives	**T**ime-Based Set a realistic end-date	How will the Houston Area Evaluation Team measure the success of the goal?
related health outcomes of the individuals being tested.						
Pillar 2: Treat						
Goal 1C: Increase Knowledge and Understanding of HIV *Activity: Establish a Houston Area HIV Education Council.* Goal 1C REV: Establish a Houston Area HIV Education Council by reaching out to colleges, consumers, in-person educators, youth, and professional healthcare workers in partnership with AETCs, the RW program, CPG, and city and county health departments to increase consumer input and participation into science-based health education and Houston Area HIV linkage to prevention and care services.	Establish a Houston Area HIV Education Council	By reaching out to college, consumers, needing in-person educators, youth, and professional healthcare workers	In partnership with AETCs, RW and CPG	Increase consumer input and participation into science-based comprehensive sexual health education	Within three (3) years.	Development of a curriculum and pre- and post- tests
Goal 2B: Increase Access to Care and Medication *Activity: Increase access to services that replace or provide identification documents.* Goal 2B REV: Increase access to services that replace or provide identification documents so that lack of identification as a barrier will decrease regardless of immigration or legal status by working with identification providers	Increase access to services that replace or provide identification documents.	Lack of identification as a barrier will decrease	By working with identification Providers inc. CBOs, NGOs and governmental agencies	Regardless of immigration or legal status	For three (3) years.	Increased number of IDs dispensed ID will not be listed as a main barrier to care in our Needs Assessments

GOAL & ACTIVITY	**Specific** Narrow for more long-term planning	**M**easurable What evidence will prove you are making progress	**A**ttainable Make sure you can reasonably accomplish your goal	**R**elevant align with your values & long-term objectives	**T**ime-Based Set a realistic end-date	How will the Houston Area Evaluation Team measure the success of the goal?
including CBOs, NGOs, and government agencies.						
Goal 2C: Increase access to HIV education, prevention and care services among priority populations. Goal 2C REV: Create a case manager job description and fund the position so that fewer people with a history of sexual offense will be lost to care by working with street outreach workers, harm reduction teams and others experienced working with people with a history of sexual offense by prioritizing this historically underserved population.	Create a CM job description and fund the position	Less lost to care for people with a history of sex offenses; linkages to care & support svcs	By working with street outreach workers, Harm Reduction teams and others experienced working with people with a history of sexual offense	By prioritizing an historically underserved population	For three (3) years	A caseload develops, linkage to care
Goal 2D: Increase access to care and medication by tying the distribution of prepaid cell phones for clients to pharmacies, making the phone a medical necessity (not an incentive). *Activity: Meet with representatives of Ryan White-funded agencies to determine if this would resolve the issue of giving consumers prepaid phones.* Goal 2D Rev: Gather information from RW-funded pharmacists, case managers, executive directors, and Coalition for the Homeless to create ease of access to care and medication via phone provision for historically underserved communities	1. Gather information from RW-funded pharmacists, Case Managers, EDs 2. Invite Coalition for the Homeless (info on Houston Community Voicemail) – find out what replaced this service as Coalition for the Homeless is no longer providing direct client services	1. Have meetings 2. Develop pros & cons 3. Synthesize info to dev. a consensus decision	By September 2024	Create ease of access via phone provision for historically underserved communities, mitigate challenges towards maintaining care	For three (3) years	1. Had meetings? 2. Develop pros & cons 3. synthesize info to dev. a consensus decision

GOAL & ACTIVITY	**Specific** Narrow for more long-term planning	**M**easurable What evidence will prove you are making progress	**A**ttainable Make sure you can reasonably accomplish your goal	**R**elevant align with your values & long-term objectives	**T**ime-Based Set a realistic end-date	How will the Houston Area Evaluation Team measure the success of the goal?
and to mitigate challenges towards maintaining care. Have meetings to develop pros and cons and to synthesize information to develop a consensus decision by September 2024.						
Pillar 3: Prevent						
Goal 3A Moved to Pillar 2 and merged with goal 1C						•
Goal 3C: Gather data both for and against policy changes related to the following issues with the goal of making data driven decisions regarding support for: Condom distribution in jails and prisons and Texas becoming a Medicaid Expansion state *Activity: Gather and review data related to policy changes.* Goal 3C REV: Gather data from SIRR members, people returning from incarceration, subject matter experts, pharmacists, and case managers related to policies both for and against condom distribution in jails and prisons and synthesize information into a consensus decision. Also, gather information from Texas Strike Force, HIV advocacy groups, HINAC (HIV is Not A Crime) related to making Texas a Medicaid expansion state to increase access to more comprehensive medical care and treatment for people	1. Condom Distribution: Gather information from SIRR members, returning from incarceration programs, SME input, pharmacists, Case Managers 2. Medicaid Expansion: gather information from Texas Strike Force, HIV advocacy groups, HINAC (HIV IS Not A Crime)	1. 2-3 number of meetings 2. Develop pros & cons 3. synthesize info to dev. a consensus decision	By March 2024	1. Increased protective factors against HIV acquisition for incarcerated populations 2. Increase access to more comprehensive medical care & treatment for people aging with HIV	For three (3) years.	1. 2-3 number of meetings 2. Develop pros & cons 3. synthesize info to dev. a consensus decision

GOAL & ACTIVITY	**Specific** Narrow for more long-term planning	**M**easurable What evidence will prove you are making progress	**A**ttainable Make sure you can reasonably accomplish your goal	**R**elevant align with your values & long-term objectives	**T**ime-Based Set a realistic end-date	How will the Houston Area Evaluation Team measure the success of the goal?
aging with HIV and create a consensus decision.						
Pillar 4: Respond						
All EHE goals.						
Pillar 5: Quality of Life						
<u>Goal 5A:</u> Improve Quality of Life for Persons Living with HIV *Activity: Develop tools which planning bodies can use to design or strengthen HIV Prevention and Care services that improve the quality of life for people living with HIV.* <u>Goal 5A REV:</u> Improve Quality of Life for persons living with HIV by promoting unfettered access to high quality life-extending prevention and care services through the identification of the top 3 services people needed but couldn't access it as well as the top 3 barriers. We will identify the number of people in need of service and who couldn't access it. This will decrease by focusing on the most needed and least accessible services and the populations benefitting least from these services by making services available, accessible and affordable for three years.	Unfettered access to high quality life-extending prevention and care services Domains 1) Top 3 services needed but couldn't get it and top 3 barriers to each service ***Needs assessment and utilization reports	Percentage of people who said they needed it but couldn't get it – this would decrease	By focusing on the most needed and least accessible services and the populations benefitting least from these services	by making services available, accessible, and affordable	For three (3) years.	Needs Assessment data

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Goal 5G: Increase coordination and cooperation among Houston area institutions, universities and agencies that collect HIV related data *Activity: Continue to host quarterly meetings of the Houston Area HIV Data Committee in order to: 1.) learn about different data being collected; 2.) create and maintain an inventory of HIV and Quality of Life data being collected; and 3.) distribute the resulting inventory of data to Houston area researchers, students, people living with HIV and others to maximize the use of this data to benefit people living with HIV* Goal 5G REV: For 3 years, continue to host quarterly meetings of the Houston Area HIV Data Committee in order to: 1.) learn about different data being collected; 2.) create and maintain an inventory of HIV data being collected; and 3.) distribute the resulting inventory of data to Houston area researchers, students, people living with HIV and others to maximize the use of this data to benefit people living with HIV. Continued on next page	Continue to host quarterly meetings of the Houston Area HIV Data Committee in order to:	1.) learn about different data being collected; 2.) create and maintain an inventory of HIV and Quality of Life data being collected; and 3.) distribute the resulting inventory of data to Houston area researchers, students, people living with HIV and others to maximize the use of this data to benefit people living with HIV	By continuing the work we have been doing by continuing to host QOL workgroups	Manifesting meaningful involvement of PLWH	For three (3) years.	

GOAL & ACTIVITY	**Specific** Narrow for more long-term planning	**M**easurable What evidence will prove you are making progress	**A**ttainable Make sure you can reasonably accomplish your goal	**R**elevant align with your values & long-term objectives	**T**ime-Based Set a realistic end-date	How will the Houston Area Evaluation Team measure the success of the goal?
No need to revise the following as SMART goals. HMMP = Houston Medical Monitoring Project.						
Goal 5B: Increase the proportion of people with diagnosed HIV who report good or better health to 95% from a 2018 baseline of 71.5%. *Activity: See HMMP.*						*See HMMP data.*
Goal 5C: Decrease by 50% the proportion of people with diagnosed HIV who report an unmet need for services from a mental health professional from a 2017 baseline of 24.2%. *Activity: See HMMP.*						*See HMMP data.*
Goal 5D: Decrease by 50% the proportion of people with diagnosed HIV who report ever being hungry and not eating because there wasn't enough money for food from a 2017 baseline of 21.1%. *Activity: See HMMP.*						*See HMMP data.*
Goal 5E: Decrease by 50% the proportion of people with diagnosed HIV who report being out of work from a 2017 baseline of 14.9%. *Activity: See HMMP.*						*See HMMP data.*
Goal 5F: Decrease by 50% the proportion of people with diagnosed HIV who report being unstably housed or homeless from a 2018 baseline of 21.0%. *Activity: See HMMP.*						*See HMMP data.*

Treat Committee

Goal 1C: Establish a Houston Area HIV Education Council by reaching out to colleges, consumers, in-person educators, youth, and professional healthcare workers in partnership with AETCs, the RW program, CPG, and city and county health departments to increase consumer input and participation into science-based health education and Houston Area HIV linkage to prevention and care services.

Goal 2A: Ensure 90% of clients are retained in care and virally suppressed.

Goal 2A.1: Ensure rapid linkage to HIV medical care and rapid ART initiation for all persons with newly diagnosed or re-engaging in care.

Key Activities:

- Increase retention in medical care through rapid treatment initiation.
  - *In FY 2020, the Ryan White Program, in partnership with South Central AETC, Baylor College of Medicine, and Harris County Public Health, launched Rapid Start Treatment Programs at Ryan White funded primary care sites. The next step is to increase outreach to priority populations and launch Rapid Start Treatment Programs at sites other than RWHAP-funded primary care sites.*
- Offer a 24-hour emotional support and resources line available with trauma informed staff considerate to the fact individuals are likely still processing a new diagnosis.
- Health literacy campaign to educate those diagnosed on benefits of rapid start and TasP.
- Support rapid antiretroviral therapy by providing ART "starter packs" for newly diagnosed clients and returning patients who have self-identified as being out of care for greater than 12 months.
- Expand community partnerships (e.g., churches and universities) to increase rapid linkage and ART availability at community-preferred gathering venues.
- Promote after-hour medical care to increase accessibility by partnering with providers currently offering expanded hours, like urgent care facilities.

- Develop a provider outreach program focused on best HIV treatment - related practices and emphasizing resources options for clients (Ryan White care system) as well as peer-to-peer support resources for providers (e.g., Project ECHO, AETC, UCSF).

Goal 2A.2: Support re-engagement and retention in HIV medical care, treatment, and viral suppression through improved treatment related practices, increased collaboration, greater service accessibility, and a whole-health emphasis.

Key Activities:

- Develop informative treatment navigation, viral suppression, and whole-health care program including regularly held community forums designed to maximize accessibility.
  - Partner with providers to expand hours and service location options based on community preferences (after-hours, mobile units, non-traditional settings).
  - Assess feasibility of expanded telehealth check-in options to enhance accessibility and promote bundling mobile care services (including ancillary services).
  - Increase the number of referrals and linkage to RW.
  - Increase integration, promotion, and the number of referrals to ancillary services (e.g., mental health, substance use, RW, and payment assistance) through expanded partnerships during service linkage.
  - Increase case management support capacity.
  - Develop system to monitor referrals to integrated health services.
  - Hire representative navigators, promote job openings in places where community members with relevant lived experience gather, and invest in programs such as the Community Health Worker Certification.
  - Survey users of services to evaluate additional service-based training needs.
- Conduct provider outreach (100 initial/100 follow-up visits) to improve multidisciplinary holistic health practices including importance of trauma-informed approach, motivational interview-based techniques, preferred language, culturally sensitive staff/setting, behavior-based risk vs demographic/race, and routine risk assessment screenings (mental health, gender-based or domestic violence, need for other ancillary services related to SDOH).
- Build and implement a mental health model for HIV treatment and care that includes routinizing screenings/opt-out integration into electronic health records.
- Source resources for referral/free initial mental health counseling sessions.
- Maintain at least one crisis intervention specialist on service link linkage staff.

- Partner community health workers with local community gathering places (e.g., churches) to recognize and reach individuals who may benefit from support and linkage to resources.
- Widely share analyses of collected data with emphasis on complete context and value to community, including annual science symposium; Allow opportunities for community to share their stories to illustrate the personal connection.
- Utilize a reporting system to endorse programs or environments that show training application and effort to end the epidemic. Conduct quarterly quality assurance checks after the secret shopper project established by END.
- Use the HIV system to fill gaps in healthcare by creating a grassroots initiative focused on social determinants of health.
- Increase access to quality health care through promoting FQHCs to reduce the number of uninsured to under 10% in the next 10 years.
- Revamp data-to-care to achieve full functionality

Goal 2A.3: Establish organized methods to raise widespread awareness on the importance of treatment.

Key Activities:

- Collaborate with CPG to gain real-time public input during meetings on preferred language and promotion of critical messages of Undetectable=Untransmittable (U=U) and Treatment as Prevention (TasP).
- Collaborate with CPG to regularly promote diversifying clinical trials.
- Increase education and awareness around the concept of U=U and TasP to reduce stigma, fear, and discrimination among PLWH.
- Implement community preferred social marketing strategies over multiple platforms to establish messaging on the benefits of rapid and sustained HIV treatment (include basic terminology, updates on treatment/progress advances, and consideration for generational understanding of information).

Goal 2A.4: Advance internal and external policies related to treatment.

Key Activities:

- Implement and monitor immediate ART with a standard of 72 hours of HIV diagnosis for Test and Treat protocols.
- Revise policies to simplify linkage through use of an encrypted universal technology such as patient portal and/or apps to easily share information across health systems, remove administrative (e.g., paperwork and registration) barriers, incorporate geo-fencing alerts and anonymous partner elicitation.
- Refresh policies to establish a retention/rewards program that empowers community to optimize health maintenance and encourages collaboration with health department services and resources.
- Focus on necessary requirements and reduce turnaround time from diagnosis to care (e.g., Change the 90-day window for Linkage Workers).

- Update prevention standards of care to reflect a person-centered approach.
- Develop standard of treatment and advocate for implementation for those incarcerated upon intake.
- Institute policies that require recurring trainings for staff/providers based on community feedback and focused on current preferred practices (emphasis on status-neutral approach, trauma-informed care, people first-language, cultural sensitivity, privacy/confidentiality, follow-up/follow-through).
- Revise funding processes and incentivize extended hours of operation to improve CBO workflow.

Goal 2B: ***Increase access to services that replace or provide identification documents so that lack of identification as a barrier will decrease regardless of immigration or legal status by working with identification providers including CBOs, NGOs, and government agencies.***

Goal 2C: ***Create a case manager job description and fund the position so that fewer people with a history of sexual offense will be lost to care by working with street outreach workers, harm reduction teams and others experienced working with people with a history of sexual offense by prioritizing this historically underserved population.***

Goal 2D: ***Gather information from RW-funded pharmacists, case managers, executive directors, and Coalition for the Homeless to create ease of access via phone provision for historically underserved communities and to mitigate challenges towards maintaining care. Have meetings to develop pros and cons and to synthesize information to develop a consensus decision by September 2024.***

Ending the HIV Epidemic/Integrated HIV Prevention and Care Planning Body

Summary Reports from Committees and Workgroups
March 2024

The following EHE/Integrated Planning Body committees and workgroups met in March 2024. Each group discussed their committee/workgroup goals and determined activities for their group over the next couple of months.

Aging & HIV Workgroup, 03/20/2024, Diane Beck, Ryan White Office of Support (RWOoS)
Shital Patel, MD, medical director of the Houston AIDS Education and Training Center (AETC), presented information on the training program currently being developed for Ryan White Part A–funded HIV case managers who will receive training in gerontology. They are surveying and holding focus groups with case managers to determine topics to be included in the training. Her colleague, Vaishnavi Sankar, presented preliminary data from an HIV and aging needs assessment conducted with agency staff. Diane will distribute the presentations to all members. In May, there will be a presentation from Senior Research Associate Daniel Castellanos, DrPH, at the Latino Commission on AIDS. The workgroup would like to receive information about best practices for frailty screening for people living with HIV and how to educate doctors on which tests they should run.
Next Meeting: Noon, Wednesday, May 15, 2024.

Consumer & Community Engagement Workgroup, 03/25/2024, Cydney Clay, Houston Health Department (HHD). Members discussed *Road 2 Success* classes hosted by members of the Ryan White Affected Community Committee and held at Ryan White–funded agencies, HOPWA-funded housing sites and more. The classes are designed to provide consumers with information about the HIV care system in the Houston 10-county area. The focus of the FY 2023–2024 classes is teaching consumers how to use the Houston Area Directory of HIV Prevention and Care Services, more commonly known as *The Blue Book.* Office of Support staff created a *Blue Book* Jeopardy game that makes the class fun and interactive. Since December 2023, over 103 **non**-Ryan White volunteers have participated in the training. **Next Meeting: 11 a.m., Monday, May 20, 2024.**

Housing Workgroup, 03/28/2024, Tori Williams, RWOoS
In reviewing the goals and seeking to build on existing data, members discussed contacting sources, including the University of Houston School of Social Work, which is believed to hold housing data that students collected and which may be useful in meeting current workgroup goals. City of Houston Director of Housing Opportunities for Persons with AIDS Megan Rowe, a workgroup co-chair, will assist in obtaining Consolidated Annual Performance and Evaluation Reports about housing program accomplishments locally. Other existing HIV-related agencies, housing enterprises serving the aging population (including short-term health recovery options), initiatives monitoring local health issues affecting housing, and others serving housing needs of the community at large were also identified as sources of retrievable information meaningful in meeting goals. **Next Meeting: 2 p.m., Thursday, May 23, 2024.**

Needing In-Person Engagement Workgroup, 03/13/2024, Tori Williams, RWOoS
Members identified a number of individuals who will be recruited to join the workgroup, including people who work in harm reduction, those who work with sex workers, and others. AETC is willing to work with the members to develop HIV training for case managers who work with the homeless. There are approximately 1,000 such case managers in Harris and surrounding counties. And, this summer, Project LEAP students will be asked to work with HPD officers who specialize in mental health to develop a pamphlet listing HIV, mental health and other resources for those living on the street. **Next meeting: 10 a.m., Wednesday, May 8, 2024.**

Prevention and Policy Committee, 03/12/24, Eliot Davis, HHD
Members reviewed goals and discussed identifying an HHD representative to address the committee on HHD

strategy and plans for implementation of EHE-related activities. Advocates/experts supporting and opposing condom distribution to persons who are incarcerated are needed to inform the committee. These tasks were assigned. Members discussed a hybrid model for meeting and endorsed exploring a strategy, such as a resource hub, to minimize duplication of efforts. **Next meeting: Noon, Tuesday, May 14, 2024.**

Racial and Social Justice Workgroup, 03/19/2024, Richon Ohafia, Ryan White Grant Administration
Members discussed existing work completed by the University of Houston School of Social Work and morbidity and mortality data for Harris County. They discussed goals for the workgroup and needing a better understanding of the purpose of the group and the meaning of racial/social justice and root causes members are looking to address. Tori is trying to locate a speaker to share tools developed by the Ft. Worth Planning Council, which relate to addressing and supporting racial and social justice issues. **Next meeting: 6 p.m., Tuesday, May 21, 2024.**

Research, Data, and Implementation Committee and Monitoring, Quality Assurance, and Evaluation Committee, 03/14/2024, Tori Williams, RWOoS Many of those assigned to develop evaluation plans for specific committees and workgroups met with their groups and learned more about their planned activities. **Next Meeting: 2 p.m., Thursday, May 9, 2024.**

Respond Committee postponed meeting until 1 p.m., Wednesday, May 22, 2024.

Status-Neutral Systems and Diagnose Committee, 03/13/2024, Chelsea Frand, HHD
The committee reviewed its goals and activities and described the current status of each. The team discussed keeping track of activities that take place in the community by using an online tracker accessible to multiple representatives of local organizations and perhaps distribute a survey or host a quarterly call or online forum with them. Such links could help identify specific services, such as those currently offering nontraditional hours. The committee will identify additional members as well as resources that can assist with carrying out the activities assigned to the Status-Neutral Systems and Diagnose Committee. Co-chair Kathryn Fergus will create a survey form that will go to community partners to capture activities conducted by local agencies. Tori will see if other committees/workgroups have survey questions they want to add. **Next meeting: 3 p.m., Wednesday, May 8, 2024.**

Treat Committee, 03/08/2024, Tori Williams, RWOoS
Members of the Treat Committee reviewed Integrated Planning goals more thoroughly, identified community leaders they wish to recruit for membership and identified groups that may be already engaged in efforts that relate to the committee's assigned goals. To meet goals, the co-chairs expressed interest in surveying case managers who work with people living with HIV and those who are homeless to find out what barriers individuals face in securing and maintaining identification documents and how the committee can help them replace documents needed to access care; determine if Harris County Centralized Patient Care Data Management System (CPCDMS) can be used to provide proof of residency, income and other essential data to make it easier for clients to go through eligibility screenings. Other actions included seeking clarification of Goal 2D by sending it back to the SMART Committee that wrote it; creating a list of agencies providing after-hours care; learning more about the Ryan White–funded position of retention nurse at Cambridge Health Alliance (Cambridge, MA), which helps ensure care, treatment adherence and more. **Next Meeting: Noon, Friday, May 10, 2024.**

Youth Workgroup, 03/04/2024, Rod Avila, RWOoS
Members discussed how best to set up a Youth Council. Three organizations that work with homeless youth, or those with a history of homelessness, were identified. Staff and workgroup members will reach out to the three organizations and see if there is an interest in partnering to develop a monthly, in-person (possibly hybrid) educational program for their clients. **Next Meeting: 6 p.m., Tuesday, May 7, 2024.**

UPDATED:
05/06/24

All meetings are subject to change. Please call in advance to confirm:
832 927-7926

Unless otherwise noted, all meetings will be held hybrid or via Zoom

IP = Integrated Planning
Z = Zoom (virtual only)

July 2024

Sun	Mon	Tue	Wed	Thu	Fri	Sat
	1	**2**	**3** 12 noon Steering Committee	**4** **Independence Day Holiday**	**5**	**6**
7	**8**	**9**	**10**	**11** 12 noon Planning Council 2:00 pm Comp HIV Planning	**12**	**13**
14	**15** 11:00 a.m. Operations	**16** 2:00 p.m. Quality Improvement	**17**	**18**	**19**	**20**
21	**22** 11:00 a.m. Affected Community	**23**	**24** ~~9:30 a.m.~~ ~~SIRR Meeting~~	**25** 12 noon Priority & Allocations	**26**	**27**
28	**29**	**30**	**31**			