HOUSTON AREA HIV SERVICES RYAN WHITE PLANNING COUNCIL
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STEERING COMMITTEE

AGENDA

12 noon, Thursday, June 6, 2019
2223 W. Loop South, Suite 240
Houston, Texas 77027

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

II. Public Comment and Announcements

(NOTE: If you wish to speak during the Public Comment portion of the meeting, please sign up on the clipboard at the front of the room. No one is required to give his or her name or HIV status. All meetings are audio taped by the Office of Support for use in creating the meeting minutes. The audiotape and the minutes are public record. If you state your name or HIV status it will be on public record. If you would like your health status known, but do not wish to state your name, you can simply say: "I am a person living with HIV", before stating your opinion. If you represent an organization, please state that you are representing an agency and give the name of the organization. If you work for an organization, but are representing yourself, please state that you are attending as an individual and not as an agency representative. Individuals can also submit written comments to a member of the staff who would be happy to read the comments on behalf of the individual at this point in the meeting. All information from the public must be provided in this portion of the meeting.)

III. Reports from Committees

A. Comprehensive HIV Planning Committee — Ted Artiaga and Daphne L. Jones, Co-Chairs

Item: 2020 HIV Needs Assessment

Recommended Action: FYI: Data collection for the 2020 Needs Assessment began in late April, with Project LEAP students assisting with piloting online survey administration for this year's class project. The students collected 28 valid online surveys, and will present select findings and lessons learned for online Needs Assessment survey administration at the June Planning Council Meeting. As of May 30th, 38 total valid surveys were collected, and 8 survey dates were set for June. The Analysis Workgroup will meet June 21st to discuss plans for analyzing the Needs Assessment data, and NAG will meet July 15th for a mid-collection check-in. If you would like to participate in either of these meetings, or if you have a suggestions for a non-primary care survey site, please see Diane.

B. Affected Community Committee — Rodney Mills and Isis Torrente, Co-Chairs

Item: Training: End the HIV Epidemic
Recommended Action: FYI: The Committee reviewed the attached materials regarding the national plan for ending the HIV epidemic.

Item: Public Hearing for the 2020 How To Best Meet the Need Results
Recommended Action: FYI: On Monday, May 20, 2019, the Affected Community Committee hosted a televised public hearing to announce proposed changes to the FY 2020 Ryan White service definitions. No comments were made.

Item: 2019 Community Events
Recommended Action: FYI: See the attached list of 2019 Community Events.

Item: 2019 Greeters
Recommended Action: FYI: See the attached list of 2019 Greeters who will host guests at monthly Council meetings.

Item: Quarterly Committee Report
Recommended Action: FYI: See the attached Quarterly Committee Report.

C. Quality Improvement Committee — Denis Kelly and Gloria Sierra, Co-Chairs

Item: Reports from AA – Part A/MAI*
Recommended Action: FYI: See the attached reports from the Part A/MAI Administrative Agent:

- FY18 Procurement Report – Part A & MAI, dated 05/02/19

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

- FY 2018/19 Procurement Report Part B – dated 05/14/19
- FY 2018/19 Procurement Report DSHS SS – dated 05/01/19
- FY 2018/19 RW Part B Service Utilization – dated 05/08/19
- FY 2018/19 Health Insurance Program Report – dated 03/29/19
- QI Committee Meeting, Questions & Responses, dated 05/14/19
- The Resource Group (TRG) Consumer Interview Results 2018, dated 05/14/19

Item: FY 2020 How To Best Meet the Need Recommendations
Recommended Action: **Motion:** Approve the attached FY 2020 Service Definitions and Financial Eligibility for Ryan White Part A, Minority AIDS Initiative, Part B and State Services funded service categories with the following understanding:

- The Recipients are going to provide information which will help the Steering Committee determine if the financial eligibility for non-HIV medication and Mental Health Services should be increased to 400%.
- Table the Mental Health service definition while waiting for proposed revised text.

Item: Targeting for FY 2020 Service Categories
Recommended Action: **Motion:** Approve the attached targeting chart.

D. Priority and Allocations Committee — Peta-gay Ledbetter and Bobby Cruz, Co-Chairs

Item: Reports from Administrative Agent – Part A/MAI
Recommended Action: FYI: See the attached reports from Part A/Minority AIDS Initiative:

- FY 2018 Service Utilization, dated 05/23/19

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

- See attached email re: State Services RR funds, dated 03/27/19

Item: FY 2019 Proposed Idea Form
Recommended Action: **Motion:** Approve page 2 of the FY 2019 Proposed Idea form.

E. Operations Committee — Ronnie Galley and Allen Murray, Co-Chairs

Item: Policy for Approving the Council Support Budget
Recommended Action: FYI: See attached policy for approving the Council Support budget.

Item: FY 2020 Council Support Budget
Recommended Action: **Motion:** Approve the attached FY 2020 Council Support Budget, which includes a $32,945 increase from the FY 2019 budget and accommodates the Blue Book budget of $51,000.

Item: Council Handouts
Recommended Action: FYI: The new process for receiving Council handouts is as follows: after the Council meeting packet has been mailed, additional handouts received at the Steering Committee meeting are emailed to Council members and others after the Steering Committee meeting adjourns. Is this working for Steering Committee members? And, do you wish to receive Task Force Reports at Steering Committee meetings?

IV. Report from Ryan White Office of Support — Tori Williams, Director

V. Report from Ryan White Grant Administration — Carin Martin, Manager

VI. Report from The Resource Group — Sha'Terra Johnson-Fairley, Health Planner

VII. Announcements

VIII. Adjournment

HOUSTON AREA HIV SERVICES RYAN WHITE PLANNING COUNCIL
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STEERING COMMITTEE

MINUTES

12 noon, Thursday, April 4, 2019
2223 W. Loop South, Suite 240; Houston, Texas 77027

MEMBERS PRESENT	MEMBERS ABSENT	OTHERS PRESENT
C. Bruce Turner, Chair	Ted Artiaga, excused	*Ryan White Grant Administration*
Tana Pradia, Secretary	John Poole, excused	Carin Martin
Rodney Mills	Gloria Sierra, excused	Samantha Bowen
Isis Torrente		
Daphne L. Jones		*The Resource Group*
Ronnie Galley		Sha'Terra Johnson-Fairley
Allen Murray		
Bobby Cruz		*Office of Support*
Peta-gay Ledbetter		Tori Williams
Denis Kelly		Amber Harbolt
		Diane Beck

Call to Order: C. Bruce Turner, Chair, called the meeting to order at 12:07 p.m.

During the opening remarks, Turner said that all Council members have taken the Open Meetings Act training so the Council is in compliance with Texas law. There will be a How to Best Meet the Need training after Council adjourns next week. All are encouraged to attend. Because the training starts at 1:30 pm, there will be no verbal Task Force Reports at the Council meeting. Please sign up to participate in the How To Best Meet the Need workgroup meetings. There will be no standing committee meetings in April so that all Council and committee members have time to participate in at least one workgroup. Also, please get involved in the NAG process if you are interested in understanding how needs assessments work. See Diane if you want to get meeting reminders. Turner then called for a Moment of Reflection.

Adoption of the Agenda: ***Motion #1:*** *it was moved and seconded (Kelly, Torrente) to adopt the agenda.* **Motion Carried Unanimously.**

Approval of the Minutes: ***Motion #2:*** *it was moved and seconded (Galley, Pradia) to approve the March 7, 2019 minutes.* **Motion Carried.** Abstentions: Ledbetter, Torrente.

Turner invited committee co-chairs to select the co-chair who would be voting on behalf of their committee. Those selected to represent their committee at today's meeting were: Torrente for Affected Community, Jones for Comprehensive HIV Planning, Murray for Operations, Ledbetter for Priority and Allocations and Kelly for Quality Improvement.

Public Comment and Announcements: None.

Reports from Committees

Comprehensive HIV Planning Committee: Daphne Jones, Co-Chair, reported on the following:
Epidemiological Profile: The Committee reviewed the revised version of Chapter 1 and Chapter 2, including data to be used in the FY 2020 How to Best Meet the Need process. Dr. Imran Shaikh provided an update on the Houston Health Department data elements currently in the internal review process.

Needs Assessment Group: The Epidemiology Workgroup met on March 18, 2019 to draft the attached 2019 Needs Assessment Survey Sampling Principles and Plan. The Survey Workgroup also met on March 18th to begin revision of the previous survey tool for 2019 and finished on April 2nd. NAG will meet on April 15, 2019 to approve both the Survey Sampling Principles and Plan and the survey tool. Please see Diane to be added to any of the NAG or NAG Workgroup lists.

FY 2020 EIIHA* Plan: ***Motion #3****: In order to meet HRSA grant application deadlines, request the Planning Council to allow the Comprehensive HIV Planning Committee to have final approval of the FY 2020 EIIHA Plan target populations, provided that:*

- *The FY 2020 EIIHA Plan is developed through a collaborative process that includes stakeholders from prevention and care, community members, and consumers; and*
- *The recommended FY 2020 EIIHA Plan target populations are distributed to Planning Council members for input prior to final approval from the Comprehensive HIV Planning Committee.*

Motion carried.

Affected Community Committee: Rodney Mills, Co-Chair, reported on the following:
Training: How To Best Meet the Need Process: The Committee reviewed the same power point presentation on the How To Best Meet the Need process that was viewed at the March Council meeting and more. Members signed up to participate in the 2019 How To Best Meet the Need workgroup meetings.

2019 Community Events: See the attached list of 2019 Community Events.

2019 Greeters: See the attached list of 2019 Greeters who will host guests at monthly Council meetings.

Quality Improvement Committee: Denis Kelly, Co-Chair, reported on the following:
Criteria for Determining the FY 2020 Service Definitions: ***Motion #4:*** *Approve the attached criteria for determining the FY 2020 Service Definitions.* **Motion Carried**.

Reports from the Administrative Agent – Part A/MAI: See the attached reports:

- FY18 Procurement Report – Part A & MAI, dated 03/19/19

Reports from the Administrative Agent – Part B/ State Services: See the attached reports:

- Procurement Report Part B – dated 03/11/19
- Procurement Report DSHS SS – dated 03/11/19
- Health Insurance Program Report – dated 02/25/19

Training: Reports Related to Consumer Experiences in Care: See the attached diagram and PowerPoint presentations.

FY 2020 How To Best Meet the Need Workgroup Schedule: See attached. Please see Diane or Rod to sign up to participate in the FY 2020 How To Best Meet the Need workgroups.

2020 Idea Forms: See two attached documents. ***Motion #5:*** *Approve the 2019 Criteria for Reviewing Ideas, and the 2019 Proposed Idea Form.* **Motion Carried.**

Checklist for the Assessment of the Administrative Mechanism: **Motion #6:** Approve the attached checklist for the 2019 Houston Ryan White Administrative Mechanism. **Motion Carried.**

Priority and Allocations Committee: No report.

Operations Committee: Ronnie Galley, Co-Chair, reported on the following:
Council Handouts: The new process for receiving Council handouts is as follows: after the Council meeting packet has been mailed, additional handouts received at the Steering Committee meeting will be emailed to Council members and others after the Steering Committee adjourns.

Training Requirements for the Open Meetings Act: Many thanks to those who took the training and turned the certificate in to the Office of Support.

Training Requirements for the Open Meetings Act: ***Motion #7:*** *The Planning Council will continue to follow Texas State law, which at this time requires Planning Council members to take the Open Meetings Act Training once in a lifetime.* **Motion Carried.** Abstention: Kelly.

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

Report from Ryan White Grant Administration: Carin Martin, Manager, summarized the attached report.

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

Announcements: Turner said that the Texas Medication Advisory Committee will vote whether to add Hepatitis B medication to the formulary. Martin added that you can now watch Advisory Committee meetings online.

Adjournment: The meeting adjourned at 12:41 p.m.

Submitted by:

_____
Tori Williams, Director Date

Approved by:

_____
Committee Chair Date

2019 Steering Committee Voting Record for Meeting Date 04/04/19

C = Chaired the meeting, JA = Just arrived, LM = Left the meeting,
VP = Participated via telephone, nv = Non-voting member

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

MEMBERS	**Motion #1** Agenda **Carried**				**Motion #2** Minutes **Carried**				**Motion #3** FY 2020 EIIHA Plan **Carried**				**Motion #4** Criteria for FY 2020 Svc Defs **Carried**				**Motion #5** 2019 Criteria for New Ideas **Carried**				**Motion #6** Checklist for Assessment of Admin Mech **Carried**				**Motion #7** TXOMA Training Requirements **Carried**			
	Absent	**Yes**	**No**	**Abstain**	**Absent**	**Yes**	**No**	**Abstain**	**Absent**	**Yes**	**No**	**Abstain**	**Absent**	**Yes**	**No**	**Abstain**	**Absent**	**Yes**	**No**	**Abstain**	**Absent**	**Yes**	**No**	**Abstain**	**Absent**	**Yes**	**No**	**Abstain**
C. Bruce Turner, Chair				**C**				**C**				**C**				**C**				**C**				**C**				**C**
Tana Pradia, Secretary		**X**				**X**				**X**				**X**				**X**				**X**				**X**		
Isis Torrente, Aff		**X**						**X**		**X**				**X**				**X**				**X**				**X**		
Daphne L. Jones, Comp		**X**				**X**				**X**				**X**				**X**				**X**				**X**		
Allen Murray, Op		**X**				**X**				**X**				**X**				**X**				**X**				**X**		
Peta-gay Ledbetter, PA		**X**						**X**		**X**				**X**				**X**				**X**				**X**		
Denis Kelly, QI		**X**				**X**				**X**				**X**				**X**				**X**						**X**
Non-voting members at the meeting:																												
Rodney Mills, Aff																												
Ronnie Galley, Op																												
Bobby Cruz, PA ja 12:30 pm																												
Absent members:																												
John Poole, Vice Chair																												
Ted Artiaga, Comp																												
Gloria Sierra, QI																												

Affected Community Committee Report

Ending the HIV Epidemic: A Plan for America

HHS is proposing a once-in-a-generation opportunity to eliminate new HIV infections in our nation. The multi-year program will infuse 48 counties, Washington, D.C., San Juan, Puerto Rico, as well as 7 states that have a substantial rural HIV burden with the additional expertise, technology, and resources needed to end the HIV epidemic in the United States. Our four strategies – diagnose, treat, protect, and respond – will be implemented across the entire U.S. within 10 years.

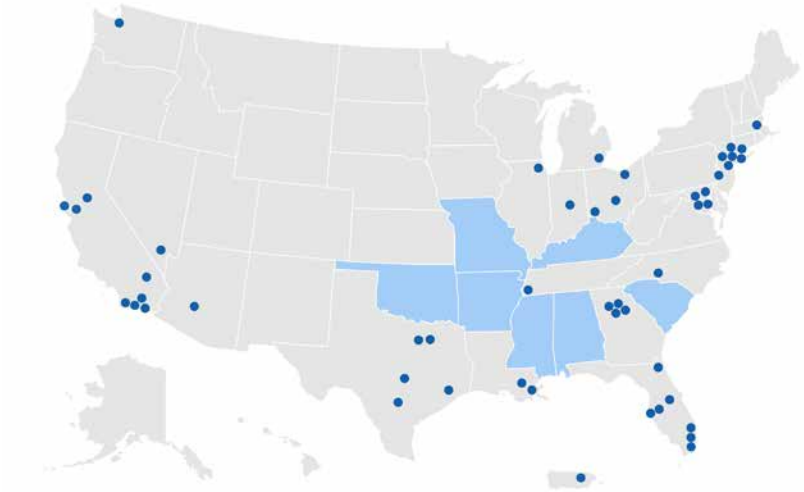
GOAL:

75% reduction in new HIV infections in 5 years and at least **90%** reduction in 10 years.

Our goal is ambitious and the pathway is clear – employ strategic practices in the *places* focused on the right *people* to:

- **Diagnose** all people with HIV as early as possible after infection.
- **Treat** the infection rapidly and effectively to achieve sustained viral suppression.
- **Protect** people at risk for HIV using potent and proven prevention interventions, including PrEP, a medication that can prevent HIV infections.
- **Respond** rapidly to detect and respond to growing HIV clusters and prevent new HIV infections.
- **HIV HealthForce** will establish local teams committed to the success of the Initiative in each jurisdiction.

The Initiative will target our resources to the 48 highest burden counties, Washington, D.C., San Juan, Puerto Rico, and 7 states with a substantial rural HIV burden.



Geographical Selection:
Data on burden of HIV in the US shows areas where HIV transmission occurs more frequently. More than 50% of new HIV diagnoses* occurred in only 48 counties, Washington, D.C., and San Juan, Puerto Rico. In addition, 7 states have a substantial rural burden – with over 75 cases and 10% or more of their diagnoses in rural areas.

*2016-2017 data

Ending the HIV Epidemic | www.HIV.gov

Ending the HIV Epidemic – Key Strategies:

Achieving elimination will require an infusion of resources to employ strategic practices in the right places targeted to the right people to maximize impact and end the HIV epidemic in America. Key strategies of the initiative include:

HRSA supports Trump Administration's Plan to End the HIV Epidemic

U.S. Department of Health & Human Services
Health Resources and Services Administration

HRSA NEWS ROOM
http://newsroom.hrsa.gov

FOR IMMEDIATE RELEASE
Wednesday, February 6

CONTACT: HRSA PRESS OFFICE 301-443-3376
Press@hrsa.gov

The Health Resources and Services Administration (HRSA) fully supports the Trump Administration's initiative: *Ending the HIV Epidemic: A Plan for America.*

Through HRSA's Ryan White HIV/AIDS Program and the HRSA-funded Health Center Program, the agency will play a leading role in helping to diagnose, treat, protect and respond to end the HIV epidemic.

"We have an unprecedented opportunity to end the HIV epidemic in America. Through this initiative, in 2020, HRSA would work with program recipients to expand evidence-informed interventions proven to increase engagement and retention in care, reduce stigma, and improve viral suppression for the hardest to reach individuals," said HRSA Administrator George Sigounas, MS, Ph.D. "HRSA's Health Center Program will play a major expanded role in providing Pre Exposure Prophylaxis (PrEP) to those populations at the greatest risk of acquiring HIV infection."

HRSA will target resources to the 48 highest burden counties, Washington, D.C., San Juan, Puerto Rico, and seven states with a substantial rural HIV burden.

The HRSA-funded Health Center Program will expand PrEP services to selected health centers in the focus jurisdictions where over half of all new HIV infections occur.

HRSA's Ryan White HIV/AIDS Program will increase HIV care and treatment efforts in the focus jurisdictions.

The Ryan White HIV/AIDS Program has a track record of success. Of all the patients that had at least one medical visit in the program in 2017, 86% were virally suppressed, significantly higher than the national average of 60% among all those living with diagnosed HIV.

The Ryan White HIV/AIDS Program will continue to provide key services such as case management, behavioral health, medications, and medical care as well as support services such as transportation and housing — all of which are critical for engaging people living with HIV in medical care and ensuring improved health outcomes.

HRSA's Health Center Program supports 12,000 service delivery sites across the country, providing affordable, accessible, high quality, and cost-effective preventive and primary health care to more than 27 million people annually.

Health centers provide a model of coordinated, comprehensive, and patient-centered primary health care, integrating a wide range of medical, dental, mental health, substance use disorder, and patient services.

Health centers are also a key point of entry for people undiagnosed with HIV. Nearly two million patients receive a HIV test at a health center annually.

Many health centers provide HIV care services, including PrEP. And within the *Ending the HIV Epidemic initiative*, HRSA's Health Center Program will play a major expanded role in providing PrEP to those populations at the greatest risk of acquiring HIV infection.

For more information on *Ending the HIV Epidemic: a Plan for America*, please visit: https://www.hiv.gov/ending-hiv-epidemic.

For more information on the Ryan White HIV/AIDS Program, please visit: https://hab.hrsa.gov.

For more information on HRSA's Health Center Program, please visit: https://bphc.hrsa.gov.

Date Last Reviewed: February 2019

Affected Community Committee
2019 Community Events (as of 05-29-19)

Point Person (PP): Committee member who picks up display materials and returns them to the Office of Support.

Day, date, times	Event	Location	Participants
Sunday, March 3 1 pm-Walk	AIDS Foundation Houston (AFH) AIDS Walk	Houston Park Downtown 1100 Bagby Street, 77002	**Need 3 volunteers – distribute LEAP flyers:** Tana, Tony and Ronnie
Friday, May 31 10 am – 2 pm	SPRY Senior Health and Resource Fair	Montrose Center	**Need 4 volunteers: PP: Isis**, Rodney, Tana, Ronnie and Eddie G.
Sun. June 2	Long-Term HIV Survivors Event	Neon Boots	**Need 5 Volunteers: PP: Skeet,** Tana, Tony, Ronnie and Johnny
June 22	Pride Festival	Downtown near City Hall	Shift 1 (11:30 am-2 pm): **PP: Rod**, Tana, Skeet & Ronnie Shift 2 (2-4:30 pm): Tana, Holly & Veronica Shift 3 (4:30-7 pm): **PP: Isis,** Johnny and maybe Tony
Monday, July 8 5 – 7 pm,	Camino hacia tu Salud	Postive713 Leonel Castillo Community Center 2101 South Street, 77009	**Need 6 Volunteers: PP: Rod,** Isis, Tana, Skeet, Ronnie, Johnny and Tony
July or August	Road 2 Success	Thomas Street Health Center	**Need 6 Volunteers: PP: Rod,** Lionel, Skeet, Ronnie, Holly and Veronica
August or September	Road 2 Success		**Need 6 Volunteers: PP: Rod,**
Monday, October 14 5 – 7 pm	Camino hacia tu Salud	Positive713 Leonel Castillo Community Center 2101 South Street, 77009	**Need 6 Volunteers: PP: Rod,** Tana, Isis, Skeet, Ronnie and Johnny
October	MISS UTOPIA	**NOTE CHANGE OF VENUE IN 2018** **CROWNE PLAZA HOUSTON** **(Near Reliant - Medical)** **8686 Kirby Drive** **Houston, Texas 77054**	**4 Volunteers: PP:** DISTRIBUTE LEAP FLYERS
November or December	Road 2 Success		**Need 6 Volunteers: PP: Rod,**
Sunday, December 1	World AIDS Day Events	SEE CALENDAR OF EVENTS	Most committee members attend events DISTRIBUTE LEAP FLYERS

Greeters for 2019 Council Meetings

(Revised: 05-29-19)

2019 Meeting Dates (**Please arrive at 11:45 a.m.** Unless otherwise noted, the meetings are held at 2223 W. Loop South)	**Greeter #1** External Member	**Greeter #2**	**Greeter #3**
Thurs. March 14	Skeet	Tony	Ronnie
Thurs. April 11	Lionel	Veronica	Holly
Thurs. May 9	Lionel	Rodney	Tony
Thurs. June 13 – LEAP presentation	Ronnie	Tony	Skeet
Thurs. July 11	Skeet	Veronica	Holly
Thurs. August 8	Skeet	Johnny	Ronnie
Thurs. September 12	Holly	Veronica	Isis
Thurs. October 10			
Thurs. November 14 External Committee Member Appreciation			
Thurs. December 12			

2019 QUARTERLY REPORT
AFFECTED COMMUNITY COMMITTEE
(May 2019)

Status of Committee Goals and Responsibilities (* indicates a HRSA mandate):

1. Educate consumers so they understand how to access HIV/AIDS treatment and medication. Provide information that can be understood by consumers of diverse educational backgrounds on client-centered issues.
   Status: Scheduled Road to Success at this time

2. Continue to get a better understanding of the needs of transgender individuals through training, attending meetings of the transgender community and more.
   Ongoing process. Distributing information about Transgender treatment aab at Pride Festival

3. Assure participation by people living with HIV in all Council work products.
   Status: On going. Participation on How to best meet the needs and Pride.

4. *Work with other committees to coordinate Public Hearings regarding the FY 2019 How to Best Meet the Need Results & Priorities and Allocations for Ryan White Parts A and B and State Services.
   Status: Dates have been set for hearings

5. Recruit Council applicants throughout the year.
   Status: See events calendar.

6. Annually, review the status of committee activities identified in the current Comprehensive Plan.
   Status: To be reviewed in the fall.

Geri Lorenti
Committee Chairperson

5-2019
Date

Quality Improvement Committee Report

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

FY 2018 Ryan White Part A and MAI
Procurement Report

Priority	Service Category	Original Allocation *RWPC Approved Level Funding Scenario*	Award Reconcilation (b)	July Adjustments (carryover)	October Adjustments	Final Quarter Adjustments	Total Allocation	Percent of Grant Award	Amount Procured (a)	Procure-ment Balance	Original Date Procured	Expended YTD	Percent YTD	Percent Expected YTD
1	**Outpatient/Ambulatory Primary Care**	**9,634,415**	**391,824**	**703,670**	**30,517**	**-120,000**	**10,640,426**	**48.14%**	**10,640,426**	**0**		**9,816,210**	**92%**	**92%**
1.a	Primary Care - Public Clinic (a)	3,520,995	70,069	378,670	0		3,969,734	17.96%	3,969,734	0	3/1/2018	$3,815,916	96%	75%
1.b	Primary Care - CBO Targeted to AA (a) (e) (f)	940,447	80,923	100,000	1,839	-40,000	1,083,209	4.90%	1,083,209	0	3/1/2018	$1,195,563	110%	92%
1.c	Primary Care - CBO Targeted to Hispanic (a) (e)	786,424	80,923	100,000	1,839	-40,000	929,186	4.20%	929,186	0	3/1/2018	$889,226	96%	92%
1.d	Primary Care - CBO Targeted to White/MSM (a) (e)	1,003,821	100,899	100,000	1,839	-40,000	1,166,559	5.28%	1,166,559	0	3/1/2018	$672,568	58%	92%
1.e	Primary Care - CBO Targeted to Rural (a) (e)	1,127,327	22,434	0	0		1,149,761	5.20%	1,149,761	0	3/1/2018	$1,031,422	90%	92%
1.f	Primary Care - Women at Public Clinic (a)	1,837,964	36,576	0			1,874,540	8.48%	1,874,540	0	3/1/2018	$1,767,966	94%	75%
1.g	Primary Care - Pediatric (a.1)	15,437	0				15,437	0.07%	15,437	0	3/1/2018	$9,900	64%	92%
1.h	Vision	402,000	0	25,000	25,000		452,000	2.05%	452,000	0	3/1/2018	$433,650	96%	92%
2	**Medical Case Management**	**2,535,802**	**0**	**0**	**-200,714**	**-30,000**	**2,305,088**	**10.43%**	**2,305,088**	**0**		**1,969,573**	**85%**	**92%**
2.a	Clinical Case Management	488,656	0	0	-30,000		458,656	2.08%	458,656	0	3/1/2018	$456,310	99%	92%
2.b	Med CM - Public Clinic (a)	482,722	0	0	0		482,722	2.18%	482,722	0	3/1/2018	$246,992	51%	75%
2.c	Med CM - Targeted to AA (a) (e)	321,070	0	0	-50,038		271,032	1.23%	271,032	0	3/1/2018	$328,437	121%	92%
2.d	Med CM - Targeted to H/L (a) (e)	321,072	0	0	-50,038		271,034	1.23%	271,034	0	3/1/2018	$178,850	66%	92%
2.e	Med CM - Targeted to W/MSM (a) (e)	107,247	0	0	-50,038		57,209	0.26%	57,209	0	3/1/2018	$140,857	246%	92%
2.f	Med CM - Targeted to Rural (a)	348,760	0	0			348,760	1.58%	348,760	0	3/1/2018	$271,090	78%	92%
2.g	Med CM - Women at Public Clinic (a)	180,311	0	0			180,311	0.82%	180,311	0	3/1/2018	$120,163	67%	75%
2.h	Med CM - Targeted to Pedi (a.1)	160,051	0	0	-20,600	-30,000	109,451	0.50%	109,451	0	3/1/2018	$112,745	103%	92%
2.i	Med CM - Targeted to Veterans	80,025	0	0	0		80,025	0.36%	80,025	0	3/1/2018	$67,084	84%	92%
2.j	Med CM - Targeted to Youth	45,888	0	0			45,888	0.21%	45,888	0	3/1/2018	$47,046	103%	75%
3	**Local Pharmacy Assistance Program (a) (e)**	**1,934,796**	**256,674**	**0**	**69,363**	**0**	**2,260,833**	**10.23%**	**2,260,833**	**0**	3/1/2018	**$2,563,420**	**113%**	**92%**
4	**Oral Health**	**166,404**	**0**	**0**	**0**	**0**	**166,404**	**0.75%**	**166,404**	**0**	3/1/2018	**166,400**	**100%**	**92%**
4.a	Oral Health - Untargeted (c)	0					0	0.00%	0	0	N/A	$0	0%	**0%**
4.b	Oral Health - Targeted to Rural	166,404	0	0			166,404	0.75%	166,404	0	3/1/2018	$166,400	100%	92%
5	**Mental Health Services (c)**	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**	**NA**	**$0**	**0%**	**0%**
6	**Health Insurance (c)**	**1,244,551**	**28,519**	**0**	**0**	**150,000**	**1,423,070**	**6.44%**	**1,423,070**	**0**	3/1/2018	**$1,442,569**	**101%**	**92%**
7	**Home and Community-Based Services (c)**	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**	**NA**	**$0**	**0%**	**0%**
8	**Substance Abuse Services - Outpatient**	**45,677**	**0**	**0**	**0**	**0**	**45,677**	**0.21%**	**45,677**	**0**	3/1/2018	**$32,306**	**71%**	**92%**
9	**Early Intervention Services (c)**	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**	**NA**	**$0**	**0%**	**0%**
10	**Medical Nutritional Therapy (supplements)**	**341,395**	**0**	**0**	**0**	**0**	**341,395**	**1.54%**	**341,395**	**0**	3/1/2018	**$327,976**	**96%**	**92%**
11	**Hospice Services**	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**	**NA**	**$0**	**0%**	**0%**
12	**Outreach Services**	**420,000**	**39,927**				**459,927**	**2.08%**	**459,927**	**0**	**3/1/2018**	**$294,500**	**64%**	**92%**
13	**Non-Medical Case Management**	**1,231,002**	**0**	**0**	**-49,400**	**0**	**1,181,602**	**5.35%**	**1,181,602**	**0**		**1,375,441**	**116%**	**92%**
13.a	Service Linkage targeted to Youth	110,793		0			110,793	0.50%	110,793	0	3/1/2018	$99,700	90%	92%
13.b	Service Linkage targeted to Newly-Diagnosed/Not-in-Care	100,000			-29,400		70,600	0.32%	70,600	0	3/1/2018	$81,269	115%	92%
13.c	Service Linkage at Public Clinic (a)	427,000		0	0		427,000	1.93%	427,000	0	3/1/2018	$446,037	104%	75%
13.d	Service Linkage embedded in CBO Pcare (a) (e)	593,209		0	-20,000		573,209	2.59%	573,209	0	3/1/2018	$748,434	131%	92%
14	**Medical Transportation**	**482,087**	**25,824**	**0**	**0**	**0**	**507,911**	**2.30%**	**507,911**	**0**		**349,864**	**69%**	**92%**
14.a	Medical Transportation services targeted to Urban	252,680	0	0	0		252,680	1.14%	252,680	0	3/1/2018	$265,776	105%	92%
14.b	Medical Transportation services targeted to Rural	97,185	0	0	0		97,185	0.44%	97,185	0	3/1/2018	$84,088	87%	92%
14.c	Transportation vouchering (bus passes & gas cards)	132,222	25,824	0	0		158,046	0.72%	158,046	0	3/1/2018	$0	0%	0%
15	**Linguistic Services (c)**	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**	**NA**	$0	**0%**	**0%**
16	**Emergency Financial Assistance**	**450,000**		**0**	**150,000**	**0**	**600,000**	**2.71%**	**600,000**	**0**	3/1/2018	$654,904	**109%**	**92%**
17	**Referral for Health Care and Support Services (c)**	**0**	**0**	**0**			**0**	**0.00%**	**0**	**0**	NA	$0	**0%**	**0%**
BES27516	**Total Service Dollars**	**18,486,129**	**742,768**	**703,670**	**-234**	**0**	**19,932,333**	**88.10%**	**19,932,333**	**0**		**18,043,759**	**91%**	**92%**
	Grant Administration	**1,675,047**	**0**	**0**	**0**	**0**	**1,675,047**	**7.58%**	**1,675,047**	0	**N/A**	**0**	**0%**	**92%**
BES27517	HCPHES/RWGA Section	1,146,388	0	0		0	1,146,388	5.19%	1,146,388	0	N/A	$0	0%	92%
PC	RWPC Support*	528,659			0	0	528,659	2.39%	528,659	0	N/A	0	0%	92%

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

FY 2018 Ryan White Part A and MAI
Procurement Report

Priority	Service Category	Original Allocation *RWPC Approved Level Funding Scenario*	Award Reconcilation (b)	July Adjustments (carryover)	October Adjustments	Final Quarter Adjustments	Total Allocation	Percent of Grant Award	Amount Procured (a)	Procure-ment Balance	Original Date Procured	Expended YTD	Percent YTD	Percent Expected YTD
BES27521	**Quality Management**	**495,000**	**0**	**0**	**0**	**0**	**495,000**	**2.24%**	**495,000**	**0**	**N/A**	**$0**	**0%**	**92%**
		20,656,176	**742,768**	**703,670**	**-234**	**0**	**22,102,380**	**97.92%**	**22,102,380**	**0**		**18,043,759**	**82%**	**92%**
								Unallocated	Unobligated					75%
	Part A Grant Award:	**21,398,944**	***Carry Over:***	**703,670**		***Total Part A:***	**22,102,614**	234	**0**					92%

		Original Allocation	Award Reconcilation (b)	July Adjusments (carryover)	October Adjustments	Final Quarter Adjustments	Total Allocation	Percent	Total Expended on Services	Percent
	Core (must not be less than 75% of total service dollars)	**15,903,040**	**677,017**	**703,670**	**-100,834**	**0**	**17,182,893**	**86.38%**	**17,182,893**	**85.94%**
	Non-Core (may not exceed 25% of total service dollars)	**2,583,089**	**25,824**	**0**	**100,600**	**0**	**2,709,513**	**13.62%**	**2,810,113**	**14.06%**
	Total Service Dollars (does not include Admin and QM)	**18,486,129**	**702,841**	**703,670**	**-234**	**0**	**19,892,406**		**19,993,006**	
	Total Admin (must be ≤ 10% of total Part A + MAI)	**1,675,047**	**0**	**0**	**0**	**0**	**1,675,047**	**7.58%**		
	Total QM (must be ≤ 5% of total Part A + MAI)	**495,000**	**0**	**0**	**0**	**0**	**495,000**	**2.24%**		

MAI Procurement Report

Priority	Service Category	Original Allocation *RWPC Approved Level Funding Scenario*	Award Reconcilation (b)	July Adjustments (carryover)	October Adjustments	Final Quarter Adjustments	Total Allocation	Percent of Grant Award	Amount Procured (a)	Procure-ment Balance	Date of Procure-ment	Expended YTD	Percent YTD	Percent Expected YTD
1	**Outpatient/Ambulatory Primary Care**	**1,797,785**	**49,060**	**90,830**	**86,270**	**0**	**2,023,945**	**88.08%**	**2,023,945**	**0**		**1,980,550**	**98%**	**92%**
1.b (MAI)	Primary Care - CBO Targeted to African American	910,163	24,530	45,415	43,135	0	1,023,243	44.53%	1,023,243	0	3/1/2018	$1,153,900	113%	92%
1.c (MAI)	Primary Care - CBO Targeted to Hispanic	887,622	24,530	45,415	43,135	0	1,000,702	43.55%	1,000,702	0	3/1/2018	$826,650	83%	92%
2	**Medical Case Management**	**320,100**	**0**	**40,000**	**-86,270**	**0**	**273,830**	**11.92%**	**320,100**	**-46,270**		**$298,363**	**93%**	92%
2.c (MAI)	MCM - Targeted to African American	160,050		20,000	-43,135		136,915	5.96%	136,915	0	3/1/2018	$193,786	142%	92%
2.d (MAI)	MCM - Targeted to Hispanic	160,050		20,000	-43,135		136,915	5.96%	136,915	0	3/1/2018	$104,577	76%	92%
	Total MAI Service Funds	**2,117,885**	**49,060**	**130,830**	**0**	**0**	**2,297,775**	**100.00%**	**2,023,945**	**273,830**		**1,980,550**	**98%**	**92%**
	Grant Administration	0	0	0	0	0	0	0.00%	0	0		0	0%	0%
	Quality Management	0	0	0	0	0	0	0.00%	0	0		0	0%	0%
	Total MAI Non-service Funds	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**		**0**	**0%**	**0%**
BEO 27516	**Total MAI Funds**	**2,117,885**	**49,060**	**130,830**	**0**	**0**	**2,297,775**	**100.00%**	**2,023,945**	**273,830**		**1,980,550**	**98%**	**92%**
	MAI Grant Award	**2,166,944**	***Carry Over:***	**0**		***Total MAI:***	**2,166,944**							92%
	Combined Part A and MAI Orginial Allocation Total	**22,774,061**												

Footnotes:

All	When reviewing bundled categories expenditures must be evaluated both by individual service category and by combined categories. One category may exceed 100% of available funding so long as other category offsets this overage.
(a)	Single local service definition is four (4) HRSA service categories (Pcare, LPAP, MCM, Non Med CM). Expenditures must be evaluated both by individual service category and by combined service categories.
(a.1)	Single local service definition is three (3) HRSA service categories (does not include LPAP). Expenditures must be evaluated both by individual service category and by combined service categories.
(b)	Adjustments to reflect actual award based on Increase or Decrease funding scenario.
(c)	Funded under Part B and/or SS
(d)	Not used at this time
(e)	10% rule reallocations

The Houston Regional HIV/AIDS Resource Group, Inc.

FY 1819 Ryan White Part B

Procurement Report

April 1, 2018 - March 31, 2019

THE RESOURCE GROUP

Reflects spending through February 2019

Spending Target: 100%

Revised 5/14/2019

Priority	Service Category	Original Allocation per RWPC	% of Grant Award	Amendment	Contractual Amount	% of Grant Award	Date of Original Procurement	Expended YTD	Percent YTD
6	Oral Health Care	$2,085,565	62%	($196,000)	$1,889,565	57%	4/1/2018	$1,931,486	93%
7	Health Insurance Premiums and Cost Sharing	$726,885	22%	$525,806	$1,252,691	38%	4/1/2018	$1,203,635	96%
9	Home and Community Based Health Services (1)	$202,315	6%	($55,000)	$147,315	4%	4/1/2018	$146,480	72%
	Unallocated funds approved by RWPC for Health Insurance	$325,806	10%	-$325,806	$0	0%	4/1/2018	$0	0%
	Total Houston HSDA	3,340,571	100%	($51,000)	$3,289,571	100%		3,281,601	98%

Note: Spending variances of 10% will be addressed:

1 HCHB- The provision of service changed plus other funding supports the program. Future allocations are lower.

2 DSHS has a required total grant spending thresold of 95%

3 Close out spending and reallocations happen very quickly because of short closing window of 45 days

The Houston Regional HIV/AIDS Resource Group, Inc.

FY 1819 DSHS State Services

Procurement Report

September 1, 2018- August 31, 2019

Chart reflects spending through February 2019

Spending Target: 58.33%

Revised 5/1/2019

Priority	Service Category	Original Allocation per RWPC	% of Grant Award	Amendment	Contractual Amount	% of Grant Award	Date of Original Procurement	Expended YTD	Percent YTD
5	**Health Insurance Premiums and Cost Sharing (1)**	$979,694	49%	**$142,285**	$1,121,979	56%	9/1/2018	$493,033	44%
6	**Mental Health Services (2)**	$300,000	15%	**$0**	$300,000	15%	9/1/2018	$84,106	28%
7	**EIS - Incarcerated**	$166,211	8%	**$0**	$166,211	8%	9/1/2018	$94,047	57%
11	**Hospice (3)**	$359,832	18%		$359,832	18%	9/1/2018	$105,380	29%
15	**Linguistic Services (4)**	$68,000	3%		$68,000	3%	9/1/2018	$20,325	30%
	Unallocated (RWPC Approved for Health Insurance - TRG will amend contract)	$142,285	7%	**-$142,285**	$0	0%	9/1/2018	$0	0%
	Total Houston HSDA	**2,016,022**	**100%**	**$0**	$2,016,022	100%		796,892	0%

First month of expenditures. Submissions/services/data entry are slow during first few months of contract.

1 HIP - Funded by Part A, B and State Services. Provider spends grant funds by ending dates Part A- 2/28; B-3/31; SS-8/31. Agency usually expends all funds.

2 Mental Health Services are under Utilized and under reported.

3 Hospice care has had lower than expected client turn out and agency has other grant funding

4 Linguistic is one month behind on reporting due to slow invoicing by provider, additionally there has been lower than expected client turn out.

2018-2019 Ryan White Part B Service Utilization Report
4/1/2018 - 3/31/2019 Houston HSDA (4816)
4th Quarter - 4/1/2018 to 3/31/2019

Revised 5/8/2019

Funded Service	UDC		Gender				Race				Age Group							
	Goal	YTD	Male	Female	FTM	MTF	AA	White	Hisp	Other	0-12	13-19	20-24	25-34	35-44	45-49	50-64	65+
Health Insurance Premiums & Cost Sharing Assistance	*1,250*	5	100.00%	0.00%	0.00%	0.00%	60.00%	20.00%	20.00%	0.00%	0.00%	0.00%	20.00%	4.00%	16.00%	20.00%	20.00%	2.94%
Home & Community Based Health Services	*30*	34	70.59%	26.47%	0.00%	2.94%	58.82%	8.82%	32.35%	0.00%	0.00%	0.00%	5.69%	16.08%	26.47%	33.33%	12.55%	5.88%
Oral Health Care	*3,100*	856	72.62%	26.22%	0.00%	1.16%	50.23%	16.47%	31.50%	1.80%	0.00%	0.00%	2.02%	20.00%	15.66%	34.16%	21.00%	7.16%
Unduplicated Clients Served By RW Part B Funds:	*NA*	895	**81.16%**	**17.47%**	**0.00%**	**1.37%**	**61.16%**	**16.96%**	**21.26%**	**0.62%**	**0.00%**	**0.00%**	**14.17%**	**13.08%**	**19.56%**	**29.49%**	**17.72%**	**5.98%**

COMMENT:

The delay in Data Upload from CPCDMS into ARIES is the reason for the discrepancy in the HIP/HIA YTD Total. Please see HINS Report for review on HIP/HIA totals.

Houston Ryan White Health Insurance Assistance Service Utilization Report

Period Reported: 09/01/2018-2/28/19

Revised: 3/29/2019

Request by Type	Assisted			NOT Assisted		
	Number of Requests (UOS)	*Dollar Amount of Requests*	Number of Clients (UDC)	*Number of Requests (UOS)*	*Dollar Amount of Requests*	*Number of Clients (UDC)*
Medical Co-Payment	1045	$102,969.18	574			*0*
Medical Deductible	227	$119,484.95	173			*0*
Medical Premium	3696	$1,458,740.33	760			*0*
Pharmacy Co-Payment	2831	$283,839.95	1223			*0*
APTC Tax Liability	0	$0.00	0			*0*
Out of Network Out of Pocket	0	$0.00	0			*0*
ACA Premium Subsidy Repayment	9	$1,042.00	8	*NA*	*NA*	*NA*
Totals:	7808	$1,963,992.41	2738	0	$0.00	

Comments: This report represents services provided under all grants.

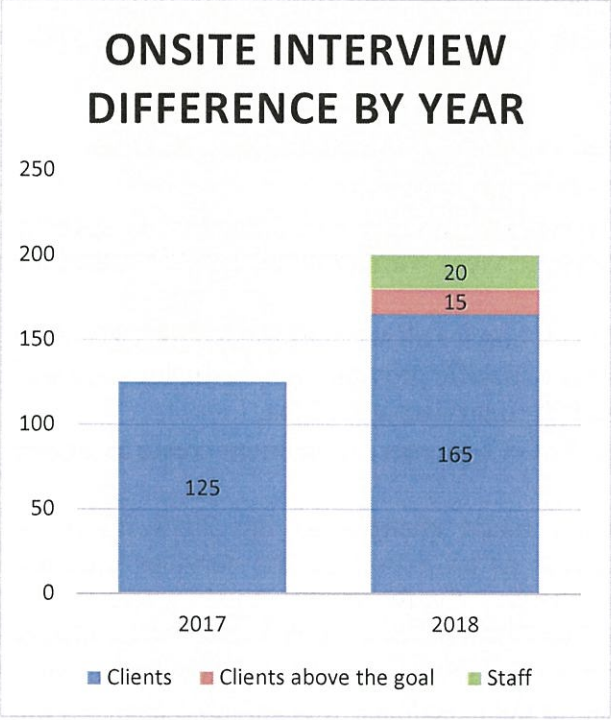
TRG Consumer Interview Results 2018

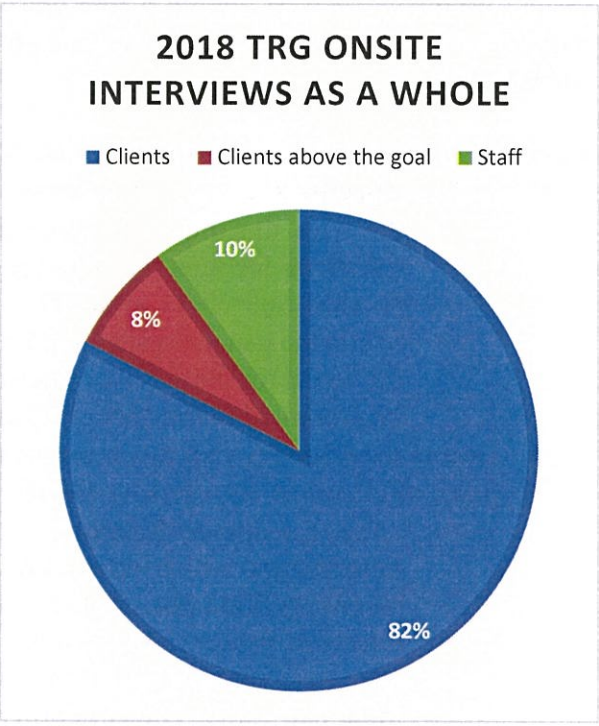
Interview and Feedback Period October 2018-December 2018

Overview

The Consumer Interview Process is used by The Resource Group (TRG) to determine consumer experience, satisfaction and collect additional feedback from consumers. Consumer interviews are required as part of TRG grant monitoring process at each agency in Houston and the fifty-one county areas of East Texas. The process which reviews consumer engagement is called the Onsite Interview (OI) Process. During the 2018 OI process one hundred and eighty (180) Consumer participated in the interview process. HIV positive consumers have been in care ranging from two weeks though thirty years. Sessions conducted were individual, couples, random pairs and as group interviews. Below is a comparison between the 2017 and 2018 reporting process showing an increase in participation. A goal was set for one hundred and sixty-five (165) for the 2018 reporting period. One hundred and sixty-five (165) would yield a 32% increase however, one hundred and eighty (180) clients participated is a 44% increase.

In 2018, staff interviews were formalized as a part of the Onsite Interview Process, to get a foster the relationship TRG expects its Subrecipients to have with consumers. Twenty (20) provider staff was interviewed or given onsite technical assistance (TA) to help improve the efforts of overall consumer engagement. The total interviews were two hundred (200).





CROSS-SERVICE TRENDS

Overall, consumers reported satisfaction with the services they are receiving. Consumers, who are in care, feel comfortable and satisfied with their medical team and care process. A high percentage of consumers felt they were leaders on their health care team or an important team member of their team. Consumers stated the medical staff answer questions and explain the things the consumer does not understand. Case managers were described as "good at helping and explaining things".

Consumers in Houston and throughout East Texas mentioned general communication between staff and consumers at most service agencies needs improvement. Consumers continue to become more open about discussing concerns and reporting dissatisfaction for improvement purposes. There is an ongoing disconnection between consumers and the agency complaint process or how concerns are resolve at some agencies. Some consumers continue to report they were not aware of the complaint process for problems with services. Some consumers were familiar with the agency process and complaint forms. This discussion has continued multiple years.

There was an increase in statements and conversations related to services. Services which received the most detailed comments were Oral Health Care. In previous years, having online surveys available for consumers who may not have the time during their day to complete a survey has been suggested.

From year to year consumers only a select few are familiar with the complaint process at the agencies they are receiving services from. Consumers who had complaints expressed their complaints have been addressed and resolved. While a few consumers worried that if they complained, it may affect their service or that it may take them longer to get an appointment. Phone system problems such as getting a live person and getting medication refills were discussed as problems. In 2017 a client suggests an exit survey to ask about any complaints or comments at the end of a visit.

The lessons learned and questions which will be added to the questionnaire for 2019 include:

- Service specific/specific population questions to all some services
  - As with the introduction of dental specific questions and incarcerated specific questions for interviews in the jail, other services warrant some specific questions to encourage client feedback.
  - While the general questionnaire will have a box for all services funded by TRG, only the boxes for the services funded through a specific provider or specific location will be presented to the service agencies staff as interview questions.
- During a HRSA TA visit it was recommended TRG Consumer Department create an expert panel of clients as an Advisory Board.
  - The Consumer Relations Coordinator made changes to the 2018 interview introduction which now identifies clients as an expert on the services they are receiving. This change has been empowering for the clients participating in the interview process. An example in the Early Intervention Service received by clients who were incarcerated at the time of the interview, allowed the clients to feel their input had value. The possibility of feeling their feedback was valuable changed the

mood of the interviews and increased the clients willing ness to share their experience. This was the same occurrence during all the consumer interviews.

- The Contact Consent form will serve as an assessment of clients' interest in participating in feedback/consumer engagement opportunities as well as a skill assessment the form is voluntary to complete, and the consumer has the right to refuse. The form gives the client's consent to be contacted about only the topics the have selected. This form was very useful to check on the safety and communicate with some consumers during and after Hurricane Harvey. TRG staff was able to communicate via cell phone with Houston and Beaumont consumers. A few clients who were evacuated were able to stay connected to information and updates on where to get service and medications.

The client satisfaction questions will be reviewed by various groups of TRG consumers and feedback is utilized to improve the evaluation process. The Onsite Interview Process has identified the need for Ryan White agencies to create and facilitate agency specific/customized trainings for their consumers which may include but are not limited to:

- Consumers reviewing and providing feedback on agency policies and procedures. This has been recommended for the previous years. During the interviewing process of 2018 The Consumer Relations Coordinator provided onsite technical assistance. The TA recommended the service provider utilize the agencies Consumer Advisory Board to review policy and procedures which directly affect clients on an annual basis. This can be addressed on the Consumer Engagement Work Plan.
- Consumer trainings on each service which the agency provides and details to help consumers understand the length of processes for specific procedures or service. This has been recommended for the previous years. During the interviewing process of 2018 The Consumer Relations Coordinator provided onsite technical assistance. The TA recommended the service provider utilize the agencies Consumer Advisory Board quarterly meetings and host service specific trainings or educational meetings for clients. This can be addressed on the Consumer Engagement Work Plan.
- Based on feedback, conversations and identified interest TRG will develop multiple Advisory Boards base on target populations and service specific focuses.

SERVICE-SPECIFIC TRENDS

Oral Health Care

Consumers in the local area have concerns about changes which affect accesses to this service. TRG is working with Subrecipients to address client concerns and provide Service update written materials and update meetings to consumers receiving or seeking this service.

For most rural area services, consumers were satisfied with this service. And very knowledgeable of this service and how to access the service.

For a few remote rule areas consumers expressed a need to have this service closer to their home. Clients expressed they were not satisfied with how for the must travel to receive the service. The concerns have been documented. For the specific areas discussed. The consumers were informed that there are were no providers closer to provide the service. The clients statements were they preferred to have it closer but, they were willing to travel to have access to the service.

Part D Patient Navigation Services
Consumers were satisfied with this service. Consumers stated that the service was useful and needed.

Mental Health Services
Consumers were satisfied with this service. Many consumers expressed satisfaction with the selection process of pairing a client with an appropriate therapist through this service. Many consumers expressed interest in learning more and understanding this service. TRG has begun to address this by creating a booklet on "Understanding Mental Health Services".

Home and Community-Based Health Care Services
Consumers were satisfied with this service. Consumers expressed satisfaction with the socialization and activities available through this service. Day treatment consumers understanding of the service they are receiving has continued to improve from the previous years. The TRG recommendations have been utilized and continually administered to day treatment consumers.

Early Intervention Services – Incarcerated (EIS)
EIS consumers seem to be very knowledgeable and appreciative of access to service. The consumers were pleased to be referred to as experts and some inquired about learning more about the Ryan White system and how to participate upon release. For this service 50% of clients were diagnosed during their current incarceration. Some clients had been newly diagnosed about month.

Linguistic Services
There were no issues related to this service and due to the nature of the service delivered, there are no Consumer interviews conducted for this service.

Hospice Care Services
There were no issues of note related to this service and due to the nature of the service delivered; Consumer interviews were not conducted for this service.

Health Insurance Premium (HIP)
HIP consumers were satisfied and appreciative for the availability of the service. Consumers stated that HIP was simple to get and easy to use. Consumers of this service are very knowledgeable of this service.

QI COMMITTEE MEETING
QUESTIONS & RESPONSES
190514

1.) ***(Related to the Interview Report)*** **What services do the agencies provide using Ryan White or State Service funding?**

We have created a DSHS-Funded Houston HSDA sub-report that is at your place. In the future, this will be the report that the Planning Council receives so that members know that they are reviewing responses that correlate to the services they are planning for.

Trends:

- Improved Communication still needed.
- Education and Encouragement regarding Complaint Process still needed.
  - Recommendation: Exit Survey for PLWH to evaluate the day's visit

2.) **How do the co-pays work for oral health?**

Co-pays are related to insurance plans and are allowable under the Health Insurance Assistance service category. Co-pays are a portion of the service cost that the insurance plan requires the PLWH to pay to access services.

"Sliding Fee Contributions" (as determined by income and outlined in the agency's fee schedule) are the portion of the service that Ryan White legislation permits to be charged to PLWH accessing services (see below).

Consumer Charges for Billable Services
Subrecipient must comply with TRG policy SR-1702 Payer of Last Resort (available at http://www.hivtrg.org/#/eligibility-for-services/4592859384). This policy includes the requirement that all Subrecipient must have a sliding-fee schedule in place that uses as its premise the latest Federal Poverty Guidelines. Persons with an annual gross family income at or below 100% of the Federal Poverty Guidelines shall not be charged for any services covered by this funding. In accordance with Title 25 Texas Administrative Code §1.91, no one shall be denied services due to their inability to pay.

Per Ryan White legislation, an annual cap on charge has been set Subrecipients must inform PLWH about the sliding fee, the annual cap on charges (including the individualized cap based on the PLWH's income), and the process by which the PLWH's progress toward the annual cap is being tracked.

Subrecipients must track the charge imposed on PLWH through the sliding fee schedule and ensure that the PLWH is not charge more that the allowable charges per Ryan White legislation. Please refer to the following chart for the annual cap on allowable charges:

INDIVIDUAL/FAMILY INCOME	*TOTAL ALLOWABLE ANNUAL CHARGES TO PLWH*
Equal to or below the official poverty line	*No charges permitted*
101 to 200 percent of the official poverty line	*5 percent or less of FPL*
201 to 300 percent of the official poverty line	*7 percent or less of FPL*
301 to 500 percent of the official poverty line	*10 percent or less of FPL*

The 2019 HHS Poverty Guidelines (FPL) are as follows:

SIZE OF FAMILY UNIT	*POVERTY GUIDELINE*
1	*$12,490*
2	*$16,910*
3	*$21,330*
4	*$25,750*
5	*$30,170*
6	*$34,590*
7	*$39,010*
8	*$43,430*

For family units with more than 8 members, add $4,420 for each additional member.

Subrecipient are required to utilize the ***most current*** *Federal Poverty Guidelines in determination of potential allowable charges. Subrecipient are required to adopt Modified Adjusted Gross Income (MAGI) for determination of income. Additional resources on MAGI can be located at DSHS's Website (https://dshs.texas.gov/hivstd/magi/).*

3.) Suggested text that will allow family therapy sessions to be 90-minute sessions in the Mental Health service definition.

Currently within the established fee structure:

- Family/Office
- Group
- Individual/Home
- Individual/Office

See the revised Mental Health Service Category at your place.

Houston Area HIV Services Ryan White Planning Council
2223 West Loop South, Suite 240, Houston, Texas 77027
832 927-7926 telephone; 713 572-3740 fax
www.rwpchouston.org

FY 2020 How to Best Meet the Need Workgroup Service Category Recommendations Summary (as of 04/29/19)

Those services for which no change is recommended include:

Ambulatory Outpatient Medical Care (includes Medical Case Management, Local Pharmacy Assistance, and Service Linkage)

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

Early Intervention Services (targeting the Incarcerated)

Emergency Financial Assistance - Pharmacy Assistance

Health Insurance Premium and Cost Sharing Assistance

Hospice Services

Linguistic Services

Medical Nutritional Therapy/Supplements

Oral Health (Untargeted and Targeting the Northern Rural Area)

Outreach Services - Primary Care Re-Engagement

Referral for Health Care and Support Services

Substance Abuse Treatment

Vision Care

Services with recommended changes include the following:

Home and Community Based Health Services (Adult Day Treatment)

- Accept the service definition as presented and keep the financial eligibility the same at 300%. Ask the Office of Support to work with the AAs to promote this service.

Mental Health Services

- Accept the service definition with one change: allow 90 minutes for family/couples session and keep the financial eligibility the same at 300%.

Transportation

- Accept the service definition as presented and keep the financial eligibility the same at 400%. Ask the Office of Support to check into the availability of alternative bus providers.

Table of Contents

FY 2020 Houston EMA/HSDA Service Categories Definitions
Ryan White Part A, Part B and State Services

FY 2015 Houston EMA Ryan White Part A/MAI Service Definition **Comprehensive Outpatient Primary Medical Care including Medical Case Management, Service Linkage and Local Pharmacy Assistance Program (LPAP) Services** (Revision Date: 5/21/15)	
HRSA Service Category Title: **RWGA Only**	1. Outpatient/Ambulatory Medical Care 2. Medical Case Management 3. AIDS Pharmaceutical Assistance (local) 4. Case Management (non-Medical)
Local Service Category Title:	Adult Comprehensive Primary Medical Care - CBO i. Community-based Targeted to African American ii. Community-based Targeted to Hispanic iii. Community-based Targeted to White/MSM
Amount Available: **RWGA Only**	Total estimated available funding: $0.00 (to be determined) 1. Primary Medical Care: $0.00 (including MAI) i. Targeted to African American: $0.00 (incl. MAI) ii. Targeted to Hispanic: $0.00 (incl. MAI) iii. Targeted to White: $0.00 2. LPAP $0.00 3. Medical Case Management: $0.00 i. Targeted to African American $0.00 ii. Targeted to Hispanic $0.00 iii. Targeted to White $0.00 4. Service Linkage: $0.00 Note: The Houston Ryan White Planning Council (RWPC) determines overall annual Part A and MAI service category allocations & reallocations. RWGA has sole authority over contract award amounts.
Target Population:	Comprehensive Primary Medical Care – Community Based i. Targeted to African American: African American ages 13 or older ii. Targeted to Hispanic: Hispanic ages 13 or older iii. Targeted to White: White (non-Hispanic) ages 13 or older
Client Eligibility: Age, Gender, Race, Ethnicity, Residence, etc.	PLWHA residing in the Houston EMA (prior approval required for non-EMA clients). Contractor must adhere to Targeting requirements and Budget limitations as applicable.
Financial Eligibility:	Refer to the RWPC's approved *Financial Eligibility for Houston EMA/HSDA Services.*
Budget Type: **RWGA Only**	Hybrid Fee for Service
Budget Requirement or Restrictions: **RWGA Only**	**Primary Medical Care:** No less than 75% of clients served in a Targeted subcategory must be members of the targeted population with the following exceptions:

	100% of clients served with MAI funds must be members of the targeted population. 10% of funds designated to primary medical care must be reserved for invoicing diagnostic procedures at actual cost. Contractors may not exceed the allocation for each individual service component (Primary Medical Care, Medical Case Management, Local Pharmacy Assistance Program and Service Linkage) without prior approval from RWGA. **Local Pharmacy Assistance Program (LPAP):** Houston RWPC guidelines for Local Pharmacy Assistance Program (LPAP) services: Contractor shall offer HIV medications from an approved formulary for a total not to exceed $18,000 per contract year per client. Contractor shall offer HIV-related medications for a total not to exceed $3,000 per contract year per client. These guidelines are determined by the RWPC. The RWPC determines the subcategories that shall include Ryan White LPAP funding. Medications must be provided in accordance with Houston EMA guidelines, HRSA/HAB rules and regulations and applicable Office of Pharmacy Affairs 340B guidelines. At least 75% of the total amount of the budget for LPAP services must be solely allocated to the actual cost of medications and may not include any storage, administrative, processing or other costs associated with managing the medication inventory or distribution.
Service Unit Definition/s: **RWGA Only**	• Outpatient/Ambulatory Medical Care: One (1) unit of service = One (1) primary care office/clinic visit which includes the following: • Primary care physician/nurse practitioner, physician's assistant or clinical nurse specialist examination of the patient, and • Medication/treatment education • Medication access/linkage • OB/GYN specialty procedures (as clinically indicated) • Nutritional assessment (as clinically indicated) • Laboratory (as clinically indicated, not including specialized tests) • Radiology (as clinically indicated, not including CAT scan or MRI) • Eligibility verification/screening (as necessary) • Follow-up visits wherein the patient is not seen by the MD/NP/PA are considered to be a component of the original primary care visit. • Outpatient Psychiatric Services: 1 unit of service = A single (1) office/clinic visit wherein the patient is seen by a State licensed and board-eligible Psychiatrist or qualified Psychiatric Nurse Practitioner. This visit may or may not occur on the same date as a primary care office visit. • Nutritional Assessment and Plan: 1 unit of service = A single

	comprehensive nutritional assessment and treatment plan performed by a Licensed, Registered Dietician initiated upon a physician's order. Does not include the provision of Supplements or other products (clients may be referred to the Ryan White funded Medical Nutritional Therapy provider for provision of medically necessary supplements). The nutritional assessment visit may or may not occur on the same date as a medical office visit. • AIDS Pharmaceutical Assistance (local): A unit of service = a transaction involving the filling of a prescription or any other allowable medication need ordered by a qualified medical practitioner. The transaction will involve at least one item being provided for the client, but can be any multiple. The cost of medications provided to the client must be invoiced at actual cost. • Medical Case Management: 1 unit of service = 15 minutes of direct medical case management services to an eligible PLWHA performed by a qualified medical case manager. • Service Linkage (non-Medical Case Management): 1 unit of service = 15 minutes of direct service linkage services to an eligible PLWHA performed by a qualified service linkage worker.
HRSA Service Category Definition: **RWGA Only**	• **Outpatient/Ambulatory medical care** is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings. Services includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies. • **AIDS Pharmaceutical Assistance (local)** includes local pharmacy assistance programs implemented by Part A or Part B Grantees to provide HIV/AIDS medications to clients. This assistance can be funded with Part A grant funds and/or Part B base award funds. Local pharmacy assistance programs are not funded with ADAP earmark funding. • **Medical Case Management** services (including treatment adherence) are a range of client-centered services that link clients with health care, psychosocial, and other services. The

	coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication. • **Case Management (non-Medical)** includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does.
Standards of Care:	Contractors must adhere to the most current published Part A/B Standards of Care for the Houston EMA/HSDA. **Services must meet or exceed applicable United States Department of Health and Human Services (DHHS) guidelines for the Treatment of HIV/AIDS.**
Local Service Category Definition/Services to be Provided:	**Outpatient/Ambulatory Primary Medical Care:** Services include on-site physician, physician extender, nursing, phlebotomy, radiographic, laboratory, pharmacy, intravenous therapy, home health care referral, licensed dietician, patient medication education, and patient care coordination. The Contractor must provide continuity of care with inpatient services and subspecialty services (either on-site or through specific referral to appropriate medical provider upon primary care Physician's order). Services provided to women shall further include OB/GYN physician & physician extender services on-site or by referral, OB/GYN services, colposcopy, nursing, phlebotomy, radiographic, laboratory, pharmacy, intravenous therapy, home health care referral, licensed dietician, patient medication/women's health education, patient care coordination, and social services. The Contractor must provide continuity of care with inpatient services and subspecialty services (either on-site or through specific referral protocols to appropriate agencies upon primary care Physician's order). **Outpatient/Ambulatory Primary Medical Care must provide:** • Continuity of care for all stages of adult HIV infection; • Laboratory and pharmacy services including intravenous medications (either on-site or through established referral systems); • Outpatient psychiatric care, including lab work necessary for the

	prescribing of psychiatric medications when appropriate (either on-site or through established referral systems); • Access to the Texas ADAP program (either on-site or through established referral systems); • Access to compassionate use HIV medication programs (either directly or through established referral systems); • Access to HIV related research protocols (either directly or through established referral systems); • Must at a minimum, comply with Houston EMA/HSDA Part A/B Standards for HIV Primary Medical Care. The Contractor must demonstrate on an ongoing basis the ability to provide state-of-the-art HIV-related primary care medicine in accordance with the most recent DHHS HIV treatment guidelines. Rapid advances in HIV treatment protocols require that the Contractor provide services that to the greatest extent possible maximize a patient's opportunity for long-term survival and maintenance of the highest quality of life possible. • On-site Outpatient Psychiatry services. • On-site Medical Case Management services. • On-site Medication Education. • Physical therapy services (either on-site or via referral). • Specialty Clinic Referrals (either on-site or via referral). • On-site pelvic exams as needed for female patients with appropriate follow-up treatment and referral. • On site Nutritional Counseling by a Licensed Dietitian. **Services for women must also provide:** • Well woman care, including but not limited to: PAP, pelvic exam, HPV screening, breast examination, mammography, hormone replacement and education, pregnancy testing, contraceptive services excluding birth control medications. • Obstetric Care: ante-partum through post-partum services, child birth/delivery services. Perinatal preventative education and treatment. • On-site or by referral Colposcopy exams as needed, performed by an OB/GYN physician, or physician extender with a colposcopy provider qualification. • Social services, including but not limited to, providing women access to child care, transportation vouchers, food vouchers and support groups at the clinic site; **Nutritional Assessment:** Services include provision of information about therapeutic nutritional/supplemental foods that are beneficial to the wellness and increased health conditions of clients by a Licensed Dietitian. Services may be provided either through educational or counseling sessions. Clients who receive these services may utilize the Ryan White Part A-funded nutritional supplement provider to obtain recommended nutritional supplements in accordance with program rules. Clients are limited to one (1) nutritional assessment per calendar year without prior approval of RWGA.

	Patient Medication Education Services must adhere to the following requirements: • Medication Educators must be State Licensed Medical Doctor (MD), Nurse Practitioner (NP), Physician Assistant PA), Nurse (RN, LVN) or Pharmacist. Prior approval must be obtained prior to utilizing any other health care professional not listed above to provide medication education. • Clients who will be prescribed ongoing medical regimens (i.e. ART) must be assessed for adherence to treatment at every clinical encounter using the EMA's approved adherence assessment tool. Clients with adherence issues related to lack of understanding must receive more education regarding their medical regimen. Clients with adherence issues that are behavioral or involve mental health issues must be provided counseling by the Medical Case Manager, Physician or Physician Extender and/or licensed nursing staff and, if clinically indicated, assessment and treatment by a qualified Psychiatrist or Psychiatric Nurse Practitioner. **Outpatient Psychiatric Services:** The program must provide: • Diagnostic Assessments: comprehensive evaluation for identification of psychiatric disorders, mental status evaluation, differential diagnosis which may involve use of other clinical and laboratory tests, case formulation, and treatment plans or disposition. • Emergency Psychiatric Services: rapid evaluation, differential diagnosis, acute treatment, crisis intervention, and referral. Must be available on a 24 hour basis including emergency room referral. • Brief Psychotherapy: individual, supportive, group, couple, family, hypnosis, biofeedback, and other psychophysiological treatments and behavior modification. • Psychopharmacotherapy: evaluation and medication treatment of psychiatric disorders, including, but not limited to, anxiety disorders, major depression, pain syndromes, habit control problems, psychosis and organic mental disorders. • Rehabilitation Services: Physical, psychosocial, behavioral, and/or cognitive training. Screening for Eye Disorders: Contractor must ensure that patients receive appropriate screening and treatment for CMV, glaucoma, cataracts, and other related problems. **Local Medication Assistance Program (LPAP):** LPAP provides pharmaceuticals to patients otherwise ineligible for medications through private insurance, Medicaid/Medicare, State ADAP, SPAP or other sources. Allowable medications are only those on the Houston EMA Ryan White Part A Formulary. Eligible clients may be provided Fuzeon™ on a case-by-case basis with prior approval of Ryan White Grant Administration (RWGA). The cost of Fuzeon™ does not count against a client's annual maximum. HIV-related medication services are the provision of physician or physician-extender prescribed HIV-related

	medications to prevent serious deterioration of health. Does not include drugs available to the patient from other programs or payers or free of charge (such as birth control and TB medications) or medications available over the counter (OTC) without prescription. Contractor must offer all medications on the Texas ADAP formulary, for a total not to exceed $18,000.00 per contract year per client. Contractor must provide allowable HIV-related medications (i.e. non-HIV medications) for a total not to exceed $3,000 per contract year per client. Contractor may be reimbursed ADAP dispensing fees (e.g. $5/Rx) in accordance with RWGA business rules for those ADAP clients who are unable to pay the ADAP dispensing fee. **Medical Case Management Services:** Services include screening all primary medical care patients to determine each patient's level of need for Medical Case Management services, performing a comprehensive assessment, including an assessment of the patient's health literary, and developing a medical service plan for each client that demonstrates a documented need for such services, monitoring medical service plan to ensure its implementation, and educating client regarding wellness, medication and health care appointment adherence. The Medical Case Manager serves as an advocate for the client and as a liaison with medical providers on behalf of the client. The Medical Case Manager ensures linkage to mental health, substance abuse and other client services as indicated by the medical service plan. **Service Linkage:** The purpose of Service Linkage is to assist clients with the procurement of needed services so that the problems associated with living with HIV are mitigated. Service Linkage is a working agreement between a client and a Service Linkage Worker for an indeterminate period, based on client need, during which information, referrals and service linkage are provided on an as-needed basis. Service Linkage assists clients who do not require the intensity of Medical Case Management per RWGA Quality Management guidelines. Service Linkage is both office-based and field based. Service Linkage Workers are expected to coordinate activities with referral sources where newly-diagnosed or not-in-care PLWHA may be identified, including 1:1 case conferences with testing site personnel to ensure the successful transition of referrals into Primary Care Services. Such incoming referral coordination includes meeting prospective clients at the referring Provider location in order to develop rapport with individuals prior to the individual's initial Primary Care appointment and ensuring such new intakes to Primary Care services have sufficient support to make the often difficult transition into ongoing primary medical care. Service Linkage also includes follow-up to re-engage lost-to-care patients. Lost-to-care patients are those patients who have not returned for scheduled appointments with Provider nor have provided Provider with updated information about their current Primary Medical Care provider (in the situation where patient may have obtained alternate service from another medical provider). Contractor must document efforts to re-engage lost-to-care patients prior to closing patients in the CPCDMS. Service Linkage

	extends the capability of existing programs by providing "hands-on" outreach and linkage to care services to those PLWHA who are not currently accessing primary medical care services. Service Linkage includes the issuance of bus pass vouchers and gas cards per published RWGA guidelines. Service Linkage complements and extends the service delivery capability of Medical Case Management services.
Agency Requirements:	**Providers and system must be Medicaid/Medicare certified.** **Eligibility and Benefits Coordination:** Contractor must implement consumer-friendly, culturally and linguistically appropriate new and ongoing patient eligibility verification and benefit coordination processes that ensure accountability with Ryan White Payer of Last Resort requirements while achieving maximum utilization of eligible benefits. Eligibility processes should provide clients with a meaningful understanding of their benefits, expected out-of-pocket expenses and other information needed to ensure full and continued participation in care. **LPAP Services:** Contractor must: Provide pharmacy services on-site or through an established contractual relationship that meets all requirements. Alternate (off-site) approaches must be approved prior to implementation by RWGA. Either directly, or via subcontract with an eligible 340B Pharmacy program entity, must: Ensure a comprehensive financial intake application to determine client eligibility for this program to insure that these funds are used as a last resort for purchase of medications. Ensure the documented capability of interfacing with the Texas HIV Medication Program operated by the Texas Department of State Health Services. This capability must be fully documented and is subject to independent verification by RWGA. Ensure medication assistance provided to clients does not duplicate services already being provided in the Houston area. The process for accomplishing this must be fully documented and is subject to independent verification by RWGA. Ensure, either directly or via a 340B Pharmacy Program Provider, at least 2 years of continuous documented experience in providing HIV/AIDS medication programs utilizing Ryan White Program or similar public sector funding. This experience must be documented and is subject to independent verification by RWGA. Ensure all medications are purchased via a qualified participant in the federal 340B Drug Pricing Program and Prime Vendor Program, administered by the HRSA Office of Pharmacy Affairs. Note: failure to maintain 340B or Prime Vendor drug pricing may result in a negative

	audit finding, cost disallowance or termination of contract awarded. Contractor must maintain 340B Program participation throughout the contract term. All eligible medications must be purchased in accordance with Program 340B guidelines and program requirements. Ensure Houston area HIV/AIDS service providers are informed of this program and how the client referral and enrollment processes functions. Contractor must maintain documentation of such marketing efforts. Implement a consistent process to enroll eligible patients in available pharmaceutical company Patient Assistance Programs prior to using Ryan White Part A funded LPAP resources. Ensure information regarding the program is provided to PLWHA, including historically under-served and unserved populations (e.g., African American, Hispanic/Latino, Asian, Native American, Pacific Islander) and women not currently obtaining prescribed HIV and HIV-related medications. Offer, at no charge to the client, delivery options for medication refills, including but not limited to courier, USPS or other package delivery service. **Case Management Operations and Supervision:** The Service Linkage Workers (SLW) and Medical Case Managers (MCM) must function within the clinical infrastructure of Contractor and receive ongoing supervision that meets or exceeds published Standards of Care. An MCM may supervise SLWs.
Staff Requirements:	Contractor is responsible for ensuring that services are provided by State licensed internal medicine and OB/GYN physicians, specialty care physicians, psychiatrists, registered nurses, nurse practitioners, vocational nurses, pharmacists, physician assistants, clinical nurse specialists, physician extenders with a colposcopy provider qualification, x-ray technologists, State licensed dieticians, licensed social worker and ancillary health care providers in accordance with appropriate State licensing and/or certification requirements and with knowledge and experience of HIV disease. In addition, Contractor must ensure the following staff requirements are met: **Outpatient Psychiatric Services:** Director of the Program must be a Board Certified Psychiatrist. Licensed and/or Certified allied health professionals (Licensed Psychologists, Physicians, Psychiatric Nurse Practitioners, Licensed Master Social Workers, Licensed Professional Counselors, Licensed Marriage and Family Therapists, Certified Alcohol and Drug Abuse Counselors, etc.) must be used in all treatment modalities. Documentation of the Director's credentials, licensures and certifications must be included in the proposal. Documentation of the Allied Health professional licensures and certifications must be included in the proposal appendices.

	Medication and Adherence Education: The program must utilize an RN, LVN, PA, NP, pharmacist or MD licensed by the State of Texas, who has at least two (2) years paid experience in the preceding five (5) years in HIV/AIDS care, to provide the educational services. Licensed social workers who have at least two (2) years paid experience in the preceding five (5) years in HIV/AIDS care may also provide adherence education and counseling. **Nutritional Assessment (primary care):** Services must be provided by a licensed registered dietician. Dieticians must have a minimum of two (2) years of experience providing nutritional assessment and counseling to PLWHA. **Medical Case Management:** The program must utilize a state licensed Social Worker to provide Medical Case Management Services. The Contractor must maintain the assigned number of Medical Case Management FTEs throughout the contract term. **Contractor must provide to RWGA the names of each Medical Case Manager and the individual assigned to supervise those Medical Case Managers by 03/30/15, and thereafter within 15 days after hire.** **Service Linkage:** The program must utilize Service Linkage Workers who have at a minimum a Bachelor's degree from an accredited college or university with a major in social or behavioral sciences. Documented paid work experience in providing client services to PLWHA may be substituted for the Bachelor's degree requirement on a 1:1 basis (1 year of documented paid experience may be substituted for 1 year of college). All Service Linkage Workers must have a minimum of one (1) year paid work experience with PLWHA. Contractor must maintain the assigned number of Service Linkage FTEs throughout the contract term. **Contractor must provide to RWGA the names of each Service Linkage Worker and the individual assigned to supervise those Service Linkage Workers by 03/30/15, and thereafter within 15 days after hire.** **Supervision of Case Managers:** The Service Linkage Workers and Medical Case Managers must function within the clinical infrastructure of Contractor and receive ongoing supervision that meets or exceeds Houston EMA/HSDA Part A/B Standards of Care for Service Linkage and Medical Case Management as applicable. An MCM may supervise SLWs.
Special Requirements:	**All primary medical care services must meet or exceed current United States DHHS Treatment Guidelines for the treatment and management of HIV disease.** Contractor must provide all required program components - Primary Medical Care, Medical Case Management, Service Linkage (non-medical Case Management) and Local Pharmacy Assistance Program (LPAP) services.

	Primary Medical Care Services: Services funded under this grant cannot be used to supplant insurance or Medicare/Medicaid reimbursements for such services. Clients eligible for such reimbursement may not be billed to this contract. Medicare and private insurance co-payments may be eligible for reimbursement under Ryan White Health Insurance Assistance (HINS) program guidelines. Patients needing such assistance should be referred to the local Ryan White-funded HINS provider for assistance. Under no circumstances may the Contractor bill the County for the difference between the reimbursement from Medicaid, Medicare or Third Party insurance and the fee schedule under the contract. Furthermore, potential clients who are Medicaid/Medicare eligible or have other Third Party payers may not be denied services or referred elsewhere by the Contractor based on their reimbursement status (i.e. Medicaid/Medicare eligible clients may not be referred elsewhere in order that non-Medicaid/Medicare eligible clients may be added to the contract). Failure to serve Medicaid/Medicare eligible clients based on their reimbursement status will be grounds for the immediate termination of contract. **For primary medical care services targeted to the Latino community at least 50% of the clinical care team must be fluent in Spanish.** **Diagnostic Procedures:** A single Diagnostic Procedure limited to procedures on the approved list of diagnostic procedures (see below) without prior County approval. Approved diagnostic procedures will be reimbursed at invoice cost. Part A and Part A/MAI-funded programs must refer to the RWGA website for the most current list of approved diagnostic procedures and corresponding codes: www.hcphes.org/rwga. **Diagnostic procedures not listed on the website must have prior approval by RWGA.** **Outpatient Psychiatric Services:** Client must not be eligible for services from other programs/providers or any other reimbursement source (i.e. Medicaid, Medicare, private insurance) unless the client is in crisis and cannot be provided immediate services from the other programs/providers. In this case, clients may be provided services, as long as the client applies for the other programs/providers, until the other programs/providers can take over services. Program must be supervised by a Psychiatrist and include diagnostic assessments, emergency evaluations and psycho-pharmacotherapy. **Maintaining Referral Relationships** (Point of Entry Agreements): Contractor must maintain appropriate relationships with entities that constitute key points of access to the health care system for individuals with HIV disease, including but not limited to, Harris Health System and other Houston EMA-located emergency rooms, Harris County Jail, Texas Department of Criminal Justice incarceration facilities, Immigration detention centers, substance abuse treatment and detoxification programs, adult and juvenile detention facilities, Sexually Transmitted Disease clinics, federally qualified health centers (FQHC), HIV disease

	counseling and testing sites, mental health programs and homeless shelters. These referral relationships must be documented with written collaborative agreements, contracts or memoranda of understanding between Contractor and appropriate point of entry entities and are subject to audit by RWGA. Contractor and POE entity staff must regularly (e.g. weekly, bi-weekly depending on volume of referrals) meet 1:1 to discuss new referrals to primary medical care services. Such case conferences must be documented in the client record and properly entered into the CPCDMS. Use of CPCDMS Data System: Contractor must comply with CPCDMS business rules and procedures. Contractor must enter into the CPCDMS all required clinical data, including but not limited to, HAART treatment including all changes in medication regimens, Opportunistic Infections, screening and treatment for STDs and Hepatitis A, B, C and other clinical screening and treatment data required by HRSA, TDSHS and the County. Contractor must perform Registration updates in accordance with RWGA CPCDMS business rules for all clients wherein Contractor is client's CPCDMS record-owning agency. Contractor must utilize an electronic verification system to verify insurance/3rd party payer status monthly or per visit (whichever is less frequent). **Bus Pass Distribution:** The County will provide Contractor with METRO bus pass vouchers. Bus Pass vouchers must be distributed in accordance with RWGA policies and procedures, standards of care and financial eligibility guidelines. Contractor may only issue METRO bus pass vouchers to clients wherein the Contractor is the CPCDMS record owning Contractor. METRO bus pass vouchers shall be distributed as follows: **Expiration of Current Bus Pass:** In those situation wherein the bus pass expiration date does not coincide with the CPCDMS registration update the Contractor must distribute METRO bus pass vouchers to eligible clients upon the expiration of the current bus pass or when a Value-based bus card has been expended on eligible transportation needs. Contractor may issue METRO bus passes to eligible clients living outside the METRO service area in those situations where the Contractor has documented in the client record that the client will utilize the METRO system to access needed HIV-related health care services located in the METRO service area. **Gas Cards:** Primary Medical Care Contractors must distribute gasoline vouchers to eligible clients residing in the rural service area in accordance with RWGA policies and procedures, standards of care and financial eligibility guidelines. Gas Cards are only available to Rural primary medical care Contractors without prior approval by RWGA.

FY 2020 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/13/19**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/06/19**
Recommendations:	Approved: Y:____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Improvement Committee**		Date: **05/14/19**
Recommendations:	Approved: Y:____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMN Workgroup #1**	Date: **04/23/19**
Recommendations:	Financial Eligibility: 300% (None, None, 300% non-HIV, 500% HIV meds)
1. Accept the service definition as presented, update the justification chart, and keep the financial eligibility the same.	
2.	
3.	

FY 2015 Houston EMA Ryan White Part A/MAI Service Definition **Comprehensive Outpatient Primary Medical Care including Medical Case Management, Service Linkage and Local Pharmacy Assistance Program (LPAP) Services** (Revision Date: 5/21/15)	
HRSA Service Category Title: **RWGA Only**	1. Outpatient/Ambulatory Medical Care 2. Medical Case Management 3. AIDS Pharmaceutical Assistance (local) 4. Case Management (non-Medical)
Local Service Category Title:	Adult Comprehensive Primary Medical Care i. Targeted to Public Clinic ii. Targeted to Women at Public Clinic
Amount Available: **RWGA Only**	Total estimated available funding: $0.00 (to be determined) # 1. Primary Medical Care: $0.00 (including MAI) i. Targeted to Public Clinic: $0.00 ii. Targeted to Women at Public Clinic: $0.00 2. LPAP $0.00 3. Medical Case Management: $0.00 i. Targeted to Public Clinic: $0.00 ii. Targeted to Women at Public Clinic: $0.00 4. Service Linkage: $0.00 Note: The Houston Ryan White Planning Council (RWPC) determines annual Part A and MAI service category allocations & reallocations. RWGA has sole authority over contract award amounts.#
Target Population:	Comprehensive Primary Medical Care – Community Based i. Targeted to Public Clinic ii. Targeted to Women at Public Clinic
Client Eligibility: Age, Gender, Race, Ethnicity, Residence, etc.	PLWHA residing in the Houston EMA (prior approval required for non-EMA clients). Contractor must adhere to Targeting requirements and Budget limitations as applicable.#
Financial Eligibility:	Refer to the RWPC's approved *Financial Eligibility for Houston EMA/HSDA Services.*
Budget Type: **RWGA Only**	Hybrid Fee for Service#
Budget Requirement or Restrictions: **RWGA Only**	**Primary Medical Care:** 100% of clients served under the *Targeted to Women at Public Clinic* subcategory must be female 10% of funds designated to primary medical care must be reserved for invoicing diagnostic procedures at actual cost. Contractors may not exceed the allocation for each individual service component (Primary Medical Care, Medical Case Management, Local Pharmacy Assistance Program and Service Linkage) without prior approval from RWGA. # **Local Pharmacy Assistance Program (LPAP):** Houston RWPC guidelines for Local Pharmacy Assistance Program

	(LPAP) services: Contractor shall offer HIV medications from an approved formulary for a total not to exceed $18,000 per contract year per client. Contractor shall offer HIV-related medications for a total not to exceed $3,000 per contract year per client. These guidelines are determined by the RWPC. The RWPC determines the subcategories that shall include Ryan White LPAP funding. Medications must be provided in accordance with Houston EMA guidelines, HRSA/HAB rules and regulations and applicable Office of Pharmacy Affairs 340B guidelines. At least 75% of the total amount of the budget for LPAP services must be solely allocated to the actual cost of medications and may not include any storage, administrative, processing or other costs associated with managing the medication inventory or distribution.#
Service Unit Definition/s: **RWGA Only**	• Outpatient/Ambulatory Medical Care: One (1) unit of service = One (1) primary care office/clinic visit which includes the following: • Primary care physician/nurse practitioner, physician's assistant or clinical nurse specialist examination of the patient, and • Medication/treatment education • Medication access/linkage • OB/GYN specialty procedures (as clinically indicated) • Nutritional assessment (as clinically indicated) • Laboratory (as clinically indicated, not including specialized tests) • Radiology (as clinically indicated, not including CAT scan or MRI) • Eligibility verification/screening (as necessary) • Follow-up visits wherein the patient is not seen by the MD/NP/PA are considered to be a component of the original primary care visit. • Outpatient Psychiatric Services: 1 unit of service = A single (1) office/clinic visit wherein the patient is seen by a State licensed and board-eligible Psychiatrist or qualified Psychiatric Nurse Practitioner. This visit may or may not occur on the same date as a primary care office visit. • Medication Education: 1 unit of service = A single pharmacy visit wherein a Ryan White eligible client is provided medication education services by a qualified pharmacist. This visit may or may not occur on the same date as a primary care office visit. Maximum reimbursement allowable for a medication education visit may not exceed $50.00 per visit. The visit must include at least one prescription medication being provided to clients. A maximum of one (1) Medication Education Visit may be provided to an individual client per day, regardless of the number of prescription medications provided. • Nutritional Assessment and Plan: 1 unit of service = A single comprehensive nutritional assessment and treatment plan performed by a Licensed, Registered Dietician initiated upon a physician's order. Does not include the provision of Supplements or other

	products (clients may be referred to the Ryan White funded Medical Nutritional Therapy provider for provision of medically necessary supplements). The nutritional assessment visit may or may not occur on the same date as a medical office visit. • AIDS Pharmaceutical Assistance (local): A unit of service = a transaction involving the filling of a prescription or any other allowable medication need ordered by a qualified medical practitioner. The transaction will involve at least one item being provided for the client, but can be any multiple. The cost of medications provided to the client must be invoiced at actual cost. • Medical Case Management: 1 unit of service = 15 minutes of direct medical case management services to an eligible PLWHA performed by a qualified medical case manager. • Service Linkage (non-Medical Case Management): 1 unit of service = 15 minutes of direct service linkage services to an eligible PLWHA performed by a qualified service linkage worker.
HRSA Service Category Definition: **RWGA Only**	• **Outpatient/Ambulatory medical care** is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings. Services includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies. • **AIDS Pharmaceutical Assistance (local)** includes local pharmacy assistance programs implemented by Part A or Part B Grantees to provide HIV/AIDS medications to clients. This assistance can be funded with Part A grant funds and/or Part B base award funds. Local pharmacy assistance programs are not funded with ADAP earmark funding. • **Medical Case Management** services (including treatment adherence) are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and

	support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication. • **Case Management (non-Medical)** includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does.
Standards of Care:	Contractors must adhere to the most current published Part A/B Standards of Care for the Houston EMA/HSDA. **Services must meet or exceed applicable United States Department of Health and Human Services (DHHS) guidelines for the Treatment of HIV/AIDS.**#
Local Service Category Definition/Services to be Provided:	**Outpatient/Ambulatory Primary Medical Care:** Services include on-site physician, physician extender, nursing, phlebotomy, radiographic, laboratory, pharmacy, intravenous therapy, home health care referral, licensed dietician, patient medication education, and patient care coordination. The Contractor must provide continuity of care with inpatient services and subspecialty services (either on-site or through specific referral to appropriate medical provider upon primary care Physician's order). Services provided to women shall further include OB/GYN physician & physician extender services on-site or by referral, OB/GYN services, colposcopy, nursing, phlebotomy, radiographic, laboratory, pharmacy, intravenous therapy, home health care referral, licensed dietician, patient medication/women's health education, patient care coordination, and social services. The Contractor must provide continuity of care with inpatient services and subspecialty services (either on-site or through specific referral protocols to appropriate agencies upon primary care Physician's order). **Outpatient/Ambulatory Primary Medical Care must provide:** • Continuity of care for all stages of adult HIV infection; • Laboratory and pharmacy services including intravenous medications (either on-site or through established referral systems); • Outpatient psychiatric care, including lab work necessary for the prescribing of psychiatric medications when appropriate (either on-

	site or through established referral systems); • Access to the Texas ADAP program (either on-site or through established referral systems); • Access to compassionate use HIV medication programs (either directly or through established referral systems); • Access to HIV related research protocols (either directly or through established referral systems); • Must at a minimum, comply with Houston EMA/HSDA Part A/B Standards for HIV Primary Medical Care. The Contractor must demonstrate on an ongoing basis the ability to provide state-of-the-art HIV-related primary care medicine in accordance with the most recent DHHS HIV treatment guidelines. Rapid advances in HIV treatment protocols require that the Contractor provide services that to the greatest extent possible maximize a patient's opportunity for long-term survival and maintenance of the highest quality of life possible. • On-site Outpatient Psychiatry services. • On-site Medical Case Management services. • On-site Medication Education. • Physical therapy services (either on-site or via referral). • Specialty Clinic Referrals (either on-site or via referral). • On-site pelvic exams as needed for female patients with appropriate follow-up treatment and referral. • On site Nutritional Counseling by a Licensed Dietitian. **Women's Services must also provide:** • Well woman care, including but not limited to: PAP, pelvic exam, HPV screening, breast examination, mammography, hormone replacement and education, pregnancy testing, contraceptive services excluding birth control medications. • Obstetric Care: ante-partum through post-partum services, child birth/delivery services. Perinatal preventative education and treatment. • On-site or by referral Colposcopy exams as needed, performed by an OB/GYN physician, or physician extender with a colposcopy provider qualification. • Social services, including but not limited to, providing women access to child care, transportation vouchers, food vouchers and support groups at the clinic site; **Nutritional Assessment:** Services include provision of information about therapeutic nutritional/supplemental foods that are beneficial to the wellness and increased health conditions of clients by a Licensed Dietitian. Services may be provided either through educational or counseling sessions. Clients who receive these services may utilize the Ryan White Part A-funded nutritional supplement provider to obtain recommended nutritional supplements in accordance with program rules.

	Clients are limited to one (1) nutritional assessment per calendar year without prior approval of RWGA. Patient Medication Education Services must adhere to the following requirements: • Medication Educators must be State Licensed Medical Doctor (MD), Nurse Practitioner (NP), Physician Assistant PA), Nurse (RN, LVN) or Pharmacist. Prior approval must be obtained prior to utilizing any other health care professional not listed above to provide medication education. • Clients who will be prescribed ongoing medical regimens (i.e. ART) must be assessed for adherence to treatment at every clinical encounter using the EMA's approved adherence assessment tool. Clients with adherence issues related to lack of understanding must receive more education regarding their medical regimen. Clients with adherence issues that are behavioral or involve mental health issues must be provided counseling by the Medical Case Manager, Physician or Physician Extender and/or licensed nursing staff and, if clinically indicated, assessment and treatment by a qualified Psychiatrist or Psychiatric Nurse Practitioner. **Outpatient Psychiatric Services:** The program must provide: • Diagnostic Assessments: comprehensive evaluation for identification of psychiatric disorders, mental status evaluation, differential diagnosis which may involve use of other clinical and laboratory tests, case formulation, and treatment plans or disposition. • Emergency Psychiatric Services: rapid evaluation, differential diagnosis, acute treatment, crisis intervention, and referral. Must be available on a 24 hour basis including emergency room referral. • Brief Psychotherapy: individual, supportive, group, couple, family, hypnosis, biofeedback, and other psychophysiological treatments and behavior modification. • Psychopharmacotherapy: evaluation and medication treatment of psychiatric disorders, including, but not limited to, anxiety disorders, major depression, pain syndromes, habit control problems, psychosis and organic mental disorders. • Rehabilitation Services: Physical, psychosocial, behavioral, and/or cognitive training. Screening for Eye Disorders: Contractor must ensure that patients receive appropriate screening and treatment for CMV, glaucoma, cataracts, and other related problems. **Local Medication Assistance Program (LPAP):** LPAP provides pharmaceuticals to patients otherwise ineligible for medications through

	private insurance, Medicaid/Medicare, State ADAP, SPAP or other sources. Allowable medications are only those on the Houston EMA Ryan White Part A Formulary. Eligible clients may be provided Fuzeon™ on a case-by-case basis with prior approval of Ryan White Grant Administration (RWGA). The cost of Fuzeon™ does not count against a client's annual maximum. HIV-related medication services are the provision of physician or physician-extender prescribed HIV-related medications to prevent serious deterioration of health. Does not include drugs available to the patient from other programs or payers or free of charge (such as birth control and TB medications) or medications available over the counter (OTC) without prescription. Contractor must offer all medications on the Texas ADAP formulary, for a total not to exceed $18,000.00 per contract year per client. Contractor must provide allowable HIV-related medications (i.e. non-HIV medications) for a total not to exceed $3,000 per contract year per client. Contractor may be reimbursed ADAP dispensing fees (e.g. $5/Rx) in accordance with RWGA business rules for those ADAP clients who are unable to pay the ADAP dispensing fee. **Medical Case Management Services:** Services include screening all primary medical care patients to determine each patient's level of need for Medical Case Management services, performing a comprehensive assessment, including an assessment of the patient's health literary, and developing a medical service plan for each client that demonstrates a documented need for such services, monitoring medical service plan to ensure its implementation, and educating client regarding wellness, medication and health care appointment adherence. The Medical Case Manager serves as an advocate for the client and as a liaison with medical providers on behalf of the client. The Medical Case Manager ensures linkage to mental health, substance abuse and other client services as indicated by the medical service plan. **Service Linkage:** The purpose of Service Linkage is to assist clients with the procurement of needed services so that the problems associated with living with HIV are mitigated. Service Linkage is a working agreement between a client and a Service Linkage Worker for an indeterminate period, based on client need, during which information, referrals and service linkage are provided on an as-needed basis. Service Linkage assists clients who do not require the intensity of Medical Case Management per RWGA Quality Management guidelines. Service Linkage is both office-based and field based. Service Linkage Workers are expected to coordinate activities with referral sources where newly-diagnosed or not-in-care PLWHA may be identified, including 1:1 case conferences with testing site personnel to ensure the successful transition of referrals into Primary Care Services. Such incoming referral coordination includes meeting prospective clients at the referring Provider location in order to develop rapport with individuals prior to the individual's initial Primary Care appointment and ensuring such new

	intakes to Primary Care services have sufficient support to make the often difficult transition into ongoing primary medical care. Service Linkage also includes follow-up to re-engage lost-to-care patients. Lost-to-care patients are those patients who have not returned for scheduled appointments with Provider nor have provided Provider with updated information about their current Primary Medical Care provider (in the situation where patient may have obtained alternate service from another medical provider). Contractor must document efforts to re-engage lost-to-care patients prior to closing patients in the CPCDMS. Service Linkage extends the capability of existing programs by providing "hands-on" outreach and linkage to care services to those PLWHA who are not currently accessing primary medical care services. Service Linkage includes the issuance of bus pass vouchers and gas cards per published RWGA guidelines. Service Linkage complements and extends the service delivery capability of Medical Case Management services.#
Agency Requirements:#	**Providers and system must be Medicaid/Medicare certified.** **Eligibility and Benefits Coordination:** Contractor must implement consumer-friendly, culturally and linguistically appropriate new and ongoing patient eligibility verification and benefit coordination processes that ensure accountability with Ryan White Payer of Last Resort requirements while achieving maximum utilization of eligible benefits. Eligibility processes should provide clients with a meaningful understanding of their benefits, expected out-of-pocket expenses and other information needed to ensure full and continued participation in care. **LPAP Services:** Contractor must: Provide pharmacy services on-site or through an established contractual relationship that meets all requirements. Alternate (off-site) approaches must be approved prior to implementation by RWGA. Either directly, or via subcontract with an eligible 340B Pharmacy program entity, must: Ensure a comprehensive financial intake application to determine client eligibility for this program to insure that these funds are used as a last resort for purchase of medications. Ensure the documented capability of interfacing with the Texas HIV Medication Program operated by the Texas Department of State Health Services. This capability must be fully documented and is subject to independent verification by RWGA. Ensure medication assistance provided to clients does not duplicate services already being provided in the Houston area. The process for accomplishing this must be fully documented and is subject to independent verification by RWGA. Ensure, either directly or via a 340B Pharmacy Program Provider, at least

	2 years of continuous documented experience in providing HIV/AIDS medication programs utilizing Ryan White Program or similar public sector funding. This experience must be documented and is subject to independent verification by RWGA. Ensure all medications are purchased via a qualified participant in the federal 340B Drug Pricing Program and Prime Vendor Program, administered by the HRSA Office of Pharmacy Affairs. Note: failure to maintain 340B or Prime Vendor drug pricing may result in a negative audit finding, cost disallowance or termination of contract awarded. Contractor must maintain 340B Program participation throughout the contract term. All eligible medications must be purchased in accordance with Program 340B guidelines and program requirements. Ensure Houston area HIV/AIDS service providers are informed of this program and how the client referral and enrollment processes functions. Contractor must maintain documentation of such marketing efforts. Implement a consistent process to enroll eligible patients in available pharmaceutical company Patient Assistance Programs prior to using Ryan White Part A funded LPAP resources. Ensure information regarding the program is provided to PLWHA, including historically under-served and unserved populations (e.g., African American, Hispanic/Latino, Asian, Native American, Pacific Islander) and women not currently obtaining prescribed HIV and HIV-related medications. Offer, at no charge to the client, delivery options for medication refills, including but not limited to courier, USPS or other package delivery service. **Case Management Operations and Supervision:** The Service Linkage Workers (SLW) and Medical Case Managers (MCM) must function within the clinical infrastructure of Contractor and receive ongoing supervision that meets or exceeds published Standards of Care. An MCM may supervise SLWs.#
Staff Requirements:#	Contractor is responsible for ensuring that services are provided by State licensed internal medicine and OB/GYN physicians, specialty care physicians, psychiatrists, registered nurses, nurse practitioners, vocational nurses, pharmacists, physician assistants, clinical nurse specialists, physician extenders with a colposcopy provider qualification, x-ray technologists, State licensed dieticians, licensed social worker and ancillary health care providers in accordance with appropriate State licensing and/or certification requirements and with knowledge and experience of HIV disease. In addition, Contractor must ensure the following staff requirements are met: **Outpatient Psychiatric Services:** Director of the Program must be a Board Certified Psychiatrist. Licensed and/or Certified allied health

	professionals (Licensed Psychologists, Physicians, Psychiatric Nurse Practitioners, Licensed Master Social Workers, Licensed Professional Counselors, Licensed Marriage and Family Therapists, Certified Alcohol and Drug Abuse Counselors, etc.) must be used in all treatment modalities. Documentation of the Director's credentials, licensures and certifications must be included in the proposal. Documentation of the Allied Health professional licensures and certifications must be included in the proposal appendices. **Medication and Adherence Education:** The program must utilize an RN, LVN, PA, NP, pharmacist or MD licensed by the State of Texas, who has at least two (2) years paid experience in the preceding five (5) years in HIV/AIDS care, to provide the educational services. Licensed social workers who have at least two (2) years paid experience in the preceding five (5) years in HIV/AIDS care may also provide adherence education and counseling. **Nutritional Assessment (primary care):** Services must be provided by a licensed registered dietician. Dieticians must have a minimum of two (2) years of experience providing nutritional assessment and counseling to PLWHA. **Medical Case Management:** The program must utilize a state licensed Social Worker to provide Medical Case Management Services. The Contractor must maintain the assigned number of Medical Case Management FTEs throughout the contract term. **Contractor must provide to RWGA the names of each Medical Case Manager and the individual assigned to supervise those Medical Case Managers by 03/30/15, and thereafter within 15 days after hire.** **Service Linkage:** The program must utilize Service Linkage Workers who have at a minimum a Bachelor's degree from an accredited college or university with a major in social or behavioral sciences. Documented paid work experience in providing client services to PLWHA may be substituted for the Bachelor's degree requirement on a 1:1 basis (1 year of documented paid experience may be substituted for 1 year of college). All Service Linkage Workers must have a minimum of one (1) year paid work experience with PLWHA. Contractor must maintain the assigned number of Service Linkage FTEs throughout the contract term. **Contractor must provide to RWGA the names of each Service Linkage Worker and the individual assigned to supervise those Service Linkage Workers by 03/30/15, and thereafter within 15 days after hire.** **Supervision of Case Managers:** The Service Linkage Workers and Medical Case Managers must function within the clinical infrastructure of Contractor and receive ongoing supervision that meets or exceeds Houston EMA/HSDA Part A/B Standards of Care for Service Linkage and Medical Case Management as applicable. An MCM may supervise

	SLWs.#
Special Requirements: **RWGA Only** #	**All primary medical care services must meet or exceed current United States DHHS Treatment Guidelines for the treatment and management of HIV disease.** Contractor must provide all required program components - Primary Medical Care, Medical Case Management, Service Linkage (non-medical Case Management) and Local Pharmacy Assistance Program (LPAP) services. **Primary Medical Care Services:** Services funded under this grant cannot be used to supplant insurance or Medicare/Medicaid reimbursements for such services. Clients eligible for such reimbursement may not be billed to this contract. Medicare and private insurance co-payments may be eligible for reimbursement under Ryan White Health Insurance Assistance (HINS) program guidelines. Patients needing such assistance should be referred to the local Ryan White-funded HINS provider for assistance. Under no circumstances may the Contractor bill the County for the difference between the reimbursement from Medicaid, Medicare or Third Party insurance and the fee schedule under the contract. Furthermore, potential clients who are Medicaid/Medicare eligible or have other Third Party payers may not be denied services or referred elsewhere by the Contractor based on their reimbursement status (i.e. Medicaid/Medicare eligible clients may not be referred elsewhere in order that non-Medicaid/Medicare eligible clients may be added to the contract). Failure to serve Medicaid/Medicare eligible clients based on their reimbursement status will be grounds for the immediate termination of contract. **Diagnostic Procedures:** A single Diagnostic Procedure limited to procedures on the approved list of diagnostic procedures (see below) without prior County approval. Approved diagnostic procedures will be reimbursed at invoice cost. Part A and Part A/MAI-funded programs must refer to the RWGA website for the most current list of approved diagnostic procedures and corresponding codes: www.hcphes.org/rwga. **Diagnostic procedures not listed on the website must have prior approval by RWGA.** **Outpatient Psychiatric Services:** Client must not be eligible for services from other programs/providers or any other reimbursement source (i.e. Medicaid, Medicare, private insurance) unless the client is in crisis and cannot be provided immediate services from the other programs/providers. In this case, clients may be provided services, as long as the client applies for the other programs/providers, until the other programs/providers can take over services. Program must be supervised by a Psychiatrist and include diagnostic assessments, emergency evaluations and psycho-pharmacotherapy. **Maintaining Referral Relationships** (Point of Entry Agreements):

	Contractor must maintain appropriate relationships with entities that constitute key points of access to the health care system for individuals with HIV disease, including but not limited to, Harris Health System and other Houston EMA-located emergency rooms, Harris County Jail, Texas Department of Criminal Justice incarceration facilities, Immigration detention centers, substance abuse treatment and detoxification programs, adult and juvenile detention facilities, Sexually Transmitted Disease clinics, federally qualified health centers (FQHC), HIV disease counseling and testing sites, mental health programs and homeless shelters. These referral relationships must be documented with written collaborative agreements, contracts or memoranda of understanding between Contractor and appropriate point of entry entities and are subject to audit by RWGA. Contractor and POE entity staff must regularly (e.g. weekly, bi-weekly depending on volume of referrals) meet 1:1 to discuss new referrals to primary medical care services. Such case conferences must be documented in the client record and properly entered into the CPCDMS. Use of CPCDMS Data System: Contractor must comply with CPCDMS business rules and procedures. Contractor must enter into the CPCDMS all required clinical data, including but not limited to, HAART treatment including all changes in medication regimens, Opportunistic Infections, screening and treatment for STDs and Hepatitis A, B, C and other clinical screening and treatment data required by HRSA, TDSHS and the County. Contractor must perform Registration updates in accordance with RWGA CPCDMS business rules for all clients wherein Contractor is client's CPCDMS record-owning agency. Contractor must utilize an electronic verification system to verify insurance/3rd party payer status monthly or per visit (whichever is less frequent). **Bus Pass Distribution:** The County will provide Contractor with METRO bus pass vouchers. Bus Pass vouchers must be distributed in accordance with RWGA policies and procedures, standards of care and financial eligibility guidelines. Contractor may only issue METRO bus pass vouchers to clients wherein the Contractor is the CPCDMS record owning Contractor. METRO bus pass vouchers shall be distributed as follows: **Expiration of Current Bus Pass:** In those situation wherein the bus pass expiration date does not coincide with the CPCDMS registration update the Contractor must distribute METRO bus pass vouchers to eligible clients upon the expiration of the current bus pass or when a Value-based bus card has been expended on eligible transportation needs. Contractor may issue METRO bus passes to eligible clients living outside the METRO service area in those situations where the Contractor has documented in the client record that the client will utilize the METRO system to access needed HIV-related health care services located in the METRO service area. **Gas Cards:** Primary Medical Care Contractors must distribute gasoline

	vouchers to eligible clients residing in the rural service area in accordance with RWGA policies and procedures, standards of care and financial eligibility guidelines. Gas Cards are only available to Rural primary medical care Contractors without prior approval by RWGA.#

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FY 2020 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/13/19**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/06/19**
Recommendations:	Approved: Y:____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Improvement Committee**		Date: **05/14/19**
Recommendations:	Approved: Y:____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMN Workgroup #1**	Date: **04/23/19**
Recommendations:	Financial Eligibility: 300% (None, None, 300% non-HIV, 500% HIV meds)
1. Accept the service definition as presented, update the justification chart, and keep the financial eligibility the same.	
2.	
3.	

FY 2015 Houston EMA Ryan White Part A/MAI Service Definition **Comprehensive Outpatient Primary Medical Care including Medical Case Management, Service Linkage and Local Pharmacy Assistance Program (LPAP) Services - Rural** (Revision Date: 5/21/15)	
HRSA Service Category Title: **RWGA Only**	1. Outpatient/Ambulatory Medical Care 2. Medical Case Management 3. AIDS Pharmaceutical Assistance (local) 4. Case Management (non-Medical)
Local Service Category Title:	Adult Comprehensive Primary Medical Care - Targeted to Rural
Amount Available: **RWGA Only**	Total estimated available funding: $0.00 (to be determined) # 1. Primary Medical Care: $0.00 2. LPAP $0.00 3. Medical Case Management: $0.00 4. Service Linkage: $0.00 Note: The Houston Ryan White Planning Council (RWPC) determines overall annual Part A and MAI service category allocations & reallocations. RWGA has sole authority over contract award amounts.#
Target Population:	Comprehensive Primary Medical Care – Targeted to Rural
Client Eligibility: Age, Gender, Race, Ethnicity, Residence, etc.	PLWHA residing in the Houston EMA/HSDA counties **other than Harris County** (prior approval required for non-EMA clients). Contractor must adhere to Targeting requirements and Budget limitations as applicable.#
Financial Eligibility:	*See FY 2015 Approved Financial Eligibility for Houston EMA/HSDA*
Budget Type: **RWGA Only**	Hybrid Fee for Service#
Budget Requirement or Restrictions: **RWGA Only**	**Primary Medical Care:** No less than 75% of clients served in a Targeted subcategory must be members of the targeted population with the following exceptions: 10% of funds designated to primary medical care must be reserved for invoicing diagnostic procedures at actual cost. Contractors may not exceed the allocation for each individual service component (Primary Medical Care, Medical Case Management, Local Pharmacy Assistance Program and Service Linkage) without prior approval from RWGA. # **Local Pharmacy Assistance Program (LPAP):** Houston RWPC guidelines for Local Pharmacy Assistance Program (LPAP) services: Contractor shall offer HIV medications from an approved formulary for a total not to exceed $18,000 per contract year per client. Contractor shall offer HIV-related medications for a total not to exceed $3,000 per contract year per client. These guidelines are determined by the RWPC. The RWPC determines the subcategories that shall include Ryan White LPAP funding. Medications must be provided in accordance with Houston EMA guidelines, HRSA/HAB rules and regulations and applicable Office of Pharmacy Affairs 340B guidelines.

	At least 75% of the total amount of the budget for LPAP services must be solely allocated to the actual cost of medications and may not include any storage, administrative, processing or other costs associated with managing the medication inventory or distribution.#
Service Unit Definition/s:	• Outpatient/Ambulatory Medical Care: One (1) unit of service = One (1) primary care office/clinic visit which includes the following: • Primary care physician/nurse practitioner, physician's assistant or clinical nurse specialist examination of the patient, and • Medication/treatment education • Medication access/linkage • OB/GYN specialty procedures (as clinically indicated) • Nutritional assessment (as clinically indicated) • Laboratory (as clinically indicated, not including specialized tests) • Radiology (as clinically indicated, not including CAT scan or MRI) • Eligibility verification/screening (as necessary) • Follow-up visits wherein the patient is not seen by the MD/NP/PA are considered to be a component of the original primary care visit. • Outpatient Psychiatric Services: 1 unit of service = A single (1) office/clinic visit wherein the patient is seen by a State licensed and board-eligible Psychiatrist or qualified Psychiatric Nurse Practitioner. This visit may or may not occur on the same date as a primary care office visit. • Nutritional Assessment and Plan: 1 unit of service = A single comprehensive nutritional assessment and treatment plan performed by a Licensed, Registered Dietician initiated upon a physician's order. Does not include the provision of Supplements or other products (clients may be referred to the Ryan White funded Medical Nutritional Therapy provider for provision of medically necessary supplements). The nutritional assessment visit may or may not occur on the same date as a medical office visit. • AIDS Pharmaceutical Assistance (local): A unit of service = a transaction involving the filling of a prescription or any other allowable medication need ordered by a qualified medical practitioner. The transaction will involve at least one item being provided for the client, but can be any multiple. The cost of medications provided to the client must be invoiced at actual cost. • Medical Case Management: 1 unit of service = 15 minutes of direct medical case management services to an eligible PLWHA performed by a qualified medical case manager. • Service Linkage (non-Medical Case Management): 1 unit of service = 15 minutes of direct service linkage services to an eligible PLWHA performed by a qualified service linkage worker.
HRSA Service Category Definition: **RWGA Only**	• **Outpatient/Ambulatory medical care** is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Settings include clinics,

	medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings. Services includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies. • **AIDS Pharmaceutical Assistance (local)** includes local pharmacy assistance programs implemented by Part A or Part B Grantees to provide HIV/AIDS medications to clients. This assistance can be funded with Part A grant funds and/or Part B base award funds. Local pharmacy assistance programs are not funded with ADAP earmark funding. • **Medical Case Management** services (including treatment adherence) are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication. • **Case Management (non-Medical)** includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does.

Standards of Care:	Contractors must adhere to the most current published Part A/B Standards of Care for the Houston EMA/HSDA. **Services must meet or exceed applicable United States Department of Health and Human Services (DHHS) guidelines for the Treatment of HIV/AIDS.**#
Local Service Category Definition/Services to be Provided:	**Outpatient/Ambulatory Primary Medical Care:** Services include on-site physician, physician extender, nursing, phlebotomy, radiographic, laboratory, pharmacy, intravenous therapy, home health care referral, licensed dietician, patient medication education, and patient care coordination. The Contractor must provide continuity of care with inpatient services and subspecialty services (either on-site or through specific referral to appropriate medical provider upon primary care Physician's order). Services provided to women shall further include OB/GYN physician & physician extender services on-site or by referral, OB/GYN services, colposcopy, nursing, phlebotomy, radiographic, laboratory, pharmacy, intravenous therapy, home health care referral, licensed dietician, patient medication/women's health education, patient care coordination, and social services. The Contractor must provide continuity of care with inpatient services and subspecialty services (either on-site or through specific referral protocols to appropriate agencies upon primary care Physician's order). **Outpatient/Ambulatory Primary Medical Care must provide:** • Continuity of care for all stages of adult HIV infection; • Laboratory and pharmacy services including intravenous medications (either on-site or through established referral systems); • Outpatient psychiatric care, including lab work necessary for the prescribing of psychiatric medications when appropriate (either on-site or through established referral systems); • Access to the Texas ADAP program (either on-site or through established referral systems); • Access to compassionate use HIV medication programs (either directly or through established referral systems); • Access to HIV related research protocols (either directly or through established referral systems); • Must at a minimum, comply with Houston EMA/HSDA Part A/B Standards for HIV Primary Medical Care. The Contractor must demonstrate on an ongoing basis the ability to provide state-of-the-art HIV-related primary care medicine in accordance with the most recent DHHS HIV treatment guidelines. Rapid advances in HIV treatment protocols require that the Contractor provide services that to the greatest extent possible maximize a patient's opportunity for long-term survival and maintenance of the highest quality of life possible. • On-site Outpatient Psychiatry services.

	• On-site Medical Case Management services. • On-site Medication Education. • Physical therapy services (either on-site or via referral). • Specialty Clinic Referrals (either on-site or via referral). • On-site pelvic exams as needed for female patients with appropriate follow-up treatment and referral. • On site Nutritional Counseling by a Licensed Dietitian. **Services for women must also provide:** • Well woman care, including but not limited to: PAP, pelvic exam, HPV screening, breast examination, mammography, hormone replacement and education, pregnancy testing, contraceptive services excluding birth control medications. • Obstetric Care: ante-partum through post-partum services, child birth/delivery services. Perinatal preventative education and treatment. • On-site or by referral Colposcopy exams as needed, performed by an OB/GYN physician, or physician extender with a colposcopy provider qualification. • Social services, including but not limited to, providing women access to child care, transportation vouchers, food vouchers and support groups at the clinic site; **Nutritional Assessment:** Services include provision of information about therapeutic nutritional/supplemental foods that are beneficial to the wellness and increased health conditions of clients by a Licensed Dietitian. Services may be provided either through educational or counseling sessions. Clients who receive these services may utilize the Ryan White Part A-funded nutritional supplement provider to obtain recommended nutritional supplements in accordance with program rules. Clients are limited to one (1) nutritional assessment per calendar year without prior approval of RWGA. Patient Medication Education Services must adhere to the following requirements: • Medication Educators must be State Licensed Medical Doctor (MD), Nurse Practitioner (NP), Physician Assistant PA), Nurse (RN, LVN) or Pharmacist. Prior approval must be obtained prior to utilizing any other health care professional not listed above to provide medication education. • Clients who will be prescribed ongoing medical regimens (i.e. ART) must be assessed for adherence to treatment at every clinical encounter using the EMA's approved adherence assessment tool. Clients with adherence issues related to lack of understanding must receive more education regarding their medical regimen. Clients with adherence issues that are behavioral or involve mental health issues must be provided counseling by the Medical Case Manager,

Physician or Physician Extender and/or licensed nursing staff and, if clinically indicated, assessment and treatment by a qualified Psychiatrist or Psychiatric Nurse Practitioner.

Outpatient Psychiatric Services:
The program must provide:

- Diagnostic Assessments: comprehensive evaluation for identification of psychiatric disorders, mental status evaluation, differential diagnosis which may involve use of other clinical and laboratory tests, case formulation, and treatment plans or disposition.
- Emergency Psychiatric Services: rapid evaluation, differential diagnosis, acute treatment, crisis intervention, and referral. Must be available on a 24 hour basis including emergency room referral.
- Brief Psychotherapy: individual, supportive, group, couple, family, hypnosis, biofeedback, and other psychophysiological treatments and behavior modification.
- Psychopharmacotherapy: evaluation and medication treatment of psychiatric disorders, including, but not limited to, anxiety disorders, major depression, pain syndromes, habit control problems, psychosis and organic mental disorders.
- Rehabilitation Services: Physical, psychosocial, behavioral, and/or cognitive training.

Screening for Eye Disorders: Contractor must ensure that patients receive appropriate screening and treatment for CMV, glaucoma, cataracts, and other related problems.

Local Medication Assistance Program (LPAP): LPAP provides pharmaceuticals to patients otherwise ineligible for medications through private insurance, Medicaid/Medicare, State ADAP, SPAP or other sources. Allowable medications are only those on the Houston EMA Ryan White Part A Formulary. Eligible clients may be provided Fuzeon™ on a case-by-case basis with prior approval of Ryan White Grant Administration (RWGA). The cost of Fuzeon™ does not count against a client's annual maximum. HIV-related medication services are the provision of physician or physician-extender prescribed HIV-related medications to prevent serious deterioration of health. Does not include drugs available to the patient from other programs or payers or free of charge (such as birth control and TB medications) or medications available over the counter (OTC) without prescription.

Contractor must offer all medications on the Texas ADAP formulary, for a total not to exceed $18,000.00 per contract year per client. Contractor must provide allowable HIV-related medications (i.e. non-HIV medications) for a total not to exceed $3,000 per contract year per client. Contractor may be reimbursed ADAP dispensing fees (e.g. $5/Rx) in accordance with RWGA business rules for those ADAP clients who are

	unable to pay the ADAP dispensing fee. **Medical Case Management Services:** Services include screening all primary medical care patients to determine each patient's level of need for Medical Case Management services, performing a comprehensive assessment, including an assessment of the patient's health literary, and developing a medical service plan for each client that demonstrates a documented need for such services, monitoring medical service plan to ensure its implementation, and educating client regarding wellness, medication and health care appointment adherence. The Medical Case Manager serves as an advocate for the client and as a liaison with medical providers on behalf of the client. The Medical Case Manager ensures linkage to mental health, substance abuse and other client services as indicated by the medical service plan. **Service Linkage:** The purpose of Service Linkage is to assist clients with the procurement of needed services so that the problems associated with living with HIV are mitigated. Service Linkage is a working agreement between a client and a Service Linkage Worker for an indeterminate period, based on client need, during which information, referrals and service linkage are provided on an as-needed basis. Service Linkage assists clients who do not require the intensity of Medical Case Management per RWGA Quality Management guidelines. Service Linkage is both office-based and field based. Service Linkage Workers are expected to coordinate activities with referral sources where newly-diagnosed or not-in-care PLWHA may be identified, including 1:1 case conferences with testing site personnel to ensure the successful transition of referrals into Primary Care Services. Such incoming referral coordination includes meeting prospective clients at the referring Provider location in order to develop rapport with individuals prior to the individual's initial Primary Care appointment and ensuring such new intakes to Primary Care services have sufficient support to make the often difficult transition into ongoing primary medical care. Service Linkage also includes follow-up to re-engage lost-to-care patients. Lost-to-care patients are those patients who have not returned for scheduled appointments with Provider nor have provided Provider with updated information about their current Primary Medical Care provider (in the situation where patient may have obtained alternate service from another medical provider). Contractor must document efforts to re-engage lost-to-care patients prior to closing patients in the CPCDMS. Service Linkage extends the capability of existing programs by providing "hands-on" outreach and linkage to care services to those PLWHA who are not currently accessing primary medical care services. Service Linkage includes the issuance of bus pass vouchers and gas cards per published RWGA guidelines. Service Linkage complements and extends the service delivery capability of Medical Case Management services.#
Agency Requirements:#	**Providers and system must be Medicaid/Medicare certified.** **Eligibility and Benefits Coordination:** Contractor must implement

	consumer-friendly, culturally and linguistically appropriate new and ongoing patient eligibility verification and benefit coordination processes that ensure accountability with Ryan White Payer of Last Resort requirements while achieving maximum utilization of eligible benefits. Eligibility processes should provide clients with a meaningful understanding of their benefits, expected out-of-pocket expenses and other information needed to ensure full and continued participation in care. **LPAP Services:** Contractor must: Provide pharmacy services on-site or through an established contractual relationship that meets all requirements. Alternate (off-site) approaches must be approved prior to implementation by RWGA. Either directly, or via subcontract with an eligible 340B Pharmacy program entity, must: Ensure a comprehensive financial intake application to determine client eligibility for this program to insure that these funds are used as a last resort for purchase of medications. Ensure the documented capability of interfacing with the Texas HIV Medication Program operated by the Texas Department of State Health Services. This capability must be fully documented and is subject to independent verification by RWGA. Ensure medication assistance provided to clients does not duplicate services already being provided in the Houston area. The process for accomplishing this must be fully documented and is subject to independent verification by RWGA. Ensure, either directly or via a 340B Pharmacy Program Provider, at least 2 years of continuous documented experience in providing HIV/AIDS medication programs utilizing Ryan White Program or similar public sector funding. This experience must be documented and is subject to independent verification by RWGA. Ensure all medications are purchased via a qualified participant in the federal 340B Drug Pricing Program and Prime Vendor Program, administered by the HRSA Office of Pharmacy Affairs. Note: failure to maintain 340B or Prime Vendor drug pricing may result in a negative audit finding, cost disallowance or termination of contract awarded. Contractor must maintain 340B Program participation throughout the contract term. All eligible medications must be purchased in accordance with Program 340B guidelines and program requirements. Ensure Houston area HIV/AIDS service providers are informed of this program and how the client referral and enrollment processes functions. Contractor must maintain documentation of such marketing efforts.

	Implement a consistent process to enroll eligible patients in available pharmaceutical company Patient Assistance Programs prior to using Ryan White Part A funded LPAP resources. Ensure information regarding the program is provided to PLWHA, including historically under-served and unserved populations (e.g., African American, Hispanic/Latino, Asian, Native American, Pacific Islander) and women not currently obtaining prescribed HIV and HIV-related medications. Offer, at no charge to the client, delivery options for medication refills, including but not limited to courier, USPS or other package delivery service. **Case Management Operations and Supervision:** The Service Linkage Workers (SLW) and Medical Case Managers (MCM) must function within the clinical infrastructure of Contractor and receive ongoing supervision that meets or exceeds published Standards of Care. An MCM may supervise SLWs.#
Staff Requirements:#	Contractor is responsible for ensuring that services are provided by State licensed internal medicine and OB/GYN physicians, specialty care physicians, psychiatrists, registered nurses, nurse practitioners, vocational nurses, pharmacists, physician assistants, clinical nurse specialists, physician extenders with a colposcopy provider qualification, x-ray technologists, State licensed dieticians, licensed social worker and ancillary health care providers in accordance with appropriate State licensing and/or certification requirements and with knowledge and experience of HIV disease. In addition, Contractor must ensure the following staff requirements are met: **Outpatient Psychiatric Services:** Director of the Program must be a Board Certified Psychiatrist. Licensed and/or Certified allied health professionals (Licensed Psychologists, Physicians, Psychiatric Nurse Practitioners, Licensed Master Social Workers, Licensed Professional Counselors, Licensed Marriage and Family Therapists, Certified Alcohol and Drug Abuse Counselors, etc.) must be used in all treatment modalities. Documentation of the Director's credentials, licensures and certifications must be included in the proposal. Documentation of the Allied Health professional licensures and certifications must be included in the proposal appendices. **Medication and Adherence Education:** The program must utilize an RN, LVN, PA, NP, pharmacist or MD licensed by the State of Texas, who has at least two (2) years paid experience in the preceding five (5) years in HIV/AIDS care, to provide the educational services. Licensed social workers who have at least two (2) years paid experience in the preceding five (5) years in HIV/AIDS care may also provide adherence education and counseling.

	Nutritional Assessment (primary care): Services must be provided by a licensed registered dietician. Dieticians must have a minimum of two (2) years of experience providing nutritional assessment and counseling to PLWHA. **Medical Case Management:** The program must utilize a state licensed Social Worker to provide Medical Case Management Services. The Contractor must maintain the assigned number of Medical Case Management FTEs throughout the contract term. **Contractor must provide to RWGA the names of each Medical Case Manager and the individual assigned to supervise those Medical Case Managers by 03/30/15, and thereafter within 15 days after hire.** **Service Linkage:** The program must utilize Service Linkage Workers who have at a minimum a Bachelor's degree from an accredited college or university with a major in social or behavioral sciences. Documented paid work experience in providing client services to PLWHA may be substituted for the Bachelor's degree requirement on a 1:1 basis (1 year of documented paid experience may be substituted for 1 year of college). All Service Linkage Workers must have a minimum of one (1) year paid work experience with PLWHA. Contractor must maintain the assigned number of Service Linkage FTEs throughout the contract term. **Contractor must provide to RWGA the names of each Service Linkage Worker and the individual assigned to supervise those Service Linkage Workers by 03/30/15, and thereafter within 15 days after hire.** **Supervision of Case Managers:** The Service Linkage Workers and Medical Case Managers must function within the clinical infrastructure of Contractor and receive ongoing supervision that meets or exceeds Houston EMA/HSDA Part A/B Standards of Care for Service Linkage and Medical Case Management as applicable. An MCM may supervise SLWs.#
Special Requirements: **RWGA Only**	**All primary medical care services must meet or exceed current United States DHHS Treatment Guidelines for the treatment and management of HIV disease.** Contractor must provide all required program components - Primary Medical Care, Medical Case Management, Service Linkage (non-medical Case Management) and Local Pharmacy Assistance Program (LPAP) services. **Primary Medical Care Services:** Services funded under this grant cannot be used to supplant insurance or Medicare/Medicaid reimbursements for such services. Clients eligible for such reimbursement may not be billed to this contract. Medicare and private insurance co-payments may be eligible for reimbursement under Ryan White Health Insurance Assistance (HINS) program guidelines. Patients needing such assistance should be referred to the local Ryan White-

	funded HINS provider for assistance. Under no circumstances may the Contractor bill the County for the difference between the reimbursement from Medicaid, Medicare or Third Party insurance and the fee schedule under the contract. Furthermore, potential clients who are Medicaid/Medicare eligible or have other Third Party payers may not be denied services or referred elsewhere by the Contractor based on their reimbursement status (i.e. Medicaid/Medicare eligible clients may not be referred elsewhere in order that non-Medicaid/Medicare eligible clients may be added to the contract). Failure to serve Medicaid/Medicare eligible clients based on their reimbursement status will be grounds for the immediate termination of contract. **For primary medical care services targeted to the Latino community at least 50% of the clinical care team must be fluent in Spanish.** **Diagnostic Procedures:** A single Diagnostic Procedure limited to procedures on the approved list of diagnostic procedures (see below) without prior County approval. Approved diagnostic procedures will be reimbursed at invoice cost. Part A and Part A/MAI-funded programs must refer to the RWGA website for the most current list of approved diagnostic procedures and corresponding codes: www.hcphes.org/rwga. **Diagnostic procedures not listed on the website must have prior approval by RWGA.** **Outpatient Psychiatric Services:** Client must not be eligible for services from other programs/providers or any other reimbursement source (i.e. Medicaid, Medicare, private insurance) unless the client is in crisis and cannot be provided immediate services from the other programs/providers. In this case, clients may be provided services, as long as the client applies for the other programs/providers, until the other programs/providers can take over services. Program must be supervised by a Psychiatrist and include diagnostic assessments, emergency evaluations and psycho-pharmacotherapy. **Maintaining Referral Relationships** (Point of Entry Agreements): Contractor must maintain appropriate relationships with entities that constitute key points of access to the health care system for individuals with HIV disease, including but not limited to, Harris Health System and other Houston EMA-located emergency rooms, Harris County Jail, Texas Department of Criminal Justice incarceration facilities, Immigration detention centers, substance abuse treatment and detoxification programs, adult and juvenile detention facilities, Sexually Transmitted Disease clinics, federally qualified health centers (FQHC), HIV disease counseling and testing sites, mental health programs and homeless shelters. These referral relationships must be documented with written collaborative agreements, contracts or memoranda of understanding between Contractor and appropriate point of entry entities and are subject to audit by RWGA. Contractor and POE entity staff must regularly (e.g. weekly, bi-weekly depending on volume of referrals) meet 1:1 to discuss new referrals to primary medical care services. Such case conferences

	must be documented in the client record and properly entered into the CPCDMS. Use of CPCDMS Data System: Contractor must comply with CPCDMS business rules and procedures. Contractor must enter into the CPCDMS all required clinical data, including but not limited to, HAART treatment including all changes in medication regimens, Opportunistic Infections, screening and treatment for STDs and Hepatitis A, B, C and other clinical screening and treatment data required by HRSA, TDSHS and the County. Contractor must perform Registration updates in accordance with RWGA CPCDMS business rules for all clients wherein Contractor is client's CPCDMS record-owning agency. Contractor must utilize an electronic verification system to verify insurance/3rd party payer status monthly or per visit (whichever is less frequent). **Bus Pass Distribution:** The County will provide Contractor with METRO bus pass vouchers. Bus Pass vouchers must be distributed in accordance with RWGA policies and procedures, standards of care and financial eligibility guidelines. Contractor may only issue METRO bus pass vouchers to clients wherein the Contractor is the CPCDMS record owning Contractor. METRO bus pass vouchers shall be distributed as follows: **Expiration of Current Bus Pass:** In those situation wherein the bus pass expiration date does not coincide with the CPCDMS registration update the Contractor must distribute METRO bus pass vouchers to eligible clients upon the expiration of the current bus pass or when a Value-based bus card has been expended on eligible transportation needs. Contractor may issue METRO bus passes to eligible clients living outside the METRO service area in those situations where the Contractor has documented in the client record that the client will utilize the METRO system to access needed HIV-related health care services located in the METRO service area. **Gas Cards:** Primary Medical Care Contractors must distribute gasoline vouchers to eligible clients residing in the rural service area in accordance with RWGA policies and procedures, standards of care and financial eligibility guidelines. Gas Cards are only available to Rural primary medical care Contractors without prior approval by RWGA.#

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FY 2020 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/13/19**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/06/19**
Recommendations:	Approved: Y:____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Improvement Committee**		Date: **05/14/19**
Recommendations:	Approved: Y:____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMN Workgroup #1**	Date: **04/23/19**
Recommendations:	Financial Eligibility: 300% (None, None, 300% non-HIV, 500% HIV meds)
1. Accept the service definition as presented, update the justification chart, and keep the financial eligibility the same.	
2.	
3.	

Houston EMA/HSDA Ryan White Part A/MAI Service Definition **Comprehensive Outpatient Primary Medical Care including Medical Case Management and Service Linkage Services - Pediatric** (Last Review/Approval Date: 6/3/16)	
HRSA Service Category Title: **RWGA Only**	1. Outpatient/Ambulatory Medical Care 2. Medical Case Management 3. Case Management (non-Medical)
Local Service Category Title:	Comprehensive Primary Medical Care Targeted to Pediatric#
Target Population:	HIV-infected resident of the Houston EMA 0 – 18 years of age. Provider may continue services to previously enrolled clients until the client's 22nd birthday.#
Financial Eligibility:	*See Current Fiscal Year Approved Financial Eligibility for Houston EMA/HSDA*
Budget Type: **RWGA Only**	Hybrid Fee for Service#
Budget Requirement or Restrictions: **RWGA Only**	**Primary Medical Care:** 10% of funds designated to primary medical care must be reserved for invoicing diagnostic procedures at actual cost. Contractors may not exceed the allocation for each individual service component (Primary Medical Care, Medical Case Management and Service Linkage) without prior approval from RWGA.#
Service Unit Definition/s: **RWGA Only**	• Outpatient/Ambulatory Medical Care: One (1) unit of service = One (1) primary care office/clinic visit which includes the following: • Primary care physician/nurse practitioner, physician's assistant or clinical nurse specialist examination of the patient, and • Medication/treatment education • Medication access/linkage • OB/GYN specialty procedures (as clinically indicated) • Nutritional assessment (as clinically indicated) • Laboratory (as clinically indicated, not including specialized tests) • Radiology (as clinically indicated, not including CAT scan or MRI) • Eligibility verification/screening (as necessary) • Follow-up visits wherein the patient is not seen by the MD/NP/PA are considered to be a component of the original primary care visit. • Outpatient Psychiatric Services: 1 unit of service = A single (1) office/clinic visit wherein the patient is seen by a State licensed and board-eligible Psychiatrist or qualified Psychiatric Nurse Practitioner. This visit may or may not occur on the same date as a primary care office visit. • Medical Case Management: 1 unit of service = 15 minutes of direct medical case management services to an eligible PLWHA performed by a qualified medical case manager. • Service Linkage (non-Medical Case Management): 1 unit of service = 15 minutes of direct service linkage services to an eligible

	PLWHA performed by a qualified service linkage worker.
HRSA Service Category Definition: **RWGA Only**	• **Outpatient/Ambulatory medical care** is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings. Services includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies. • **Medical Case Management** services (including treatment adherence) are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication. • **Case Management (non-Medical)** includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does.
Standards of Care:	Contractors must adhere to the most current published Part A/B Standards of Care for the Houston EMA/HSDA. **Services must meet or**

	exceed applicable United States Department of Health and Human Services (DHHS) guidelines for the Treatment of HIV/AIDS.#
Local Service Category Definition/Services to be Provided:	**Outpatient/Ambulatory Primary Medical Care:** Services include on-site physician, physician extender, nursing, phlebotomy, radiographic, laboratory, pharmacy, intravenous therapy, home health care referral, licensed dietician, patient medication education, and patient care coordination. The Contractor must provide continuity of care with inpatient services and subspecialty services (either on-site or through specific referral to appropriate medical provider upon primary care Physician's order). Services provided to women shall further include OB/GYN physician & physician extender services on-site or by referral, OB/GYN services, colposcopy, nursing, phlebotomy, radiographic, laboratory, pharmacy, intravenous therapy, home health care referral, licensed dietician, patient medication/women's health education, patient care coordination, and social services. The Contractor must provide continuity of care with inpatient services and subspecialty services (either on-site or through specific referral protocols to appropriate agencies upon primary care Physician's order). **Outpatient/Ambulatory Primary Medical Care must provide:** • Continuity of care for all stages of adult HIV infection; • Laboratory and pharmacy services including intravenous medications (either on-site or through established referral systems); • Outpatient psychiatric care, including lab work necessary for the prescribing of psychiatric medications when appropriate (either on-site or through established referral systems); • Access to the Texas ADAP program (either on-site or through established referral systems); • Access to compassionate use HIV medication programs (either directly or through established referral systems); • Access to HIV related research protocols (either directly or through established referral systems); • Must at a minimum, comply with Houston EMA/HSDA Part A/B Standards for HIV Primary Medical Care. The Contractor must demonstrate on an ongoing basis the ability to provide state-of-the-art HIV-related primary care medicine in accordance with the most recent DHHS HIV treatment guidelines. Rapid advances in HIV treatment protocols require that the Contractor provide services that to the greatest extent possible maximize a patient's opportunity for long-term survival and maintenance of the highest quality of life possible. • On-site Outpatient Psychiatry services. • On-site Medical Case Management services. • On-site Medication Education. • Physical therapy services (either on-site or via referral).

- Specialty Clinic Referrals (either on-site or via referral).
- On-site pelvic exams as needed for female patients with appropriate follow-up treatment and referral.
- On site Nutritional Counseling by a Licensed Dietitian.

Services for females of child bearing age must also provide:

- Well woman care, including but not limited to: PAP, pelvic exam, breast examination, mammography, hormone replacement and education, pregnancy testing, contraceptive services excluding birth control medications.
- Obstetric Care: ante-partum through post-partum services, child birth/delivery services. Perinatal preventative education and treatment.
- On-site or by referral Colposcopy exams as needed, performed by an OB/GYN physician, or physician extender with a colposcopy provider qualification.
- Social services, including but not limited to, providing women access to child care, transportation vouchers, food vouchers and support groups at the clinic site;

Patient Medication Education Services must adhere to the following requirements:

- Medication Educators must be State Licensed Medical Doctor (MD), Nurse Practitioner (NP), Physician Assistant PA), Nurse (RN, LVN) or Pharmacist. Prior approval must be obtained prior to utilizing any other health care professional not listed above to provide medication education.
- Clients who will be prescribed ongoing medical regimens (i.e. ART) must be assessed for adherence to treatment at every clinical encounter using the EMA's approved adherence assessment tool. Clients with adherence issues related to lack of understanding must receive more education regarding their medical regimen. Clients with adherence issues that are behavioral or involve mental health issues must be provided counseling by the Medical Case Manager, Physician or Physician Extender and/or licensed nursing staff and, if clinically indicated, assessment and treatment by a qualified Psychiatrist or Psychiatric Nurse Practitioner.

Outpatient Psychiatric Services:

The program must provide:

- Diagnostic Assessments: comprehensive evaluation for identification of psychiatric disorders, mental status evaluation, differential diagnosis which may involve use of other clinical and laboratory tests, case formulation, and treatment plans or disposition.
- Emergency Psychiatric Services: rapid evaluation, differential diagnosis, acute treatment, crisis intervention, and referral. Must be available on a 24 hour basis including emergency room referral.

	• Brief Psychotherapy: individual, supportive, group, couple, family, hypnosis, biofeedback, and other psychophysiological treatments and behavior modification. • Psychopharmacotherapy: evaluation and medication treatment of psychiatric disorders, including, but not limited to, anxiety disorders, major depression, pain syndromes, habit control problems, psychosis and organic mental disorders. • Rehabilitation Services: Physical, psychosocial, behavioral, and/or cognitive training. Screening for Eye Disorders: Contractor must ensure that patients receive appropriate screening and treatment for CMV, glaucoma, cataracts, and other related problems. **Medical Case Management Services:** Services include screening all primary medical care patients to determine each patient's level of need for Medical Case Management services, performing a comprehensive assessment, including an assessment of the patient's health literary, and developing a medical service plan for each client that demonstrates a documented need for such services, monitoring medical service plan to ensure its implementation, and educating client regarding wellness, medication and health care appointment adherence. The Medical Case Manager serves as an advocate for the client and as a liaison with medical providers on behalf of the client. The Medical Case Manager ensures linkage to mental health, substance abuse and other client services as indicated by the medical service plan. **Service Linkage:** The purpose of Service Linkage is to assist clients with the procurement of needed services so that the problems associated with living with HIV are mitigated. Service Linkage is a working agreement between a client and a Service Linkage Worker for an indeterminate period, based on client need, during which information, referrals and service linkage are provided on an as-needed basis. Service Linkage assists clients who do not require the intensity of Medical Case Management per RWGA Quality Management guidelines. Service Linkage is both office-based and field based. Service Linkage Workers are expected to coordinate activities with referral sources where newly-diagnosed or not-in-care PLWHA may be identified, including 1:1 case conferences with testing site personnel to ensure the successful transition of referrals into Primary Care Services. Such incoming referral coordination includes meeting prospective clients at the referring Provider location in order to develop rapport with individuals prior to the individual's initial Primary Care appointment and ensuring such new intakes to Primary Care services have sufficient support to make the often difficult transition into ongoing primary medical care. Service Linkage also includes follow-up to re-engage lost-to-care patients. Lost-to-care patients are those patients who have not returned for scheduled appointments with Provider nor have provided Provider with updated information about their current Primary Medical Care provider (in the

	situation where patient may have obtained alternate service from another medical provider). Contractor must document efforts to re-engage lost-to-care patients prior to closing patients in the CPCDMS. Service Linkage extends the capability of existing programs by providing "hands-on" outreach and linkage to care services to those PLWHA who are not currently accessing primary medical care services. Service Linkage includes the issuance of bus pass vouchers and gas cards per published RWGA guidelines. Service Linkage complements and extends the service delivery capability of Medical Case Management services.#
Agency Requirements:#	**Providers and system must be Medicaid/Medicare certified.** **Eligibility and Benefits Coordination:** Contractor must implement consumer-friendly, culturally and linguistically appropriate new and ongoing patient eligibility verification and benefit coordination processes that ensure accountability with Ryan White Payer of Last Resort requirements while achieving maximum utilization of eligible benefits. Eligibility processes should provide clients with a meaningful understanding of their benefits, expected out-of-pocket expenses and other information needed to ensure full and continued participation in care. **Case Management Operations and Supervision:** The Service Linkage Workers (SLW) and Medical Case Managers (MCM) must function within the clinical infrastructure of Contractor and receive ongoing supervision that meets or exceeds published Standards of Care. An MCM may supervise SLWs.#
Staff Requirements:#	Contractor is responsible for ensuring that services are provided by State licensed internal medicine and OB/GYN physicians, specialty care physicians, psychiatrists, registered nurses, nurse practitioners, vocational nurses, pharmacists, physician assistants, clinical nurse specialists, physician extenders with a colposcopy provider qualification, x-ray technologists, State licensed dieticians, licensed social worker and ancillary health care providers in accordance with appropriate State licensing and/or certification requirements and with knowledge and experience of HIV disease. In addition, Contractor must ensure the following staff requirements are met: **Outpatient Psychiatric Services:** Director of the Program must be a Board Certified Psychiatrist. Licensed and/or Certified allied health professionals (Licensed Psychologists, Physicians, Psychiatric Nurse Practitioners, Licensed Master Social Workers, Licensed Professional Counselors, Licensed Marriage and Family Therapists, Certified Alcohol and Drug Abuse Counselors, etc.) must be used in all treatment modalities. Documentation of the Director's credentials, licensures and certifications must be included in the proposal. Documentation of the Allied Health professional licensures and certifications must be included in the proposal appendices. **Medication and Adherence Education:** The program must utilize an RN, LVN, PA, NP, pharmacist or MD licensed by the State of Texas,

	who has at least two (2) years paid experience in the preceding five (5) years in HIV/AIDS care, to provide the educational services. Licensed social workers who have at least two (2) years paid experience in the preceding five (5) years in HIV/AIDS care may also provide adherence education and counseling. **Medical Case Management:** The program must utilize a state licensed Social Worker to provide Medical Case Management Services. The Contractor must maintain the assigned number of Medical Case Management FTEs throughout the contract term. **Contractor must provide to RWGA the names of each Medical Case Manager and the individual assigned to supervise those Medical Case Managers by 03/30/17, and thereafter within 15 days after hire.** **Service Linkage:** The program must utilize Service Linkage Workers who have at a minimum a Bachelor's degree from an accredited college or university with a major in social or behavioral sciences. Documented paid work experience in providing client services to PLWHA may be substituted for the Bachelor's degree requirement on a 1:1 basis (1 year of documented paid experience may be substituted for 1 year of college). All Service Linkage Workers must have a minimum of one (1) year paid work experience with PLWHA. Contractor must maintain the assigned number of Service Linkage FTEs throughout the contract term. **Contractor must provide to RWGA the names of each Service Linkage Worker and the individual assigned to supervise those Service Linkage Workers by 03/30/17, and thereafter within 15 days after hire.** **Supervision of Case Managers:** The Service Linkage Workers and Medical Case Managers must function within the clinical infrastructure of Contractor and receive ongoing supervision that meets or exceeds Houston EMA/HSDA Part A/B Standards of Care for Service Linkage and Medical Case Management as applicable. An MCM may supervise SLWs.
Special Requirements: **RWGA Only**	**All primary medical care services must meet or exceed current United States DHHS Treatment Guidelines for the treatment and management of HIV disease.** Contractor must provide all required program components - Primary Medical Care, Medical Case Management and Service Linkage (non-medical Case Management) services. **Primary Medical Care Services:** Services funded under this grant cannot be used to supplant insurance or Medicare/Medicaid reimbursements for such services. Clients eligible for such reimbursement may not be billed to this contract. Medicare and private insurance co-payments may be eligible for reimbursement under Ryan White Health Insurance Assistance (HINS) program guidelines. Patients needing such assistance should be referred to the local Ryan White-funded HINS provider for assistance. Under no circumstances may the

	Contractor bill the County for the difference between the reimbursement from Medicaid, Medicare or Third Party insurance and the fee schedule under the contract. Furthermore, potential clients who are Medicaid/Medicare eligible or have other Third Party payers may not be denied services or referred elsewhere by the Contractor based on their reimbursement status (i.e. Medicaid/Medicare eligible clients may not be referred elsewhere in order that non-Medicaid/Medicare eligible clients may be added to the contract). Failure to serve Medicaid/Medicare eligible clients based on their reimbursement status will be grounds for the immediate termination of contract. **Diagnostic Procedures:** A single Diagnostic Procedure limited to procedures on the approved list of diagnostic procedures (see below) without prior County approval. Approved diagnostic procedures will be reimbursed at invoice cost. Part A and Part A/MAI-funded programs must refer to the RWGA website for the most current list of approved diagnostic procedures and corresponding codes: www.hcphes.org/rwga. **Diagnostic procedures not listed on the website must have prior approval by RWGA.** **Outpatient Psychiatric Services:** Client must not be eligible for services from other programs/providers or any other reimbursement source (i.e. Medicaid, Medicare, private insurance) unless the client is in crisis and cannot be provided immediate services from the other programs/providers. In this case, clients may be provided services, as long as the client applies for the other programs/providers, until the other programs/providers can take over services. Program must be supervised by a Psychiatrist and include diagnostic assessments, emergency evaluations and psycho-pharmacotherapy. **Maintaining Referral Relationships** (Point of Entry Agreements): Contractor must maintain appropriate relationships with entities that constitute key points of access to the health care system for individuals with HIV disease, including but not limited to, Harris Health System and other Houston EMA-located emergency rooms, Harris County Jail, Texas Department of Criminal Justice incarceration facilities, Immigration detention centers, substance abuse treatment and detoxification programs, adult and juvenile detention facilities, Sexually Transmitted Disease clinics, federally qualified health centers (FQHC), HIV disease counseling and testing sites, mental health programs and homeless shelters. These referral relationships must be documented with written collaborative agreements, contracts or memoranda of understanding between Contractor and appropriate point of entry entities and are subject to audit by RWGA. Contractor and POE entity staff must regularly (e.g. weekly, bi-weekly depending on volume of referrals) meet 1:1 to discuss new referrals to primary medical care services. Such case conferences must be documented in the client record and properly entered into the CPCDMS. Use of CPCDMS Data System: Contractor must comply with CPCDMS

	business rules and procedures. Contractor must enter into the CPCDMS all required clinical data, including but not limited to, HAART treatment including all changes in medication regimens, Opportunistic Infections, screening and treatment for STDs and Hepatitis A, B, C and other clinical screening and treatment data required by HRSA, TDSHS and the County. Contractor must perform Registration updates in accordance with RWGA CPCDMS business rules for all clients wherein Contractor is client's CPCDMS record-owning agency. Contractor must utilize an electronic verification system to verify insurance/3rd party payer status monthly or per visit (whichever is less frequent). **Bus Pass Distribution:** The County will provide Contractor with METRO bus pass vouchers. Bus Pass vouchers must be distributed in accordance with RWGA policies and procedures, standards of care and financial eligibility guidelines. Contractor may only issue METRO bus pass vouchers to clients wherein the Contractor is the CPCDMS record owning Contractor. METRO bus pass vouchers shall be distributed as follows: **Expiration of Current Bus Pass:** In those situation wherein the bus pass expiration date does not coincide with the CPCDMS registration update the Contractor must distribute METRO bus pass vouchers to eligible clients upon the expiration of the current bus pass or when a Value-based bus card has been expended on eligible transportation needs. Contractor may issue METRO bus passes to eligible clients living outside the METRO service area in those situations where the Contractor has documented in the client record that the client will utilize the METRO system to access needed HIV-related health care services located in the METRO service area.

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FY 2020 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/13/19**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/06/19**
Recommendations:	Approved: Y:____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
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3.		

Step in Process: **Quality Improvement Committee**		Date: **05/14/19**
Recommendations:	Approved: Y:____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMN Workgroup #1**	Date: **04/23/19**
Recommendations:	Financial Eligibility: 300% (None, None)
1. Accept the service definition as presented, update the justification chart, and keep the financial eligibility the same.	
2.	
3.	

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Houston EMA/HSDA Ryan White Part A/MAI Service Definition **Clinical Case Management** (Last Review/Approval Date: 6/3/16)	
HRSA Service Category Title: **RWGA Only**	**Medical Case Management**
Local Service Category Title:	**Clinical Case Management (CCM)**
Budget Type: **RWGA Only**	**Unit Cost**
Budget Requirements or Restrictions: **RWGA Only**	Not applicable.
HRSA Service Category Definition: **RWGA Only**	***Medical Case Management services (including treatment adherence)*** are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication.
Local Service Category Definition:	**Clinical Case Management**: Identifying and screening clients who are accessing HIV-related services from a clinical delivery system that provides Mental Health treatment/counseling and/or Substance Abuse treatment services; assessing each client's medical and psychosocial history and current service needs; developing and regularly updating a clinical service plan based upon the client's needs and choices; implementing the plan in a timely manner; providing information, referrals and assistance with linkage to medical and psychosocial services as needed; monitoring the efficacy and quality of services through periodic reevaluation; advocating on behalf of clients to decrease service gaps and remove barriers to services helping clients develop and utilize independent living skills and strategies. Assist clients in obtaining needed resources, including bus pass vouchers and gas cards per published HCPHS/RWGA policies.
Target Population (age,	Services will be available to eligible HIV-infected clients residing in

gender, geographic, race, ethnicity, etc.):	the Houston EMA with priority given to clients most in need. All clients who receive services will be served without regard to age, gender, race, color, religion, national origin, sexual orientation, or handicap. Services will target low income individuals with HIV/AIDS who demonstrate multiple medical, mental health, substance use/abuse and psychosocial needs including, but not limited to: mental health counseling (i.e. professional counseling), substance abuse treatment, primary medical care, specialized care, alternative treatment, medications, placement in a medical facility, emotional support, basic needs for food, clothing, and shelter, transportation, legal services and vocational services. Services will also target clients who cannot function in the community due to barriers which include, but are not limited to, mental illness and psychiatric disorders, drug addiction and substance abuse, extreme lack of knowledge regarding available services, inability to maintain financial independence, inability to complete necessary forms, inability to arrange and complete entitlement and medical appointments, homelessness, deteriorating medical condition, illiteracy, language/cultural barriers and/or the absence of speech, sight, hearing, or mobility. *Clinical Case Management* is intended to serve eligible clients, especially those underserved or unserved population groups which include: African American, Hispanic/Latino, Women and Children, Veteran, Deaf/Hard of Hearing, Substance Abusers, Homeless and Gay/Lesbian/Transsexual.
Services to be Provided:	Provision of Clinical Case Management activities performed by the Clinical Case Manager. *Clinical Case Management* is a working agreement between a client and a Clinical Case Manager for a defined period of time based on the client's assessed needs. *Clinical Case Management* services include performing a comprehensive assessment and developing a clinical service plan for each client; monitoring plan to ensure its implementation; and educating client regarding wellness, medication and health care compliance in order to maximize benefit of mental health and/or substance abuse treatment services. The *Clinical Case Manager* serves as an advocate for the client and as a liaison with mental health, substance abuse and medical treatment providers on behalf of the client. The Clinical Case Manager ensures linkage to mental health, substance abuse, primary medical care and other client services as indicated by the clinical service plan. The Clinical Case Manager will perform *Mental Health* and *Substance Abuse/Use Assessments* in accordance with RWGA Quality Management guidelines. Service plan must reflect an ongoing discussion of mental health treatment and/or substance abuse treatment, primary medical care and medication adherence, per client need. *Clinical Case Management is* both office and community-based. Clinical

	Case Managers will interface with the primary medical care delivery system as necessary to ensure services are integrated with, and complimentary to, a client's medical treatment plan.
Service Unit Definition(s): **RWGA Only**	One unit of service is defined as 15 minutes of direct client services and allowable charges.
Financial Eligibility:	Refer to the RWPC's approved *Financial Eligibility for Houston EMA Services*.
Client Eligibility:	HIV-infected individuals residing in the Houston EMA.
Agency Requirements:	*Clinical Case Management* services will comply with the HCPHS/RWGA published Clinical Case Management Standards of Care and policies and procedures as published and/or revised, including linkage to the CPCDMS data system *Clinical Case Management Services* must be provided by an agency with a documented history of, and current capacity for, providing mental health counseling services (categories b., c. and d. as listed under *Amount Available* above) or substance abuse treatment services to PLWH/A (category a. under *Amount Available* above) in the Houston EMA. Specifically, an applicant for this service category must clearly demonstrate it has provided mental health treatment services (e.g. professional counseling) or substance abuse treatment services (as applicable to the specific CCM category being applied for) in the previous calendar or grant year to individuals with an HIV diagnosis. Acceptable documentation for such treatment activities includes standardized reporting documentation from the County's *CPCDMS* or Texas Department of State Health Services' *ARIES* data systems, Ryan White Services Report (RSR), SAMSHA or TDSHS/SAS program reports or other verifiable published data. Data submitted to meet this requirement is subject to audit by HCPHS/RWGA prior to an award being recommended. **Agency-generated non-verifiable data is not acceptable.** In addition, applicant agency must demonstrate it has the capability to continue providing mental health treatment and/or substance abuse treatment services for the duration of the contract term and any subsequent one-year contract renewals. Acceptable documentation of such continuing capability includes current funding from Ryan White (all Parts), TDSHS HIV-related funding (Ryan White, State Services, State-funded Substance Abuse Services), SAMSHA and other ongoing federal, state and/or public or private foundation HIV-related funding for mental health treatment and/or substance abuse treatment services. Proof of such funding must be documented in the application and is subject to independent verification by HCPHS/RWGA prior to an award being recommended. Loss of funding and corresponding loss of capacity to provide mental health counseling or substance abuse treatment services as applicable may result in the termination of Clinical Case Management Services

	awarded under this service category. Continuing eligibility for Clinical Case Management Services funding is explicitly contingent on applicant agency maintaining verifiable capacity to provide mental health counseling or substance abuse treatment services as applicable to PLWH/A during the contract term. **Applicant agency must be Medicaid and Medicare Certified**.
Staff Requirements:	Clinical Case Managers must spend at least 42% (867 hours per FTE) of their time providing direct case management services. Direct case management services include any activities with a client (face-to-face or by telephone), communication with other service providers or significant others to access client services, monitoring client care, and accompanying clients to services. Indirect activities include travel to and from a client's residence or agency, staff meetings, supervision, community education, documentation, and computer input. Direct case management activities must be documented in the Centralized Patient Care Data Management System (CPCDMS) according to CPCDMS business rules. *Must comply with applicable HCPHS/RWGA Houston EMA/HSDA Part A/B Ryan White Standards of Care:* <u>Minimum Qualifications:</u> **Clinical Case Managers** must have at a minimum a Bachelor's degree from an accredited college or university with a major in social or behavioral sciences and have a current and in good standing State of Texas license (LBSW, LSW, LMSW, LCSW, LPC, LPC-I, LMFT, LMFT-A or higher level of licensure). The Clinical Case Manager may supervise the Service Linkage Worker. CCM targeting Hispanic PLWHA must demonstrate both written and verbal fluency in Spanish. <u>Supervision:</u> The **Clinical Case Manager** (CCM) must function with the clinical infrastructure of the applicant agency and receive supervision in accordance with the CCM's licensure requirements. At a minimum, the CCM must receive ongoing supervision that meets or exceeds HCPHS/RWGA published Ryan White Part A/B Standards of Care for Clinical Case Management. If applicant agency also has Service Linkage Workers funded under Ryan White Part A the CCM may supervise the Service Linkage Worker(s). Supervision provided by a CCM that is <u>not</u> client specific is considered **indirect time** and is not billable.
Special Requirements: **RWGA Only**	Contractor must employ full-time Clinical Case Managers. Prior approval must be obtained from RWGA to split full-time equivalent (FTE) CCM positions among other contracts or to employ part-time staff. **Contractor must provide to RWGA the names of each Clinical Case Manager and the program supervisor no later than 3/30/17. Contractor must inform RWGA in writing of any**

	changes in personnel assigned to contract within seven (7) business days of change. Contractor must comply with CPCDMS data system business rules and procedures. Contractor must perform CPCDMS new client registrations and registration updates for clients needing ongoing case management services as well as those clients who may only need to establish system of care eligibility. Contractor must issue bus pass vouchers in accordance with HCPHS/RWGA policies and procedures.

FY 2020 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/13/19**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
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Step in Process: **Steering Committee**		Date: **06/06/19**
Recommendations:	Approved: Y:____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Improvement Committee**		Date: **05/14/19**
Recommendations:	Approved: Y:____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMN Workgroup #1**	Date: **04/23/19**
Recommendations:	Financial Eligibility: No financial cap
1. Accept the service definition as presented, update the justification chart, and keep the financial eligibility the same.	
2.	
3.	

FY 2015 Houston EMA/HSDA Ryan White Part A Service Definition **Service Linkage at Testing Sites** (Revision Date: 03/03/14)	
HRSA Service Category Title: **RWGA Only**	**Non-medical Case Management**
Local Service Category Title:	**A. Service Linkage targeted to Not-In-Care and Newly-Diagnosed PLWHA in the Houston EMA/HDSA** **Not-In-Care PLWHA** are individuals who know their HIV status but have not been actively engaged in outpatient primary medical care services for more than six (6) months. **Newly-Diagnosed** PLWHA are individuals who have learned their HIV status within the previous six months and are not currently receiving outpatient primary medical care or case management services as documented in the CPCDMS data system. **B.** ***Youth targeted Service Linkage, Care and Prevention:*** Service Linkage Services targeted to Youth (13 – 24 years of age), including a focus on not-in-care and newly-diagnosed Youth in the Houston EMA. *Not-In-Care PLWHA are Youth who know their HIV status but have not been actively engaged in outpatient primary medical care services in the previous six (6) months. *Newly-Diagnosed Youth are Youth who have learned their HIV status within the previous six months and are not currently receiving outpatient primary medical care or case management services as documented in the CPCDMS data system.
Budget Type: **RWGA Only**	Fee-for-Service
Budget Requirements or Restrictions: **RWGA Only**	Early intervention services, including HIV testing and Comprehensive Risk Counseling Services (CRCS) must be supported via alternative funding (e.g. TDSHS, CDC) and may not be charged to this contract.
HRSA Service Category Definition: **RWGA Only**	***Case Management (non-Medical)*** includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does. ***Early intervention services (EIS)*** include counseling individuals with respect to HIV/AIDS; testing (including tests to confirm the presence of the disease, tests to diagnose to extent of immune deficiency, tests to provide information on appropriate therapeutic measures); referrals; other clinical and diagnostic services regarding HIV/AIDS; periodic medical evaluations for individuals with HIV/AIDS; and providing therapeutic measures.
Local Service Category Definition:	**A.** ***Service Linkage:*** Providing allowable Ryan White Program outreach and service linkage activities to newly-diagnosed and/or ***Not-In-Care*** PLWHA who know their status but are not currently enrolled

	in outpatient primary medical care with information, referrals and assistance with linkage to medical, mental health, substance abuse and psychosocial services as needed; advocating on behalf of clients to decrease service gaps and remove barriers to services helping clients develop and utilize independent living skills and strategies. Assist clients in obtaining needed resources, including bus pass vouchers and gas cards per published HCPHS/RWGA policies. **B. *Youth targeted Service Linkage, Care and Prevention:*** Providing Ryan White Program appropriate outreach and service linkage activities to newly-diagnosed and/or not-in-care HIV-positive Youth who know their status but are not currently enrolled in outpatient primary medical care with information, referrals and assistance with linkage to medical, mental health, substance abuse and psychosocial services as needed; advocating on their behalf to decrease service gaps and remove barriers to services; helping Youth develop and utilize independent living skills and strategies. Assist clients in obtaining needed resources, including bus pass vouchers and gas cards per published HCPHS/RWGA policies. Provide comprehensive medical case management to HIV-positive youth identified through outreach and in-reach activities.
Target Population (age, gender, geographic, race, ethnicity, etc.):	**A. Service Linkage:** Services will be available to eligible HIV-infected clients residing in the Houston EMA/HSDA with priority given to clients most in need. All clients who receive services will be served without regard to age, gender, race, color, religion, national origin, sexual orientation, or handicap. Services will target low income individuals with HIV/AIDS who demonstrate multiple medical, mental health, substance use/abuse and psychosocial needs including, but not limited to: mental health counseling, substance abuse treatment, primary medical care, specialized care, alternative treatment, medications, placement in a medical facility, emotional support, basic needs for food, clothing, and shelter, transportation, legal services and vocational services. Services will also target clients who cannot function in the community due to barriers which include, but are not limited to, mental illness and psychiatric disorders, drug addiction and substance abuse, extreme lack of knowledge regarding available services, inability to maintain financial independence, inability to complete necessary forms, inability to arrange and complete entitlement and medical appointments, homelessness, deteriorating medical condition, illiteracy, language/cultural barriers and/or the absence of speech, sight, hearing, or mobility. **Service Linkage** is intended to serve eligible clients in the Houston EMA/HSDA, especially those underserved or unserved population groups which include: African American, Hispanic/Latino, Women and Children, Veteran, Deaf/Hard of Hearing, Substance Abusers, Homeless and Gay/Lesbian/Transsexual. **B. *Youth targeted Service Linkage, Care and Prevention:*** Services will be available to eligible HIV-infected Youth (ages 13 – 24) residing

	in the Houston EMA/HSDA with priority given to clients most in need. All Youth who receive services will be served without regard to age (i.e. limited to those who are between 13- 24 years of age), gender, race, color, religion, national origin, sexual orientation, or handicap. Services will target low income Youth living with HIV/AIDS who demonstrate multiple medical, mental health, substance use/abuse and psychosocial needs including, but not limited to: mental health counseling, substance abuse treatment, primary medical care, specialized care, alternative treatment, medications, placement in a medical facility, emotional support, basic needs for food, clothing, and shelter, transportation, legal services and vocational services. Services will also target Youth who cannot function in the community due to barriers which include, but are not limited to, mental illness and psychiatric disorders, drug addiction and substance abuse, extreme lack of knowledge regarding available services, inability to maintain financial independence, inability to complete necessary forms, inability to arrange and complete entitlement and medical appointments, homelessness, deteriorating medical condition, illiteracy, language/cultural barriers and/or the absence of speech, sight, hearing, or mobility. ***Youth Targeted Service Linkage, Care and Prevention*** is intended to serve eligible youth in the Houston EMA/HSDA, especially those underserved or unserved population groups which include: African American, Hispanic/Latino, Substance Abusers, Homeless and Gay/Lesbian/Transsexual.
Services to be Provided:	**Goal (A): Service Linkage:** The expectation is that a single Service Linkage Worker Full Time Equivalent (FTE) targeting Not-In-Care and/or newly-diagnosed PLWHA can serve approximately 80 newly-diagnosed or not-in-care PLWH/A per year. The purpose of **Service Linkage** is to assist clients with the procurement of needed services so that the problems associated with living with HIV are mitigated. **Service Linkage** is a working agreement between a client and a Service Linkage Worker (SLW) for an indeterminate period, based on client need, during which information, referrals and service linkage are provided on an as-needed basis. The purpose of **Service Linkage** is to assist clients who do not require the intensity of *Clinical or Medical Case Management*, as determined by RWGA Quality Management guidelines. **Service Linkage** is both office- and field-based and **may include the issuance of bus pass vouchers and gas cards per published guidelines.** Service Linkage targeted to Not-In-Care and/or Newly-Diagnosed PLWHA extends the capability of existing programs with a documented track record of identifying Not-In-Care and/or newly-diagnosed PLWHA by providing "hands-on" outreach and linkage to care services to those PLWHA who are not currently accessing primary medical care services.

	In order to ensure linkage to an ongoing support system, eligible clients identified funded under this contract, including clients who may obtain their medical services through non-Ryan White-funded programs, must be transferred to a Ryan White-funded Primary Medical Care, Clinical Case Management or Service Linkage program within 90 days of initiation of services as documented in both ECLIPS and CPCDMS data systems. Those clients who choose to access primary medical care from a non-Ryan White source, including private physicians, may receive ongoing service linkage services from provider or must be transferred to a Clinical (CCM) or Primary Care/Medical Case Management site per client need and the preference of the client**.** **GOAL (B):** This effort will continue a program of ***Service Linkage, Care and Prevention to Engage HIV Seropositive Youth*** targeting youth (ages 13-24) with a focus on Youth of color. This service is designed to reach HIV seropositive youth of color not engaged in clinical care and to link them to appropriate clinical, supportive, and preventive services. The specific objectives are to: (1) conduct outreach (service linkage) to assist seropositive Youth learn their HIV status, (2) link HIV-infected Youth with primary care services, and (3) prevent transmission of HIV infection from targeted clients.
Service Unit Definition(s): **RWGA Only**	One unit of service is defined as 15 minutes of direct client services and allowable charges.
Financial Eligibility:	Refer to the RWPC's approved *Financial Eligibility for Houston EMA/HSDA Services.*
Client Eligibility:	Not-In-Care and/or newly-diagnosed HIV-infected individuals residing in the Houston EMA.
Agency Requirements:	**Service Linkage** services will comply with the HCPHS/RWGA published **Service Linkage** Standards of Care and policies and procedures as published and/or revised, including linkage to the CPCDMS data system. Agency must comply with all applicable City of Houston DHHS *ECLIPS* and RWGA/HCPHS *CPCDMS* business rules and policies & procedures. **Service Linkage** targeted to Not-In-Care and/or newly diagnosed PLWHA must be planned and delivered in coordination with local HIV prevention/outreach programs to avoid duplication of services and be designed with quantified program reporting that will accommodate local effectiveness evaluation. Contractor must document established linkages with agencies that serve HIV-infected clients or serve individuals who are members of high-risk population groups (e.g., men who have sex with men, injection drug users, sex-industry workers, youth who are sentenced under the juvenile justice system, inmates of state and local jails and prisons). Contractor must have formal collaborative, referral or Point of Entry (POE) agreements with Ryan White funded HIV/AIDS primary care providers.

Staff Requirements:	Service Linkage Workers must spend at least 42% (867 hours per FTE) of their time providing direct client services. Direct service linkage and case management services include any activities with a client (face-to-face or by telephone), communication with other service providers or significant others to access client services, monitoring client care, and accompanying clients to services. Indirect activities include travel to and from a client's residence or agency, staff meetings, supervision, community education, documentation, and computer input. Direct case management activities must be documented in the CPCDMS according to system business rules. *Must comply with applicable HCPHS/RWGA published Ryan White Part A/B Standards of Care:* Minimum Qualifications: **Service Linkage Workers** must have at a minimum a Bachelor's degree from an accredited college or university with a major in social or behavioral sciences. Documented paid work experience in providing client services to PLWH/A may be substituted for the Bachelor's degree requirement on a 1:1 basis (1 year of documented paid experience may be substituted for 1 year of college). All Service Linkage Workers must have a minimum of one (1) year paid work experience with PLWHA. Supervision: The Service Linkage Worker must function within the clinical infrastructure of the applicant agency and receive ongoing supervision that meets or exceeds HCPHS/RWGA published Ryan White Part A/B Standards of Care for Service Linkage.
Special Requirements: **RWGA Only**	Contractor must be have the capability to provide Public Health Follow-Up by qualified Disease Intervention Specialists (DIS) to locate, identify, inform and refer newly-diagnosed and not-in-care PLWHA to outpatient primary medical care services. Contractor must perform CPCDMS new client registrations and, for those newly-diagnosed or out-of-care clients referred to non-Ryan White primary care providers, registration updates per RWGA business rules for those needing ongoing service linkage services as well as those clients who may only need to establish system of care eligibility. This service category does not routinely distribute Bus Passes. However, if so directed by RWGA, Contractor must issue bus pass vouchers in accordance with HCPHS/RWGA policies and procedures.

FY 2020 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/13/19**
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Step in Process: **Steering Committee**		Date: **06/06/19**
Recommendations:	Approved: Y:____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Improvement Committee**		Date: **05/14/19**
Recommendations:	Approved: Y:____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMN Workgroup #1**	Date: **04/23/19**
Recommendations:	Financial Eligibility: No financial cap
1. Accept the service definition as presented, update the justification chart, and keep the financial eligibility the same.	
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Local Service Category:	**Non-Medical Case Management Targeting Substance Use Disorder**
Amount Available**:**	**To be determined**
Unit Cost	
Budget Requirements or Restrictions **(TRG Only)**:	Maximum 10% of budget for Administrative Cost. Direct medical costs and Substance Abuse Treatment/Counseling cannot be billed under this contract.
DSHS Service Category Definition:	**Non-Medical Case Management (N-MCM)** model is responsive to the immediate needs of a person living with HIV (PLWH) and includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, entitlements, housing, and other needed services. **Non-Medical Case Management Services (N-MCM)** provide guidance and assistance in accessing medical, social, community, legal, financial, and other needed services. N-MCM services may also include assisting eligible persons living with HIV (PLWH) to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, or health insurance Marketplace plans. This service category includes several methods of communication (e.g., face-to-face, phone contact, and any other forms of communication) as deemed appropriate by the Texas DSHS HIV Care Services Group Ryan White Part B program.
Local Service Category Definition:	***Non-Medical Case Management:*** The purpose of Non-Medical Case Management targeting Substance Use Disorders (SUD) is to assist PLWHs with the procurement of needed services so that the problems associated with living with HIV are mitigated. N-MCM targeting SUD is intended to serve eligible people living with HIV in the Houston EMA/HSDA who are also facing the challenges of substance use disorder. Non-Medical Case Management is a working agreement between a PLWH and a Non-Medical Case Manager for an indeterminate period, based on PLWH need, during which information, referrals and Non-Medical Case Management is provided on an as- needed basis and assists PLWHs who do not require the intensity of Medical Case Management. Non-Medical Case Management is both office-based and field based. N-MCMs are expected to coordinate activities with referral sources where newly-diagnosed or not-in-care PLWH may be identified, including substance use disorder treatment/counseling and/or recovery support personnel. Such incoming referral coordination includes meeting prospective PLWHs at the referring provider location in order to develop rapport with and ensuring sufficient support is available. Non-Medical Case Management also includes follow-up to re-engage lost-to-care patients. Lost-to-care patients are those PLWHs who have not returned for scheduled appointments with the provider nor have provided updated information about their current Primary Medical Care provider (in the situation where PLWH may have obtained alternate service from another medical provider). Contractor must document efforts to re-engage lost-to-care patients prior to closing patients in the CPCDMS. Non-Medical Case Management extends the capability of existing programs by providing "hands-on" outreach and linkage to care services to those PLWH who are not currently accessing primary medical care services.

Target Population (age, gender, geographic, race, ethnicity, etc.):	**Non-Medical Case Management targeting SUD** is intended to serve eligible people living with HIV in the Houston EMA/HSDA, especially those underserved or unserved population groups who are also facing the challenges of substance use disorder. The target populations should also include individuals who misuse prescription medication or who use illegal substances or recreational drugs and are also: – Transgender, – Men who have sex with men (MSM), – Women or – Incarcerated/recently released from incarceration.
Services to be Provided:	**Goals:** The primary goal for N-MCM targeting SUD is to improve the health status of PLWHs who use substances by promoting linkages between community-based substance use disorder treatment programs, health clinics and other social service providers. N-MCM targeting SUD shall have a planned and coordinated approach to ensure that PLWHs have access to all available health and social services necessary to obtain an optimum level of functioning. N-MCM targeting SUD shall focus on behavior change, risk and harm reduction, retention in HIV care, and lowering risk of HIV transmission. The expectation is that each Non-Medical Case Management Full Time Equivalent (FTE) targeting SUD can serve approximately 80 PLWHs per year. **Purpose:** To promote Human Immunodeficiency Virus (HIV) disease management and recovery from substance use disorder by providing comprehensive Non-Medical Case Management and support for PWLH who are also dealing with substance use disorder and providing support to their families and significant others. **N-MCM targeting SUD** assists PLWHs with the procurement of needed services so that the problems associated with living with HIV are mitigated. **N-MCM targeting SUD** is a working agreement between a person living with HIV and a Non-Medical Case Manager (N-MCM) for an indeterminate period, based on identified need, during which information, referrals and Non-Medical Case Management is provided on an as- needed basis. The purpose of **N-MCM targeting SUD** is to assist PLWHs who do not require the intensity of *Clinical or Medical Case Management*. **N-MCM targeting SUD** is community-based (i.e. both office- and field-based). This Non-Medical Case Management targets PLWHs who are also dealing with the challenges of substance use disorder. N-MCMs also provide "hands-on" outreach and linkage to care services to those PLWHA who are not currently accessing primary medical care services. Efforts may include coordination with other case management providers to ensure the specialized needs of PLWHs who are dealing with substance use disorder are thoroughly addressed. For this population, this is not a duplication of service but rather a set of agreed upon coordinated activities that clearly delineate the unique and separate roles of N-MCMs and medical case managers who work jointly and collaboratively with the PLWH's knowledge and consent to partialize and prioritize goals in order to effectively achieve those goals.

	N-MCMs should provide activities that enhance the motivation of PLWHs on N-MCM's caseload to reduce their risks of overdose and how risk-reduction activities may be impacted by substance use and sexual behaviors. N-MCMs shall use motivational interviewing techniques and the Transtheoretical Model of Change, (DiClemente and Prochaska - Stages of Change). N-MCMs should promote and encourage entry into substance use disorder services and make referrals, if appropriate, for PLWHs who are in need of formal substance use disorder treatment or other recovery support services. However, N-MCMs shall ensure that PLWHs are not required to participate in substance use disorder treatment services as a condition for receiving services. For those PLWH in treatment, N-MCMs should address ongoing services and support for discharge, overdose prevention, and aftercare planning during and following substance use disorder treatment and medically-related hospitalizations. N-MCMs should ensure that appropriate harm- and risk-reduction information, methods and tools are used in their work with the PLWH. Information, methods and tools shall be based on the latest scientific research and best practices related to reducing sexual risk and HIV transmission risks. Methods and tools must include, but are not limited to, a variety of effective condoms and other safer sex tools as well as substance abuse risk-reduction tools, information, discussion and referral about Pre- Exposure Prophylactics (PrEP) for PLWH's sexual or drug using partners and overdose prevention. N-MCMs should make information and materials on overdose prevention available to appropriate PLWHs as a part of harm- and risk-reduction. Those PLWHs who choose to access primary medical care from a non-Ryan White source, including private physicians, may receive ongoing Non-Medical Case Management services from provider**.**
Service Unit Definition(s) **(TRG Only)**:	One unit of service is defined as 15 minutes of direct services or coordination of care on behalf of PLWH.
Financial Eligibility:	Refer to the RWPC's approved *Financial Eligibility for Houston EMA Services*.
Client Eligibility:	PLWHs dealing with challenges of substance use/abuse and dependence. Resident of the Houston HSDA.
Agency Requirements **(TRG Only)**:	These services will comply with the TRG's published **Non-Medical Case Management Targeting Substance Use Disorder** Standards of Care and policies and procedures as published and/or revised, including linkage to the CPCDMS data system as well as DSHS Universal Standards and Non-Medical Case Management Standards of Care. **Non-Medical Case Management targeted SUD** must be planned and delivered in coordination with local HIV treatment/prevention/outreach programs to avoid duplication of services and be designed with quantified program reporting that will accommodate local effectiveness evaluation. Subrecipients must document established linkages with agencies that serve PLWH or serve individuals who are members of high-risk population groups (e.g., men who have sex with men, injection drug users, sex-industry workers, youth who are sentenced under the juvenile justice system, inmates

	of state and local jails and prisons). Contractor must have formal collaborative, referral or Point of Entry (POE) agreements with Ryan White funded HIV primary care providers.
Staff Requirements:	Minimum Qualifications: **Non-Medical Case Management Workers** must have at a minimum a Bachelor's degree from an accredited college or university with a major in social or behavioral sciences. Documented paid work experience in providing services to PLWH may be substituted for the Bachelor's degree requirement on a 1:1 basis (1 year of documented paid experience may be substituted for 1 year of college). All Non-Medical Case Management Workers must have a minimum of one (1) year work experience with PLWHA and/or substance use disorders. Supervision: The Non-Medical Case Management Worker must function within the clinical infrastructure of the applicant agency and receive ongoing supervision that meets or exceeds TRG's published **Non-Medical Case Management Targeting Substance Use Disorder** Standards of Care.
Special Requirements **(TRG Only)**:	Must comply with the Houston EMA/HSDA Standards of Care. The agency must comply with **the DSHS Universal Standards and non-Medical Case Management Standards of Care**. The agency must have policies and procedures in place that comply with the standards ***prior*** to delivery of the service. Contractor must be licensed in Texas to directly provide substance use treatment/counseling.

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Step in Process: **Steering Committee**		Date: **06/06/19**
Recommendations:	Approved: Y:____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Improvement Committee**		Date: **05/14/19**
Recommendations:	Approved: Y:____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMN Workgroup #2**	Date: **04/23/19**
Recommendations:	Financial Eligibility: No financial cap
1. Accept the service definition as presented, update the justification chart, and keep the financial eligibility the same.	
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Service Category Definition - DSHS State Services

Local Service Category:	**Early Intervention Services – Incarcerated**
Amount Available**:**	**To be determined**
Unit Cost	
Budget Requirements or Restrictions **(TRG Only)**:	Maximum 10% of budget for Administrative Cost. No direct medical costs may be billed to this grant.
DSHS Service Category Definition:	Support of Early Intervention Services (EIS) that include identification of individuals at points of entry and access to services and provision of: • HIV Testing and Targeted counseling • Referral services • Linkage to care • Health education and literacy training that enable clients to navigate the HIV system of care These services must focus on expanding key points of entry and documented tracking of referrals. Counseling, testing, and referral activities are designed to bring people living with HIV into Outpatient Ambulatory Medical Care. The goal of EIS is to decrease the number of underserved individuals with HIV/AIDS by increasing access to care. EIS also provides the added benefit of educating and motivating clients on the importance and benefits of getting into care.
Local Service Category Definition:	This service includes the connection of incarcerated in the Harris County Jail into medical care, the coordination of their medical care while incarcerated, and the transition of their care from Harris County Jail to the community. Services must include: assessment of the client, provision of client education regarding disease and treatment, education and skills building to increase client's health literacy, completion of THMP/ADAP application and submission via ARIES upload process, care coordination with medical resources within the jail, care coordination with service providers outside the jail, and discharge planning.
Target Population (age, gender, geographic, race, ethnicity, etc.):	People living with HIV incarcerated in The Harris County Jail.
Services to be Provided:	Services include but are not limited to CPCDMS registration/update, assessment, provision of client education, coordination of medical care services provided while incarcerated, medication regimen transition, multidisciplinary team review, discharge planning, and referral to community resources.
Service Unit Definition(s) **(TRG Only)**:	One unit of service is defined as 15 minutes of direct client services or coordination of care on behalf of client.
Financial Eligibility:	Due to incarceration, no income or residency documentation is required.
Client Eligibility:	People living with HIV incarcerated in the Harris County Jail.
Agency Requirements **(TRG Only)**:	As applicable. the agency's facility(s) shall be appropriately licensed or certified as required by Texas Department of State Health Services, for the provision of HIV Early Intervention Services, including phlebotomy services. Agency/staff will establish memoranda of understanding (MOUs) with key points of entry into care to facilitate access to care for those who are identified by testing in HCJ. Agency must execute Memoranda of Understanding with Ryan White funded Outpatient Ambulatory Medical Care providers. The Administrative Agency must be notified in writing if any OAMC providers refuse to execute an MOU.

Staff Requirements:	Not Applicable.
Special Requirements **(TRG Only)**:	Must comply with the Houston EMA/HSDA Standards of Care. The agency must comply with **the DSHS Early Intervention Services Standards of Care** and **the Houston HSDA Early Intervention Services for the Incarcerated Standards of Care**. The agency must have policies and procedures in place that comply with the standards ***prior*** to delivery of the service.

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Step in Process: **Quality Improvement Committee**		Date: **05/14/19**
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Step in Process: **HTBMN Workgroup #2**	Date: **04/23/19**
Recommendations:	Financial Eligibility: 300%
1. Accept the service definition as presented, update the justification chart, and keep the financial eligibility the same.	
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Houston EMA/HSDA Ryan White Part A Service Definition **Emergency Financial Assistance – Pharmacy Assistance** (Revised April 2017)	
HRSA Service Category Title: **RWGA Only**	Emergency Financial Assistance
Local Service Category Title:	Emergency Financial Assistance – Pharmacy Assistance
Budget Type: **RWGA Only**	Hybrid Fee-for-Service
Budget Requirements or Restrictions: **RWGA Only**	Direct cash payments to clients are not permitted. It is expected that all other sources of funding in the community for emergency financial assistance will be effectively used and that any allocation of RWHAP funds for these purposes will be as the payer of last resort, and for limited amounts, uses, and periods of time. Continuous provision of an allowable service to a client should not be funded through emergency financial assistance.
HRSA Service Category Definition: **RWGA Only**	*Emergency Financial Assistance* provides limited one-time or short-term payments to assist the RWHAP client with an emergent need for paying for essential utilities, housing, food (including groceries, and food vouchers), transportation, and medication. Emergency financial assistance can occur as a direct payment to an agency or through a voucher program.
Local Service Category Definition:	Emergency Financial Assistance – Pharmacy Assistance provides limited one-time and/or short-term 14-day supply of pharmaceuticals to patients otherwise ineligible for medications through private insurance, Medicaid/Medicare, State ADAP, SPAP or other sources. One refill for up to 14-day supply available with RWGA prior approval. Allowable medications are only those on the Houston EMA Ryan White Part A Formulary. HIV-related medication services are the provision of physician or physician-extender prescribed HIV medications to prevent serious deterioration of health. Does not include drugs available to the patient from other programs or payers or free of charge or medications available over the counter (OTC) without prescription. Contractor must offer all medications on the Texas ADAP formulary.
Target Population (age, gender, geographic, race, ethnicity, etc.):	Services will be available to eligible HIV-infected clients residing in the Houston EMA/HSDA.
Services to be Provided:	Contractor must: Provide pharmacy services on-site or through an established contractual relationship that meets all requirements. Alternate (off-site) approaches must be approved prior to implementation by RWGA. Either directly, or via subcontract with an eligible 340B Pharmacy program entity, must: Ensure a comprehensive financial intake application to determine client eligibility for this program to insure that these funds are used as a last resort for purchase of medications. Ensure the documented capability of interfacing with the Texas HIV Medication Program operated by the Texas Department of State Health Services. This capability must be fully documented and is subject to independent verification by RWGA. Ensure

	medication assistance provided to clients does not duplicate services already being provided in the Houston area. The process for accomplishing this must be fully documented and is subject to independent verification by RWGA. Ensure, either directly or via a 340B Pharmacy Program Provider, at least 2 years of continuous documented experience in providing HIV/AIDS medication programs utilizing Ryan White Program or similar public sector funding. This experience must be documented and is subject to independent verification by RWGA. Ensure all medications are purchased via a qualified participant in the federal 340B Drug Pricing Program and Prime Vendor Program, administered by the HRSA Office of Pharmacy Affairs. Note: failure to maintain 340B or Prime Vendor drug pricing may result in a negative audit finding, cost disallowance or termination of contract awarded. Contractor must maintain 340B Program participation throughout the contract term. All eligible medications must be purchased in accordance with Program 340B guidelines and program requirements. Ensure Houston area HIV/AIDS service providers are informed of this program and how the client referral and enrollment processes functions. Contractor must maintain documentation of such marketing efforts. Implement a consistent process to enroll eligible patients in available pharmaceutical company Patient Assistance Programs prior to using Ryan White Part A funded Emergency Financial Assistance – Pharmacy Assistance or LPAP resources. Ensure information regarding the program is provided to PLWHA, including historically under-served and unserved populations (e.g., African American, Hispanic/Latino, Asian, Native American, Pacific Islander) and women not currently obtaining prescribed HIV and HIV-related medications.
Service Unit Definition(s): **RWGA Only**	A unit of service = a transaction involving the filling of a prescription or any other allowable HIV treatment medication need ordered by a qualified medical practitioner. The transaction will involve at least one item being provided for the client, but can be any multiple. The cost of medications provided to the client must be invoiced at actual cost.
Financial Eligibility:	Refer to the RWPC's approved *Financial Eligibility for Houston EMA/HSDA Services*.
Client Eligibility:	PLWHA residing in the Houston EMA (prior approval required for non-EMA clients).
Agency Requirements:	Contractor must provide all required program components - Primary Medical Care, Medical Case Management, Service Linkage (non-medical Case Management), Local Pharmacy Assistance Program (LPAP), and Emergency Financial Assistance-Pharmacy services.
Staff Requirements:	Must meet all applicable Houston EMA/HSDA Part A/B Standards of Care.
Special Requirements: **RWGA Only**	Not Applicable.

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Step in Process: **Steering Committee**		Date: **06/06/19**
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Step in Process: **Quality Improvement Committee**		Date: **05/14/19**
Recommendations:	Approved: Y:____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMN Workgroup #1**	Date: **04/23/19**
Recommendations:	Financial Eligibility: 500%
1. Accept the service definition as presented, update the justification chart, and keep the financial eligibility the same.	
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2019-20 Service Category Definition
Ryan White Part B and DSHS State Services

Local Service Category:	**Health Insurance Premium and Cost Sharing Assistance**
Amount Available**:**	**To be determined**
Budget Requirements or Restrictions **(TRG Only)**:	Contractor must spend no more than 20% of funds on disbursement transactions. The remaining 80% of funds must be expended on the actual cost of the payment(s) disbursed. ADAP dispensing fees are not allowable under this service category.
Local Service Category Definition:	**Health Insurance Premium and Cost Sharing Assistance:** The Health Insurance Premium and Cost Sharing Assistance service category is intended to help people living with HIV continue medical care without gaps in health insurance coverage or disruption of treatment. A program of financial assistance for the payment of health insurance premiums and co-pays, co-insurance and deductibles to enable eligible individuals with HIV disease to utilize their existing third party or public assistance (e.g. Medicare) medical insurance. Co-Payment: A cost-sharing requirement that requires the insured to pay a specific dollar amount for each unit of service. Co-Insurance: A cost-sharing requirement that requires the insured to pay a percentage of costs for covered services/prescription Deductible: A cost-sharing requirement that requires the insured pay a certain amount for health care or prescription, before the prescription drug plan or other insurance begins to pay. Premium: The amount paid by the insured to an insurance company to obtain or maintain and insurance policy. Advance Premium Tax Credit (APTC) Tax Liability: Tax liability associated with the APTC reconciliation; reimbursement cap of 50% of the tax due up to a maximum of $500.
Target Population (age, gender, geographic, race, ethnicity, etc.):	All Ryan White eligible clients with 3rd party insurance coverage (COBRA, private policies, Qualified Health Plans, CHIP, Medicaid, Medicare and Medicare Supplemental plans) within the Houston HSDA.
Services to be Provided:	Contractor may provide assistance with: • Insurance premiums, • And deductibles, co-insurance and/or co-payments.
Service Unit Definition **(TRG Only)**:	A unit of service will consist of payment of health insurance premiums, co-payments, co-insurance, deductible, or a combination.
Financial Eligibility:	Affordable Care Act (ACA) Marketplace Plans: 100-400% of federal poverty guidelines. All other insurance plans at or below 400% of federal poverty guidelines. Exception: Clients who were enrolled prior to November 1, 2015 will maintain their eligibility in subsequent plan years even if below 100% or between 400-500% of federal poverty guidelines.
Client Eligibility:	People living with HIV in the Houston HSDA and have insurance or be eligible (within local financial eligibility guidelines) to purchase a Qualified Health Plan through the Marketplace.

Agency Requirements **(TRG Only)**:	Agency must: • Provide a comprehensive financial intake/application to determine client eligibility for this program to insure that these funds are used as a last resort in order for the client to utilize his/her existing insurance or be eligible to purchase a qualified health plan through the Marketplace. • Clients will not be put on wait lists nor will Health Insurance Premium and Cost Sharing Assistance services be postponed or denied due to funding without notifying the Administrative Agency. • Conduct marketing in-services with Houston area HIV/AIDS service providers to inform them of this program and how the client referral and enrollment processes function. • Establish formal written agreements with all Houston HSDA Ryan White-funded (Part A, B, C, D) primary care, mental health and substance abuse provider agencies to enable clients of these agencies to enroll in Health Insurance assistance at his/her primary care, mental health or substance abuse provider site. (i.e. No need for client to physically present to Health Insurance provider.) • Utilizes the RW Planning Council-approved prioritization of cost sharing assistance when limited funds warrant it (premiums take precedence). o **Priority Ranking of Requests (in descending order)**: ▪ HIV medication co-pays and deductibles (medications on the Texas ADAP formulary) ▪ Non-HIV medication co-pays and deductibles ▪ Co-payments for provider visits (eg. physician visit and/or lab copayments) ▪ Medicare Part D (Rx) premiums ▪ APTC Tax Liability ▪ Out of Network out-of-pocket expenses • Utilizes the RW Planning Council –approved consumer out-of-pocket methodology.
Special Requirements **(TRG Only)**:	Must comply with the **DSHS Health Insurance Assistance Standards of Care** and the **Houston HSDA Health Insurance Assistance Standards of Care** ~~and, pending the most current DSHS guidance, client must:~~ ~~• Purchase Silver Level Plan with formulary equivalency~~ ~~• Take advance premium credit~~ • ~~No assistance for Out of Network out-of-pocket expenses without prior approval of the Administrative Agent.~~ ~~Must comply with DSHS Interim Guidance.~~ Must comply with updated guidance from DSHS. Must comply with the Eastern HASA Health Insurance Assistance Policy and Procedure ~~(HIA-1701)~~.

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Step in Process: **Steering Committee**		Date: **06/06/19**
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Step in Process: **Quality Improvement Committee**		Date: **05/14/19**
Recommendations:	Approved: Y:____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMN Workgroup #2**	Date: **04/23/19**
Recommendations:	Financial Eligibility: 0 - 400%, ACA plans: must have a subsidy
1. Accept the service definition as presented, update the justification chart, and keep the financial eligibility the same.	
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Houston EMA/HSDA Ryan White Part A/MAI Service Definition **Health Insurance Co-Payments and Co-Insurance Assistance** (Revision Date: 5/21/15)	
HRSA Service Category Title:	**Health Insurance Premium and Cost Sharing Assistance**
Local Service Category Title:	**Health Insurance Co-Payments and Co-Insurance**
Budget Type**:**	**Hybrid Fee for Service**
Budget Requirements or Restrictions:	Agency must spend no more than 20% of funds on disbursement transactions. The remaining 80% of funds must be expended on the actual cost of the payment(s) disbursed.
HRSA Service Category Definition**:**	***Health Insurance Premium & Cost Sharing Assistance*** is the provision of financial assistance for eligible individuals living with HIV to maintain a continuity of health insurance or to receive medical benefits under a health insurance program. This includes premium payments, risk pools, co-payments, and deductibles.
Local Service Category Definition:	A program of financial assistance for the payment of health insurance premiums, deductibles, co-insurance, co-payments and tax liability payments associated with Advance Premium Tax Credit (APTC) reconciliation to enable eligible individuals with HIV disease to utilize their existing third party or public assistance (e.g. Medicare) medical insurance. Co-Payment: A cost-sharing requirement that requires the insured to pay a specific dollar amount for each unit of service. Co-Insurance: A cost-sharing requirement that requires the insured to pay a percentage of costs for covered services/prescription Deductible: A cost-sharing requirement that requires the insured to pay a certain amount for health care or prescription, before the prescription drug plan or other insurance begins to pay. Premium: The amount paid by the insured to an insurance company to obtain or maintain and insurance policy. APTC Tax Liability: The difference paid on a tax return if the advance credit payments that were paid to a health care provider were more than the actual eligible credit.
Target Population (age, gender, geographic, race, ethnicity, etc.):	All Ryan White eligible clients with 3rd party insurance coverage (COBRA, private policies, Qualified Health Plans, CHIP, Medicaid, Medicare and Medicare Supplemental) within the Houston EMA.
Services to be Provided:	Provision of financial assistance with premiums, deductibles, co-insurance, and co-payments. Also includes tax liability payments associated with APTC reconciliation up to 50% of liability with a $500 maximum.
Service Unit Definition(s): **(RWGA only)**	1 unit of service = A payment of a premium, deductible, co-insurance, co-payment or tax liability associated with APTC reconciliation for an HIV-infected person with insurance coverage.

Financial Eligibility:	Refer to the RWPC's approved *Financial Eligibility for Houston EMA/HSDA Services*.
Client Eligibility:	HIV-infected individuals residing in the Houston EMA meeting financial eligibility requirements and have insurance or be eligible to purchase a Qualified Health Plan through the Marketplace.
Agency Requirements:	Agency must: • Provide a comprehensive financial intake/application to determine client eligibility for this program to insure that these funds are used as a last resort in order for the client to utilize his/her existing insurance or be eligible to purchase a qualified health plan through the Marketplace. • Ensure that assistance provided to clients does not duplicate services already being provided through Ryan White Part B or State Services. The process for ensuring this requirement must be fully documented. • Have mechanisms to vigorously pursue any excess premium tax credit a client receives from the IRS upon submission of the client's tax return for those clients that receive financial assistance for eligible out of pocket costs associated with the purchase and use of Qualified Health Plans obtained through the Marketplace. • Conduct marketing with Houston area HIV/AIDS service providers to inform such entities of this program and how the client referral and enrollment processes function. Marketing efforts must be documented and are subject to review by RWGA. • Clients will not be put on wait lists nor will Health Insurance Premium and Cost Sharing Assistance services be postponed or denied without notifying the Administrative Agency. • Establish formal written agreements with all Houston HSDA Ryan White-funded (Part A, B, C, D) primary care, mental health and substance abuse provider agencies to enable clients of these agencies to enroll in Health Insurance assistance at his/her primary care, mental health or substance abuse provider site. (i.e. No need for client to physically present to Health Insurance provider.) • Utilize RWGA approved prioritization of cost sharing assistance, when limited funds warrant it. • Utilize consumer out-of-pocket methodology approved by RWGA.
Staff Requirements:	None
Special Requirements:	Agency must: • Comply with the Houston EMA/HSDA Standards of Care and Health Insurance Assistance service category program policies.

FY 2020 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/13/19**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Steering Committee**		Date: **06/06/19**
Recommendations:	Approved: Y:____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Improvement Committee**		Date: **05/14/19**
Recommendations:	Approved: Y:____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMN Workgroup #2**	Date: **04/23/19**
Recommendations:	Financial Eligibility: 0-400%; ACA plans must have a subsidy
1. Accept the service definition as presented, update the justification chart, and keep the financial eligibility the same.	
2.	
3.	

Service Category Definition - Ryan White Part B Grant

Local Service Category:	**Home and Community-Based Health Services (Facility-Based)**
Amount Available**:**	**To be determined**
Unit Cost	
Budget Requirements or Restrictions:	Maximum of 10% of budget for Administrative Cost
DSHS Service Category Definition:	Home and Community-Based Health Care Services are therapeutic, nursing, supportive and/or compensatory health services provided by a licensed/certified home health agency in a home or community-based setting in accordance with a written, individualized plan of care established by a licensed physician. Home and Community-Based Health Services include the following: • **Para–professional care** is the provision of services by a home health aide, personal caretaker, or attendant caretaker. This definition also includes non–medical, non–nursing assistance with cooking and cleaning activities to help clients remain in their homes. • **Professional care** is the provision of services in the home by licensed health care workers such as nurses. • **Specialized care** is the provision of services that include intravenous and aerosolized treatment, parenteral feeding, diagnostic testing, and other high–tech therapies. physical therapy, social worker services. Home and Community-Based Health Care Providers work closely with the multidisciplinary care team that includes the client's case manager, primary care provider, and other appropriate health care professionals. Allowable services include: • Durable medical equipment • Home health aide and personal care services • Day treatment or other partial hospitalization services • Home intravenous and aerosolized drug therapy (including prescription drugs administered as part of such therapy) • Routine diagnostic testing • Appropriate mental health, developmental, and rehabilitation services • Specialty care and vaccinations for hepatitis co-infection, provided by public and private entities
Local Service Category Definition:	***Home and Community-based Health Services (facility-based)*** *is* defined as a day treatment program that includes Physician ordered therapeutic nursing, supportive and/or compensatory health services based on a written plan of care established by an interdisciplinary care team that includes appropriate healthcare professionals and paraprofessionals. Services include skilled nursing, nutritional counseling, evaluations and education, and additional therapeutic services and activities. Inpatient hospitals services, nursing home and other long-term care facilities are **NOT** included.
Target Population (age, gender, geographic, race, ethnicity, etc.):	Eligible recipients for home and community-based health services are persons living with HIV residing within the Houston HIV Service Delivery Area (HSDA) who are at least 18 years of age.
Services to be Provided:	Community-Based Health Services are designed to support the increased functioning and the return to self-sufficiency of clients through the provision of treatment and activities of daily living. Services must include: • **Skilled Nursing:** Services to include medication administration, medication supervision, medication ordering, filling pill box, wound dressing changes, straight catheter insertion, education of family/significant others in patient

	care techniques, ongoing monitoring of patients' physical condition and communication with attending physicians (s), personal care, and diagnostics testing. • **Other Therapeutic Services:** Services to include recreational activities (fine/gross motor skills and cognitive development), replacement of durable medical equipment, information referral, peer support, and transportation. • **Nutrition:** Services to include evaluation and counseling, supplemental nutrition, and daily nutritious meals. • **Education:** Services to include instructional workshops of HIV related topics and life skills. Services will be provided at least Monday through Friday for a minimum of 10 hours/day.
Service Unit Definition(s):	A unit of service is defined as one (1) visit/day of care for one (1) client for a minimum of four hours. Services consist of medical health care and social services at a licensed adult day.
Financial Eligibility:	Income at or below 300% of Federal Poverty Guidelines
Client Eligibility:	People living with HIV at least 18 years of age residing within the Houston HSDA.
Agency Requirements:	Must be licensed by the Texas Department of Aging and Disability Services (DADS) as an Adult Day Care provider.
Staff Requirements:	• **Skilled Nursing Services** must be provided by a Licensed Vocational or Registered Nurse. • **Other Therapeutic Services** are provided by paraprofessionals, such as an activities coordinator, and counselors (LPC, LMSW, and LMFTA). • **Nutritional Services** are provided by a Registered Dietician and food managers. • **Education Services** are provided by a health educator.
Special Requirements:	Must comply with the Houston EMA/HSDA Standards of Care. The agency must comply with **the DSHS Home and Community-Based Health Services Standards of Care** and **Houston HSDA**. The agency must have policies and procedures in place that comply with the standards ***prior*** to delivery of the service.

FY 2020 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/13/19**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Steering Committee**		Date: **06/06/19**
Recommendations:	Approved: Y:____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Improvement Committee**		Date: **05/14/19**
Recommendations:	Approved: Y:____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMN Workgroup #3**	Date: **04/24/19**
Recommendations:	Financial Eligibility: **300%**
1. Accept the service definition as presented, update the justification chart, and keep the financial eligibility the same.	
2. Ask the Office of Support to work with the AAs to promote this service.	
3.	

Service Category Definition - DSHS State Services

Local Service Category:	**Hospice Services**
Amount Available**:**	**To be determined**
Unit Cost	
Budget Requirements or Restrictions:	Maximum 10% of budget for Administrative Cost
DSHS Service Category Definition:	Provision of Hospice Care provided by licensed hospice care providers to clients in the terminal stages of illness, in a home or other residential setting, including a non-acute-care section of a hospital that has been designated and staffed to provide hospice care for terminal patients. Hospice services include, but are not limited to, the palliation and management of the terminal illness and conditions related to the terminal illness. Allowable Ryan White/State Services funded services are: • Room • Board • Nursing care • Mental health counseling, to include bereavement counseling • Physician services • Palliative therapeutics Ryan White/State Service funds may not be used for funeral, burial, cremation, or related expenses. Funds may not be used for nutritional services, durable medical equipment and medical supplies or case management services.
Local Service Category Definition:	Hospice services encompass palliative care for terminally ill clients and support services for clients and their families. Services are provided by a licensed nurse and/or physical therapist. Additionally, unlicensed personnel may deliver services under the delegation of a licensed nurse or physical therapist, to a client or a client's family as part of a coordinated program. A physician must certify that a patient is terminal, defined under Medicaid hospice regulations as having a life expectancy of 6 months or less. Services must include but are not limited to medical and nursing care, palliative care, and psychosocial support for the patient, as well as a mechanism for bereavement referral for surviving family members. Counseling services provided in the context of hospice care must be consistent with the (Ryan White) definition of mental health counseling. Palliative therapies must be consistent with those covered under respective State Medicaid Program.
Target Population (age, gender, geographic, race, ethnicity, etc.):	Individuals with AIDS residing in the Houston HIV Service Delivery (HSDA).

Services to be Provided:	Services must include but are not limited to medical and nursing care, palliative care, psychosocial support and spiritual guidance for the patient, as well as a mechanism for bereavement referral for surviving family members. Counseling services provided in the context of hospice care must be consistent with the (Ryan White) definition of mental health counseling. Palliative therapies must be consistent with those covered under respective State Medicaid Program. Allowable Ryan White/State Services funded services are: • Room • Board • Nursing care • Mental health counseling, to include bereavement counseling • Physician services • Palliative therapeutics Services NOT allowed under this category: • HIV medications under hospice care unless paid for by the client. • Medical care for acute conditions or acute exacerbations of chronic conditions other than HIV for potentially Medicaid eligible residents. • Funeral, burial, cremation, or related expenses. • Nutritional services, • Durable medical equipment and medical supplies. • Case management services.
Service Unit Definition(s):	A unit of service is defined as one (1) twenty-four (24) hour day of hospice services that includes a full range of physical and psychological support to HIV patients in the final stages of AIDS.
Financial Eligibility:	Income at or below 300% Federal Poverty Guidelines.
Client Eligibility:	Individuals with an AIDS diagnosis and certified by his or her physician that the individual's prognosis is for a life expectancy of six (6) months or less if the terminal illness runs its normal course
Agency Requirements:	Agency/provider is a licensed hospital/facility and maintains a valid State license with a residential AIDS Hospice designation, or is certified as a Special Care Facility with Hospice designation. Provider must inform Administrative Agency regarding issue of long term care facilities denying admission for people living with HIV based on inability to provide appropriate level of skilled nursing care. Services must be provided by a medically directed interdisciplinary team, qualified in treating individual requiring hospice services.

	Staff will refer Medicaid/Medicare eligible clients to a Hospice Provider for medical, support, and palliative care. Staff will document an attempt has been made to place Medicaid/Medicare eligible clients in another facility prior to admission.
Staff Requirements:	All hospice care staff who provide direct-care services and who require licensure or certification, must be properly licensed or certified by the State of Texas.
Special Requirements:	These services must be: a) Available 24 hours a day, seven days a week, during the last stages of illness, during death, and during bereavement; b) Provided by a medically directed interdisciplinary team; c) Provided in nursing home, residential unit, or inpatient unit according to need. These services do not include inpatient care normally provided in a licensed hospital to a terminally ill person who has not elected to be a hospice client. d) Residents seeking care for hospice at Agency must first seek care from other facilities and denial must be documented in the resident's chart. Must comply with the **Houston HSDA Hospice Standards of Care**. The agency must comply with **the DSHS Hospice Standards of Care**. The agency must have policies and procedures in place that comply with the standards ***prior*** to delivery of the service.

FY 2020 RWPC "How to Best Meet the Need" Decision Process

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Step in Process: **Steering Committee**		Date: **06/06/19**
Recommendations:	Approved: Y:____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Improvement Committee**		Date: **05/14/19**
Recommendations:	Approved: Y:____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMN Workgroup #3**	Date: **04/24/19**
Recommendations:	Financial Eligibility: **300%**
1. Accept the service definition as presented, update the justification chart, and keep the financial eligibility the same.	
2.	
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Service Category Definition - DSHS State Services

Local Service Category:	**Linguistics Services**
Amount Available**:**	**To be determined**
Unit Cost**:**	
Budget Requirements or Restrictions **(TRG Only)**:	Maximum of 10% of budget for Administrative Cost.
DSHS Service Category Definition	Support for Linguistic Services includes interpretation (oral) and translation (written) services, provided by qualified individuals as a component of HIV service delivery between the provider and the client, when such services are necessary to facilitate communication between the provider and client and/or support delivery of Ryan White-eligible services. Linguistic Services include interpretation/translation services provided by qualified interpreters to people living with HIV (including those who are deaf/hard of hearing and non-English speaking individuals) for the purpose of ensuring communication between client and providers while accessing medical and Ryan White fundable support services that have a direct impact on primary medical care. These standards ensure that language is not barrier to any client seeking HIV related medical care and support; and linguistic services are provided in a culturally appropriate manner. Services are intended to be inclusive of all cultures and sub-cultures and not limited to any particular population group or sets of groups. They are especially designed to assure that the needs of racial, ethnic, and linguistic populations severely impacted by the HIV epidemic receive quality, unbiased services.
Local Service Category Definition:	To provide one hour of interpreter services including, but not limited to, sign language for deaf and /or hard of hearing and native language interpretation for monolingual people living with HIV.
Target Population (age, gender, geographic, race, ethnicity, etc.):	People living with HIV in the Houston HIV Service Delivery Area (HSDA).
Services to be Provided:	Services include language translation and signing for deaf and/or hearing impaired HIV+ persons. Services exclude Spanish Translation Services.
Service Unit Definition(s) **(TRG Only)**:	A unit of service is defined as one hour of interpreter services to an eligible client.
Financial Eligibility:	Income at or below 300% Federal Poverty Guidelines.
Client Eligibility:	people living with HIV in the Houston HSDA
Agency Requirements **(TRG Only)**:	Any qualified and interested agency may apply and subcontract actual interpretation services out to various other qualifying agencies.
Staff Requirements:	ASL interpreters must be certified. Language interpreters must have completed a forty (40) hour community interpreter training course approved by the DSHS.
Special Requirements **(TRG Only)**:	Must comply with the Houston HSDA **Linguistic Services Standards of Care**. The agency must comply with **the DSHS Linguistic Services Standards of Care**. The agency must have policies and procedures in place that comply with the standards ***prior*** to delivery of the service.

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Step in Process: **HTBMN Workgroup #3**	Date: **04/24/19**
Recommendations:	Financial Eligibility: **300%**
1. Accept the service definition as presented, update the justification chart, and keep the financial eligibility the same.	
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Houston EMA/HSDA Ryan White Part A Service Definition **Medical Nutritional Therapy** (Last Review/Approval Date: 6/3/16)	
HRSA Service Category Title: **RWGA Only**	**Medical Nutritional Therapy**
Local Service Category Title:	**Medical Nutritional Therapy and Nutritional Supplements**
Budget Type: **RWGA Only**	**Hybrid**
Budget Requirements or Restrictions: **RWGA Only**	***Supplements:*** An individual client may not exceed $1,000.00 in supplements annually without **prior** approval by RWGA. ***Nutritional Therapy:*** An individual nutritional education/counseling session lasting a minimum of 45 minutes. Provision of professional (licensed registered dietician) education/counseling concerning the therapeutic importance of foods and nutritional supplements that are beneficial to the wellness and improved health conditions of clients. Medically, it is expected that symptomatic or mildly symptomatic clients will be seen once every 12 weeks while clients with higher acuity will be seen once every 6 weeks.
HRSA Service Category Definition: **RWGA Only**	***Medical nutrition therapy*** is provided by a licensed registered dietitian outside of a primary care visit **and may include the provision of nutritional supplements.**
Local Service Category Definition:	***Supplements:*** Up to a 90-day supply at any given time, per client, of approved nutritional supplements that are listed on the Houston EMA/HSDA Nutritional Supplement Formulary. Nutritional counseling must be provided for each disbursement of nutritional supplements. ***Nutritional Therapy:*** An individual nutritional education/counseling session lasting a minimum of 45 minutes. Provision of professional (licensed registered dietician) education/counseling concerning the therapeutic importance of foods and nutritional supplements that are beneficial to the wellness and improved health conditions of clients. Medically, it is expected that symptomatic or mildly symptomatic clients will be seen once every 12 weeks while clients with higher acuity will be seen once every 6 weeks. Services must be provided under written order from a state licensed medical provider (MD, DO or PA) with prescribing privileges and must be based on a written nutrition plan developed by a licensed registered dietician.
Target Population (age, gender, geographic, race, ethnicity, etc.):	HIV/AIDS infected persons living within the Houston Eligible Metropolitan Area (EMA) or HIV Service Delivery Area (HSDA).
Services to be Provided:	***Supplements:*** The provision of nutritional supplements to eligible clients with a written referral from a licensed physician or PA that specifies frequency, duration and amount and includes a written nutritional plan prepared by a licensed, registered dietician. *Nutritional Supplement Disbursement Counseling* is a component of

	Medical Nutritional Therapy. *Nutritional Supplement Disbursement Counseling* is a component of the disbursement transaction and is defined as the provision of information by a licensed registered dietitian about therapeutic nutritional and/or supplemental foods that are beneficial to the wellness and increased health condition of clients provided in conjunction with the disbursement of supplements. Services may be provided either through educational or counseling sessions. Also included in this service are follow up sessions with clients' Primary Care provider regarding the effectiveness of the supplements. The number of sessions for each client shall be determined by a written assessment conducted by the Licensed Dietitian but may not exceed twelve (12) sessions per client per contract year. ***Medical Nutritional Therapy:*** Service must be provided under written order of a state licensed medical provider (MD, DO, PA) with prescribing privileges and must include a written plan developed by state licensed registered dietician. Client must receive a full range of medical nutritional therapy services including, but not limited to, diet history and recall; estimation of nutrition intake; assessment of weight change; calculation of nutritional requirements related to specific medication regimes and disease status, meal preparation and selection suggestions; calorie counts; evaluation of clinically appropriate laboratory results; assessment of medication-nutrient interactions; and bio-impedance assessment. If patient evaluation indicates the need for interventions such as nutritional supplements, appetite stimulants, or treatment of underlying pathogens, the dietician must share such findings with the patient's primary medical provider (MD, DO or PE) and provide recommendations. Clients needing additional nutritional resources will be referred to case management services as appropriate and/or local food banks. Provider must furnish information on this service category to at least the health care providers funded by Ryan White Parts A, B, C and D and TDSHS State Services.
Service Unit Definition(s): **RWGA Only**	***Supplements:*** One (1) unit of service = a single visit wherein an eligible client receives allowable nutritional supplements (up to a 90 day supply) and nutritional counseling by a licensed dietician as clinically indicated. A visit wherein the client receives counseling but no supplements is not a billable disbursement transaction. ***Medical Nutritional Therapy:*** An individual nutritional counseling session lasting a minimum of 45 minutes.
Financial Eligibility:	Refer to the RWPC's approved *Financial Eligibility for Houston EMA/HSDA Services*.
Client Eligibility:	***Nutritional Supplements:*** HIV-infected and documentation that the client is actively enrolled in primary medical care.

	Medical Nutritional Therapy: HIV-infected resident and documentation that the client is actively enrolled in primary medical care.
Agency Requirements:	None.
Staff Requirements:	The nutritional counseling services under this category must be provided by a licensed registered dietician. Dieticians must have a minimum of two (2) years experience providing nutritional assessment and counseling to PLWHA.
Special Requirements: **RWGA Only**	Must comply with Houston EMA/HSDA Part A/B Standards of Care, HHS treatment guidelines and applicable HRSA/HAB HIV Clinical Performance Measures. Must comply with the Houston EMA/HSDA approved Medical Nutritional Therapy Formulary.

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Step in Process: **Steering Committee**		Date: **06/06/19**
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Step in Process: **Quality Improvement Committee**		Date: **05/14/19**
Recommendations:	Approved: Y:____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMN Workgroup #2**	Date: **04/23/19**
Recommendations:	Financial Eligibility: 300%
1. Accept the service definition as presented, update the justification chart, and keep the financial eligibility the same.	
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Local Service Category:	**Mental Health Services**
Amount Available**:**	**To be determined**
Unit Cost	
Budget Requirements or Restrictions **(TRG Only)**:	Maximum of 10% of budget for Administrative Cost.
DSHS Service Category Definition	Mental Health Services include psychological and psychiatric treatment and counseling services offered to individuals with a diagnosed mental illness, conducted in a group or individual setting, based on a detailed treatment plan, and provided by a mental health professional licensed or authorized within the State to provide such services, typically including psychiatrists, psychologists, and licensed clinical social workers. Mental health counseling services includes outpatient mental health therapy and counseling (individual and family) provided solely by Mental Health Practitioners licensed in the State of Texas. Mental health services include: • Mental Health Assessment • Treatment Planning • Treatment Provision • Individual psychotherapy • Family psychotherapy • Conjoint psychotherapy • Group psychotherapy • Psychiatric medication assessment, prescription and monitoring • Psychotropic medication management • Drop-In Psychotherapy Groups • Emergency/Crisis Intervention General mental health therapy, counseling and short-term (based on the mental health professionals judgment) bereavement support is available for family members or significant others of people living with HIV.
Local Service Category Definition:	**Individual Therapy/counseling** is defined as 1:1 or family-based crisis intervention and/or mental health therapy provided by a licensed mental health practitioner to an eligible person living with HIV. **Support Groups** are defined as professionally led (licensed therapists or counselor) groups that comprise people living with HIV, family members, or significant others for the purpose of providing emotional support directly related to the stress of caring for people living with HIV.
Target Population (age, gender, geographic, race, ethnicity, etc.):	People living with HIV and affected individuals living within the Houston HIV Service Delivery Area (HSDA).
Services to be Provided:	Agencies are encouraged to have available to clients all modes of counseling services, i.e., crisis, individual, family, and group. Sessions may be conducted in-home. Agency must provide professional support group sessions led by a licensed counselor.
Service Unit Definition(s) **(TRG Only)**:	**Individual and Family Crisis Intervention and Therapy:** A unit of service is defined as an individual counseling session lasting a minimum of 45 minutes. **Group Therapy:** A unit of service is defined as one (1) eligible client attending 90 minutes of group therapy. The minimum time allowable for a single group session is 90 minutes and maximum time allowable for a single group session is 120 minutes. No more than one unit may be billed per session for an individual or group session.

	A minimum of three (3) clients must attend a group session in order for the group session to eligible for reimbursement. **Consultation:** One unit of service is defined as 15 minutes of communication with a medical or other appropriate provider to ensure case coordination.
Financial Eligibility:	Income at or below 300% Federal Poverty Guidelines.
Client Eligibility:	For individual therapy session, person living with HIV or the affected significant other of an person living with HIV, resident of Houston HSDA. Person living with HIV must have a current DSM diagnosis eligible for reimbursement under the State Medicaid Plan. Client must not be eligible for services from other programs or providers (i.e. MHMRA of Harris County) or any other reimbursement source (i.e. Medicaid, Medicare, Private Insurance) unless the client is in crisis and cannot be provided immediate services from the other programs/providers. In this case, clients may be provided services, as long as the client applies for the other programs /providers, until the other programs/providers can take over services. Medicaid/Medicare, Third Party Payer and Private Pay status of clients receiving services under this grant must be verified by the provider prior to requesting reimbursement under this grant. For support group sessions, client must be either a person living with HIV or the significant other of person living with HIV. Affected significant other is eligible for services only related to the stress of caring for an person living with HIV.
Agency Requirements **(TRG Only)**:	Agency must provide assurance that the mental health practitioner shall be supervised by a licensed therapist qualified by the State to provide clinical supervision. This supervision should be documented through supervision notes. Keep attendance records for group sessions. Must provide 24-hour access to a licensed counselor for current clients with emotional emergencies. Clients eligible for Medicaid or 3rd party payer reimbursement may not be billed to grant funds. Medicare Co-payments may be billed to the contract as ½ unit of service. Documentation of at least one therapist certified by Medicaid/Medicare on the staff of the agency must be provided in the proposal. All funded agencies must maintain the capability to serve and seek reimbursement from Medicaid/Medicare throughout the term of their contract. Potential clients who are Medicaid/ Medicare eligible may not be denied services by a funded agency based on their reimbursement status (Medicaid/Medicare eligible clients may not be referred elsewhere in order that non-Medicaid/Medicare eligible clients may be added to this grant). Failure to serve Medicaid/Medicare eligible clients based on their reimbursement status will be grounds for the immediate termination of the provider's contract. Must comply with the State Services Standards of Care. Must provide a plan for establishing criteria for prioritizing participation in group sessions and for termination from group participation. Providers and system must be Medicaid/Medicare certified to ensure that Ryan

	White funds are the payer of last resort.
Staff Requirements:	It is required that counselors have the following qualifications: Licensed Mental Health Practitioner by the State of Texas (LCSW, LMSW, LPC PhD, Psychologist, or LMFT). At least two years experience working with HIV disease or two years work experience with chronic care of a catastrophic illness. Counselors providing family sessions must have at least two years experience in family therapy. Counselors must be covered by professional liability insurance with limits of at least $300,000 per occurrence.
Special Requirements **(TRG Only)**:	All mental health interventions must be based on proven clinical methods and in accordance with legal and ethical standards. The importance of maintaining confidentiality is of critical importance and cannot be overstated unless otherwise indicated based on Federal, state and local laws and guidelines (i.e. abuse, self or other harm). All programs must comply with the Health Insurance Portability and Accountability Act (HIPAA) standards for privacy practices of protected health information (PHI) information. Medicare and private insurance co-payments are eligible for reimbursement under this grant (in this situation the agency will be reimbursed the client's co-payment only, not the cost of the session which must be billed to Medicare and/or the Third party payer). Extensions will be addressed on an individual basis when meeting the criteria of counseling directly related to HIV illness. Under no circumstances will the agency be reimbursed more than two (2) units of individual therapy per client in any single 24-hour period. Agency should develop services that focus on the Special Populations identified in the *2012 Houston Area Comprehensive Plan for HIV Prevention and Care Services* including Adolescents, Homeless, Incarcerated & Recently Released (IRR), Injection Drug Users (IDU), Men who Have Sex with Men (MSM), and Transgender populations. Additionally, services should focus on increasing access for individuals living in rural counties. Must comply with the Houston EMA/HSDA Standards of Care. The agency must comply with **the DSHS Mental Health Services Standards of Care**. The agency must have policies and procedures in place that comply with the standards ***prior*** to delivery of the service.

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Step in Process: **Council**		Date: **06/13/19**
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Step in Process: **Steering Committee**		Date: **06/06/19**
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Step in Process: **Quality Improvement Committee**		Date: **05/14/19**
Recommendations:	Approved: Y:____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMN Workgroup #2**	Date: **04/23/19**
Recommendations:	Financial Eligibility: 300%
1. Accept the service definition with one change: allow 90 minutes for family/couples session, update the justification chart, and keep the financial eligibility the same.	
2.	
3.	

Service Category Definition - Ryan White Part B

Local Service Category:	**Oral Health Care**
Amount Available:	**To be determined**
Unit Cost**:**	
Budget Requirements or Restrictions **(TRG Only)**:	Maximum of 10% of budget for Administrative Costs
Local Service Category Definition:	Restorative dental services, oral surgery, root canal therapy, fixed and removable prosthodontics; periodontal services includes subgingival scaling, gingival curettage, osseous surgery, gingivectomy, provisional splinting, laser procedures and maintenance. Oral medication (including pain control) for HIV patients 15 years old or older must be based on a comprehensive individual treatment plan. Prosthodontics services to people living with HIV including but not limited to examinations and diagnosis of need for dentures, crowns, bridgework and implants, diagnostic measurements, laboratory services, tooth extraction, relines and denture repairs. Emergency procedures will be treated on a walk-in basis as availability and funding allows. Funded Oral Health Care providers are permitted to provide necessary emergency care regardless of a client's annual benefit balance. If a provider cannot provide adequate services for emergency care, the patient should be referred to a hospital emergency room.
Target Population (age, gender, geographic, race, ethnicity, etc.):	People living with HIV residing in the Houston HIV Service Delivery Area (HSDA).

Services to be Provided:	Services must include, but are not limited to: individual comprehensive treatment plan; diagnosis and treatment of HIV-related oral pathology, including oral Kaposi's Sarcoma, CMV ulceration, hairy leukoplakia, xerostomia, lichen planus, aphthous ulcers and herpetic lesions; diffuse infiltrative lymphocytosis; standard preventive procedures, including oral hygiene instruction, diet counseling and home care program; oral prophylaxis; restorative care; oral surgery including dental implants; root canal therapy; fixed and removable prosthodontics including crowns and bridges; periodontal services, including subgingival scaling, gingival curettage, osseous surgery, gingivectomy, provisional splinting, laser procedures and maintenance. Proposer must have mechanism in place to provide oral pain medication as prescribed for clients by the dentist.
	
	Limitations:
	• Cosmetic dentistry for cosmetic purposes only is prohibited.
	• Maximum amount that may be funded by Ryan White/State Services per patient is $3,000/year.
	  • In cases of emergency, the maximum amount may exceed the above cap
	  • In cases where there is extensive care needed once the procedure has begun, the maximum amount may exceed the above cap.
	• Dental providers must document *via approved waiver* the reason for exceeding the yearly maximum amount.

Service Unit Definition(s) **(TRG Only)**:	General Dentistry: A unit of service is defined as one (1) dental visit which includes restorative dental services, oral surgery, root canal therapy, fixed and removable prosthodontics; periodontal services includes subgingival scaling, gingival curettage, osseous surgery, gingivectomy, provisional splinting, laser procedures and maintenance. Oral medication (including pain control) for HIV patients 15 years old or older must be based on a comprehensive individual treatment plan.

	Prosthodontics: A unit of services is defined as one (1) Prosthodontics visit.
Financial Eligibility:	Income at or below 300% Federal Poverty Guidelines. Maximum amount that may be funded by Ryan White/State Services per patient is $3,000/year.
Client Eligibility:	Person living with HIV; Adult resident of Houston HSDA
Agency Requirements **(TRG Only)**:	**To ensure that Ryan White is payer of last resort, Agency and/or dental providers (clinicians) must be Medicaid certified and enrolled in all Dental Plans offered to Texas STAR+PLUS eligible clients in the Houston EMA/HSDA**. Agency/providers must ensure Medicaid certification and billing capability for STAR+PLUS eligible patients remains current throughout the contract term. Agency must document that the primary patient care dentist has 2 years prior experience treating HIV disease and/or on-going HIV educational programs that are documented in personnel files and updated regularly. Dental facility and appropriate dental staff must maintain Texas licensure/certification and follow all applicable OSHA requirements for patient management and laboratory protocol.
Staff Requirements:	State of Texas dental license; licensed dental hygienist and state radiology certification for dental assistants.
Special Requirements **(TRG Only)**:	Must comply with the Houston EMA/HSDA Standards of Care. The agency must comply with **the DSHS Oral Health Care Standards of Care**. The agency must have policies and procedures in place that comply with the standards ***prior*** to delivery of the service.

FY 2020 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/13/19**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Steering Committee**		Date: **06/06/19**
Recommendations:	Approved: Y:____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Improvement Committee**		Date: **05/14/19**
Recommendations:	Approved: Y:____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMN Workgroup #2**	Date: **04/23/19**
Recommendations:	Financial Eligibility: 300%
1. Accept the service definition as presented, update the justification chart, and keep the financial eligibility the same.	
2.	
3.	

Houston EMA/HSDA Ryan White Part A/MAI Service Definition **Oral Health/Rural** (Last Review/Approval Date: 6/3/16)	
HRSA Service Category Title: **RWGA Only**	**Oral Health**
Local Service Category Title:	**Oral Health – <u>Rural (North)</u>**
Budget Type: **RWGA Only**	**Unit Cost**
Budget Requirements or Restrictions: **RWGA Only**	Not Applicable
HRSA Service Category Definition: **RWGA Only**	**Oral health care** includes diagnostic, preventive, and therapeutic services provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries, and other trained primary care providers.
Local Service Category Definition:	Restorative dental services, oral surgery, root canal therapy, fixed and removable prosthodontics; periodontal services includes subgingival scaling, gingival curettage, osseous surgery, gingivectomy, provisional splinting, laser procedures and maintenance. Oral medication (including pain control) for HIV patients 15 years old or older must be based on a comprehensive individual treatment plan. Prosthodontics services to HIV-infected individuals including, but not limited to examinations and diagnosis of need for dentures, diagnostic measurements, laboratory services, tooth extractions, relines and denture repairs.
Target Population (age, gender, geographic, race, ethnicity, etc.):	HIV/AIDS infected individuals residing in Houston Eligible Metropolitan Area (EMA) or Health Service Delivery Area (HSDA) counties other than Harris County. Comprehensive Oral Health services targeted to individuals residing in the northern counties of the EMA/HSDA, including Waller, Walker, Montgomery, Austin, Chambers and Liberty Counties.
Services to be Provided:	Services must include, but are not limited to: individual comprehensive treatment plan; diagnosis and treatment of HIV-related oral pathology, including oral Kaposi's Sarcoma, CMV ulceration, hairy leukoplakia, xerostomia, lichen planus, aphthous ulcers and herpetic lesions; diffuse infiltrative lymphocytosis; standard preventive procedures, including oral hygiene instruction, diet counseling and home care program; oral prophylaxis; restorative care; oral surgery including dental implants; root canal therapy; fixed and removable prosthodontics including crowns, bridges and implants; periodontal services, including subgingival scaling, gingival curettage, osseous surgery, gingivectomy, provisional splinting, laser procedures and maintenance. Proposer must have mechanism in place to provide oral pain medication as prescribed for clients by the dentist.
Service Unit Definition(s): **RWGA Only**	General Dentistry: A unit of service is defined as one (1) dental visit which includes restorative dental services, oral surgery, root

	canal therapy, fixed and removable prosthodontics; periodontal services includes subgingival scaling, gingival curettage, osseous surgery, gingivectomy, provisional splinting, laser procedures and maintenance. Oral medication (including pain control) for HIV patients 15 years old or older must be based on a comprehensive individual treatment plan. Prosthodontics: A unit of services is defined as one (1) Prosthodontics visit.
Financial Eligibility:	Refer to the RWPC's approved *Financial Eligibility for Houston EMA/HSDA Services*.
Client Eligibility:	HIV-infected adults residing in the rural area of Houston EMA/HSDA meeting financial eligibility criteria.
Agency Requirements:	Agency must document that the primary patient care dentist has 2 years prior experience treating HIV disease and/or on-going HIV educational programs that are documented in personnel files and updated regularly. Service delivery site must be located in one of the northern counties of the EMA/HSDA area: Waller, Walker, Montgomery, Austin, Chambers or Liberty Counties
Staff Requirements:	State of Texas dental license; licensed dental hygienist and state radiology certification for dental assistants.
Special Requirements: **RWGA Only**	Agency and/or dental providers (clinicians) must be Medicaid certified and enrolled in all Dental Plans offered to Texas STAR+PLUS eligible clients in the Houston EMA/HSDA. Agency/providers must ensure Medicaid certification and billing capability for STAR+PLUS eligible patients remains current throughout the contract term. Must comply with the joint Part A/B standards of care where applicable.

FY 2020 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/13/19**
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Step in Process: **Steering Committee**		Date: **06/06/19**
Recommendations:	Approved: Y:____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Improvement Committee**		Date: **05/14/19**
Recommendations:	Approved: Y:____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMN Workgroup #2**	Date: **04/23/19**
Recommendations:	Financial Eligibility: 300%
1. Accept the service definition as presented, update the justification chart, and keep the financial eligibility the same.	
2.	
3.	

Houston EMA/HSDA Ryan White Part A Service Definition **Outreach Services – Primary Care Re-Engagement** Revised June 2017	
HRSA Service Category Title: **RWGA Only**	Outreach Services
Local Service Category Title:	Outreach Services – Primary Care Re-Engagement
Budget Type: **RWGA Only**	Fee-for-Service
Budget Requirements or Restrictions: **RWGA Only**	Outreach services are restricted to those patients who have not returned for scheduled appointments with Provider as outlined in the RWGA approved Outreach Inclusion Criteria, and are included on the Outreach list.
HRSA Service Category Definition: **RWGA Only**	*Outreach Services* include the provision of the following three activities: Identification of people who do not know their HIV status and linkage into Outpatient/Ambulatory Health Services, Provision of additional information and education on health care coverage options, Reengagement of people who know their status into Outpatient/Ambulatory Health Services
Local Service Category Definition:	Providing allowable Ryan White Program outreach and service linkage activities to PLWHA who know their status but are not actively engaged in outpatient primary medical care with information, referrals and assistance with medical appointment setting, mental health, substance abuse and psychosocial services as needed; advocating on behalf of clients to decrease service gaps and remove barriers to services helping clients develop and utilize independent living skills and strategies. Assist clients in obtaining needed resources, including bus pass vouchers and gas cards per published HCPHES/RWGA policies. Outreach services must be conducted at times and in places where there is a high probability that individuals with HIV infection will be contacted, designed to provide quantified program reporting of activities and outcomes to accommodate local evaluation of effectiveness, planned and delivered in coordination with local and state HIV prevention outreach programs to avoid duplication of effort, targeted to populations known, through review of clinic medical records, to be at disproportionate risk of disengagement with primary medical care services.
Target Population (age, gender, geographic, race, ethnicity, etc.):	Services will be available to eligible HIV-infected clients residing in the Houston EMA/HSDA with priority given to clients most in need. Services are restricted to those clients who meet the contractor's RWGA approved Outreach Inclusion Criteria. The Outreach Inclusion Criteria components must include, at minimum 2 consecutive missed primary care provider and/or HIV lab appointments. Outreach Inclusion Criteria may also include VL suppression, substance abuse, and ART treatment failure components.
Services to be Provided:	Outreach service is field based. Outreach workers are expected to coordinate activities with PLWHA, including locations outside of primary care clinic in order to develop rapport with individuals and

	ensuring intakes to Primary Care services have sufficient support to make the often difficult transition into ongoing primary medical care. Outreach patients are those patients who have not returned for scheduled appointments with Provider as outlined in the RWGA approved Outreach Inclusion Criteria. Contractor must document efforts to re-engage Primary Care Re-Engagement Outreach patients prior to closing patients in the CPCDMS.
Service Unit Definition(s): **RWGA Only**	15 Minutes = 1 Unit
Financial Eligibility:	Refer to the RWPC's approved *Current Fiscal Year Financial Eligibility for Houston EMA/HSDA Services*.
Client Eligibility:	PLWHA residing in the Houston EMA (prior approval required for non-EMA clients).
Agency Requirements:	Outreach Services must function within the clinical infrastructure of Contractor and receive ongoing supervision that meets or exceeds published Standards of Care.
Staff Requirements:	Must meet all applicable Houston EMA/HSDA Part A/B Standards of Care.
Special Requirements: **RWGA Only**	Not Applicable.

FY 2020 RWPC "How to Best Meet the Need" Decision Process

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Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Steering Committee**		Date: **06/06/19**
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Step in Process: **Quality Improvement Committee**		Date: **05/14/19**
Recommendations:	Approved: Y:____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMN Workgroup #1**	Date: **04/23/19**
Recommendations:	Financial Eligibility: No financial cap
1. Accept the service definition as presented, update the justification chart, and keep the financial eligibility the same.	
2.	
3.	

Service Category Definition - DSHS State Services-R
September 1, 2019 - August 31, 2020

Local Service Category:	**Referral for Health Care: ADAP Enrollment Worker**
Amount Available**:**	**To be determined**
Unit Cost	
Budget Requirements or Restrictions **(TRG Only)**:	Maximum 10% of budget for Administrative Cost. No direct medical costs may be billed to this grant.
DSHS Service Category Definition:	Direct a client to a service in person or through telephone, written, or other types of communication, including management of such services where they are not provided as part of Ambulatory Outpatient Medical Care or Case Management Services.
Local Service Category Definition:	AIDS Drug Assistance Program (ADAP) Enrollment Workers (AEWs) are co-located at Ryan-White funded clinics to ensure the efficient and accurate submission of ADAP applications to the Texas HIV Medication Program (THMP). AEWs will meet with all potential new ADAP enrollees, explain ADAP program benefits and requirements, and assist clients with the submission of complete, accurate ADAP applications. AEWs will submit annual re-certifications by the last day of the client's birth month and semi-annual Attestations six months later to ensure there is no the lapse in ADAP eligibility and loss of benefits. Other responsibilities will include: • Track the status of all pending applications and promptly follow-up with applicants regarding missing documentation or other needed information to ensure completed applications are submitted as quickly as feasible; • Maintain communication with designated THMP staff to quickly resolve any missing or questioned application information or documentation to ensure any issues affecting pending applications are resolved as quickly as possible; AEWs must maintain relationships with the Ryan White ADAP Network (RWAN).
Target Population (age, gender, geographic, race, ethnicity, etc.):	People living with HIV in the Houston HDSA in need of medications through the Texas HIV Medication Program.
Services to be Provided:	Services include but are not limited to completion of ADAP applications/six-month attestations/recertifications, gathering of supporting documentation for ADAP applications/six-month attestations/recertifications, submission of ADAP applications/six-month attestations/recertifications, and interactions with clients as part of the ADAP application process.
Service Unit Definition(s) **(TRG Only)**:	One unit of service is defined as 15 minutes of direct client services or coordination of application process on behalf of client.
Financial Eligibility:	Income at or below 300% of Federal Poverty Guidelines
Client Eligibility:	People living with HIV in the Houston HDSA
Agency Requirements **(TRG Only)**:	Agency must be funded for Outpatient Ambulatory Medical Care bundled service category under Ryan White Part A/B/DSHS SS.
Staff Requirements:	Not Applicable.
Special Requirements **(TRG Only)**:	The agency must comply with **the DSHS Referral to Healthcare Standards of Care** and **the Houston HSDA Referral for Health Care and Support Services Standards of Care**. The agency must have policies and procedures in place that comply with the standards ***prior*** to delivery of the service.

FY 2020 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/13/19**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Steering Committee**		Date: **06/06/19**
Recommendations:	Approved: Y:____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Improvement Committee**		Date: **05/14/19**
Recommendations:	Approved: Y:____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMN Workgroup #1**	Date: **04/23/19**
Recommendations:	Financial Eligibility: 300%
1. Accept the service definition as presented, update the justification chart, and keep the financial eligibility the same.	
2.	
3.	

Houston EMA/HSDA Ryan White Part A Service Definition **Substance Abuse Services - Outpatient** (Last Review/Approval Date: 6/3/16)	
HRSA Service Category Title: **RWGA Only**	Substance Abuse Services Outpatient
Local Service Category Title:	Substance Abuse Treatment/Counseling
Budget Type: **RWGA Only**	Fee-for-Service
Budget Requirements or Restrictions: **RWGA Only**	Minimum group session length is 2 hours
HRSA Service Category Definition: **RWGA Only**	***Substance abuse services outpatient*** is the provision of medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) in an outpatient setting, rendered by a physician or under the supervision of a physician, or by other qualified personnel.
Local Service Category Definition:	Treatment and/or counseling HIV-infected individuals with substance abuse disorders delivered in accordance with State licensing guidelines.
Target Population (age, gender, geographic, race, ethnicity, etc.):	HIV-infected individuals with substance abuse disorders, residing in the Houston Eligible Metropolitan Area (EMA/HSDA).
Services to be Provided:	Services for all eligible HIV/AIDS patients with substance abuse disorders. Services provided must be integrated with HIV-related issues that trigger relapse. All services must be provided in accordance with the Texas Department of Health Services/Substance Abuse Services (TDSHS/SAS) Chemical Dependency Treatment Facility Licensure Standards. Service provision must comply with the applicable treatment standards.
Service Unit Definition(s): **RWGA Only**	**Individual Counseling:** One unit of service = one individual counseling session of at least 45 minutes in length with one (1) eligible client. **A single session lasting longer than 45 minutes qualifies as only a single unit** – no fractional units are allowed. Two (2) units are allowed for initial assessment/orientation session. **Group Counseling:** One unit of service = 60 minutes of group treatment for one eligible client. A single session must last a minimum of 2 hours. Support Groups are defined as professionally led groups that are comprised of HIV-positive individuals, family members, or significant others for the purpose of providing Substance Abuse therapy.
Financial Eligibility:	Refer to the RWPC's approved *Financial Eligibility for Houston EMA/HSDA Services.*
Client Eligibility:	HIV-infected individuals with substance abuse co-morbidities/ disorders.
Agency Requirements:	Agency must be appropriately licensed by the State. All services must be provided in accordance with applicable Texas Department of State Health Services/Substance Abuse Services (TDSHS/SAS) Chemical Dependency Treatment Facility Licensure Standards. Client must not be eligible for services from other programs or providers (i.e. MHMRA of

	Harris County) or any other reimbursement source (i.e. Medicaid, Medicare, Private Insurance) unless the client is in crisis and cannot be provided immediate services from the other programs/providers. In this case, clients may be provided services, as long as the client applies for the other programs/providers, until the other programs/providers can take over services. All services must be provided in accordance with the TDSHS/SAS Chemical Dependency Treatment Facility Licensure Standards. Specifically, regarding service provision, services must comply with the most current version of the applicable Rules for Licensed Chemical Dependency Treatment. Services provided must be integrated with HIV-related issues that trigger relapse. Provider must provide a written plan no later than 3/30/17 documenting coordination with local TDSHS/SAS HIV Early Intervention funded programs if such programs are currently funded in the Houston EMA.
Staff Requirements:	Must meet all applicable State licensing requirements and Houston EMA/HSDA Part A/B Standards of Care.
Special Requirements: **RWGA Only**	Not Applicable.

FY 2020 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/13/19**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Steering Committee**		Date: **06/06/19**
Recommendations:	Approved: Y:____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Improvement Committee**		Date: **05/14/19**
Recommendations:	Approved: Y:____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMN Workgroup #2**	Date: **04/23/19**
Recommendations:	Financial Eligibility: **300%**
1. Accept the service definition as presented, update the justification chart, and keep the financial eligibility the same.	
2.	
3.	

Houston EMA/HSDA Ryan White Part A Service Definition **Medical Transportation (Van Based)** (Revision Date: 03/03/14)	
HRSA Service Category Title: **RWGA Only**	**Medical Transportation**
Local Service Category Title:	**a. Transportation targeted to Urban** **b. Transportation targeted to Rural**
Budget Type: **RWGA Only**	**Hybrid Fee for Service**
Budget Requirements or Restrictions: **RWGA Only**	• Units assigned to Urban Transportation must only be used to transport clients whose residence is in Harris County. • Units assigned to Rural Transportation may only be used to transport clients who reside in Houston EMA/HSDA counties other than Harris County. • Mileage reimbursed for transportation is based on the documented distance in miles from a client's Trip Origin to Trip Destination **as documented by a standard Internet-based mapping program (i.e. Google Maps, Map Quest, Yahoo Maps) approved by RWGA.** Agency must print out and file in the client record a trip plan from the appropriate Internet-based mapping program that clearly delineates the mileage between Point of Origin and Destination (and reverse for round trips). This requirement is subject to audit by the County. • Transportation to employment, employment training, school, or other activities not directly related to a client's treatment of HIV disease is not allowable. Clients may not be transported to entertainment or social events under this contract. • Taxi vouchers must be made available for documented emergency purposes and to transport a client to a disability hearing, emergency shelter or for a documented medical emergency. • Contractor must reserve 7% of the total budget for Taxi Vouchers. • Maximum monthly utilization of taxi vouchers cannot exceed 14% of the total amount of funding reserved for Taxi Vouchers. • Emergencies warranting the use of Taxi Vouchers include: van service is unavailable due to breakdown, scheduling conflicts or inclement weather or other unanticipated event. A spreadsheet listing client's 11-digit code, age, date of service, number of trips, and reason for emergency should be kept on-site and available for review during Site Visits. • **Contractor must provide RWGA a copy of the agreement between Contractor and a licensed taxi vendor by March 30, 2015.** • All taxi voucher receipts must have the taxi company's name, the driver's name and/or identification number, number of miles driven, destination (to and from), and exact cost of trip. The Contractor will add the client's 11-digit code to the receipt and include all receipts with the monthly Contractor Expense Report (CER).

	• A copy of the taxi company's statement (on company letterhead) must be included with the monthly CER. Supporting documentation of disbursement payments may be requested with the CER.
HRSA Service Category Definition: **RWGA Only**	**Medical transportation services** include conveyance services provided, directly or through voucher, to a client so that he or she may access health care services.
Local Service Category Definition:	a. Urban Transportation: Contractor will develop and implement a medical transportation program that provides essential transportation services to **HRSA-defined Core Services** through the use of individual employee or contract drivers with vehicles/vans to Ryan White Program-eligible individuals residing in Harris County. Clients residing outside of Harris County are ineligible for Urban transportation services. Exceptions to this requirement require prior written approval from RWGA. b. Rural Transportation: Contractor will develop and implement a medical transportation program that provides essential transportation services to **HRSA-defined Core Services** through the use of individual employee or contract drivers with vehicles/vans to Ryan White Program-eligible individuals residing in Houston EMA/HSDA counties other than Harris County. Clients residing in Harris County are ineligible for this transportation program. Exceptions to this requirement require prior written approval from RWGA. Essential transportation is defined as transportation to public and private outpatient medical care and physician services, substance abuse and mental health services, pharmacies and other services where eligible clients receive Ryan White-defined Core Services and/or medical and health-related care services, including clinical trials, essential to their well-being. The Contractor shall ensure that the transportation program provides taxi vouchers to eligible clients only in the following cases: • To access emergency shelter vouchers or to attend social security disability hearings; • Van service is unavailable due to breakdown or inclement weather; • Client's medical need requires immediate transport; • Scheduling Conflicts. **Contractor must provide clear and specific justification (reason) for the use of taxi vouchers and include the documentation in the client's file for each incident. RWGA must approve supporting documentation for taxi voucher reimbursements.** For clients living in the METRO service area, written certification from the client's principal medical provider (e.g. medical case manager or physician) is required to access van-based transportation, to be renewed every 180 days. **Medical Certifications should be maintained on-site by the provider in a single file (listed alphabetically by 11-digit code) and will be monitored at least annually during a Site Visit.** It is the

	Contractor's responsibility to determine whether a client resides within the METRO service area. Clients who live outside the METRO service area but within Harris County (e.g. Baytown) are not required to provide a written medical certification to access van-based transportation. All clients living in the Metro service area may receive a maximum of 4 non-certified round trips per year (including taxi vouchers). Non-certified trips will be reviewed during the annual Site Visit. Provider must maintain an up-to-date spreadsheet documenting such trips. The Contractor must implement the general transportation program in accordance with the Transportation Standards of Care that include entering all transportation services into the Centralized Patient Care Data Management System (CPCDMS) and providing eligible children with transportation services to Core Services appointments. Only actual mileage (documented per the selected Internet mapping program) transporting eligible clients from Origin to Destination will be reimbursed under this contract. The Contractor must make reasonable effort to ensure that routes are designed in the most efficient manner possible to minimize actual client time in vehicles.
Target Population (age, gender, geographic, race, ethnicity, etc.):	a. Urban Transportation: HIV/AIDS-infected and Ryan White Part A/B eligible affected individuals residing in Harris County. b. Rural Transportation: HIV/AIDS-infected and Ryan White Part A/B eligible affected individuals residing in Fort Bend, Waller, Walker, Montgomery, Austin, Colorado, Liberty, Chambers and Wharton Counties.
Services to be Provided:	To provide Medical Transportation services to access Ryan White Program defined **Core Services** for eligible individuals. Transportation will include round trips to single destinations and round trips to multiple destinations. Taxi vouchers will be provided to eligible clients only for identified emergency situations. Caregiver must be allowed to accompany the HIV-infected rider. **Eligibility for Transportation Services is determined by the client's County of residence as documented in the CPCDMS**.
Service Unit Definition(s): **RWGA Only**	One (1) unit of service = one (1) mile driven with an eligible client as passenger. Client cancellations and/or no-shows are <u>not</u> reimbursable.
Financial Eligibility:	Refer to the RWPC's approved *Financial Eligibility for Houston EMA/HSDA Services*.
Client Eligibility:	a. Urban Transportation: Only individuals diagnosed with HIV/AIDS and Ryan White Program eligible HIV-affected individuals residing inside Harris County will be eligible for services. b. Rural Transportation: Only individuals diagnosed with HIV/AIDS and Ryan White Program eligible HIV-affected individuals residing in Houston EMA/HSDA Counties other than Harris County are eligible for Rural Transportation services. Documentation of the client's eligibility in accordance with approved

	Transportation Standards of Care must be obtained by the Contractor prior to providing services. The Contractor must ensure that eligible clients have a signed consent for transportation services, client rights and responsibilities prior to the commencement of services. Affected significant others may accompany an HIV-infected person as medically necessary (minor children may accompany their caregiver as necessary). Ryan White Part A/B eligible affected individuals may utilize the services under this contract for travel to Core Services when the aforementioned criteria are met and the use of the service is directly related to a person with HIV infection. An example of an eligible transportation encounter by an affected individual is transportation to a Professional Counseling appointment.
Agency Requirements	Proposer must be a Certified Medicaid Transportation Provider. Contractor must furnish such documentation to Harris County upon request from Ryan White Grant Administration prior to March 1st annually. Contractor must maintain such certification throughout the term of the contract. Failure to maintain certification as a Medicaid Transportation provider may result in termination of contract. Contractor must provide each client with a written explanation of contractor's scheduling procedures upon initiation of their first transportation service, and annually thereafter. Contractor must provide RWGA with a copy of their scheduling procedures by March 30, 2014, and thereafter within 5 business days of any revisions. **Contractor must also have the following equipment dedicated to the general transportation program:** • A separate phone line from their main number so that clients can access transportation services during the hours of 7:00 a.m. to 10:00 p.m. directly at no cost to the clients. **The telephone line must be managed by a live person between the hours of 8:00 a.m. – 5:00 p.m.** Telephone calls to an answering machine utilized after 5:00 p.m. must be returned by 9:00 a.m. the following business day. • A fax machine with a dedicated line. • All equipment identified in the Transportation Standards of Care necessary to transport children in vehicles. • Contractor must assure clients eligible for Medicaid transportation are billed to Medicaid. This is subject to audit by the County. The Contractor is responsible for maintaining documentation to evidence that drivers providing services have a valid Texas Driver's License and have completed a State approved "Safe Driving" course. Contractor must maintain documentation of the automobile liability insurance of each vehicle utilized by the program as required by state law. All vehicles must have a current Texas State Inspection. The minimum acceptable limit of automobile liability insurance is $300,000.00 combined single limit. Agency must maintain detailed records of mileage driven and names of

	individuals provided with transportation, as well as origin and destination of trips. ***It is the Contractor's responsibility to verify the County in which clients reside in.***
Staff Requirements	A picture identification of each driver must be posted in the vehicle utilized to transport clients. Criminal background checks must be performed on all direct service transportation personnel prior to transporting any clients. Drivers must have annual proof of a safe driving record, which shall include history of tickets, DWI/DUI, or other traffic violations. Conviction on more than three (3) moving violations within the past year will disqualify the driver. Conviction of one (1) DWI/DUI within the past three (3) years will disqualify the driver.
Special Requirements: **RWGA Only**	Individuals who qualify for transportation services through Medicaid are not eligible for these transportation services. **Contractor must ensure the following criteria are met for all clients transported by Contractor's transportation program:** Transportation Provider must ensure that clients use transportation services for an appropriate purpose through one of the following three methods: 1. Follow-up hard copy verification between transportation provider and Destination Agency (DA) program confirming use of eligible service(s), or 2. Client provides receipt documenting use of eligible services at Destination Agency on the date of transportation, or 3. Scheduling of transportation services was made by receiving agency's case manager or transportation coordinator. The verification/receipt form must at a minimum include all elements listed below: • Be on Destination Agency letterhead • Date/Time • CPCDMS client code • Name and signature of Destination Agency staff member who attended to client (e.g. case manager, clinician, physician, nurse) • Destination Agency date stamp to ensure DA issued form.

FY 2020 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/13/19**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/06/19**
Recommendations:	Approved: Y:____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Improvement Committee**		Date: **05/14/19**
Recommendations:	Approved: Y:____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMN Workgroup #3**	Date: **04/24/19**
Recommendations:	Financial Eligibility: 400%
1. Accept the service definition as presented, update the justification chart, and keep the financial eligibility the same.	
2. Ask the Office of Support to check into the availability of alternative bus providers.	
3.	

Houston EMA/HSDA Ryan White Part A/MAI Service Definition **Vision Care** (Last Review/Approval Date: 6/3/16)	
HRSA Service Category Title: **RWGA Only**	**Ambulatory/Outpatient Medical Care**
Local Service Category Title:	**Vision Care**
Budget Type: **RWGA Only**	**Fee for Service**
Budget Requirements or Restrictions: **RWGA Only**	Corrective lenses are not allowable under this category. Corrective lenses may be provided under Health Insurance Assistance and/or Emergency Financial Assistance as applicable/available.
HRSA Service Category Definition: **RWGA Only**	***Outpatient/Ambulatory medical care*** is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings. Services includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). *Primary medical care* for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies. HRSA policy notice 10-02 states funds awarded under Part A or Part B of the Ryan White CARE Act (Program) may be used for optometric or ophthalmic services under Primary Medical Care. Funds may also be used to purchase corrective lenses for conditions related to HIV infection, through either the Health Insurance Premium Assistance or Emergency Financial Assistance service categories as applicable.
Local Service Category Definition:	**Primary Care Office/Clinic Vision Care** is defined as a comprehensive examination by a qualified Optometrist or Ophthalmologist, including Eligibility Screening as necessary. A visit with a credentialed Ophthalmic Medical Assistant for any of the following is an allowable visit: • Routine and preliminary tests including Cover tests, Ishihara Color Test, NPC (Near Point of Conversion), Vision Acuity Testing, Lensometry. • Visual field testing • Glasses dispensing including fittings of glasses, visual acuity testing, measurement, segment height. • Fitting of contact lenses is not an allowable follow-up visit.

Target Population (age, gender, geographic, race, ethnicity, etc.):	HIV-infected individuals residing in the Houston EMA/HSDA.
Services to be Provided:	Services must be provided at an eye care clinic or Optometrist's office. Services must include but are not limited to external/internal eye health evaluations; refractions; dilation of the pupils; glaucoma and cataract evaluations; CMV screenings; prescriptions for eyeglasses and over the counter medications; provision of eyeglasses (contact lenses are not allowable); and referrals to other service providers (i.e. Primary Care Physicians, Ophthalmologists, etc.) for treatment of CMV, glaucoma, cataracts, etc. Agency must provide a written plan for ensuring that collaboration occurs with other providers (Primary Care Physicians, Ophthalmologists, etc.) to ensure that patients receive appropriate treatment for CMV, glaucoma, cataracts, etc.
Service Unit Definition(s): **RWGA Only**	One (1) unit of service = One (1) patient visit to the Optometrist, Ophthalmologist or Ophthalmic Assistant.
Financial Eligibility:	Refer to the RWPC's approved *Financial Eligibility for Houston EMA/HSDA Services.*
Client Eligibility:	HIV-infected resident of the Houston EMA/HSDA.
Agency Requirements:	Providers and system must be Medicaid/Medicare certified to ensure that Ryan White Program funds are the payer of last resort to the extent examinations and eyewear are covered by the State Medicaid program.
Staff Requirements:	Vendor must have on staff a Doctorate of Optometry licensed by the Texas Optometry Board as a Therapeutic Optometrist.
Special Requirements: **RWGA Only**	Vision care services must meet or exceed current U.S. Dept. of Health and Human Services (HHS) guidelines for the treatment and management of HIV disease as applicable to vision care.

FY 2020 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/13/19**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/06/19**
Recommendations:	Approved: Y:____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Improvement Committee**		Date: **05/14/19**
Recommendations:	Approved: Y:____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMN Workgroup #1**	Date: **04/23/19**
Recommendations:	Financial Eligibility: 300%
1. Accept the service definition as presented, update the justification chart, and keep the financial eligibility the same.	
2.	
3.	

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.	Documentation of Need (Sources of Data include: 2016 Needs Assessment, 2017-2021 Comp Plan, 2016 Outcome Measures, 2016 Chart Reviews, Special Studies and surveys, etc.) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources (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?	Recommendation(s)
Part 1: Services offered by Ryan White Part A, Part B, and State Services in the Houston EMA/HSDA as of 03-19-19							
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:** (Galley/Hamilton) Votes: Y=7; N=0; Abstentions=Andrews, Bailey, Francis, Miertschin*	✔ Yes ___No	☒ EIIHA ☒ Unmet Need ☒ Continuum of Care EIIHA: The purpose of the HRSA EIIHA initiative is to identify the status-*unaware* and facilitate their entry into Primary Care Unmet Need: Facilitating entry/reentry into Primary Care reduces unmet need. Additionally, a criterion for met need is evidence of an ART prescription, and clients cannot access LPAP until they are enrolled in Primary Care. Continuum of Care: Primary Care, MCM, and LPAP support	Epi: An estimated 6,625 people in the EMA are HIV+ and unaware of their status (2017). The current estimate of unmet need in the EMA is 6,952, or 25% of all PLWH (2017). Need (2016): Current # of living HIV cases in EMA: 28,225 (2017) Rank w/in 10 Core Services: *Primary Care: #1* *LPAP: #3* *Case Management: #2* Service Utilization (2018): # clients served: *Primary Care: 8,874 (5% increase v. 2017)* *LPAP: 4,639 (<1% decrease v. 2017)*	Primary Care: Medicaid, Medicare, RW Part D, and private providers, including federal health insurance marketplace participants LPAP: ADAP, State Pharmacy Assistance Program, Medicaid, Medicare Part D, RW Health Insurance Assistance, the public clinic's pharmacy program, private sector Patient Assistance Programs, and private pharmacy benefit programs, including federal health insurance marketplace participants Medical Case Management:	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 Care is the goal of the national and local EIIHA initiative - Referring and linking the	Can we make this service more efficient? No Can we bundle this service? Currently bundled with: EFA, LPAP, Medical Case Management, Outreach and Service Linkage Has a recent capacity issue been identified? No	**Motion:** Accept the service definition as presented, update the justification chart, and keep the financial eligibility the same: PriCare=300%, LPAP=300% +500%, MCM=none, SLW=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.	**Documentation of Need** (Sources of Data include: 2016 Needs Assessment, 2017-2021 Comp Plan, 2016 Outcome Measures, 2016 Chart Reviews, Special Studies and surveys, etc.) Which populations experience disproportionate need for and/or barriers to accessing this service?	**Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources** (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?	**Recommendation(s)**
		maintenance/retention in care and viral suppression for PLWH.	*Medical Case Mgmt: 6,083 (20% increase v. 2017) Non-Medical Case Mgmt, or Service Linkage: 7,431 (9% increase v. 2017)* Outcomes (FY2017): *Primary Care/LPAP:* 71% of Primary Care clients and 72% of LPAP clients were virally suppressed; *Medical Case Mgmt:* 51% of clients were in continuous HIV care following MCM; 67% of clients who received MCM were virally suppressed; *Non-Medical Case Mgmt, or Service Linkage:* 46% of clients were in continuous HIV care following Service Linkage Disproportionate Need /	RW Part C and D Service Linkage: RW Part C and D, HOPWA, and a grant from a private foundation Covered under QHP? ✔ Yes ___No	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 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,		

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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.	Documentation of Need (Sources of Data include: 2016 Needs Assessment, 2017-2021 Comp Plan, 2016 Outcome Measures, 2016 Chart Reviews, Special Studies and surveys, etc.) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources (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?	Recommendation(s)
			Inaccessibility: *Primary Care*: Higher need – 18-24, out of care, rural; Difficult access – 18-24, out of care, rural *LPAP*: Higher need – Females, Hispanic/Latino, 18-24, recently released, rural ; Difficult access – Rural, recently released *Case Management:* Higher need – Recently released, rural; Difficult access – White, MSM		and (3) those with private sector health insurance.		
Public Clinic, Adult – Part A, Including LPAP, MCM & Svc Linkage (Includes OB/GYN) *See below for Rural, Pediatric, Vision* ***Workgroup #1*** ***Motion:** (Hamilton/Galley)*	✔ 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	Epi: An estimated 6,625 people in the EMA are HIV+ and unaware of their status (2017). The current estimate of unmet need in the EMA is 6,952, or 25% of all PLWH (2017). Need (2016): Current # of living HIV cases in EMA: 28,225 (2017)	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,	Justify the use of funds: This service category: - Is a HRSA-defined Core Medical Service - Is ranked as the #1 service need by PLWH; and use has increased - Adheres to a medical home model and is bundled with LPAP, Medical Case Management, and Service	Can we make this service more efficient? No Can we bundle this service? Currently bundled with: EFA, LPAP, Medical Case Management, Outreach and Service Linkage Has a recent capacity issue been identified?	**Motion:** Accept the service definition as presented, update the justification chart, and keep the financial eligibility the same: PriCare=300%, LPAP=300% +500%, MCM=none, SLW=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.	**Documentation of Need** (Sources of Data include: 2016 Needs Assessment, 2017-2021 Comp Plan, 2016 Outcome Measures, 2016 Chart Reviews, Special Studies and surveys, etc.) Which populations experience disproportionate need for and/or barriers to accessing this service?	**Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources** (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?	**Recommendation(s)**
Votes: Y=7; N=0; Abstentions=Andrews, Bailey, Francis, Miertschin		Care reduces unmet need. Additionally, a criterion for met need is evidence of an ART prescription, and clients cannot access LPAP until they are enrolled in Primary Care. Continuum of Care: Primary Care, MCM, and LPAP support maintenance/retention in care and viral suppression for PLWH.	Rank w/in 10 Core Services: *Primary Care: #1* *LPAP: #3* *Case Management: #2* Service Utilization (2018): # clients served: *Primary Care: 8,874 (5% increase v. 2017)* *LPAP: 4,639 (<1% decrease v. 2017)* *Medical Case Mgmt: 6,083 (20% increase v. 2017)* *Non-Medical Case Mgmt, or Service Linkage: 7,431 (9% increase v. 2017)* Outcomes (FY2017): *Primary Care/LPAP:* 71% of Primary Care clients and 72% of LPAP clients were virally suppressed; *Medical Case Mgmt:* 51% of clients were in continuous HIV care following MCM;	RW Health Insurance Assistance, the public clinic's pharmacy program, private sector Patient Assistance Programs, and private pharmacy benefit programs, including federal health insurance marketplace participants Medical Case Management: RW Part C and D Service Linkage: RW Part C and D, HOPWA, and a grant from a private foundation Covered under QHP? ✔ Yes ___No	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 addresses certain Special Populations named in the Plan	No	

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			67% of clients who received MCM were virally suppressed; *Non-Medical Case Mgmt, or Service Linkage:* 46% of clients were in continuous HIV care following Service Linkage <u>Disproportionate Need / Inaccessibility</u>: *Primary Care*: Higher need – 18-24, out of care, rural; Difficult access – 18-24, out of care, rural *LPAP*: Higher need – Females, Hispanic/Latino, 18-24, recently released, rural ; Difficult access – Rural, recently released *Case Management:* Higher need – Recently released, rural; Difficult access – White, MSM		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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Rural, Adult – Part A, Including LPAP, MCM & Svc Linkage (Includes OB/GYN) *See below for Pediatric, Vision* ***Workgroup #1*** ***Motion:*** *(Hamilton/Torrente)* *Votes: Y=7; N=0;* *Abstentions=Andrews, Bailey, Francis, Miertschin*	✔ Yes ___No	☒ EIIHA ☒ Unmet Need ☒ Continuum of Care EIIHA: The purpose of the HRSA EIIHA initiative is to identify the status-*unaware* and facilitate their entry into Primary Care Unmet Need: Facilitating entry/reentry into Primary Care reduces unmet need. Additionally, a criterion for met need is evidence of an ART prescription, and clients cannot access LPAP until they are enrolled in Primary Care. Continuum of Care*:* Primary Care, MCM, and LPAP support maintenance/retention in care and viral suppression for	Epi: An estimated 6,625 people in the EMA are HIV+ and unaware of their status (2017). The current estimate of unmet need in the EMA is 6,952, or 25% of all PLWH (2017). Need (2016): Current # of living HIV cases in EMA: 28,225 (2017) Rank w/in 10 Core Services: *Primary Care: #1* *LPAP: #3* *Case Management: #2* Service Utilization (2018): # clients served: *Primary Care: 8,874 (5% increase v. 2017)* *LPAP: 4,639 (<1% decrease v. 2017)* *Medical Case Mgmt: 6,083 (20% increase v. 2017)*	Primary Care: Medicaid, Medicare, RW Part D, and private providers, including federal health insurance marketplace participants LPAP: ADAP, State Pharmacy Assistance Program, Medicaid, Medicare Part D, RW Health Insurance Assistance, the public clinic's pharmacy program, private sector Patient Assistance Programs, and private pharmacy benefit programs, including federal health insurance marketplace 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 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 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	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	**Motion:** Accept the service definition as presented, update the justification chart, and keep the financial eligibility the same: PriCare=300%, LPAP=300% +500%, MCM=none, SLW=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.	**Documentation of Need** (Sources of Data include: 2016 Needs Assessment, 2017-2021 Comp Plan, 2016 Outcome Measures, 2016 Chart Reviews, Special Studies and surveys, etc.) Which populations experience disproportionate need for and/or barriers to accessing this service?	**Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources** (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?	**Recommendation(s)**
		PLWH.	*Non-Medical Case Mgmt, or Service Linkage: 7,431 (9% increase v. 2017)* Outcomes (FY2017): *Primary Care/LPAP:* 71% of Primary Care clients and 72% of LPAP clients were virally suppressed; *Medical Case Mgmt:* 51% of clients were in continuous HIV care following MCM; 67% of clients who received MCM were virally suppressed; *Non-Medical Case Mgmt, or Service Linkage:* 46% of clients were in continuous HIV care following Service Linkage Disproportionate Need / Inaccessibility: *Primary Care*: Higher need –	RW Part C and D, HOPWA, and a grant from a private foundation Covered under QHP? ✔ Yes ___No	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 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.		

‡ 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.	Documentation of Need (Sources of Data include: 2016 Needs Assessment, 2017-2021 Comp Plan, 2016 Outcome Measures, 2016 Chart Reviews, Special Studies and surveys, etc.) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources (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?	Recommendation(s)
			18-24, out of care, rural; Difficult access – 18-24, out of care, rural *LPAP*: Higher need – Females, Hispanic/Latino, 18-24, recently released, rural ; Difficult access – Rural, recently released *Case Management:* Higher need – Recently released, rural; Difficult access – White, MSM				
Pediatric – Part A ***Workgroup #1*** ***Motion:*** *(Miertschin/Hamilton)* *Votes: Y=10; N=0;* *Abstentions=Bailey*	✔ 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: An estimated 6,625 people in the EMA are HIV+ and unaware of their status (2017). The current estimate of unmet need in the EMA is 6,952, or 25% of all PLWH (2017). Need (2016): Current # of living HIV cases in EMA: 28,225 (2017) Rank w/in 10 Core Services: *Primary Care: #1*	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: RW Part C and D, HOPWA, and a grant from a private foundation	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 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: Medical Case Management and Service Linkage Has a recent capacity issue been identified? No	**Motion:** Accept the service definition as presented, update the justification chart, and keep the financial eligibility the same: PriCare=300%, MCM=none, SLW=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.	**Documentation of Need** (Sources of Data include: 2016 Needs Assessment, 2017-2021 Comp Plan, 2016 Outcome Measures, 2016 Chart Reviews, Special Studies and surveys, etc.) Which populations experience disproportionate need for and/or barriers to accessing this service?	**Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources** (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?	**Recommendation(s)**
		Continuum of Care: Primary Care, MCM, and Service Linkage support maintenance/retention in care and viral suppression for PLWH.	*Case Management: #2* Service Utilization (2018): # clients served: *Primary Care: 8,874 (5% increase v. 2017)* *Medical Case Mgmt: 6,083 (20% increase v. 2017)* *Non-Medical Case Mgmt, or Service Linkage: 7,431 (9% increase v. 2017)* Outcomes (FY2017): *Primary Care:* 71% of Primary Care clients were virally suppressed; *Medical Case Mgmt:* 51% of clients were in continuous HIV care following MCM; 67% of clients who received MCM were virally suppressed; *Non-Medical Case Mgmt, or Service Linkage:* 46% of clients were in continuous	Covered under QHP? ✔ Yes ___No	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 Is this a duplicative service or activity? - This service is funded		

‡ 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.	Documentation of Need (Sources of Data include: 2016 Needs Assessment, 2017-2021 Comp Plan, 2016 Outcome Measures, 2016 Chart Reviews, Special Studies and surveys, etc.) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources (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?	Recommendation(s)
			HIV care following Service Linkage. Disproportionate Need / Inaccessibility: *Primary Care*: Higher need – 18-24, out of care, rural; Difficult access – 18-24, out of care, rural		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.		
Vision – Part A ***Workgroup #1*** ***Motion:** (Hamilton/Galley) Votes: Y=9; N=0; Abstentions=Andrews, Bailey, Francis*	✔ Yes ___No	☐ EIIHA ☐ Unmet Need ☒ Continuum of Care Continuum of Care: Vision services support maintenance/ retention in HIV care by increasing access to care and treatment for HIV-related and general ocular diagnoses. Untreated ocular diagnoses may act as logistical or financial barriers to HIV care.	Need (2017): Current # of living HIV cases in EMA: 28,225 Service Utilization (2018): # clients served: 2,565 *(1% decrease v. 2017)* Outcomes (FY2017): 1,584 diagnoses were reported for HIV-related ocular disorders, 93% were resolved, improved or remained the same.	No known alternative funding sources exist for this service Covered under QHP?* ___Yes ✔ No *QHPs cover pediatric vision	No known alternative funding sources exist for this service	Can we make this service more efficient? No Can we bundle this service? Currently bundled with Primary Care Has a recent capacity issue been identified? No	**Motion:** Accept the service definition as presented, update the justification chart, and keep the financial eligibility the same: 300%.

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	Documentation of Need (Sources of Data include: 2016 Needs Assessment, 2017-2021 Comp Plan, 2016 Outcome Measures, 2016 Chart Reviews, Special Studies and surveys, etc.) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources (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?	Recommendation(s)
			Disproportionate Need / Inaccessibility: N/A				
Clinical Case Management - Part A ***Workgroup #1*** ***Motion:** (Hamilton/Galley) Votes: Y=7; N=0; Abstentions=Andrews, Bailey, Francis, Miertschin*	✔ 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-	Need (2016): Current # of living HIV cases in EMA: 28,225 (2017) Rank w/in 10 Core Services: #2 (Case Management - general) Service Utilization (2018): # clients served: 1,149 *(10% decrease v. 2017)* Outcomes (FY2017): 50% of clients were in continuous care following receipt of CCM. 71% of	RW Part C 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,	Can we make this service more efficient? No Can we bundle this service? No Has a recent capacity issue been identified? No	**Motion:** Accept the service definition as presented, update the justification chart, and keep 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.	**Documentation of Need** (Sources of Data include: 2016 Needs Assessment, 2017-2021 Comp Plan, 2016 Outcome Measures, 2016 Chart Reviews, Special Studies and surveys, etc.) Which populations experience disproportionate need for and/or barriers to accessing this service?	**Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources** (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?	**Recommendation(s)**
		morbidities Continuum of Care: CCM supports maintenance/ retention in care and viral suppression for PLWH.	clients utilizing CCM were virally suppressed. Disproportionate Need / Inaccessibility: *Case Management:* Higher need – Recently released, rural; Difficult access – White, MSM		and local goals related to continuous HIV care and reducing unmet need - Addresses a system-level objective (#8) from the Comprehensive Plan and addresses certain Special Populations named in the Plan Is this a duplicative service or activity? - This service is funded locally by other RW Parts for specific Special Populations and for clients served by specific funded agencies/programs only		

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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.	Documentation of Need (Sources of Data include: 2016 Needs Assessment, 2017-2021 Comp Plan, 2016 Outcome Measures, 2016 Chart Reviews, Special Studies and surveys, etc.) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources (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?	Recommendation(s)
Case Management – Non-Medical - Part A (Service Linkage at testing sites) ***Workgroup #1*** ***Motion:** (Mills/Hamilton) Votes: Y=8; N=0; Abstentions=Andrews, Bailey, Miertschin*	___Yes ✔ No	☒ EIIHA ☒ Unmet Need ☒ Continuum of Care EIIHA: The EMA's EIIHA Strategy identifies Service Linkage as a local strategy for attaining Goals #3-4 of the national EIIHA initiative. Additionally, linking the newly diagnosed into HIV care via strategies such as Service Linkage fulfills the national, state, and local goal of linkage to HIV medical care ≤ 3 months of diagnosis. In 2015, 19% of the newly diagnosed in the EMA were *not* linked within this timeframe. Unmet Need: Service Linkage at HIV testing sites is specifically designed to prevent newly diagnosed PLWH from falling out-of-care	Need (2016): Current # of living HIV cases in EMA: 28,225 (2017) Medical, Clinical and SLW case management were not surveyed explicitly in the 2016 Needs Assessment (Case Management – General: Rank w/in 5 Support Services: #2) Service Utilization (2018): # clients served: 180 *(2% decrease v. 2017)* Outcomes (FY2017): Following Service Linkage, 46% of clients were in continuous HIV care, and 43% accessed HIV primary care for the first time Disproportionate Need / Inaccessibility: *Case Management:* Higher need – Recently released,	RW Part C and D, HOPWA, and a grant from a private foundation Covered under QHP? ___Yes ✔ No	Justify the use of funds: This service category: - Is a HRSA-defined Support Service - Results in desirable health outcomes for clients who access the service - Is a strategy for attaining national EIIHA goals locally - Prevents the newly diagnosed from having unmet need - Facilitates national, state, 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	Can we make this service more efficient? No Can we bundle this service? No Has a recent capacity issue been identified? No	**Motion:** Accept the service definition as presented, update the justification chart, and keep 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.	Documentation of Need (Sources of Data include: 2016 Needs Assessment, 2017-2021 Comp Plan, 2016 Outcome Measures, 2016 Chart Reviews, Special Studies and surveys, etc.) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources (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?	Recommendation(s)
		by facilitating entry into HIV primary care immediately upon diagnosis. In 2015, 12% of the newly diagnosed PLWH were not linked to care by the end of the year. Continuum of Care: Service Linkage supports linkage to care, maintenance/retention in care and viral suppression for PLWH.	rural; Difficult access – White, MSM				
Case Management – Non-Medical - State Services (Targeting Substance Use Disorders) ***Workgroup #2*** ***Motion:** (Torrente/Galley) Votes: Y=9; N=0; Abstentions=Andrews, Robinson*	___Yes ✔No	☒ EIIHA ☒ Unmet Need ☒ Continuum of Care EIIHA: The EMA's EIIHA Strategy identifies Service Linkage as a local strategy for attaining Goals #3-4 of the national EIIHA initiative. Additionally, linking the newly diagnosed into HIV care via strategies such as Service Linkage fulfills the	Need (2016): Current # of living HIV cases in EMA: 28,225 (2017) Medical, Clinical and SLW case management were not surveyed explicitly in the 2016 Needs Assessment (Case Management – General: Rank w/in 5 Support Services: #2) Service Utilization (2018): Service delivery will begin on	This service was previously funded under SAMHSA. Covered under QHP? ___Yes ✔No	Justify the use of funds: This service category: - Is a HRSA-defined Support Service - Results in desirable health outcomes for clients who access the service - Is a strategy for attaining national EIIHA goals locally - Prevents the newly diagnosed from having unmet need	Can we make this service more efficient? No Can we bundle this service? No Has a recent capacity issue been identified? No	**Motion:** Accept the service definition as presented, update the justification chart, and keep 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.	**Documentation of Need** (Sources of Data include: 2016 Needs Assessment, 2017-2021 Comp Plan, 2016 Outcome Measures, 2016 Chart Reviews, Special Studies and surveys, etc.) Which populations experience disproportionate need for and/or barriers to accessing this service?	**Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources** (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?	**Recommendation(s)**
		national, state, and local goal of linkage to HIV medical care ≤ 3 months of diagnosis. In 2015, 19% of the newly diagnosed in the EMA were *not* linked within this timeframe. Unmet Need: Service Linkage at HIV testing sites is specifically designed to prevent newly diagnosed PLWH from falling out-of-care by facilitating entry into HIV primary care immediately upon diagnosis. In 2015, 12% of the newly diagnosed PLWH were not linked to care by the end of the year. Continuum of Care: Service Linkage supports linkage to care, maintenance/retention in care and viral suppression for PLWH.	September 1, 2019 Disproportionate Need / Inaccessibility: *Case Management:* Higher need – Recently released, rural; Difficult access – White, MSM		- 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		

‡ 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.	Documentation of Need (Sources of Data include: 2016 Needs Assessment, 2017-2021 Comp Plan, 2016 Outcome Measures, 2016 Chart Reviews, Special Studies and surveys, etc.) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources (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?	Recommendation(s)
Early Intervention Services (EIS)‡ (Incarcerated) (Harris County Jail) ***Workgroup #3*** ***Motion:*** *(Hamilton/Torrente)* *Votes: Y=12; N=0;* *Abstentions=none.*	✔ Yes ___No	☒ EIIHA ☒ Unmet Need ☒ Continuum of Care EIIHA: Local jail policy mandates HIV testing within 14 days of incarceration, thereby identifying status-unaware members of this population. In 2017, an estimated 180 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. This is accomplished through care coordination by EIS staff in partnership with community-based providers/MOUs.	Need (2016): # of estimated PLWH released from TDCJ into Harris County: 180 (*2017*) Rank w/in 10 Core Services: #10 Service Utilization (2018): # clients served: 789 *(6% increase v. 2017)* Chart Review (2018): Of the client records reviewed, 100% of newly diagnosed clients had a discharge plan present and 83% of all client records reviewed had a discharge plan present. 46% of recently released respondents in a 2012 Special Study reported receiving EIS; 31% received a referral to a community-based primary care provider.	RW Part C provides non-targeted EIS Covered under QHP? ___Yes ✔ No	Justify the use of funds: This service category: - Is a HRSA-defined Core Medical Service - Results in desirable outcomes for clients who access the service - Links those newly diagnosed in a local EMA jail to community-based HIV primary care upon release, thereby maintaining linkage to care for and preventing unmet need in this Special Population - Addresses specific activities from Strategy #3 of the Comprehensive Plan and addresses certain Special Populations named in the Plan Is this a duplicative service or activity?	Can we make this service more efficient? No Can we bundle this service? No Has a recent capacity issue been identified? No	**Motion:** Accept the service definition as presented, update the justification chart, and keep 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.	**Documentation of Need** (Sources of Data include: 2016 Needs Assessment, 2017-2021 Comp Plan, 2016 Outcome Measures, 2016 Chart Reviews, Special Studies and surveys, etc.) Which populations experience disproportionate need for and/or barriers to accessing this service?	**Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources** (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?	**Recommendation(s)**
		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. Continuum of Care: EIS supports linkage to care, maintenance/retention in care and viral suppression for PLWH.	Also, ≤3 months of release from incarceration: *87% reported seeing a community-based HIV care provider; 59% reported meeting with a case manager; and 53% reported completing RW and ADAP eligibility.* Disproportionate Need / Inaccessibility: *EIS:* Higher need – Unstably housed, recently released; Difficult access – Recently released		- No, there is no known alternative funding for this service as designed		

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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.	Documentation of Need (Sources of Data include: 2016 Needs Assessment, 2017-2021 Comp Plan, 2016 Outcome Measures, 2016 Chart Reviews, Special Studies and surveys, etc.) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources (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?	Recommendation(s)
Emergency Financial Assistance-Pharmacy Assistance - Part A ***Workgroup #1*** ***Motion:** (Galley/Torrente) Votes: Y=7; N=0; Abstentions=Andrews, Bailey, Francis, Miertschin.*	___Yes ✔ No Emergency Financial Assistance – Pharmacy Assistance will provided limited one-time and/or short-term 14-day supply of pharmaceuticals to patients otherwise ineligible for medications other payers.	☒ EIIHA ☒ Unmet Need ☒ Continuum of Care EIIHA: Early access to HIV medications following diagnosis is a critical component to effective service linkage and improved long-term health outcomes. EFA-Pharmacy Assistance covers HIV medications while other payers are sought. Unmet Need: Medication provided through EFA-Pharmacy Assistance would reduce unmet need by increasing the proportion of PLWH in the Houston EMA/HSDA with access to HIV medications, a measure of met need. Continuum of Care: Short-	Need (2016): As EFA-Pharmacy Assistance is a new service category, it was not evaluated in the 2016 Needs Assessment. However, when participants reported not taking HIV medication at the time of survey, this was most often because they lacked prescription drug coverage (29% of medication barriers reported). Additionally, 27% of participants reported that they experience difficulty paying for HIV medications. Service Utilization (2018): # clients served: 621 *(202% increase v. 2017)* Disproportionate Need / Inaccessibility: *LPAP*: Higher need – Females, Hispanic/Latino, 18-	While multiple other HIV medication payers exist (e.g. ADAP, PAP programs, health insurance providers), prolonged application and approval processes delay initiation or continuation of HIV medication. This service would provide HIV medications for a limited term while other payment sources are sought. Covered under QHP? ✔ Yes ____No	Justify the use of funds: This service category: - Is a HRSA-defined Support Service - Per HRSA/HAB Policy Clarification Notice (PCN) #16-02, LPAP is operated as a supplemental means of providing medication assistance when an ADAP has a restricted formulary, waiting list and/or restricted financial eligibility criteria, not when ADAP applications are pending submission or approval. Furthermore, program guidance indicates, "LPAP funds are not to be used for Emergency Financial Assistance. Emergency Financial Assistance may assist with medications not covered by the LPAP."	Can we make this service more efficient? No Can we bundle this service? Currently bundled with Primary Medical Care, Medical Case Management, Service Linkage, and LPAP. Has a recent capacity issue been identified? No	**Motion:** Accept the service definition as presented, update the justification chart, and keep the financial eligibility the same: 500%.

‡ Service Category for Part B/State Services only.

Service Category	**Is this a core service?** If no, how does the service support access to core services & support clients achieving improved outcomes?	**How does this service assist individuals *not in care** to access primary care?** **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	**Documentation of Need** (Sources of Data include: 2016 Needs Assessment, 2017-2021 Comp Plan, 2016 Outcome Measures, 2016 Chart Reviews, Special Studies and surveys, etc.) Which populations experience disproportionate need for and/or barriers to accessing this service?	**Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources** (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?	**Recommendation(s)**
		term access to HIV medication supports medication adherence and viral suppression. Additionally, initiation of HIV medications soon after diagnosis is linked to improved long-term health outcomes, including viral suppression.	24, recently released, rural ; Difficult access – Rural, recently released		Is this a duplicative service or activity? - No, there is no known alternative funding for this service as designed		
Health Insurance Premium & Co-Pay Assistance **Part A, Part B, State Services** ***Workgroup #2*** ***Motion:** (Boyle/Crawford) Votes: Y=9; N=1; Abstentions=Andrews, Francis*	✔ Yes __No	☐ EIIHA ☒ Unmet Need ☒ Continuum of Care Unmet Need: Reductions in unmet need can be aided by *preventing* PLWH from lapsing their HIV care. This service category can directly prevent unmet need by removing financial barriers to HIV care for those who are eligible for public or private health insurance. Currently,	Need (2016): Current # of living HIV cases in EMA: 28,225 (2017) Rank w/in 10 Core Services: #5 *% of RW clients with health insurance: 38% (5,288)* *% of RW clients with Marketplace coverage: 4% (606)* Service Utilization (2018): # clients served: 2,203 *(7% increase v. 2017)*	No known alternative funding sources exist for this service, though consumers between 100% and 400% FPL may qualify for Advanced Premium Tax Credits (subsidies). COBRA plans seems to have fewer out-of-pocket costs. Covered under QHP?	Justify the use of funds: This service category: - Is a HRSA-defined Core Medical Service - Has limited or no alternative funding source - Removes potential barriers to entry/retention in HIV care, thereby contributing to EIIHA goals and preventing unmet need - Facilitates national, state, and local goals related to retention in care and	Can we make this service more efficient? Yes, see attached service definitions for changes. Can we bundle this service? No Has a recent capacity issue been identified? No	**Motion:** Accept the service definition as presented, update the justification chart, and keep the financial eligibility the same: 0-400%; ACA plans: must have a subsidy.

‡ 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.	**Documentation of Need** (Sources of Data include: 2016 Needs Assessment, 2017-2021 Comp Plan, 2016 Outcome Measures, 2016 Chart Reviews, Special Studies and surveys, etc.) Which populations experience disproportionate need for and/or barriers to accessing this service?	**Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources** (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?	**Recommendation(s)**
		42% of RW clients have some form of health insurance, and 6% have Marketplace coverage. This service will assist those clients to remain in HIV care via all insurance resources; This will also be utilized to assist federal health insurance marketplace participants. Continuum of Care: Health Insurance Assistance facilitates maintenance/ retention in care and viral suppression by increasing access to non-RW private and public medical and pharmaceutical coverage. The savings yielded by securing non-RW healthcare coverage for PLWH increases the amount of funding available to provide	Disproportionate Need / Inaccessibility: *HIA*: Higher need – White, 50+, MSM, transgender; Difficult access – Female, recently released, rural	___Yes ✔ No	reducing unmet need - Supports federal health insurance marketplace participants Is this a duplicative service or activity? - No, there is no known alternative funding for this service as designed		

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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.	Documentation of Need (Sources of Data include: 2016 Needs Assessment, 2017-2021 Comp Plan, 2016 Outcome Measures, 2016 Chart Reviews, Special Studies and surveys, etc.) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources (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?	Recommendation(s)
		other needed services throughout the Continuum of Care.					
Home and Community-Based Services‡ (Facility-based) (Adult Day Treatment) ***Workgroup #3*** ***Motion:*** *(Torrente/Hamilton)* *Votes: Y=11; N=0;* *Abstentions=Stacy.*	✔ Yes __No	☐ EIIHA ☒ Unmet Need ☒ Continuum of Care Unmet Need: Facilitating entry into/return of the out-of-care into primary care is the intent of reducing unmet need. 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	Need (2016): Current # of living HIV cases in EMA: 28,225 (2017) Rank w/in 10 Core Services: #8 Service Utilization (2018): # clients served: 38 *(36% increase v. 2017)* Chart Review (2018): 82% of clients receiving Home & Community Based Health Services (Adult Day Treatment) had documentation of a completed care plan based on the primary medical care provider's order. A change in the review tool, resulted in no assessment of comorbidities	Medicaid Covered under QHP? ___Yes ✔ No	Justify the use of funds: This service category: - Is a HRSA-defined Core Medical Service; and use has increased - Results in desirable health outcomes for clients who access the service - Helps prevent unmet need for those with advanced HIV-related health concerns - Facilitates national, state, and local goals related to retention in care, reducing unmet need, and viral load suppression Is this a duplicative service or activity? - This service is funded	Can we make this service more efficient? No Can we bundle this service? No Has a recent capacity issue been identified? No	**Motion:** Accept the service definition as presented, update the justification chart, and keep the financial eligibility the same: 300%, and ask the Office of Support to work with the AAs to promote this service.

‡ 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.	**Documentation of Need** (Sources of Data include: 2016 Needs Assessment, 2017-2021 Comp Plan, 2016 Outcome Measures, 2016 Chart Reviews, Special Studies and surveys, etc.) Which populations experience disproportionate need for and/or barriers to accessing this service?	**Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources** (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?	**Recommendation(s)**
		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. Continuum of Care*:* Adult Day Treatment facilitates re-linkage and retention in care for PLWH 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.	this review period. Disproportionate Need / Inaccessibility: *Day Treatment:* Higher need – transgender; Difficult access – Hispanic/Latino		locally by one other public source for those meeting income or disability-related eligibility criteria		

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	Documentation of Need (Sources of Data include: 2016 Needs Assessment, 2017-2021 Comp Plan, 2016 Outcome Measures, 2016 Chart Reviews, Special Studies and surveys, etc.) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources (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?	Recommendation(s)
Hospice ‡ ***Workgroup #3*** ***Motion:*** *(Hamilton/Pennamon)* *Votes: Y=9; N=0;* *Abstentions=Stacy, Tankeu.*	✔ Yes __No	☐ EIIHA ☒ Unmet Need ☒ Continuum of Care Unmet Need: Facilitating entry into/return of the out-of-care into primary care is the intent of reducing unmet need. Hospice contributes to this goal by providing facility-based skilled nursing and palliative care for those with a terminal diagnosis. This, in turn, may prevent PLWH from becoming out-of-care. In 2015, 19% of people with a Stage 3 HIV diagnosis were out-of-care in the EMA. 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.	Need (2017): Current # of living HIV cases in EMA: 28,225 Service Utilization (2018): # clients served: 46 *(4% decrease v. 2017)* Chart Review (2018): Of the 39 (85%) client charts reviewed: • *23% had experienced homeless at the time of admission* • *8% had active substance abuse* • *8% of clients with an active psychiatric health concerns* Disproportionate Need / Inaccessibility: *Hospice:* N/a	Medicaid, Medicare Covered under QHP? ✔ Yes ___No	Justify the use of funds: This service category: - Is a HRSA-defined Core Medical Service - Prevents unmet need among PWA and those with co-occurring conditions - Facilitates national, state, and local goals related to retention in care and reducing unmet need - Addresses a system-level objective (#8) from the Comprehensive Plan and addresses certain Special Populations named in the Plan Is this a duplicative service or activity? - This service is funded locally by other public sources for those meeting income, disability, and/or	Can we make this service more efficient? No Can we bundle this service? No Has a recent capacity issue been identified? No	**Motion:** Accept the service definition as presented, update the justification chart, and keep the financial eligibility the same: 300%.

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	Documentation of Need (Sources of Data include: 2016 Needs Assessment, 2017-2021 Comp Plan, 2016 Outcome Measures, 2016 Chart Reviews, Special Studies and surveys, etc.) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources (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?	Recommendation(s)
		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.			age-related eligibility criteria		
Linguistic Services‡ ***Workgroup #3*** ***Motion:** (Torrente/Francis) Votes: Y=9; N=0; Abstentions=Tankeu.*	___Yes ✔ No	☐ EIIHA ☒ Unmet Need ☒ Continuum of Care Unmet Need: Facilitating entry into/return of the out-of-care into primary care is the intent of reducing unmet need. By eliminating language barriers in RW-funded HIV care, this service facilitates entry into care and helps prevent lapses in care for monolingual PLWH.	Need (2017): Current # of living HIV cases in EMA: 28,225 Service Utilization (2018): # clients served: 50 *(19% decrease v. 2017)* Disproportionate Need / Inaccessibility: Linguistics:	RW providers must have the capacity to serve monolingual Spanish-speakers; Medicaid may provide language translation for *non-Spanish* monolingual clients Covered under QHP? ___Yes ✔ No	Justify the use of funds: This service category: - Is a HRSA-defined Support Service - Has limited or no alternative funding source - Removes potential barriers to entry/retention in HIV care for monolingual PLWH, thereby contributing to EIIHA goals and preventing unmet need - Facilitates national, state, and local goals related to	Can we make this service more efficient? No Can we bundle this service? No Has a recent capacity issue been identified? There is no waiting list at this time; however, the need for this service has the potential to exceed capacity due to new cohorts of languages	**Motion:** Accept the service definition as presented, update the justification chart, and keep the financial eligibility the same: 300%.

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	Documentation of Need (Sources of Data include: 2016 Needs Assessment, 2017-2021 Comp Plan, 2016 Outcome Measures, 2016 Chart Reviews, Special Studies and surveys, etc.) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources (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?	Recommendation(s)
		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.			retention in care and reducing unmet need - Linguistic and cultural competence is a Guiding Principle of the Comprehensive HIV Plan Is this a duplicative service or activity? - No, there is no known alternative funding for this service as designed	spoken in the EMA/HSDA	
Medical Nutritional Supplements and Therapy - Part A ***Workgroup #2*** ***Motion:** (Deal/Torrente) Votes: Y=12; N=0; Abstentions=Andrews, Crawford*	✔ Yes ___No	☐ EIIHA ☒ Unmet Need ☒ Continuum of Care Unmet Need: The most commonly cited reason for referral to this service by a RW clinician is to mitigate side effects from HIV medication. Currently, 8% of PLWH report that side effects prevent them from taking HIV medication. This service	Need (2016): Current # of living HIV cases in EMA: 28,225 (2017) Rank w/in 10 Core Services: #9 Clinician Survey (2012): 95% of clinicians surveyed by RWGA stated the service is "very useful" or "useful" for clients; most common referrals to the service were for weight loss, wasting	No known alternative funding sources exist for this service Covered under QHP?* ___Yes ✔ No *Some QHPs may cover prescribed supplements	Justify the use of funds: This service category: - Is a HRSA-defined Core Medical Service - Is ranked as the #9 service need by PLWH - Has limited or no alternative funding source - Results in desirable health outcomes for clients who access the service - Removes barriers to HIV	Can we make this service more efficient? No Can we bundle this service? No Has a recent capacity issue been identified? No	**Motion:** Accept the service definition as presented, update the justification chart, and keep the financial eligibility the same: 300%.

‡ Service Category for Part B/State Services only.

Service Category	**Is this a core service?** If no, how does the service support access to core services & support clients achieving improved outcomes?	**How does this service assist individuals *not in care** to access primary care?** **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	**Documentation of Need** (Sources of Data include: 2016 Needs Assessment, 2017-2021 Comp Plan, 2016 Outcome Measures, 2016 Chart Reviews, Special Studies and surveys, etc.) Which populations experience disproportionate need for and/or barriers to accessing this service?	**Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources** (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?	**Recommendation(s)**
		category eliminates potential barriers to HIV medication adherence by helping to alleviate side effects. In addition, evidence of an ART prescription is a criterion for met need. Continuum of Care: Medical Nutrition Therapy facilitates viral suppression by allowing PLWH to mitigate HIV medication side effects with supplements, and increasing medication adherence.	syndrome, and medication side effects Service Utilization (2018): # clients served: 476 *(6% decrease v. 2017)* Outcomes (FY2017): 81% of Medical Nutritional Therapy clients were virally suppressed Disproportionate Need / Inaccessibility: *MNT*: Higher need – Recently released, transgender ; Difficult access – Rural		medication adherence, thereby facilitating national, state, and local goals related to viral load suppression Is this a duplicative service or activity? - Alternative funding for this service may be available through Medicaid.		

‡ 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.	Documentation of Need (Sources of Data include: 2016 Needs Assessment, 2017-2021 Comp Plan, 2016 Outcome Measures, 2016 Chart Reviews, Special Studies and surveys, etc.) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources (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?	Recommendation(s)
Mental Health Services‡ (Professional Counseling) ***Workgroup #2*** ***Motion:** (Boyle/Deal)* *Votes: Y=11; N=0;* *Abstentions=Andrews, Francis*	✔ Yes ___No	☐ EIIHA ☒ Unmet Need ☒ Continuum of Care Unmet Need: Of 29% of 2016 Needs Assessment participants who reported falling out of care for >12 months since first entering care, 9% reported mental health concerns caused the lapse. Over half (57%) of participants recorded having a current mental health condition diagnosis, and 65% reported experiencing at least one mental/emotional distress symptom in the past 12 months to such an extent that they desired professional help. Mental Health Services offers professional counseling for those with a mental health condition/concern, and, as a result, may help reduce lapses in HIV care. Mental	Need (2016): Current # of living HIV cases in EMA: 28,225 (2017) Rank w/in 10 Core Services: #6 Service Utilization (2018): # clients served: 217 *(28% decrease v. 2017)* Chart Review (2018): Of 24% of client charts reviewed, 100% had documentation of clients receiving mental health services receiving a comprehensive assessment, a psychosocial history, and a treatment plan. Disproportionate Need / Inaccessibility: *Mental Health:* Higher need – White, unstably housed, MSM, recently released, transgender; Difficult access	RW Part D (targets WICY), Medicaid, Medicare, private providers, and self-pay Some services provided by MHMRA Covered under QHP? ✔ Yes ___No	Justify the use of funds: This service category: - Is a HRSA-defined Core Medical Service - Is ranked as the #7 service need by PLWH - Facilitates national, state, and local goals related to retention in care and preventing unmet need - Addresses a system-level objective (#8) from the Comprehensive Plan and (as a result of the motion) 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),	Can we make this service more efficient? No Can we bundle this service? No Has a recent capacity issue been identified? No	**Motion:** Accept the service definition with one change: allow 90 minutes for family/couples session, update the justification chart, and keep the financial eligibility the same: 300%.

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	Documentation of Need (Sources of Data include: 2016 Needs Assessment, 2017-2021 Comp Plan, 2016 Outcome Measures, 2016 Chart Reviews, Special Studies and surveys, etc.) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources (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?	Recommendation(s)
		Health Services also address local priorities related to mental health co-morbidities. Continuum of Care: Mental Health Services facilitate linkage, maintenance/ retention in care, and viral suppression by helping PLWH manage mental and emotional health concerns that may act as barriers to HIV care.	– White, unstably housed, rural		(2) those meeting income, disability, and/or age-related eligibility criteria, and (3) those with private sector health insurance.		
Oral Health Untargeted – Part B Rural (North) – Part A ***Workgroup #2*** ***Motion:** (Torrente/Boyle)* *Votes: Y=11; N=0;* *Abstentions=none*	✔ Yes ___No	☐ EIIHA ☐ Unmet Need ☒ Continuum of Care Continuum of Care: Oral Health services support maintenance in HIV care by increasing access to care and treatment for HIV-related and general oral health diagnoses. Untreated oral health diagnoses can create poor health outcomes and	Need (2016): Current # of living HIV cases in EMA: 28,225 (2017) Rank w/in 10 Core Services: #4 Service Utilization (2018): # clients served: 3,590 *(10% increase v. 2017)* Outcomes (FY2017): Oral Health Care – Rural Target: 88% of clients	In FY12, Medicaid Managed Care expanded benefits to include oral health services Covered under QHP*? ___Yes ✔No *Some QHPs cover pediatric dental; low-cost add-on dental coverage can be purchased in Marketplace	Justify the use of funds: This service category: - Is a HRSA-defined Core Medical Service - Is ranked as the #4 service need by PLWH. Is this a duplicative service or activity? - This service is funded locally by one other public sources for its Managed	Can we make this service more efficient? No Can we bundle this service? No Has a recent capacity issue been identified? Yes, clients report waiting lists for this service	**Motion:** Accept the service definition as presented, update the justification chart, and keep the financial eligibility the same: 300%.

‡ Service Category for Part B/State Services only.

Service Category	**Is this a core service?** If no, how does the service support access to core services & support clients achieving improved outcomes?	**How does this service assist individuals *not in care** to access primary care?** **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	**Documentation of Need** (Sources of Data include: 2016 Needs Assessment, 2017-2021 Comp Plan, 2016 Outcome Measures, 2016 Chart Reviews, Special Studies and surveys, etc.) Which populations experience disproportionate need for and/or barriers to accessing this service?	**Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources** (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?	**Recommendation(s)**
		may act as a financial barrier to HIV care.	received an intraoral and an extraoral exam, and 81% received periodontal screening Oral Health Care – Untargeted: 97% had chart evidence for vital signs assessment at initial visit, 98% had updated health histories in their chart, 93% had a signed dental treatment plan established or updated within the last year, and 81% had chart evidence of receipt of oral health education including smoking cessation. <u>Disproportionate Need / Inaccessibility</u>: *Oral Health Care:* Higher need – Females, white, 50+, rural; Difficult access – Unstably housed, rural		Care clients only		

‡ 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.	Documentation of Need (Sources of Data include: 2016 Needs Assessment, 2017-2021 Comp Plan, 2016 Outcome Measures, 2016 Chart Reviews, Special Studies and surveys, etc.) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources (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?	Recommendation(s)
Outreach Services: Primary Care Re-Engagement - Part A ***Workgroup #1*** ***Motion:*** *(Hamilton/Murray)* *Votes: Y=7; N=0;* *Abstentions=Andrews, Bailey, Francis, Miertschin*	___Yes ✔ No	☐ EIIHA ☒ Unmet Need ☒ Continuum of Care Unmet Need: Facilitating maintenance in Primary Care reduces unmet need. In 2016, the Needs Assessment found that 29% of participants had a lapse in care of greater than 12 months at any point since their diagnosis. Additionally, in the 2014 Needs Assessment, 50% of participants responded that support of a clinician helps keep them in HIV medical care. Continuum of Care: Outreach Services is designed to facilitate maintenance in care for consumers at risk for falling out of care, thereby	As Outreach Services is a newly funded service category, it was not evaluated in the 2016 Needs Assessment. However, 29% of participants reported falling out of care for a period of 12 months or longer since their diagnosis, most often due to substance abuse concerns. Service Utilization (2018): # clients served: 1,016 *(first year of implementation)* Disproportionate Need / Inaccessibility: *Populations with percent retained lower than the Houston EMA (2017):* 13-24, 25-34, 35-44, transgender men (n=4, FtM), cisgender men, Black males (at birth), White females (at birth), Other females (at birth)	Beyond retention efforts offered in the provision of case management care coordination, there is currently no funding to support Outreach Services staff. Covered under QHP? ___Yes ✔ No	Justify the use of funds: This service category: - Is a HRSA-defined Support Service - Only 68% of diagnosed PLWH in the Houston EMA were retained in care in 2015 (60% not counting viral suppression as a measure of retention), lower than any other EMA/TGA in Texas - Maintenance in care supports better health outcomes and viral suppression Is this a duplicative service or activity? No	Can we make this service more efficient? No Can we bundle this service? Bundled with Primary Care, LPAP, Service Linkage, EFA and MCM. Has a recent capacity issue been identified? No	**Motion:** Accept the service definition as presented, update the justification chart, and keep 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.	**Documentation of Need** (Sources of Data include: 2016 Needs Assessment, 2017-2021 Comp Plan, 2016 Outcome Measures, 2016 Chart Reviews, Special Studies and surveys, etc.) Which populations experience disproportionate need for and/or barriers to accessing this service?	**Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources** (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?	**Recommendation(s)**
		increasing retention in care as well as viral suppression for PLWH.					
Program Support: (WITHIN THE ADMINISTRATIVE BUDGET)							
Council Support	___Yes ✔ No						
Project LEAP	___Yes ✔ No						
Blue Book	___Yes ✔ No						
Referral for Health Care and Support Services‡ ***Workgroup #1*** ***Motion:*** *(Galley/Hamilton) Votes: Y=8; N=0;*	___Yes ✔ No Referral For Health Care/Support Services – AIDS Drug Assistance Program Enrollment Worker at Ryan White Care Sites will fund one	☐ EIIHA ☒ Unmet Need ☒ Continuum of Care Unmet Need: Assistance submitting complete and accurate ADAP applications and re-certifications reduces	As Referral For Health Care/Support Services – AIDS Drug Assistance Program Enrollment Worker at Ryan White Care Sites is a new service category, it was not evaluated in the 2016	Beyond assistance offered in the provision of case management care coordination, there is currently no funding to support dedicated ADAP Enrollment Workers at Ryan	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	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	**Motion:** Accept the service definition as presented, update the justification chart, and keep 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.	**Documentation of Need** (Sources of Data include: 2016 Needs Assessment, 2017-2021 Comp Plan, 2016 Outcome Measures, 2016 Chart Reviews, Special Studies and surveys, etc.) Which populations experience disproportionate need for and/or barriers to accessing this service?	**Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources** (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?	**Recommendation(s)**
Abstentions=Andrews, Bailey, Francis, Miertschin	FTE ADAP enrollment worker per Ryan White Part A primary care site. Each ADAP enrollment worker will meet with all potential new ADAP enrollees, explain ADAP program benefits and requirements, and assist clients with submission of complete, accurate ADAP applications, as well as appropriate re-certifications and attestations.	unmet need by increasing the proportion of PLWH in the Houston EMA/HSDA with access to HIV medication coverage. Continuum of Care: Increased access to HIV medication coverage supports medication adherence and viral suppression.	Needs Assessment. However, when participants reported not taking HIV medication at the time of survey, this was most often because they lacked prescription drug coverage (29% of medication barriers reported). Additionally, 27% of participants reported that they experience difficulty paying for HIV medications. Service Utilization (2018): # clients served: 6,628 *(first year of implementation)*	White primary care sites. Covered under QHP? ___Yes ✔ No	continuation or bridge service gaps. - ADAP medication coverage reduces use of LPAP funding. Is this a duplicative service or activity? No	placement at a single site. Can we bundle this service? N/a – this would be the only use of SS-R funding in the Houston EMA/HSDA Has a recent capacity issue been identified? No	

‡ 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.	Documentation of Need (Sources of Data include: 2016 Needs Assessment, 2017-2021 Comp Plan, 2016 Outcome Measures, 2016 Chart Reviews, Special Studies and surveys, etc.) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources (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?	Recommendation(s)
Substance Abuse Treatment – Part A ***Workgroup #2*** ***Motion:** (Boyle/Deal)* *Votes: Y=9; N=0;* *Abstentions = Andrews, Crawford*	✔ Yes ___No	☐ EIIHA ☒ Unmet Need ☒ Continuum of Care Unmet Need: Among PLWH with a history of unmet need, substance use is the #2 reason cited for falling out-of-care. Therefore, Substance Abuse Treatment services can directly prevent or reduce unmet need. Substance Abuse Treatment also addresses local priorities related to substance abuse co-morbidities. Continuum of Care: Substance Abuse Treatment facilitates linkage, maintenance/retention in care, and viral suppression by helping PLWH manage substance abuse that may act as barriers to HIV care.	Need (2016): Current # of living HIV cases in EMA: 28,225 (2017) Rank w/in 10 Core Services: #9 Service Utilization (2018): # clients served: 28 *(22% increase v. 2017)* Outcomes (FY2017): 46% of clients accessed primary care at least once after receiving Substance Abuse Treatment services and 67% were virally suppressed. Disproportionate Need / Inaccessibility: *Substance Abuse Treatment:* Higher need – Females, recently released, transgender; Difficult access – Recently released	RW Part C, Medicaid, Medicare, private providers, and self-pay. Some services provided by SAMHSA Covered under QHP? ✔ Yes ___No	Justify the use of funds: This service category: - Is a HRSA-defined Core Medical Service - Removes potential barriers to early entry into HIV care, thereby contributing to EIIHA goals - Prevents unmet need by addressing the #2 cause cited by PLWH for lapses in HIV care - Facilitates national, state, and local goals related to continuous HIV care and reducing unmet need - Addresses a system-level objective (#8) from the Comprehensive Plan and addresses certain Special Populations named in the Plan Is this a duplicative service or activity?	Can we make this service more efficient? No Can we bundle this service? No Has a recent capacity issue been identified? No	**Motion:** Accept the service definition as presented, update the justification chart, and keep the financial eligibility the same: 300%.

‡ Service Category for Part B/State Services only.

Service Category	**Is this a core service?** If no, how does the service support access to core services & support clients achieving improved outcomes?	**How does this service assist individuals *not in care** to access primary care?** **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	**Documentation of Need** (Sources of Data include: 2016 Needs Assessment, 2017-2021 Comp Plan, 2016 Outcome Measures, 2016 Chart Reviews, Special Studies and surveys, etc.) Which populations experience disproportionate need for and/or barriers to accessing this service?	**Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources** (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?	**Recommendation(s)**
					- This service is funded locally by other public and private sources for (1) those meeting income, disability, and/or age-related eligibility criteria, and (2) those with private sector health insurance.		
Transportation – Pt A (Van-based, bus passes & gas vouchers) ***Workgroup #3*** ***Motion:*** *(Hamilton/Oshingbade)* *Votes: Y=12; N=0;* *Abstentions=none.*	___Yes ✔ No	☐ EIIHA ☒ Unmet Need ☒ Continuum of Care Unmet Need: Lack of transportation is the *fourth* most commonly-cited barrier among PLWH to accessing HIV core medical services. Transportation services eliminate this barrier to care, thereby supporting PLWH in continuous HIV care.	Need (2016): Current # of living HIV cases in EMA: 28,225 (2017) Rank w/in 5 Support Services: #2 Service Utilization (2018): # clients served: *Van-based: 863* *(<1% decrease v. 2017)* *Bus pass: 2,291* *(5% increase v. 2017)* Outcomes (FY2017):	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. Covered under QHP*? ___Yes ✔ No	Justify the use of funds: This service category: - Is a HRSA-defined Support Service - Is ranked as the #2 need among Support Services by PLWH - Results in clients accessing HIV primary care - Removes potential barriers to entry/retention in HIV care, thereby contributing	Can we make this service more efficient? No Can we bundle this service? No Has a recent capacity issue been identified? No	**Motion:** Accept the service definition as presented, update the justification chart, and keep the financial eligibility the same: 400%, ask the Office of Support to check into alternative bus providers.

‡ 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.	**Documentation of Need** (Sources of Data include: 2016 Needs Assessment, 2017-2021 Comp Plan, 2016 Outcome Measures, 2016 Chart Reviews, Special Studies and surveys, etc.) Which populations experience disproportionate need for and/or barriers to accessing this service?	**Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources** (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?	**Recommendation(s)**
		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.	66% of clients accessed primary care at least once after using van transportation; and 34% of clients accessed primary care after using bus pass services. Disproportionate Need / Inaccessibility: *Transportation:* Higher need – Females, Black, unstably housed, recently released, transgender; Difficult access – Recently released, transgender		to EIIHA goals and preventing unmet need - Facilitates national, state, and local goals related to continuous HIV care and reducing unmet need Is this a duplicative service or activity? - This service is funded locally by other public sources for (1) specific Special Populations (e.g., WICY), and (2) those meeting income, disability, and/or age-related eligibility criteria.		

‡ 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 03-01-19 *(In order for any of the services listed below to be considered for funding, an Idea Form must be submitted to the Office of Support for the Ryan White Planning Council no later than **5 p.m. on May 6, 2019**. 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.
Psychosocial Support Services (Counseling/Peer)	Duplicates patient education program in primary care and case management. The boundary between peer and client gets confusing and difficult to supervise. Not cost effective, costs almost as much per client as medical services.
Rehabilitation	Service available from alternative sources.

‡ Service Category for Part B/State Services only.

DRAFT

TARGETING FOR FY 2020 SERVICE CATEGORIES FOR RYAN WHITE PART A, B, MAI AND STATE SERVICES FUNDING

HIV Prevalence	AIDS Prevalence	HIV & AIDS Prevalence	Geographic Targeting	Other Targeting	N/A or No Targeting	Service Category
			X*	X**		Ambulatory/Outpatient Medical Care
			X*	X		Case Management Services - Core
				X		Case Management Services - Non-Core
				X		Early Medical Intervention
					X	Emergency Financial Assistance - Pharmacy Assistance
					X	Health Insurance
					X	Home and Community Based Services
					X	Hospice Services
					X	Linguistic Services
					X	Local Pharmacy Assistance Program
					X	Medical Nutritional Therapy
					X	Mental Health Treatment
					X	Other Professional Services
					X****	Outreach Services - Primary Care Retention in Care
			X***		X	Oral Health
					X	Referral for Health Care & Support Services - ADAP Enrollment Worker
					X	Substance Abuse Treatment
			X	X		Transportation Services
					X	Vision

* Geographic targeting in rural area only.

** In an effort to provide a base line that reflects actual client utilization, for community based organizations base this percentage on the FY 2019 final expenditures that targeted African Americans, Whites and Hispanics.

*** Geographic targeting in the north only.

**** Pay particular attention to youth who are transitioning into adult care.

Priority and Allocations Committee Report

Prepared by: Ryan White Grant Administration

FY 2018 Ryan White Part A and MAI Service Utilization Report

SUR - 4th Quarter Cumulative (3/1-2/28)																	
Priority	Service Category	Goal	Unduplicated Clients Served YTD	Male	Female	AA (non-Hispanic)	White (non-Hispanic)	Other (non-Hispanic)	Hispanic	0-12	13-19	20-24	25-34	35-44	45-49	50-64	65 plus
1	**Outpatient/Ambulatory Primary Care (excluding Vision)**	6,467	7,785	74%	26%	48%	14%	2%	35%	0%	0%	4%	27%	27%	13%	26%	2%
1.a	Primary Care - Public Clinic (a)	2,350	3,498	69%	31%	51%	10%	2%	37%	0%	0%	2%	19%	26%	15%	34%	4%
1.b	Primary Care - CBO Targeted to AA (a)	1,060	1,793	69%	31%	99%	0%	1%	0%	0%	0%	8%	39%	27%	10%	15%	1%
1.c	Primary Care - CBO Targeted to Hispanic (a)	960	1,337	85%	15%	0%	0%	0%	100%	0%	1%	6%	29%	30%	14%	19%	1%
1.d	Primary Care - CBO Targeted to White and/or MSM (a)	690	721	88%	12%	0%	88%	12%	0%	0%	0%	3%	27%	21%	15%	31%	3%
1.e	Primary Care - CBO Targeted to Rural (a)	400	633	71%	29%	47%	24%	2%	27%	0%	0%	7%	32%	27%	11%	21%	1%
1.f	Primary Care - Women at Public Clinic (a)	1,000	1,078	0%	100%	61%	8%	2%	29%	0%	0%	1%	14%	29%	18%	33%	5%
1.g	Primary Care - Pediatric (a)	7	11	73%	27%	36%	9%	0%	55%	9%	45%	45%	0%	0%	0%	0%	0%
1.h	Vision	1,600	2,716	75%	25%	48%	16%	2%	34%	0%	0%	5%	24%	22%	14%	32%	3%
2	**Medical Case Management (f)**	3,075	5,318														
2.a	Clinical Case Management	600	1,096	73%	27%	64%	18%	2%	17%	0%	0%	5%	28%	25%	11%	28%	3%
2.b	Med CM - Targeted to Public Clinic (a)	280	683	90%	10%	61%	9%	1%	29%	0%	1%	3%	27%	22%	13%	32%	3%
2.c	Med CM - Targeted to AA (a)	550	1,716	69%	31%	99%	0%	1%	0%	0%	0%	8%	35%	25%	10%	20%	2%
2.d	Med CM - Targeted to H/L(a)	550	959	85%	15%	0%	0%	0%	100%	0%	1%	6%	33%	30%	10%	18%	2%
2.e	Med CM - Targeted to White and/or MSM (a)	260	639	87%	13%	0%	88%	11%	0%	0%	0%	3%	26%	19%	14%	34%	3%
2.f	Med CM - Targeted to Rural (a)	150	737	70%	30%	48%	26%	2%	23%	0%	0%	7%	27%	23%	11%	28%	4%
2.g	Med CM - Targeted to Women at Public Clinic (a)	240	272	0%	100%	66%	7%	3%	23%	0%	0%	1%	17%	30%	18%	30%	3%
2.h	Med CM - Targeted to Pedi (a)	125	104	63%	37%	73%	4%	0%	23%	64%	26%	10%	0%	0%	0%	0%	0%
2.i	Med CM - Targeted to Veterans	200	182	96%	4%	70%	20%	1%	9%	0%	0%	0%	2%	4%	7%	64%	23%
2.j	Med CM - Targeted to Youth	120	26	96%	4%	46%	8%	0%	46%	0%	19%	81%	0%	0%	0%	0%	0%
3	**Local Drug Reimbursement Program (a)**	2,845	4,654	77%	23%	48%	15%	2%	35%	0%	0%	5%	30%	28%	13%	22%	1%
4	**Oral Health**	200	327	70%	30%	43%	31%	2%	25%	0%	0%	5%	20%	30%	10%	31%	4%
4.a	Oral Health - Untargeted (d)	NA	NA	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
4.b	Oral Health - Rural Target	200	327	70%	30%	43%	31%	2%	25%	0%	0%	5%	20%	30%	10%	31%	4%
5	**Mental Health Services (d)**	NA	NA														
6	**Health Insurance**	1,700	1,753	81%	19%	44%	27%	3%	26%	0%	0%	2%	16%	20%	14%	41%	8%
7	**Home and Community Based Services (d)**	NA	NA														
8	**Substance Abuse Treatment - Outpatient**	40	28	96%	4%	21%	50%	4%	25%	0%	0%	0%	43%	21%	18%	18%	0%
9	**Early Medical Intervention Services (d)**	NA	NA														
10	**Medical Nutritional Therapy/Nutritional Supplements**	650	474	78%	22%	42%	20%	3%	35%	0%	0%	2%	14%	14%	16%	46%	8%
11	**Hospice Services (d)**	NA	NA														
12	**Outreach**	NA	887	74%	26%	59%	13%	1%	27%	0%	0%	7%	31%	25%	13%	21%	2%
13	**Non-Medical Case Management**	7,045	8,037														
13.a	Service Linkage Targeted to Youth	320	180	82%	18%	59%	4%	4%	33%	0%	12%	88%	0%	0%	0%	0%	0%
13.b	Service Linkage at Testing Sites	260	129	67%	33%	64%	6%	3%	26%	0%	0%	0%	53%	23%	9%	13%	2%
13.c	Service Linkage at Public Clinic Primary Care Program (a)	3,700	3,578	67%	33%	60%	10%	2%	28%	0%	0%	0%	18%	23%	14%	39%	6%
13.d	Service Linkage at CBO Primary Care Programs (a)	2,765	4,150	78%	22%	52%	14%	2%	31%	0%	1%	6%	30%	23%	13%	24%	2%
14	**Transportation**	2,850	3,430														
14.a	Transportation Services - Urban	170	597	69%	31%	60%	12%	3%	24%	0%	0%	6%	30%	23%	14%	24%	3%
14.b	Transportation Services - Rural	130	171	70%	30%	40%	34%	2%	24%	0%	1%	4%	19%	26%	13%	33%	5%
14.c	Transportation vouchering	2,550	2,662														
15	**Linguistic Services (d)**	NA	NA														
16	**Emergency Financial Assistance (e)**	NA	NA														
17	**Referral for Health Care - Non Core Service (d)**	NA	NA														
Net unduplicated clients served - all categories*		12,941	13,728	74%	26%	53%	15%	2%	30%	0%	1%	4%	24%	23%	12%	30%	4%
Living AIDS cases + estimated Living HIV non-AIDS (from FY 17 App) (b)		NA	22,830	74%	26%	49%	23%	3%	25%	0%	6%		18%	27%	30%	18%	

***11,657** clients to be served is based on the number of unduplicated clients served in FY 2016 (update per CPCDMS)

Available Data As Of: 5/23/2019

FY 2018 Ryan White Part A and MAI Service Utilization Report

RW MAI Service Utilization Report

Priority	Service Category MAI unduplicated served includes clients also served under Part A	Goal	Unduplicated MAI Clients Served YTD	Male	Female	AA (non-Hispanic)	White (non-Hispanic)	Other (non-Hispanic)	Hispanic	0-12	13-19	20-24	25-34	35-44	45-49	50-64	65 plus
	Outpatient/Ambulatory Primary Care (excluding Vision)																
1.b	Primary Care - MAI CBO Targeted to AA (g)	1,060	2,432	72%	28%	100%	0%	0%	0%	0%	1%	7%	36%	25%	11%	19%	1%
1.c	Primary Care - MAI CBO Targeted to Hispanic (g)	960	1,551	86%	14%	0%	0%	0%	100%	0%	1%	6%	31%	30%	13%	17%	2%
2	**Medical Case Management (f)**																
2.c	Med CM - Targeted to AA (a)	1,060	873	78%	22%	50%	16%	2%	32%	0%	2%	9%	34%	27%	11%	16%	1%
2.d	Med CM - Targeted to H/L(a)	960	167	81%	19%	57%	21%	4%	18%	0%	1%	11%	35%	23%	8%	18%	4%

RW Part A New Client Service Utilization Report

Report reflects the number & demographics of clients served during the report period who did not receive services during previous 12 months (3/1/12 - 2/28/13)

Priority	Service Category	Goal	Unduplicated New Clients Served YTD	Male	Female	AA (non-Hispanic)	White (non-Hispanic)	Other (non-Hispanic)	Hispanic	0-12	13-19	20-24	25-34	35-44	45-49	50-64	65 plus
1	**Primary Medical Care**	**2,100**	**1,858**	**76%**	**24%**	**54%**	**13%**	**2%**	**30%**	**0%**	**1%**	**9%**	**34%**	**25%**	**11%**	**18%**	**2%**
2	**LPAP**	**1,200**	**873**	**78%**	**22%**	**50%**	**16%**	**2%**	**32%**	**0%**	**2%**	**9%**	**34%**	**27%**	**11%**	**16%**	**1%**
3.a	Clinical Case Management	400	167	81%	19%	57%	21%	4%	18%	0%	1%	11%	35%	23%	8%	18%	4%
3.b-3.h	Medical Case Management	1,600	1443	76%	24%	54%	14%	2%	29%	2%	2%	10%	34%	23%	10%	18%	2%
3.i	Medical Case Manangement - Targeted to Veterans	60	40	98%	3%	65%	20%	0%	15%	0%	0%	0%	3%	10%	15%	48%	25%
4	**Oral Health**	**40**	**65**	**80%**	**20%**	**49%**	**28%**	**0%**	**23%**	**0%**	**2%**	**15%**	**28%**	**25%**	**9%**	**20%**	**2%**
12.a. 12.c. 12.d.	**Non-Medical Case Management (Service Linkage)**	**3,700**	**2,271**	**74%**	**26%**	**58%**	**12%**	**2%**	**28%**	**0%**	**2%**	**8%**	**30%**	**23%**	**11%**	**23%**	**3%**
12.b	**Service Linkage at Testing Sites**	**260**	**148**	**74%**	**26%**	**63%**	**5%**	**3%**	**29%**	**0%**	**1%**	**24%**	**40%**	**17%**	**7%**	**9%**	**1%**

Footnotes:

(a)	Bundled Category
(b)	Age groups 13-19 and 20-24 combined together; Age groups 55-64 and 65+ combined together.
(d)	Funded by Part B and/or State Services
(e)	Not funded in FY 2017
(f)	Total MCM served does not include Clinical Case Management

Important

Williams, Victoria (County Judge's Office)

From: Yvette Garvin <ygarvin@hivtrg.org>
Sent: Wednesday, March 27, 2019 5:24 PM
To: Williams, Victoria (County Judge's Office)
Cc: Patrick Martin; ShaTerra Fairley
Subject: Re: State Services - RR funds

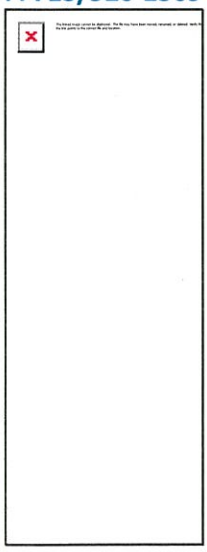
Thanks for reaching out but not at this time. For our curent SSR funds, DSHS has stated it is moving the contract period from 9/1-8/31 to 4/1-3/31. DSHS will need to amend TRG's contract to reflect that change.

After the contract amendment, TRG will need to figure out what changes are needed to accommodate the change. Whether we will end current contracts with provider and begin a new contract period or amend the current contracts to extend the contract period based on how TRG has to track the information.

I will keep you posted.

Thanks,

Yvette Garvin
Executive Director
The Resource Group
500 Lovett Blvd, Suite 100
Houston, Texas 77006
E: ygarvin@hivtrg.org.
P: 713/526-1016
F: 713/526-2369



DRAFT

2019 Proposed Idea

(Applicant must complete this two-page form as it is. Agency identifying information must be removed or the application will not be reviewed. Please read the attached documents before completing this form: 1.) HRSA HIV-Related Glossary of Service Categories to understand federal restrictions regarding each service category, 2.) Criteria for Reviewing New Ideas, and 3.) Criteria & Principles to Guide Decision Making.)

THIS BOX TO BE COMPLETED BY RWPC SUPPORT STAFF ONLY

_____ Control Number Date Received_____

Proposal will be reviewed by the: Quality Improvement Committee on:_____ (date)
Priority & Allocation Committee on: _____ (date)

THIS PAGE IS FOR THE QUALITY IMPROVEMENT COMMITTEE
(See Glossary of HIV-Related Service Categories & Criteria for Reviewing New Ideas)

1. SERVICE CATEGORY:_____
   (The service category must be one of the Ryan White Part A or B service categories as described in the HRSA Glossary of HIV-Related Service Categories.)

   This will provide _____ clients with _____ units of service.

2. ADDRESS THE FOLLOWING:
   - **A. DESCRIPTION OF SERVICE:**
   - **B. TARGET POPULATION (Race or ethnic group and/or geographic area):**
   - **C. SERVICES TO BE PROVIDED (including goals and objectives):**
   - **D. ANTICIPATED HEALTH OUTCOMES (Related to Knowledge, Attitudes, Practices, Health Data, Quality of Life, and Cost Effectiveness):**

3. ATTACH DOCUMENTATION IN ORDER TO JUSTIFY THE NEED FOR THIS NEW IDEA. AND, DEMONSTRATE THE NEED IN AT LEAST ONE OF THE FOLLOWING PLANNING COUNCIL DOCUMENTS:

___ Current Needs Assessment (Year:_____) Page(s): ___Paragraph: ___
___ Current HIV Comprehensive Plan (Year:_____) Page(s): ___Paragraph: ___
___ Health Outcome Results: Date: _____ Page(s): ___Paragraph: ___
___ Other Ryan White Planning Document:
Name & Date of Document: _____ Page(s): ___Paragraph: ___

RECOMMENDATION OF QUALITY IMPROVEMENT COMMITTEE:
___ Recommended ___ Not Recommended ___ Sent to How To Best Meet Need

REASON FOR RECOMMENDATION:

(Continue on Page 2 of this application form)

DRAFT

Proposed Idea

THIS PAGE IS FOR THE PRIORITY AND ALLOCATIONS COMMITTEE
(See Criteria and Principles to Guide Decision Making)

THIS BOX TO BE COMPLETED BY RWPC SUPPORT STAFF ONLY AND INCLUDE A BRIEF HISTORY OF RELATED SERVICE CATEGORY, IF AVAILABLE.

CURRENTLY APPROVED RELATED SERVICE CATEGORY ALLOCATION/UTILIZATION:
Allocation: $_____
Expenditure: $_____ Year-to-Date

Utilization: _____ Unduplicated Clients Served Year-to-Date
_____ Units of Service Provided Year-to-Date

AMOUNT OF FUNDING REQUESTED:
$_____This will provide funding for the following purposes which will further the objectives in this service category: (describe how):

PLEASE STATE HOW THIS IDEA WILL MEET THE PRIORITY AND ALLOCATIONS CRITERIA AND PRINCIPLES TO GUIDE DECISION MAKING. SITE SPECIFIC STEPS AND ITEMS WITHIN THE STEPS:

RECOMMENDATION OF PRIORITY AND ALLOCATIONS COMMITTEE:

___ Recommended for Funding in the Amount of: $_____
___ Not Recommended for Funding
___ Other:

REASON FOR RECOMMENDATION:

Operations Committee Report

HOUSTON AREA HIV HEALTH SERVICES RYAN WHITE PLANNING COUNCIL

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

PROCESS FOR APPROVING THE COUNCIL SUPPORT BUDGET

PURPOSE

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

AUTHORITY

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

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

INTENT

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

PROCEDURE

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

1. The Manager of the Office of Support prepares a proposed budget.
2. The Manager distributes the proposed budget to members of the Operations Committee, the liaison to the CEO and the manager of Harris County Public

Health/Ryan White Grants Administration Section (the "grantee").

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

FY 2019 vs. FY 2020 Council Support Budget Comparison

(as of 05/06-19)

Budget Item	FY 2019 Amount	FY 2020 Amount	Difference	Notes
Employee Fringe • Health Insurance Changed from $13,650/FTE/year to $13,900/FTE/year • Workers Comp changed from .94% to .50%	$118,605	$118,470	- $135	
Travel	3,500	13,500	+ 10,000	HRSA Conference in 2020
Resource Guide	8,000	51,000*	+ 43,000	New edition in 2020
Needs Assessment	10,700	0	- 10,700	
PC member expenses	23,686	26,686	+ 3,000	Comp Planning Process
Road 2 Success	11,220	5,000	- 6,220	Added in FY 2017
Postage	10,000	5,000	- 5,000	
Copier Rental	$9,250	8,250	- 1,000	
TOTALS			+ $32,945	Increase between FY 2019 and FY 2020

* Office of Support printed 50,000 copies of the Blue Book in FY 2018 but will only print 30,000 in FY 2020 and approximately 10,000 reprints in FY 2021 if necessary.

FY 2019 Budget Total	$491,963
FY 2020 Budget Total	524,908
Difference	+ 32,945

Houston Ryan White Planning Council
FY 2020 Council Support Budget
March 1, 2020 - February 28, 2021
(DRAFT - 05-06-19)

		Subtotal	Total
PERSONNEL			
RWPC Manager (V. Williams) ($6621/mo. X 12 mos. X 100%) Responsible for overall functioning of planning council, supervises all support staff.	$79,446	**$258,002**	
RWPC Health Planner (A. Harbolt) ($6068/mo. X 12 mos. X 100%) Responsible for coordinating Comprehensive Planning and Needs Assessment activities. Analyzing and presenting data.	$72,820		
RWPC Coordinator (D. Beck) ($4,718/mo x 12 mos. X 100%) Coordinates support activities for the RW Planning Council and committees. Provides routine administrative duties (minutes, scheduling of meetings, mailouts, etc.).	$56,611		
Assistant Coordinator (R. Avila) ($4094/mo x 12 mos. X 100%) Coordinates support activities for assigned committees. Provides routine administrative duties (minutes, scheduling of meetings, mailouts, etc.)	$49,125		
FRINGE		**$118,470**	
Social Security @ 7.65%	$19,737		
Health Insurance (4 x $13,900/FTE)	$55,600		
Retirement @ 14.5%	$37,410		
Workers Compensation @ 0.50%	$1,290		
Supplemental Death Insurance @ 0.50	$1,290		
Unemployment Insurance @ 0.23%	$593		
Incentives/allowances	$2,550		

Houston Ryan White Planning Council
FY 2020 Council Support Budget
March 1, 2020 - February 28, 2021
(DRAFT - 05-06-19)

		Subtotal	Total
EQUIPMENT Replacement computers to replace obsolete units	$2,000	**$2,000**	
TRAVEL		**$13,500**	
Local travel @ $0.58/mile for Planning Council Support Staff	$500		
Out of EMA travel: One out of state trip to a national conference for two Office of Support staff and two Ryan White volunteers and four in State trips for staff and/or Ryan White volunteers.	$13,000		
SUPPLIES General consumable office supplies including materials for Council Members and Public Meetings	$5,000	**$5,000**	
CONTRACTUAL	$0	**$0**	
OTHER		**$127,936**	
Resource Guide	$51,000		
Reimbursement for Ryan White volunteer expenses Reimbursement for travel, childcare, meals and other eligible expenses resulting from participation in Council approved/ HRSA grant required activities.	$26,686		
Advertising for PC Activities: For publication of meeting announcements in community papers; invitations to participate in needs assessment activities and focus groups; advertisments for additional volunteers.	$6,000		
Communications (phone, pagers): For local and long distance phone expenses and internet charges.	$3,500		
Web Page Technical Assitance Costs: For additional training/consultation to staff in order to update/improve web site.	$500		

Houston Ryan White Planning Council
FY 2020 Council Support Budget
March 1, 2020 - February 28, 2021
(DRAFT - 05-06-19)

	Subtotal	Total
Council Education: For speakers & training costs primarily for room rentals & the cost of speakers for ongoing training to insure that key decision-makers receive necessary & relevant information. This includes the January Orientation and one Council meeting to be held off-site in Harris County.	$4,000	
Project LEAP Student Reimbursement: 30 participants for 17 week course including travel, childcare and other eligible expenses resulting from participation in Council approved training activities related to the HRSA grant.	$5,500	
Project LEAP Education: Training costs for 17 weeks including speaker fees, room rental for off-site meetings & educational materials.	$9,500	
Consumer Education: Training costs for 5 seminars including speaker fees & room rental for off-site meetings & educational materials.	$5,000	
Interpreter Services For Spanish-speaking and sign-language interpretation services during public meetings, focus groups, etc.	$1,500	
Fees and Dues Registration costs for attending meetings, trainings and conferences related to HIV/AIDS health planning.	$500	
English/Spanish Translation (written): For professional translation of Council materials into Spanish.	$1,000	
Postal Machine Rental & Postage: For mailouts of Committee and Council agendas, minutes and attachments; HIV/AIDS Resource Guides for those who are unable to pickup in person; other office of support communications.	$5,000	
Copier Rental: For rental, service agreement of high-use Xerox machine used for Council and Office of Support.	$8,250	
TOTAL		**$524,908**

Proposed
Budget for the
2020-2021 Blue Book

(revised 05-06-19)

FY 2019 Budget – Prepare the new Blue Book for printing

Graphic Design	5,000
Updating the Book (in house)	0
Spanish Translation	2,000
Software	1,000
FY 2019 TOTAL	**$ 8,000**

FY 2020 Budget – Print and release the new Blue Book

Advertising	3,000
App Support	1,000
Postage	2,000
Printing 30,000 copies ($1.50/book)**	45,000*
FY 2020 TOTAL	**$ 51,000**

TOTAL COST OF THE 2020-2021 BLUE BOOK **$59,000**

* The exact cost of reproducing the 2020–2021 Blue Book is not available at this time since the largest budget item, which is the cost of printing, fluctuates with the price of oil/ink.

** Historically, the Office of Support has printed 50,000 copies of the Blue Book and another 15,000 in reprints. In 2018, requests for hard copies of the book have decreased significantly, possibly because the book is being accessed online.

FYI

HIV Vaccine Awareness Day 2019

By: Anthony Fauci, M.D., Director, National Institute of Allergy and Infectious Diseases (NIAID), National Institutes of Health, and Maureen M. Goodenow, Ph.D., NIH Associate Director for AIDS Research, Director, Office of AIDS Research | **Published:** May 17, 2019

Topics

Awareness Days | HIV Vaccine Awareness Day | NIAID | NIH | Research | Vaccine

Since the first cases of what would become known as HIV/AIDS were initially reported in 1981, scientists and public health officials have been working to better understand HIV, develop strategies to effectively treat and prevent infection, and bring about an end to the pandemic. This effort remains a critical focus globally and for the United States.

HIV Vaccine Awareness Day May 18, 2019

We have the tools at hand that could—if fully implemented—end the HIV pandemic. Large clinical studies have proven that individuals with HIV who use antiretroviral therapy to achieve and maintain an undetectable viral load do not sexually transmit HIV to others—a concept known as undetectable = untransmittable (U=U). People who are at high risk for HIV can take a single daily pill known as PrEP, or pre-exposure prophylaxis, that is highly effective at protecting them from the virus. In addition, post-exposure prophylaxis, or PEP, provides a highly effective emergency means of preventing HIV transmission from a recent high-risk exposure and can serve as a bridge to PrEP.

In his State of the Union Address earlier this year, President Donald J. Trump announced his Administration's goal to end the HIV epidemic in the United States within 10 years. *Ending the HIV Epidemic: A Plan for America* aims to reduce new HIV infections in the United States by 90 percent by 2030. This approach is feasible in large part because the majority of new HIV infections in the United States are concentrated in certain geographic areas and within certain populations. More than 50 percent of new HIV diagnoses occur in 48 counties; Washington, DC; and San Juan, Puerto Rico. Additionally, seven states have a disproportionate occurrence of HIV in rural areas. In addition, young African American and Latino men who have sex with men bear a disproportionate burden of new infections. Targeted implementation of scientifically proven tools for HIV prevention, diagnosis, and treatment, as well as resources, expertise and technology, in these locales and among these

populations could end the domestic HIV epidemic.

While the ambitious Plan for America aims to end HIV as an epidemic within the United States in 10 years, achieving a durable end to the pandemic will almost certainly require a safe and effective HIV vaccine. The development and deployment of an effective vaccine would provide long-lasting protection and alleviate the need to depend heavily on prevention methods that require continued access and adherence. Such a vaccine, along with the optimal implementation of existing HIV treatment and prevention strategies would achieve the goal of durably ending the HIV epidemic in this country and worldwide. For geographic areas where the implementation of treatment and prevention is complicated by various social, economic and political concerns, a vaccine is critical to halting the epidemic. Indeed, even in countries with a good track record of implementing HIV treatment and prevention tools, a vaccine would hasten the end of the epidemic and ensure its durability./p>

In this regard, NIH is pursuing two scientific paths to develop a safe and effective HIV vaccine. One path aims to build on the promise of modest results seen in RV144, the U.S. Army-led HIV vaccine trial in Thailand. RV144 was the first and only trial to-date to demonstrate that an HIV vaccine can protect against infection. The Phase 2b/3 HIV vaccine trial HVTN 702 began on World AIDS Day 2016 and has nearly completed enrollment of 5,400 men and women in South Africa. Another large vaccine efficacy clinical trial called HVTN 705/HPX2008 or Imbokodo launched in 2017. This Phase 2b proof-of-concept trial is evaluating an investigational vaccine regimen designed to induce immune responses against a variety of global HIV strains. This trial is nearing complete enrollment of 2,600 women in sub-Saharan Africa.

The second path to developing an HIV vaccine is based on theory and involves studying the body's immune response to HIV infection and generating and enhancing those responses through vaccination. The main theoretical approach to developing an HIV vaccine aims to prevent HIV infection by eliciting broadly neutralizing antibodies (bNAbs) —antibodies shown in the laboratory to stop most HIV strains from infecting human cells. Some people living with HIV naturally produce bNAbs. However, these antibodies develop too late after initial infection to clear the virus. Scientists at NIH and other institutions have isolated numerous bNAbs from people living with HIV and are working to develop vaccines that elicit these antibodies in healthy people.

Two experimental structure-based vaccines aimed at eliciting bNAbs directed against various components of the HIV envelope are in or near the early stages of human study. A Phase 1 trial testing the BG505 SOSIP.664 gp140 trimer vaccine candidate is currently enrolling men and women in Boston; Seattle; and Nairobi, Kenya. Planning for a Phase 1 clinical trial to test a fusion peptide HIV vaccine

developed by scientists at the NIAID Vaccine Research Center also is under way.

In addition to attempts to elicit antibodies to HIV via a vaccine, two multinational clinical trials are testing whether it is possible to prevent HIV by directly infusing people with bNAbs several times a year. Known as the AMP Studies, for antibody-mediated prevention, these trials have completed enrollment of 4,600 men and women across four continents. If these studies prove successful, it will provide a rationale for using bNAbs as tools to prevent HIV infection. In addition, it would provide the proof of concept that if vaccines induce these bNAbs, such vaccines would be successful in preventing HIV infection.

The pursuit of a safe and effective HIV vaccine holds lifesaving potential for people worldwide and is among the highest HIV research priorities for NIH. On this HIV Vaccine Awareness Day, we recognize and thank the thousands of HIV vaccine clinical trial volunteers, researchers, health professionals, activists, and others who work with us toward this goal.

Metabolic Syndrome Among People Living with HIV Receiving Medical Care in Southern United States: Prevalence and Risk Factors

Sabeena Sears, Justin R. Buendia, Sylvia Odem, Mina Qobadi, Pascale Wortley, Osaro Mgbere, Jontae Sanders, Emma C. Spencer, et al.

AIDS and Behavior

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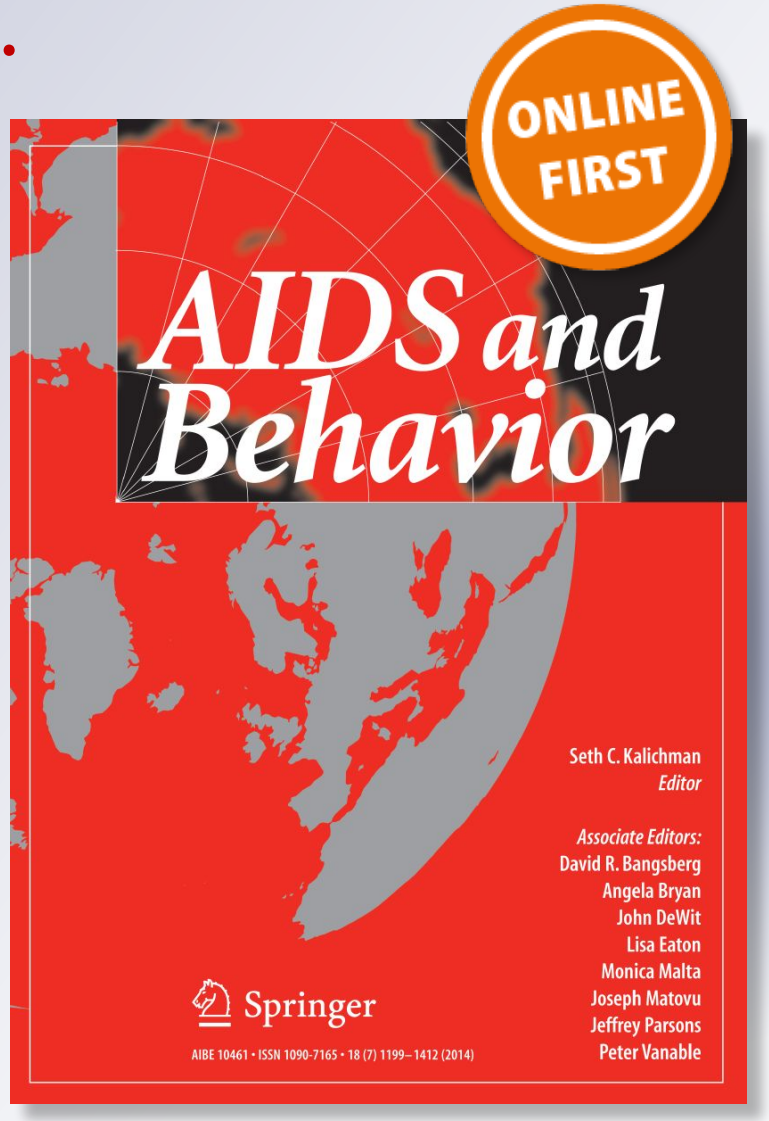

Springer

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https://doi.org/10.1007/s10461-019-02487-8

ORIGINAL PAPER

Metabolic Syndrome Among People Living with HIV Receiving Medical Care in Southern United States: Prevalence and Risk Factors

Sabeena Sears[1,8] · Justin R. Buendia[1] · Sylvia Odem[1] · Mina Qobadi[2] · Pascale Wortley[3] · Osaro Mgbere[4] · Jontae Sanders[5] · Emma C. Spencer[5] · Arti Barnes[6,7]

Abstract

Using representative data among 1861 in care people living with HIV (PLWH) in four southern states (Texas, Mississippi, Florida, and Georgia) from the 2013–2014 Medical Monitoring Project (MMP) survey, we estimated the prevalence and odds of metabolic syndrome (MetS) among various demographic and HIV related risk factors. Overall MetS prevalence was 34%, with our participants being mostly black (55%), male (72%), ≥ 50 years old (46%), and overweight or obese (60%) with undetectable viral loads (≤ 200 copies/ml, 69%), and were currently taking antiretroviral medication (98%). Compared to those who were ≥ 60 years, 18–39 year olds had a 79% (95% CI 0.13–0.33) lower odds of having MetS. Women were 2.24 times more likely to have MetS than men (95% CI 1.69–2.97). Age and sex were significant predictors of MetS. Since MetS is a combination of chronic disease risk factors, regular screening for MetS risk factors among aging PLWH is crucial.

Keywords HIV · Metabolic syndrome · Medical Monitoring Project · Southern United States

Resumen

Usando datos representativos entre 1861 personas viviendo con VIH y recibiendo cuidado para VIH en cuatro estados del sur (Texas, Mississippi, Florida y Georgia) de la encuesta del Proyecto de Monitoreo Médico (MMP, siglas en inglés) 2013-2014, estimamos la prevalencia y las probabilidades del síndrome metabólico (MetS) entre varios factores de riesgo demográficos y relacionados con el VIH. La prevalencia general de MetS fue del 34%, y nuestros participantes fueron en su mayoría negros (55%), hombres (72%), ≥ 50 años (46%), con sobrepeso u obesidad (60%), con carga viral indetectable (≤ 200 copias/ml, 69%), y actualmente tomando medicamentos antirretrovirales (98%). En comparación con los que tenían ≥ 60 años, los de 18 a 39 años tuvieron un 79% (IC del 95%: 0.13-0.33) más baja probabilidad de tener MetS. Las mujeres tuvieron 2.24 veces más probabilidad de tener MetS que los hombres (IC del 95%:1.69-2.97). La edad y el sexo fueron predictores significativos de MetS. Dado que el MetS es una combinación de factores de riesgo para enfermedades crónicas, la evaluación regular de los factores de riesgo de MetS a lo largo del proceso de envejecimiento de personas que viven con VIH es crucial.

✉ Sabeena Sears
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Abbreviations

MetS	Metabolic syndrome
CVD	Cardiovascular disease
HIV	Human immunodeficiency virus
PLWH	People living with HIV
AIDS	Acquired immunodeficiency syndrome
aOR	Adjusted odds ratio
CI	Confidence intervals
MMP	Medical Monitoring Project
IDF	International Diabetes Federation
HDL	High density lipoprotein
BP	Blood pressure
BMI	Body mass index
ART	Antiretroviral therapy

Published online: 30 March 2019

T2DM	Type II diabetes mellitus
NFHL	Nutrition for healthy living
NHBLI	National Heart, Blood, and Lung Institute
AHA	American Heart Association
HAART	Highly active antiretroviral therapy
ATP	Adult treatment panel

Introduction

The success of highly active antiretroviral therapy has led to a dramatic decline in immunodeficiency-related causes of death and improvement in life expectancy among PLWH [1–3]. However, as patients are aging with HIV, the decline in morbidity and mortality has been clouded by the emergence of a number of cardio-metabolic perturbations [4]. Cardio-metabolic perturbations, which are collectively known as the metabolic syndrome, refer to a cluster of coexisting metabolic risk factors, such as abdominal obesity, dyslipidemia, defective glucose metabolism, and arterial hypertension [5], that are associated with increased risk of cardiovascular disease (CVD) and diabetes mellitus [6, 7]. In addition to the cardiovascular outcomes, individuals with MetS are thought to be more susceptible to a range of conditions. This includes, but is not limited to, vascular diseases (e.g., atherosclerotic cardiovascular disease and hypertension), adiposity-related disorders (e.g., sleep disordered breathing and fatty liver disease), insulin resistance conditions (e.g., type 2 diabetes or gestational diabetes and polycystic ovary syndrome), atherogenic dyslipidemia, hormonal dysfunction, and chronic kidney disease [8].

With a wide range of estimates from 11.2 to 45.4%, the prevalence of MetS among PLWH is debatable [9, 10]. These large differences may be attributed to differences in study design, small sample sizes, different demographic characteristics of sample populations, and the several MetS definitions used, which make it difficult to draw consistent and comparable population level conclusions on MetS prevalence among PLWH [9].

Although unhealthy behaviors such as poor diet and low levels of physical activity contribute to chronic diseases such as diabetes [11], the natural course of HIV infection and its treatment further increase the susceptibility to cardio-metabolic disorders among PLWH [12]. HIV infection itself, through chronic deregulated inflammatory response, may also play an important role in the pathogenesis of both diabetes mellitus and atherosclerosis [9, 13]. Moreover, the use of certain antiretroviral therapy regimens that include a protease inhibitor is associated with adipose tissue changes and disorders of glucose and lipid metabolism [14]. These findings have raised concerns that PLWH may be at a higher risk of developing MetS, which subsequently may be linked to an increase in CVD risk and diabetes.

CVD is the number one cause of death in adults worldwide [15]. It has been shown that patients with HIV experience a 2–3 times higher CVD risk compared to those without HIV [16, 17]. Previous studies [18–21] reported gender differences on CVD risk among PLWH, but the results are inconsistent. Cross-sectional data from the Data Collection on Adverse Events of Anti-HIV Drugs study [18] showed that female sex was a protective factor against the risk of myocardial infarction among adults living with HIV. However, two studies reported higher relative risk of acute myocardial infarction in HIV positive women than in HIV positive men [19, 20]. Chow et al. found a similar gender effect for stroke among adults living with HIV, indicating an increased risk of stroke among women with HIV compared to men with HIV [21].

Diabetes is the seventh leading cause of death in the US and one of the major causes of CVD, adult-onset blindness, kidney failure, and lower-limb amputations, affecting 9.4% of the US population [22]. It has been shown that patients living with HIV can have up to a twofold higher risk of diabetes when compared to the general population [23], with the prevalence estimate of up to 14% [24]. The direct influence of HIV on diabetes remains unclear. There is mixed evidence regarding HIV as an independent risk factor for diabetes, with some studies reporting an increased prevalence and incidence of impaired glucose tolerance and diabetes among PLWH [25, 26] and others showing no independent effect of HIV on the development of diabetes [25, 27].

In the US, the South is generally behind other regions in some key HIV prevention and care indicators such as having the highest numbers of people without health insurance [28] and not adopting newer HIV prevention advances such as antigen/antibody HIV tests that can detect acute HIV infection. Consequently, it is important to understand disease prevalence to better allocate resources essential for developing preventive and management strategies, healthcare service planning, and the implementation of specific targeted interventions. Studies indicate that southern states are disproportionately affected by diseases linked with MetS such as obesity [29], diabetes [30], and hypertension [31, 32]. In addition, southern states account for nearly half of all PLWH (44%) in the US, despite making up about one-third (37%) of the overall US population [33, 34]. In 2014, eight of the top 10 states in the US with the highest HIV morbidity rates were in the South and included Texas, Mississippi, Georgia, and Florida [35]. Therefore, understanding the potential overlapping impact of being a PLWH in the South, with respect to cardiovascular and diabetes risk, could lead to better clinical assessments and risk mitigation in this population. With a paucity of data available on CVD and diabetes among southern PLWH, we aimed to estimate the prevalence of metabolic syndrome and to establish its associated risk factors among PLWH in the southern US.

Methods

Medical record abstraction and interview data from the 2013–2014 MMP survey, which includes statewide surveillance of PLWH for Texas (including the city of Houston), Mississippi, Georgia, and Florida, were used in this study. MMP is a Centers for Disease Control (CDC) supplemental surveillance system that monitors behavioral and clinical characteristics of people living with HIV (PLWH) aged 18 years or older receiving medical care across 23 sites nationwide. MMP is a cross-sectional survey with a three-stage sampling design: (1) At a geographic level for the US and dependent areas, (2) At a facility level through outpatient HIV care facilities, and (3) on an individual level for PLWH aged ≥ 18 years who had at least one medical care visit at a sampled facility between the months of January and April of 2013 and 2014. Data collection occurred between June 2013 and May 2015. The data obtained were weighted to account for the probabilities of selection at each sampling stage and adjusted for nonresponse and multiplicity. Nonresponse adjustments accounted for differing response at both facility and patient levels, and multiplicity adjustments accounted for patient's visits to more than one HIV care facility [36]. After excluding participants for missing data, our sample included 1861 participants representing 80,596 of adults living with HIV in the four southern US states (Texas, Florida, Mississippi, and Georgia).

Measures

These analyses used the International Diabetes Federation (IDF) definition of metabolic syndrome (MetS) was used for these analyses, which is characterized by central obesity plus two of the following criteria: raised triglycerides, reduced HDL (high density lipoprotein) cholesterol, raised blood pressure (BP), or raised fasting blood glucose [37]. Central obesity for MMP participants was calculated from body mass index (BMI, kg/m^2), race/ethnicity, and birth sex-specific equations developed by Bozeman et al. [38]. Multiracial, Asian, Native Hawaiian/Pacific Islander, American Indian/Alaskan Native, and transgender participants (n = 94) were excluded because there were no equations developed for these populations. BMI measurements, as documented in the medical chart within 1 year of the participant interview, were abstracted from medical records. Participants with missing height or weight (n = 275) were excluded.

MMP participants were classified as having the following four MetS criteria if any of the following was documented in the medical record:

Raised triglycerides (1) hypertriglyceridemia diagnosis or (2) prescription medications for raised triglycerides treatment as determined by clinician review of all the recorded medications abstracted or (3) most recent fasting triglyceride laboratory (lab) value ≥ 150 mg/dl.

Reduced high density lipoprotein (HDL) cholesterol (1) "low HDL" diagnosis or (2) prescription medications for low HDL (medications which could be used for both hypertriglyceridemia and low HDL such as statins, among others, were not double counted among criteria for raised triglycerides and low HDL) or (3) most recent fasting HDL lab < 40 mg/dl (males) or < 50 mg/dl (females).

Elevated blood pressure (BP) or hypertension (1) hypertension diagnosis or (2) prescription medications for hypertension treatment or (3) most recent systolic BP ≥ 130 or diastolic BP ≥ 85 mmHg.

Raised fasting blood glucose (1) Type 2 diabetes diagnosis or (2) most recent fasting blood glucose > 100 mg/dl.

If the participants met the waist circumference criteria, they were further evaluated on whether they had enough non-missing criteria to be considered for the study. Because participants could be seeking non-HIV care and/or receiving prescriptions for non-HIV medications at other medical facilities from which we did not review their medical chart, we assumed that the participant did not meet criteria only if they had labs that fell within normal range at the sampled facility, otherwise the criterion was set to missing for that participant. For this study, we determined that if a participant met the waist criterion but did not meet at least two other criteria for MetS and had two or more criteria missing due to non-availability of lab values or other diagnostic variables, then they were excluded from the analysis (n = 383). Additionally, if a participant met one criteria but had at least one criteria missing, they were excluded from the analysis because it is possible that they could have MetS if the value of the missing criteria was known (n = 110). Figure 1 displays the flowchart of the study sample selection process and highlights the inclusion and exclusion criteria used.

Other variables included were: sociodemographic variables including age, sex at birth, race/ethnicity, education, health insurance type, current smoking status, alcohol use, and poverty level. Length of time on antiretroviral therapy (ART) was determined from patient self-report. Clinical variables measured within the past year included BMI, time since HIV diagnosis, viral suppression status, prescription of ART, and geometric mean CD4+ T-lymphocyte (CD4) count.

Statistical Analysis

Among PLWH, weighted prevalence and 95% confidence intervals (CI) of MetS were calculated as overall

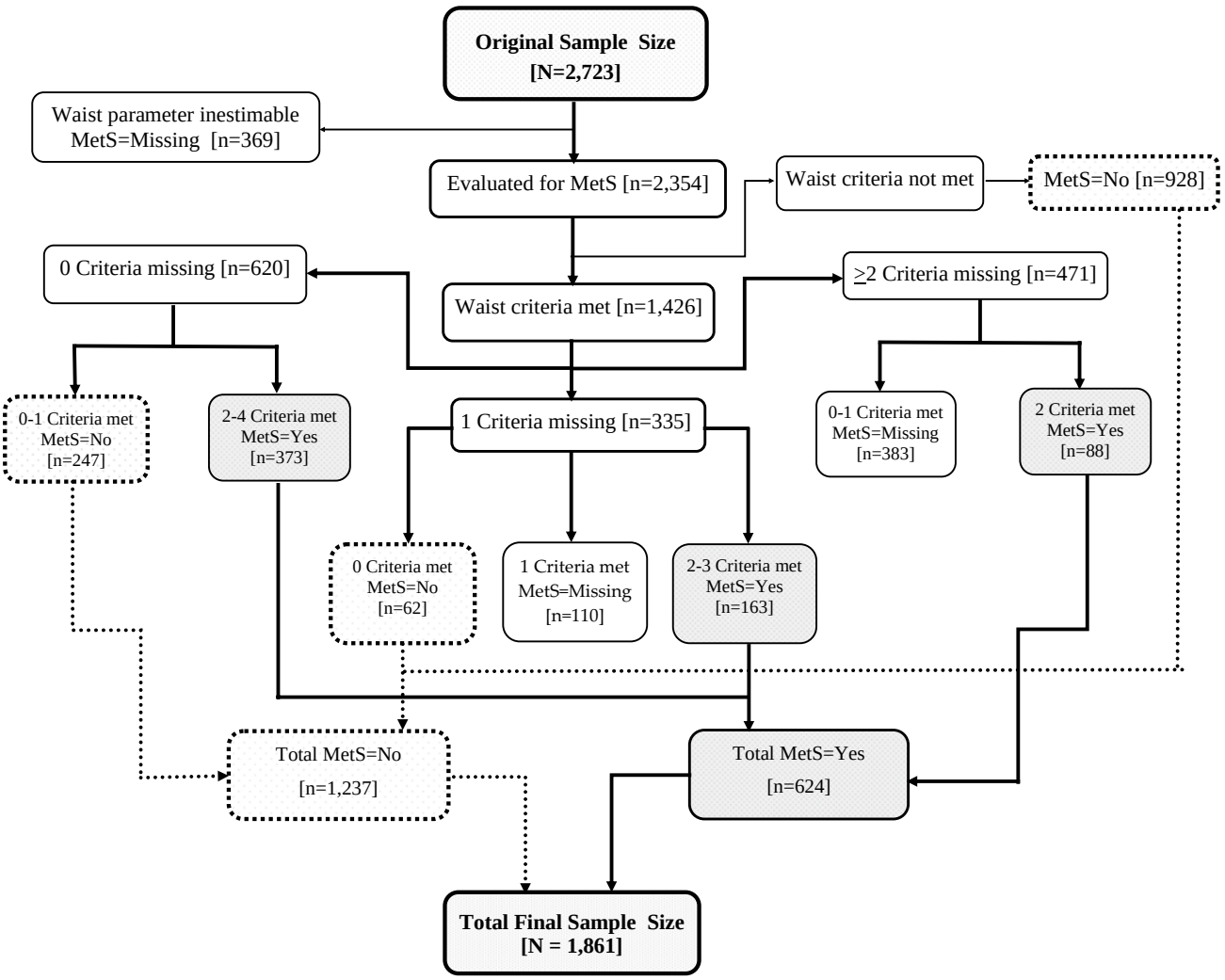

Fig. 1 Flowchart of study sample selection process

measure and by each of the following categories of sociodemographic and HIV-related characteristics: age (18–39, 40–49, 50–59, or ≥ 60 years), sex at birth, race/ethnicity (non-Hispanic White, Black, Hispanic), education (< high school, high school or equivalent, or > high school), poverty level (at or below federal poverty line and above federal poverty line), BMI (normal weight, overweight, or obese), time since HIV diagnosis (< 5 years, 5–9 years, or ≥ 10 years), and length of time on antiretroviral therapy (ART) (< 5 years, 5–9 years, or ≥ 10 years). To identify factors associated with MetS and to compute adjusted odds ratios (aOR) and corresponding 95% CIs among PLWH, multivariable logistic regression models were used with MetS as the outcome, and all the aforementioned characteristics except for BMI were included as independent predictors. Variables that changed the aOR by > 10% were retained in the multivariable model. All analyses were performed using SAS 9.4 (SAS Institute, Cary, North Carolina, USA) and weighted to account for clustering, unequal selection probabilities, and non-response.

Human Subjects Protection

MMP has been determined by the National Center for HIV, Viral Hepatitis, STD and TB Prevention's Office of the Associate Director for Science at the CDC to be a non-research, public health surveillance activity used for disease control program or policy purposes. As such, MMP is not subject to human subjects' regulations, including federal institutional review board (IRB) approval. All data collection was Health Insurance Portability and Accountability Act compliant. Informed consent was obtained from all individual participants included in the study.

Results

Of the 2723 total participants from the four southern US states (Texas, Florida, Mississippi, and Georgia), 862 were excluded from the analysis due to missing data, leaving a final analytic sample of 1861 participants. Table 1 shows the baseline characteristics of these participants by MetS. Thirty-four percent of the total sample (n = 624) had MetS, most of whom were men (62%), black (50%), ≥ 50 years of age (61%), and overweight or obese (97%).

Table 2 shows the aORs and 95% CIs of having MetS by the various predictors. Age, sex, and current smoking were all significantly associated with MetS prevalence ($p < 0.01$ for all). Compared to those ≥ 60 years old, 18–39 year-olds had a 79% lower odds of having MetS (95% CI 0.13–0.33). Similarly, lower odds were observed in males compared to females (aOR: 0.45, 95% CI 0.34–0.59). Current smokers had a 39% reduced odds of having MetS (95% CI 0.46–0.81).

Since sex at birth was a strong predictor of MetS, Table 3 illustrates the sex-stratified aORs of MetS by various sociodemographic factors. Age and smoking remained significant predictors of MetS for men whereas only age remained as a significant predictor for women ($p < 0.01$ for all). In both men and women, those aged 18-39 years had an 81% and 73% lower odds of having MetS, respectively. Male current smokers had a 42% reduced odds of having MetS (95% CI 0.34–0.66).

Discussion

We found that approximately a third of PLWH living in southern states have MetS. Given the disproportionate impact of diseases linked to MetS in the South, we expected the prevalence of MetS in our study to be higher, but this could be partially explained by demographic differences and our conservative selection process. Additionally, we used the IDF definition rather than the ATP III definition used in other studies. Currently, there are no regional population-based estimates for MetS in the southern US, but our results are within range of several studies among PLWH. A recent systematic review of MetS among PLWH by Paula et al. [9] showed that MetS prevalence ranged from 11% in a Mediterranean multicenter lipodystrophy case definition cohort [39] to up to 45% in an Italian cohort [40]. Differences in characteristics among study participants may contribute to the variability observed in previously published MetS prevalence estimates. For example, a cohort of only men in an international cohort [41] saw a significantly lower MetS prevalence (18%) compared to 25.5% among a cohort of South African men and women [42]. An analysis using the Nutrition for Healthy Living (NFHL) study found MetS prevalence to be 24% among American PLWH [43], which is lower than our current result. Several factors including the use of the National Heart Blood and Lung Institute/American Heart Association (NHBLI/AHA) guidelines (vs IDF), a younger cohort (mean age = 42 vs. 47 years), and a predominantly white sample (52% vs. 25% in MMP) may further explain the reasons for the lower estimate.

Our results show that women have more than double the odds of having MetS than men, which could be explained by more women (75%) meeting the waist criteria compared to men (43%). Cultural factors like different diets in males compared to females may be a possible contributor. According to Freimer et al. cultural variation may play an important role in human nutrition and must be considered in either clinical or public health intervention strategy particularly in areas with large immigrant populations [44]. The increased MetS odds may not only be due to gender differences in traditional risk factors such as body weight [45], abdominal adiposity [46], and genetic biomarkers differences [47], but also to drug exposure, antiretroviral-associated toxicities [45], and combined ARV treatment. Pernerstofer-Schoen et al. [48], in a prospective longitudinal cohort study compared gender-stratified HIV positive individuals initiating a protease inhibitor containing highly active antiretroviral therapy (HAART) regimen with matched HIV negative individuals. The authors found that LDL:HDL was higher among female HIV patients compared to males after initiation of a combined antiretroviral therapy and that circulating levels of E-selectin, an endothelium-associated marker of inflammation and atherosclerotic risk, declined in males whereas they remained elevated in women [48]. This indicates that HAART-suppressed immunological/inflammatory processes are less effective in HIV positive female patients than in males [48]. Furthermore, lower rates of risk factor modification due to lower risk perception in women compared to men [49] can contribute to gender differences in CVD among HIV positive adults. Sobieszczyk et al. in a study of 2393 women (1725 HIV positive and 668 HIV negative), reported that nearly one-third of HIV positive women met criteria for MetS diagnosis, and that MetS prevalence was significantly higher among women living with an HIV diagnosis compared to those with a negative HIV status (33% vs. 22%, $p < 0.0001$) [50]. The authors also reported an increased prevalence of high triglycerides, low HDL, higher BMI, older age, and current smoking status as risk factors associated with higher MetS prevalence among HIV positive women compared to HIV negative women [50]. Prior studies show that estrogen reduction due to menopause is associated with weight gain, insulin resistance and central adiposity, and may contribute to an increased risk of hypertension, dyslipidemia, diabetes, and cardiovascular disease

Table 1 Baseline characteristics by metabolic syndrome status

Characteristic	Metabolic syndrome status					
	No MetS		MetS		Test statistics	
	N	%[a]	N	%[a]	Rao-Scott Chi-square statistic	*p* value
Sex						
Male	953	70	387	30	35.42	< 0.001***
Female	284	55	237	45		
Race/ethnicity						
White	304	66	164	34	4.63	0.100[ns]
Black	707	68	313	32		
Hispanic	226	62	147	38		
Age group (years)						
18–39	426	87	62	13	96.25	< 0.001***
40–49	339	64	182	36		
50–59	329	56	253	44		
≥ 60	143	54	127	46		
BMI (kg/m^2)						
< 25 (normal)	726	97	21	3	658.49	< 0.001***
25– < 30 (overweight)	386	60	255	40		
≥ 30 (obese)	125	26	348	74		
Education						
< High school	255	62	154	38	5.37	0.070[ns]
High school/equivalent	332	64	179	36		
> High school	649	69	291	31		
Insurance						
Private	307	65	160	35	13.91	< 0.01**
Public	542	63	321	37		
Ryan White only	341	73	126	27		
Unspecified	12	59	7	41		
None	32	83	7	17		
Poverty						
Above	561	65	288	35	0.18	0.670[ns]
Below	614	67	312	33		
Smoking status						
Never	550	64	300	36	16.48	< 0.001***
Former	207	59	147	41		
Current	475	73	172	27		
Binge drinking (30 days)						
No	1017	65	550	35	3.25	0.070[ns]
Yes	199	72	67	28		
HIV related characteristics						
ART Use						
No	31	76	12	24	2.21	0.140[ns]
Yes	1170	66	601	34		
ART use duration						
Not on ART	34	76	9	24	32.38	< 0.001***
< 5 years	3875	77	121	24		
5–9 years	241	69	109	31		
≥ 10 years	465	59	314	41		

Table 1 (continued)

Characteristic	Metabolic syndrome status					
	No MetS		MetS		Test statistics	
	N	%[a]	N	%[a]	Rao-Scott Chi-square statistic	*p* value
HIV diagnosis duration						
< 5 years	332	77	100	23	37.08	< 0.001***
5–9 years	290	71	117	28		
≥ 10 years	615	59	407	41		
Mean CD4 count (cells/µl)						
0–199	128	73	47	27	17.99	< 0.001***
200–349	178	75	65	25		
350–499	278	70	110	30		
≥ 500	616	61	382	39		
Viral load (copies/ml)						
< 200 (undetectable)	831	65	450	35	2.23	0.140[ns]
≥ 200	406	69	174	31		
Total	1237	100	624	100		

[a]Within a given level of the characteristic, some percentages may not add up to exactly 100 due to rounding

Significance Level: *p<0.05, **p<0.01, ***p<0.001, *ns* not significant (p > 0.05)

among postmenopausal women compared with premenopausal women [51]. Thus, HIV positive postmenopausal women are more likely to develop metabolic disorders not only from HIV related factors such as HAART but also from the consequences of hypoestrogenism. These metabolic changes to some extent may explain the increased risk of MetS among women, especially post-menopausal women [52]. We noted a similar age-related prevalence of MetS in older women in the current study (Table 3). Further research is needed to determine underlying mechanisms of the gender differences in MetS among PLWH.

While there were initial differences noted in the prevalence of MetS by HIV-specific variables, such as longer duration of HIV diagnosis, longer duration of ART use, and higher mean CD4 count, the logistic regression model did not reveal any significant impact of these factors. The initial significance of longer duration of HIV diagnosis and longer ART use may have been explained by age since many of the participants who had been diagnosed and have been taking ART therapy longer were also older. It is also important to note that other conditions or factors not considered in our current study may also be implicated in the odds of acquiring MetS among PLWH.

Study Limitations and Strengths

Our study had several strengths including the robust MMP sampling methodology, which is designed to achieve generalizability to HIV positive adults receiving medical care with weighted sampling. Medical chart reviews provided in-depth clinical data that allowed the measurement of various demographic and cardio-metabolic parameters. When combined with detailed patient interviews that provided extensive sociodemographic and other behavioral risk factors, we were able to measure and capture a wide array of potential confounders on MetS among PLWH.

Our study has certain limitations. First, MMP was not specifically designed to measure the prevalence of MetS. For our study, labs from abstracted patient charts were considered fasting if they were clearly marked as such in the medical record. A significant percentage of the labs were not used due to abnormal value (e.g., a glucose value of 101 mg/dL) and unknown fasting status. However, the majority of our study participants who met the criteria had either a diagnosis or were on prescription medication for these criteria (77% for glucose, 81% for triglyceride, and 91% for HDL). We tried to overcome this issue with the use of the well-accepted IDF rather than Adult Treatment Panel (ATP) III criteria, which relies less heavily on fasting lab status for the glucose criteria and allows for the inclusion of type II diabetes diagnoses. Another limitation is the extrapolation of waist circumference from BMI measure. Although we used an equation that has been found to be highly predictive of waist circumference from BMI with minimal error [38], its predictive power was less for women than for men. Waist circumference estimates derived from BMI may be less accurate for women than for men due to the shift in body fat distribution in middle-aged/older women [53]. However, the Bozeman et al. [17] equation does try to mitigate these limitations by using age-specific waist circumference equations for women. Several other known risk factors

Table 2 Odds of metabolic syndrome among PLWH

Characteristic	aOR	95% CI
Sex		
Male (*Ref*)	1.00	–
Female	2.24	1.69–2.97*
Race/ethnicity		
White (*Ref*)	1.00	–
Black	0.81	0.58–1.14^{ns}
Hispanic	1.52	0.98–2.35^{ns}
Age group (years)		
18–39	0.21	0.13–0.33*
40–49	0.80	0.55–1.16^{ns}
50–59	1.08	0.68–1.71^{ns}
≥ 60 (*Ref*)	1.00	–
Education		
< High school	1.51	1.00–2.27^{ns}
High school/equivalent	1.41	0.99–1.99^{ns}
> High school (*Ref*)	1.00	–
Poverty		
Above (*Ref*)	1.00	–
Below	0.79	0.57–1.10^{ns}
Smoking status		
Never (*Ref*)	1.00	–
Former	1.07	0.68–1.71^{ns}
Current	0.61	0.46–0.81*
ART use duration		
< 5 years (*Ref*)	1.00	–
5–9 years	1.11	0.59–2.09^{ns}
≥ 10 years	0.84	0.42–1.68^{ns}
HIV diagnosis duration		
< 5 years	0.68	0.35–1.32^{ns}
5–9 years	0.62	0.33–1.51^{ns}
≥ 10 years (*Ref*)	1.00	–
Mean CD4 count (cells/μl)		
0–199 (*Ref*)	1.00	–
200–349	0.84	0.48–1.47^{ns}
350–499	1.04	0.63–1.73^{ns}
≥ 500	1.50	0.90–2.50^{ns}
Current ART use		
No (*Ref*)	1.00	–
Yes	1.09	0.44–2.67^{ns}

aOR adjusted odds ratio, *95% CI* 95% confidence interval, *Ref* referent, *ns* not significant

Significance level: *significance based on 95% confidence interval

Table 3 Odds of metabolic syndrome stratified by sex

Characteristic	Men		Women	
	aOR	95% CI	aOR	95% CI
Race/ethnicity				
White (*Ref*)	1.00	–	1.00	–
Black	0.69	0.47–1.00^{ns}	1.33	0.67–2.66^{ns}
Hispanic	1.44	0.91–2.27^{ns}	2.17	0.82–5.78^{ns}
Age group (years)				
18-39	0.19	0.10–0.35*	0.27	0.12–0.62*
40-49	0.94	0.60–1.49^{ns}	0.62	0.31–1.25^{ns}
50-59	1.22	0.72–2.09^{ns}	0.82	0.40–1.68^{ns}
≥ 60 (*Ref*)	1.00	–	1.00	–
Education				
< High school	1.51	0.94–2.43^{ns}	1.52	0.82–2.80^{ns}
High school/equivalent	1.53	1.00–2.35^{ns}	1.21	0.67–2.18^{ns}
> High school (*Ref*)	1.00	–	1.00	–
Poverty				
Above (*Ref*)	1.00	–	1.00	–
Below	0.78	0.54–1.11^{ns}	0.86	0.48–1.56^{ns}
Smoking status				
Never (*Ref*)	1.00	–	1.00	–
Former	1.05	0.61–1.82^{ns}	1.10	0.52–2.32^{ns}
Current	0.48	0.34–0.66*	1.11	0.70–1.77^{ns}
ART use duration				
< 5 years (*Ref*)	1.00	–	1.00	–
5–9 years	1.17	0.49–2.76^{ns}	1.16	0.42–3.21^{ns}
≥ 10 years	0.94	0.38–2.34^{ns}	0.68	0.27–1.72^{ns}
HIV diagnosis duration				
< 5 years	0.74	0.31–1.76^{ns}	0.64	0.22–1.84^{ns}
5–9 years	0.72	0.34–1.52^{ns}	0.41	0.16–1.06^{ns}
≥ 10 years (*Ref*)	1.00	–	1.00	–
Mean CD4 count (cells/μl)				
0–199 (*Ref*)	1.00	–	–	1.00
200–349	0.66	0.36–1.20^{ns}	1.29	0.40–4.10^{ns}
350–499	1.06	0.56–2.00^{ns}	0.81	0.32–2.06^{ns}
≥ 500	1.42	0.83–2.42^{ns}	1.49	0.60–3.71^{ns}
Current ART use				
No (*Ref*)	1.00	–	1.00	–
Yes	1.39	0.26–7.45^{ns}	0.85	0.26–2.83^{ns}

aOR adjusted odds ratio, *95% CI* 95% confidence interval, *Ref* referent, *ns* not significant

Significance level: *significance based on 95% confidence interval

for MetS were not measured in our data. These include: diet, physical activity, family history for chronic diseases in MetS (hypertension, diabetes, and cardiovascular disease). As with any observational study, residual or uncontrolled confounding associated with these risk factors may have impacted our estimates. Finally, cross-sectional surveillance data was utilized from which causality cannot be inferred from the results.

Conclusions

Our study addressed the lack of available data on MetS on PLWH in the southern US. Thus, our study is the first population level estimate of the prevalence of MetS among PLWH in these four southern US states. This regional assessment is critical for the understanding of how to prioritize risk mitigation and primary care prevention services in an aging HIV population that is increasingly diagnosed with additional chronic diseases other than HIV itself. Given that PLWH are living longer, longitudinal data are warranted to assess long-term MetS risk and how MetS may impact mortality among PLWH. Since HIV care providers may also provide primary care to PLWH, our study highlights the need for HIV care providers to regularly screen and monitor chronic disease risk factors if not already doing so. Additionally, intervention programs that promote and encourage healthy lifestyle such as physical activity and nutritional counseling should be offered to PLWH as part of an integrated HIV care during clinic visits.

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Compliance with Ethical Standards

Conflict of interest The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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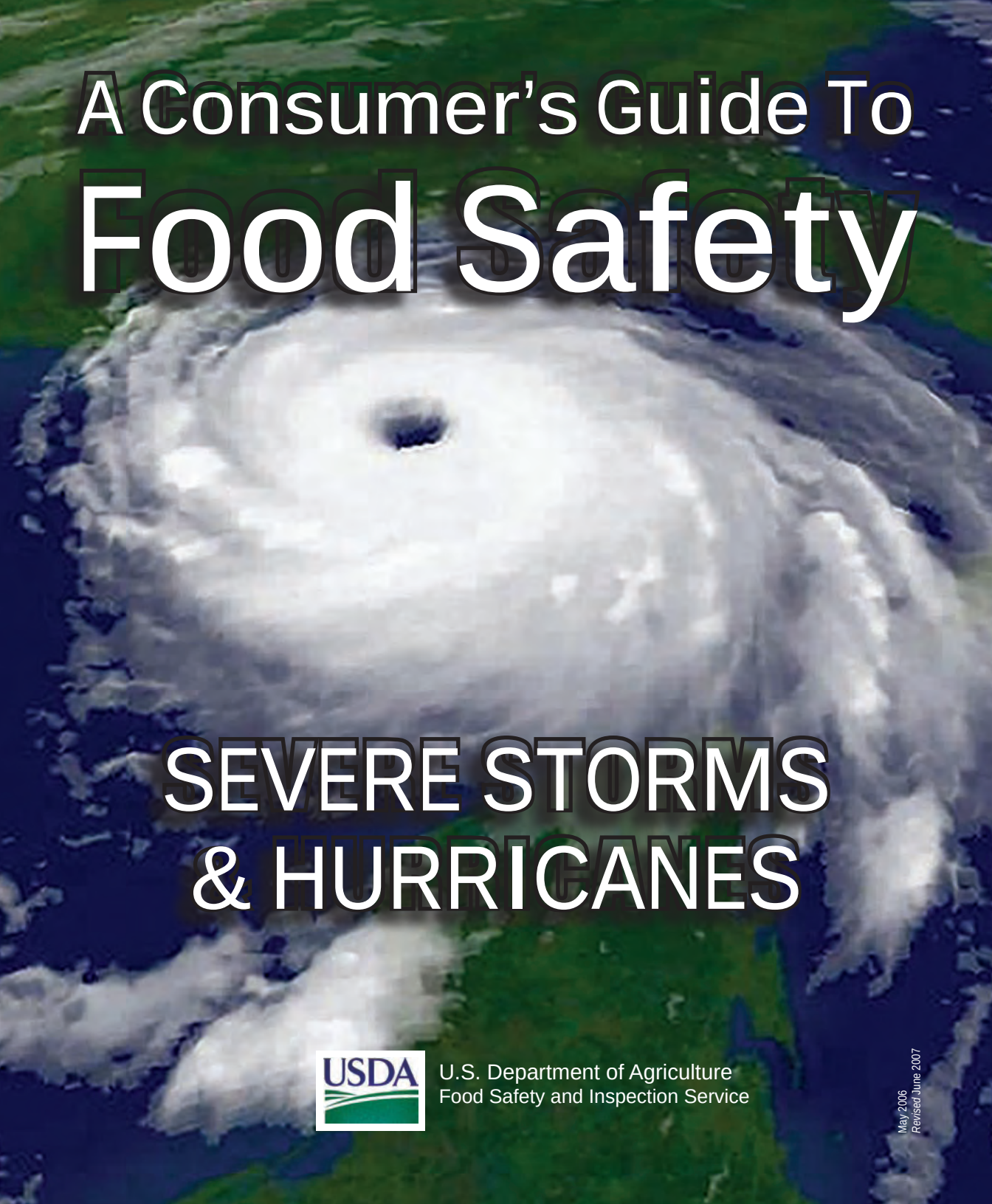


A Consumer's Guide To Food Safety

SEVERE STORMS & HURRICANES

U.S. Department of Agriculture
Food Safety and Inspection Service

May 2006
Revised June 2007

Food Safety During An Emergency

Did you know that a flood, fire, national disaster, or the loss of power from high winds, snow, or ice could jeopardize the safety of your food? Knowing how to determine if food is safe and how to keep food safe will help minimize the potential loss of food and reduce the risk of food-borne illness. This Consumer's Guide will help you make the right decisions for keeping your family safe during an emergency.

Power Outages

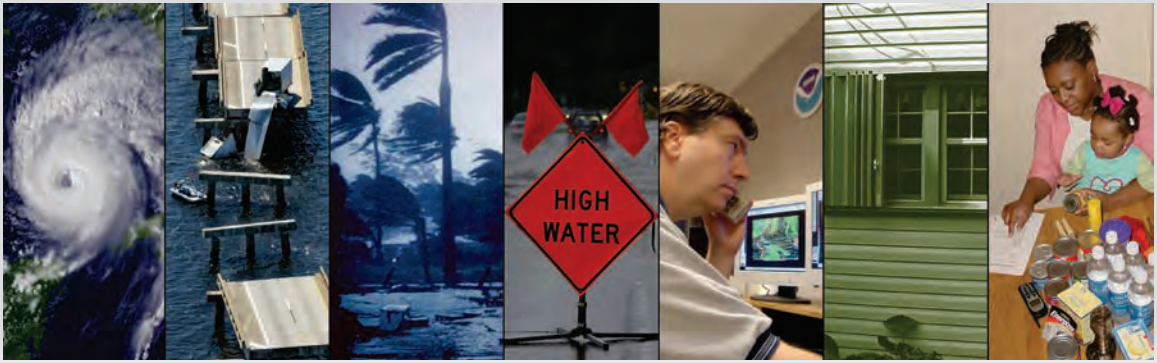
We practice basic safe food handling in our daily lives, but obtaining and storing food safely becomes more challenging during a power outage or natural disasters such as hurricanes and floods.

STEPS TO FOLLOW TO PREPARE FOR A POSSIBLE WEATHER EMERGENCY:

Keep an appliance thermometer in the refrigerator and freezer. An appliance thermometer will indicate the temperature in the refrigerator and freezer in case of a power outage and help determine the safety of the food.

- Make sure the freezer is at 0 °F (Fahrenheit) or below and the refrigerator is at 40 °F or below.
- Freeze containers of water for ice to help keep food cold in the freezer, refrigerator, or coolers after the power is out.
- Freeze refrigerated items such as leftovers, milk, and fresh meat and poultry that you may not need immediately-this helps keep them at a safe temperature longer.
- Plan ahead and know where dry ice and block ice can be purchased.
- Store food on shelves that will be safely out of the way of contaminated water in case of flooding.
- Have coolers on hand to keep refrigerator food cold if the power will be out for more than 4 hours. Purchase or make ice cubes and store in the freezer for use in the refrigerator or in a cooler. Freeze gel packs ahead of time for use in coolers.
- Group food together in the freezer—this helps the food stay cold longer.

Photos Courtesy of National Oceanic & Atmospheric Administration/Department of Commerce



STEPS TO FOLLOW DURING AND AFTER THE WEATHER EMERGENCY:

- Never taste a food to determine its safety!
- Keep the refrigerator and freezer doors closed as much as possible to maintain the cold temperature.
- The refrigerator will keep food safely cold for about 4 hours if it is unopened. A full freezer will hold the temperature for approximately 48 hours (24 hours if it is half full and the door remains closed).
- Food may be safely refrozen if it still contains ice crystals or is at 40 °F or below.
- Obtain block ice or dry ice to keep your refrigerator and freezer as cold as possible if the power is going to be out for a prolonged period of time. Fifty pounds of dry ice should hold an 18-cubic-foot full freezer for 2 days.
- If the power has been out for several days, then check the temperature of the freezer with an appliance thermometer or food thermometer. If the food still contains ice crystals or is at 40 °F or below, the food is safe.
- If a thermometer has not been kept in the freezer, then check each package of food to determine its safety. If the food still contains ice crystals, the food is safe.
- Discard refrigerated perishable food such as meat, poultry, fish, soft cheeses, milk, eggs, leftovers, and deli items after 4 hours without power.
- **When in Doubt, Throw it Out!**

Safety of Food in Containers Exposed to Flood Waters

HOW TO DETERMINE WHAT FOOD TO KEEP OR DISCARD

- Do not eat any food that may have come into contact with flood water.
- Discard any food that is not in a waterproof container if there is any chance that it has come into contact with flood water. Food containers that are not waterproof include those with screw-caps, snap lids, pull tops, and crimped caps. Also, discard cardboard juice/milk/baby formula boxes and home canned foods if they have come in contact with flood water, because they cannot be effectively cleaned and sanitized.
- Inspect canned foods and discard any food in damaged cans. Can damage is shown by swelling, leakage, punctures, holes, fractures, extensive deep rusting, or crushing/denting severe enough to prevent normal stacking or opening with a manual, wheel-type can opener.

POTS, PANS, DISHES, AND UTENSILS:

- Thoroughly wash metal pans, ceramic dishes, and utensils (including can openers) with soap and water, using hot water if available. Rinse and then sanitize them by boiling in clean water or immersing them for 15 minutes in a solution of 1 tablespoon of unscented, liquid chlorine bleach per gallon of drinking water (or the cleanest, clearest water available).

COUNTERTOPS:

- Thoroughly wash countertops with soap and water, using hot water if available. Rinse and then sanitize them by applying a solution of 1 tablespoon of unscented, liquid chlorine bleach per gallon of drinking water (or the cleanest, clearest water available). Allow to air-dry.

STEPS TO SALVAGE ALL-METAL CANS AND RETORT POUCHES

Undamaged, commercially prepared foods in all-metal cans and retort pouches (for example, flexible, shelf-stable juice or seafood pouches) can be saved if you do the following:

- Remove the labels, if they are the removable kind, since they can harbor dirt and bacteria.
- Thoroughly wash the cans or retort pouches with soap and water, using hot water if it is available.
- Brush or wipe away any dirt or silt.
- Rinse the cans or retort pouches with water that is safe for drinking, if available, since dirt or residual soap will reduce the effectiveness of chlorine sanitation.
- Then, sanitize them by immersion in one of the two following ways:
    - Place in water and allow the water to come to a boil and continue boiling for 2 minutes, or

    - Place in a freshly made solution consisting of 1 tablespoon of unscented, liquid chlorine bleach per gallon of drinking water (or the cleanest, clearest water available) for 15 minutes.
- Air-dry cans or retort pouches for a minimum of 1 hour before opening or storing.
- If the labels were removable, then re-label your cans or retort pouches, including the expiration date (if available), with a marker.
- Food in reconditioned cans or retort pouches should be used as soon as possible, thereafter.
- Any concentrated baby formula in reconditioned, all-metal containers must be diluted with clean, drinking water.

SAFETY OF DRINKING WATER IF FLOODING OCCURS

- Use bottled water that has not been exposed to flood waters if it is available.
- If you don't have bottled water, you should boil water to make it safe. Boiling water will kill most types of disease-causing organisms that may be present. If the water is cloudy, filter it through clean cloths or allow it to settle, and draw off the clear water for boiling. Boil the water for one minute, let it cool, and store it in clean containers with covers.
- If you can't boil water, you can disinfect it using household bleach. Bleach will kill some, but not all, types of disease-causing organisms that may be in the water. If the water is cloudy, filter it through clean cloths or allow it to settle, and draw off the clear water for disinfection. Add 1/8 teaspoon (or 8 drops) of regular, unscented, liquid household bleach for each gallon of water, stir it well and let it stand for 30 minutes before you use it. Store disinfected water in clean containers with covers.
- If you have a well that has been flooded, the water should be tested and disinfected after flood waters recede. If you suspect that your well may be contaminated, contact your local or State health department or agriculture extension agent for specific advice.

Food Safety: Removing Odors from Refrigerators & Freezers

Refrigerators and freezers are two of the most important pieces of equipment in the kitchen for keeping food safe. We are instantly reminded of their importance when the power goes off, flooding occurs, or the unit fails, causing food to become unsafe and spoil. The odors that develop when food spoils can be difficult to remove. Use this information to learn how to remove odors from units or how to safely discard an affected unit.

TO REMOVE ODORS FROM REFRIGERATORS AND FREEZERS

If food has spoiled in a refrigerator or freezer and odors from the food remain, they may be difficult to remove. The following procedures may help but may have to be repeated several times.

- Dispose of any spoiled or questionable food.
- Remove shelves, crispers, and ice trays. Wash them thoroughly with hot water and detergent. Then rinse with a sanitizing solution (1 tablespoon unscented, liquid chlorine bleach per gallon of water).
- Wash the interior of the refrigerator and freezer, including the door and gasket, with hot water and baking soda. Rinse with sanitizing solution as above.
- Leave the door open for about 15 minutes to allow free air circulation.

If odor remains, try any or all of the following:

- Wipe inside of unit with equal parts vinegar and water. Vinegar provides acid which destroys mildew.
- Leave the door open and allow to air out for several days.
- Stuff both the refrigerator and freezer with rolled newspapers. Close the door and leave for several days. Remove paper and clean with vinegar and water.
- Sprinkle fresh coffee grounds or baking soda loosely in a large, shallow container in the bottom of the refrigerator and freezer.
- Place a cotton swab soaked with vanilla inside the refrigerator and freezer. Close door for 24 hours. Check for odors.
- Use a commercial product available at hardware and housewares stores. Follow the manufacturer's instructions.

IF ODORS REMAIN

If odors cannot be removed, then the refrigerator or freezer may need to be discarded. If you need to discard the refrigerator or freezer, discard it in a safe manner:

- "Childproof" old refrigerators or freezers so children do not get trapped inside. The surest way is to take the door off.
- If the door will not come off, chain and padlock the door permanently and close tightly, or remove or disable the latch completely so the door will no longer lock when closed.

It is unlawful in many jurisdictions to discard old refrigerators or freezers without first removing the door.

Depending on where you live, your appliance will be picked up by your solid waste provider, a recycler, a retailer (if you buy a new unit), or program sponsored by local or regional utilities.

Refrigerator Foods

WHEN TO SAVE AND WHEN TO THROW IT OUT

FOOD	Held above 40 ºF for over 2 hours
MEAT, POULTRY, SEAFOOD	
Raw or leftover cooked meat, poultry, fish, or seafood; soy meat substitutes	Discard
Thawing meat or poultry	Discard
Meat, tuna, shrimp, chicken, or egg salad	Discard
Gravy, stuffing, broth	Discard
Lunchmeats, hot dogs, bacon, sausage, dried beef	Discard
Pizza – with any topping	Discard
Canned hams labeled "Keep Refrigerated"	Discard
Canned meats and fish, opened	Discard
CHEESE	
Soft Cheeses: blue/bleu, Roquefort, Brie, Camembert, cottage, cream, Edam, Monterey Jack, ricotta, mozzarella, Muenster, Neufchatel, queso blanco, queso fresco	Discard
Hard Cheeses: Cheddar, Colby, Swiss, Parmesan, provolone, Romano	Safe
Processed Cheeses	Safe

FOOD	Held above 40 ºF for over 2 hours
Shredded Cheeses	Discard
Low-fat Cheeses	Discard
Grated Parmesan, Romano, or combination (in can or jar)	Safe
DAIRY	
Milk, cream, sour cream, buttermilk, evaporated milk, yogurt, eggnog, soy milk	Discard
Butter, margarine	Safe
Baby formula, opened	Discard
EGGS	
Fresh eggs, hard-cooked in shell, egg dishes, egg products	Discard
Custards and puddings	Discard
CASSEROLES, SOUPS, STEWS	Discard
FRUITS	
Fresh fruits, cut	Discard
Fruit juices, opened	Safe
Canned fruits, opened	Safe
Fresh fruits, coconut, raisins, dried fruits, candied fruits, dates	Safe
SAUCES, SPREADS, JAMS	
Opened mayonnaise, tartar sauce, horseradish	Discard if above 50 °F for over 8 hrs.
Peanut butter	Safe
Jelly, relish, taco sauce, mustard, catsup, olives, pickles	Safe
Worcestershire, soy, barbecue, Hoisin sauces	Safe
Fish sauces (oyster sauce)	Discard
Opened vinegar-based dressings	Safe
Opened creamy-based dressings	Discard
Spaghetti sauce, opened jar	Discard
BREAD, CAKES, COOKIES, PASTA, GRAINS	
Bread, rolls, cakes, muffins, quick breads, tortillas	Safe
Refrigerator biscuits, rolls, cookie dough	Discard
Cooked pasta, rice, potatoes	Discard
Pasta salads with mayonnaise or vinaigrette	Discard
Fresh pasta	Discard
Cheesecake	Discard
Breakfast foods –waffles, pancakes, bagels	Safe
PIES, PASTRY	
Pastries, cream filled	Discard
Pies – custard, cheese filled, or chiffon; quiche	Discard
Pies, fruit	Safe
VEGETABLES	
Fresh mushrooms, herbs, spices	Safe
Greens, pre-cut, pre-washed, packaged	Discard
Vegetables, raw	Safe
Vegetables, cooked; tofu	Discard
Vegetable juice, opened	Discard
Baked potatoes	Discard
Commercial garlic in oil	Discard
Potato Salad	Discard

Frozen Food

WHEN TO SAVE AND WHEN TO THROW IT OUT

FOOD	Still contains ice crystals and feels as cold as if refrigerated	Thawed Held above 40 ºF for over 2 hours
MEAT, POULTRY, SEAFOOD		
Beef, veal, lamb, pork, and ground meats	Refreeze	Discard
Poultry and ground poultry	Refreeze	Discard
Variety meats (liver, kidney, heart, chitterlings)	Refreeze	Discard
Casseroles, stews, soups	Refreeze	Discard
Fish, shellfish, breaded seafood products	Refreeze However, there will be some texture and flavor loss	Discard
DAIRY		
Milk	Refreeze May lose some texture	Discard
Eggs (out of shell) and egg products	Refreeze	Discard
Ice cream, frozen yogurt	Discard	Discard
Cheese (soft and semi-soft)	Refreeze May lose some texture	Discard
Hard cheeses	Refreeze	Refreeze
Shredded cheeses	Refreeze	Discard
Casseroles containing milk, cream, eggs, soft cheeses	Refreeze	Discard
Cheesecake	Refreeze	Discard
FRUITS		
Juices	Refreeze	Refreeze. Discard if mold, yeasty smell, or sliminess develops
Home or commercially packaged	Refreeze Will change texture and flavor	Refreeze. Discard if mold, yeasty smell, or sliminess develops
VEGETABLES		
Juices	Refreeze	Discard after held above 40 ºF for 6 hours
Home or commercially packaged or blanched	Refreeze May suffer texture and flavor loss	Discard after held above 40 ºF for 6 hours
BREADS, PASTRIES		
Breads, rolls, muffins, cakes (without custard fillings)	Refreeze	Refreeze
Cakes, pies, pastries with custard or cheese filling	Refreeze	Discard

FOOD	Still contains ice crystals and feels as cold as if refrigerated	Thawed Held above 40 °F for over 2 hours
BREADS, PASTRIES		
Pie crusts, commercial and homemade bread dough	Refreeze Some quality loss may occur	Refreeze Quality loss is considerable
OTHER		
Casseroles – pasta, rice based	Refreeze	Discard
Flour, cornmeal, nuts	Refreeze	Refreeze
Breakfast items –waffles, pancakes, bagels	Refreeze	Refreeze
Frozen meal, entree, specialty items (pizza, sausage and biscuit, meat pie, convenience foods)	Refreeze	Discard

Got Food Safety Questions?

ASK KAREN!

The FSIS automated response system can provide food safety information 24/7. Visit us at *AskKaren.gov*

USDA Meat and Poultry HOTLINE

1-888-MPHotline

(1-888-674-6854)

English & Spanish

10:00-4:00 ET

TTY: 1-800 256-7072

Food Safety Contacts for Areas Affected by Severe Storms and Hurricanes

FSIS

USDA's Food Safety and Inspection Service

Consumers with food safety questions can phone the toll-free **USDA Meat and Poultry Hotline** at **1-888-MPHotline** (1-888-674-6854); TTY, 1-800-256-7072.

The Hotline is available in English and Spanish and can be reached from 10 a.m. to 4 p.m. (ET) Monday through Friday. Recorded food safety messages are available 24 hours a day.

Consumers can also ask safe food handling questions by logging on to FSIS' online automated response system called "Ask Karen," on the Food Safety and Inspection Service's Web site: *www.fsis.usda.gov*

E-mail inquiries can be directed to *MPHotline.fsis@usda.gov*.

Additional information about USDA's food safety efforts can be accessed on the FSIS Web site at *www.fsis.usda.gov*

CDC

Centers for Disease Control and Prevention

- Call 1-800-CDC-INFO or 1-800-232-4636, TTY 1-888-232-6348, for information on hazards, safe clean up, and preventing illness and injury. Available in English and Spanish, 24 hours a day, 7 days a week. *www.cdc.gov*

FDA

Food and Drug Administration

- For information on safe food handling for foods other than meat, poultry, or egg products, call FDA's toll-free information line at 1-888- SAFEFOOD or 1-888-723-3366. *www.cfsan.fda.gov*
- FDA emergency number, staffed 24 hours a day, 1-866-300-4374.

OTHER

Environmental Protection Agency

EPA's Safe Drinking Water Hotline: 1-800-426-4791
www.epa.gov

Federal Emergency Management Agency (FEMA)

Food and Water in an Emergency
www.fema.gov

General Disaster Assistance Site: *www.foodsafety.gov*