2019 Council Attendance
Updated 11-26-19

NUMBER OF COUNCIL MEETINGS HELD IN 2019: 9

Council Members Shaded = retiring from Council on 12/31/19	Number of meetings attended in 2019	Number of meetings unable to attend in 2019
Bruce Turner	9	
John Poole	1	8
Tana Pradia	8	1
Veronica Ardoin	6	3
Rosalind Belcher	4	5
Tony Crawford	9	
Bobby Cruz	9	
Johnny Deal	8	1
Ronnie Galley	9	
Ahmier Gibson	4	5
Gregory Hamilton	6	3
Angela F. Hawkins	8	1
Allison Hesterman	8	1
Dawn Jenkins	7	2
Arlene Johnson		9
Daphne Jones	8	1
Hoxi Jones	5	4
Mel Joseph	4	5
Denis Kelly	8	1
Peta-gay Ledbetter	4	5
Tom Lindstrom	3	6
Holly McLean	6	3
Rodney Mills	7	2
Niquita Moret	6	3
Allen Murray	9	
Matilda Padilla	6	3
Shital Patel	6	3
Faye Robinson	5	4
Pete Rodriguez	7	2
Imran Shaikh	7	2
Gloria Sierra	4	5
Crystal Starr	6	3
Carol Suazo	3	6
Isis Torrente	7	2

Houston Area HIV Services Ryan White Planning Council

Office of Support
2223 West Loop South, Suite 240, Houston, Texas 77027
832 927-7926 telephone; 713 572-3740 fax
www.rwpchouston.org

MEMORANDUM

To: Steering Committee Members:
Bruce Turner, Chair
John Poole, Vice Chair
Tana Pradia, Secretary
Rodney Mills, Co-Chair, Affected Community Committee
Daphne L. Jones, Co-Chair, Comprehensive HIV Planning Committee
Ronnie Galley, Co-Chair, Operations Committee
Allen Murray, Co-Chair, Operations Committee
Bobby Cruz, Co-Chair, Priority and Allocations Committee
Peta-gay Ledbetter, Co-Chair, Priority and Allocations Committee
Denis Kelly, Co-Chair, Quality Improvement Committee
Gloria Sierra, Co-Chair, Quality Improvement Committee

Copy:
Carin Martin
Samantha Bowen
Yvette Garvin
Sha'Terra Johnson-Fairley
Amber Harbolt
Diane Beck
Ann Robison
David Williams (email only)

From: Tori Williams

Date: Wednesday, November 27, 2019

Re: Meeting Announcement

Please note that there will be a:

Steering Committee Meeting
12 noon, December 5, 2019
Office of Support for the Ryan White Planning Council
2223 West Loop South, Room 240
Houston, Texas 77027
Lunch will be provided

Please contact Rod to RSVP, even if you cannot attend. Rod can be reached by telephone at: 832 927-7926 or by email at: Rodriga.Avila@cjo.hctx.net.

Thank you!

HOUSTON AREA HIV SERVICES RYAN WHITE PLANNING COUNCIL
<<>>
STEERING COMMITTEE

AGENDA

12 noon, Thursday, December 5, 2019
2223 W. Loop South, Suite 240
Houston, Texas 77027

I. Call to Order — Bruce Turner, Chair, Ryan White Planning Council
   A. Welcoming Remarks
   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 — Daphne L. Jones, Chair

Item: Epidemiological Profile
Recommended Action: **Motion:** Approve the *2019 Houston Area Integrated Epidemiologic Profile for HIV Prevention and Care Services Planning.* See email reminders for an electronic version of this 214 page report. Contact our office asap if you would like a hard copy. A hard copy will be included in the Council meeting packet.

Item: Needs Assessment Progress
Recommended Action: FYI: As of 11/26/19, 578 surveys have been collected. This is 98% of the minimum target sample size.

Item: Quarterly Committee Report
Recommended Action: FYI: Please see the attached quarterly committee report.

B. Affected Community Committee — Rodney Mills, Chair

Item: Training: Building Healthy Numeracy Skills
Recommended Action: FYI: Samantha Bowen from Ryan White Grant Administration and Cecilia Ross-Oshingbade from Living Without Limits Living Large gave an excellent presentation On Building Healthy Numeracy Skills.

Item: HIV and Aging Coalition Holiday Party
Recommended Action: FYI: The HIV and Aging Holiday party for Long-term HIV survivors will be at the Montrose Center at 7 pm on Saturday, December 14, 2019.

Item: Quarterly Committee Report
Recommended Action: FYI: Please 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:

- FY19 Procurement Report – Part A & MAI, dated 11/11/19
- FY19 Service Utilization Report – Part A & MAI, as of 11/04/19

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

- FY 2019/20 Procurement Report Part B – dated 11/20/19
- FY 2018/19 Procurement Report DSHS** SS – dated 11/20/19
- FY 2019/20 RW Part B Service Utilization – 2nd Quarter dated 10/25/19
- Health Insurance Program Report 09/01/19-09/30/19 – dated 11/07/19
- Health Insurance Program Report 09/01/19-10/31/19 – dated 11/07/19

Item: Telehealth and Telemedicine
Recommended Action: See the attached definitions and power point presentation from Brian Rosemond, BSN, RN, DSHS Nurse Consultant.

Item: Telehealth and Telemedicine
Recommended Action: **Motion:** The Houston Planning Council supports the idea of telehealth and telemedicine and would like to start implementing the model.

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

No report

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

Item: Alternate Name for External Committee Members
Recommended Action: **Motion:** In 2020, replace the term "External Committee members" with "Affiliate Committee members".

Item: 2020 Project LEAP Service Definition
Recommended Action: **Motion:** Approve the attached Evaluation of 2019 Project LEAP and use the 2019 Project LEAP service definition for the 2020 program.

Item: 2020 Project LEAP Student Selection Guidelines
Recommended Action: **Motion:** Approve the attached 2020 Project LEAP Student Selection Guidelines.

Item: Youth Committee/Council
Recommended Action: FYI: See the attached CHATT webinar on engaging youth and young adults. See page 19 regarding Youth Councils.

Item: Attendance Requirements for 2020 Council Officers
Recommended Action: **Motion:** If an officer of the Houston Ryan White Planning Council misses four (4) consecutive Steering and/or Council meetings, they must step down as an officer and an election will be held to fill the position. (Example: an officer must step down if he/she misses the October Steering Committee, October Planning Council, November Steering Committee and November Council meetings.) Staff is asked to remind nominees for officer positions of this new requirement. And, when presenting their qualifications to the Council before an election, nominees must state that, to the best of their knowledge, they will not have difficulty meeting this additional attendance requirement.

Item: Election of Officers for the 2020 Planning Council
Recommended Action: FYI: See the attached slate of nominees and credentials for officers of the 2020 Ryan White Planning Council. The floor will be open for additional nominees the day of the election, which is Thursday, December 12, 2019. Please note the new attendance requirements.

Item: Important Dates in 2020
Recommended Action: FYI: Please note the following important meeting dates in 2020:

- Mentor Luncheon – Thursday, January 16, 2020
- All-day Council Orientation – Thursday, January 23, 2020

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
<<>>
STEERING COMMITTEE

MINUTES

12 noon, Thursday, November 7, 2019
2223 W. Loop South, Suite 240; Houston, Texas 77027

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

Call to Order: C. Bruce Turner, Chair, called the meeting to order at 12:03 p.m.

During the opening remarks, Turner said the speaker at the Council meeting next week will be Shelley Lucas, the Manager of the HIV/STD Prevention and Care Branch of the Texas Department of Health Services. She will be providing an update on ADAP and other services provided by the State. Turner then called for a Moment of Reflection.

Those selected to represent their committee at today's meeting were: Mills for Affected Community and Comprehensive HIV Planning, Murray for Operations, Ledbetter for Priority and Allocations and Kelly for Quality Improvement.

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

Approval of the Minutes: ***Motion #2:*** *it was moved and seconded (Ledbetter, Mills) to approve the October 3, 2019 minutes.* **Motion Carried.** Abstention: Cruz, Kelly.

Public Comment and Announcements: None.

Reports from Committees
Comprehensive HIV Planning Committee: Rodney Mills, Vice Chair, reported on the following: Epidemiological Profile: The Committee reviewed and offered content feedback on drafts of Chapter 6 (Special Topics in HIV Epidemiology in the Houston Area), and two additional chapters from the Houston Health Department (HHD): National HIV Behavioral Surveillance (NHBS) and Houston Medical Monitoring Project (HMMP).

Needs Assessment Progress: As of 11/07/19, 575 surveys have been collected. This is 97% of the minimum target sample size. Office of Support staff will be conducting Needs Assessment surveys

at multiple non-medical sites throughout the community in the month of November. A meal will be provided, and participants will receive a $10 gift card in appreciation for their assistance. Eligible participants must be living with HIV; reside or receive HIV medical care in the EMA or the HSDA; may not have participated in the survey earlier this year; and may not be current members of the Houston Ryan White Planning Council. See the attached document for survey days and sites. Please take some mini-flyers before leaving today's meeting; share the information with friends, colleagues, clients, and social media; and see Diane if you would like mini-flyers in bulk or electronically. Harbolt stated that she will have a community survey site in Cypress this afternoon, where they hope to get respondents from Waller and Prairie View. The two data entry people are moving quickly and have entered approximately 40% of the surveys.

Affected Community Committee: Rodney Mills, Co-Chair, reported on the following:
Training: Intimate Partner Violence and HIV: Samantha Bowen from Ryan White Grant Administration gave an excellent presentation and training exercise on Intimate Partner Violence and HIV.

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

2019 Greeters: See the attached list of 2019 Greeters.

Quality Improvement Committee: Denis Kelly, Co-Chair, reported on the following:
Reports from Administrative Agent (AA) – Part A/MAI*: See attached reports from the Part A/MAI Administrative Agent:

- FY19 Procurement Report – Part A & MAI, dated 10/24/19
- FY19 Service Utilization Report – Part A & MAI, as of 09/06/19

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

- FY 2019/20 Procurement Report Part B – dated 09/26/19
- FY 2018/19 Procurement Report DSHS** SS – dated 09/26/19
- FY 2019/20 RW Part B Service Utilization – 1st Quarter dated 07/31/19
- FY 2018/19 DSHS Service Utilization – dated 09/30/19
- FY 2018/19 Health Insurance Program Report – dated 09/24/19

FY 2020 Standards of Care and Performance Measures: ***Motion #3:*** *Approve the recommended changes regarding the FY 2020 Standards of Care and Performance Measures for Ryan White Part A, B and State Services.* **Motion Carried.**

Priority and Allocations Committee: Bobby Cruz, Co-Chair, reported on the following:
Item: FY 2019 RW Part A Funding Increases: ***Motion #4:*** *Per the attached chart, reallocate $155,000 in RW Part A funds.* **Motion Carried.** Abstention: Kelly.

FY 2019 Unspent Funds: ***Motion #5:*** *In the final quarter of the FY 2019 Ryan White Part A, Part B and State Services grant years, after implementing the year end Council-approved reallocation of unspent funds and utilizing the existing 10% reallocation rule to the extent feasible, Ryan White Grant Administration (RWGA) may reallocate any remaining unspent funds as necessary to ensure the Houston EMA has less than 5% unspent Formula funds and no unspent Supplemental funds. The Resource Group (TRG) may reallocate any remaining unspent funds as necessary to ensure no funds are returned to the Texas Department of State Health Services. RWGA and TRG must inform the Council of these shifts no later than the next scheduled Ryan White Planning Council Steering Committee meeting.* **Motion Carried.**

Ryan White Part A - FY 2019 Carryover Funds: ***Motion #6****: If there are FY 2019 Ryan White Part A carryover funds, it is the intent of the committee to recommend allocating the full amount to Outpatient/Ambulatory Primary Medical Care.* **Motion Carried.** Abstention: Kelly.

Quarterly Committee Report: See the attached Quarterly Committee Report.

Operations Committee: Ronnie Galley, Co-Chair, reported on the following:
Ryan White Attendance Policy 600.01: After much discussion, it was agreed that the Operations Committee should look at the excused absence policy for Council officers, as well as the attendance policy for committee co-chairs. ***Motion #7:*** *If an officer of the Ryan White Planning Council misses three, unexcused consecutive meetings of the Steering Committee and Planning Council, they must step down as an officer and an election will be held to fill the position. (Example: an officer must step down if he/she does not contact the Office of Support and request an excused absence and if they miss the October Steering Committee, October Planning Council and the November Steering Committee meetings.) Staff is asked to remind nominees for officer positions of this new requirement. And, when presenting their qualifications to the Council before an election, nominees must state that, to the best of their knowledge, they will not have difficulty meeting this additional attendance requirement.* ***Motion Carried.*** Abstention: Kelly.

Slate of Nominees for Officers of the 2020 Ryan White Council: Kelly asked that his name be removed from the slate of nominees. ***Motion #8:*** *Approve the updated slate of nominees for officers of the 2020 Ryan White Planning Council which include:*

Chair: Allen Murray, Tana Pradia and Carol Suazo
Vice Chair: Ronnie Galley and Tana Pradia
Secretary: Tony Crawford and Tana Pradia

Motion Carried.

Important Dates in 2020: Please note the following important meeting dates in 2020:

- Mentor Luncheon – Thursday, January 16, 2020
- All-day Council Orientation – Thursday, January 23, 2020

Quarterly Committee Report: See the attached Quarterly Committee Report.

Report from Office of Support: Tori Williams, Director, summarized the attached report. She also encouraged members to review the enclosed fact sheet regarding Fast Track Cities.

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

Announcements: Pradia encouraged members to apply for the Biomedical Summit scholarship. The HIV and Aging Coalition Christmas event will be 7:00 p.m. on December 14, 2019 at the Montrose Center. Murray said there will be a community update at 6:00 p.m. on November 14th at Bering Connect in room 218. Kelly stated that transgender activist Nikki Araguz passed away.

Adjournment: The meeting adjourned at 1:26 p.m.

Submitted by: Approved by:

Tori Williams, Director Date Committee Chair Date

2019 Steering Committee Voting Record for Meeting Date 11/07/19

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** Oct 3, 2019 Minutes **Carried**				**Motion #3** FY2020 Pt A, B and SS SOC/PM **Carried**				**Motion #4** FY19 Part A Reallocations **Carried**				**Motion #5** FY19 Unspent Funds **Carried**				**Motion #6** FY19 Carryover Funds **Carried**				**Motion #7** RW Policy 600.01 **Carried**				**Motion #8** Slate of Nominees for 2020 Officers **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	Absent	Yes	No	Abstain
C. Bruce Turner, Chair				C				C				C				C				C				C				C				C
Tana Pradia, Secretary		X				X				X				X				X				X				X				X			
Rodney Mills, Aff		X				X				X				X				X				X				X				X			
Allen Murray, Op		X				X				X				X				X				X				X				X			
Peta-gay Ledbetter, PA		X				X				X				X				X				X				X				X			
Denis Kelly, QI		X						X		X						X		X						X				X		X			
Non-voting members at the meeting:																																	
Daphne L. Jones, Comp																																	
Ronnie Galley, Op						X																											
Bobby Cruz, PA								X																									
Absent members:																																	
John Poole, Vice Chair																																	
Isis Torrente, Aff																																	
Gloria Sierra, QI																																	

Comprehensive HIV Planning Committee Report

The 2019 Houston Area Integrated Epidemiologic Profile for HIV Prevention and Care Services Planning

See email meeting reminders for an electronic copy of this 214 page report. A hard copy will be included in the Council meeting packet.

2019 QUARTERLY REPORT
COMPREHENSIVE HIV PLANNING COMMITTEE

Status of Committee Goals and Responsibilities (*means mandated by HRSA):

1. Assess, evaluate, and make ongoing recommendations for the Comprehensive HIV Prevention and Care Services Plan and corresponding areas of the End HIV Plan.

Ongoing, will continuously develop.

2. *Determine the size and demographics of the estimated population of individuals who are unaware of their HIV status.

EHHA + Epi Profile.

3. *Work with the community and other committees to develop a strategy for identifying those with HIV who do not know their status, make them aware of their status, and link and refer them into care.

EHHA, completed.

4. *Explore and develop on-going needs assessment and comprehensive planning activities including the identification and prioritization of special studies.

Done for 2019

5. *Review and disseminate the most current Joint Epidemiological Profile.

Done / Completed Item

Committee Chairperson **Date** 11.14.19

Affected Community Committee Report

HRSA Ryan White HIV/AIDS Program
CENTER FOR QUALITY IMPROVEMENT & INNOVATION

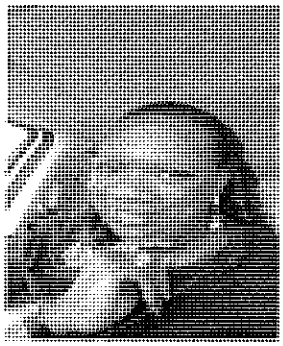
TCQ (Training for Consumers on Quality) "Mini Module"

Building Health Numeracy Skills

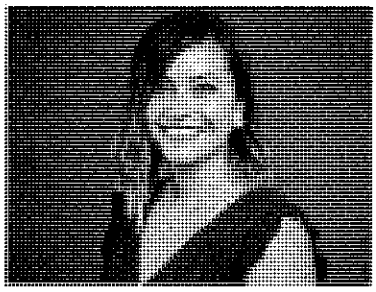
NEW YORK STATE Department of Health

HRSA Ryan White HIV/AIDS Program
CENTER FOR QUALITY IMPROVEMENT & INNOVATION

Your Facilitators



Cecilia Ross-Oshingbade
Founder of Living Without Limits Living Large, Inc.; Community Advocate



Harris County Public Health
Building a Healthy Community

Samantha Bowen
Ryan White Grant Administration
Quality Management Coordinator

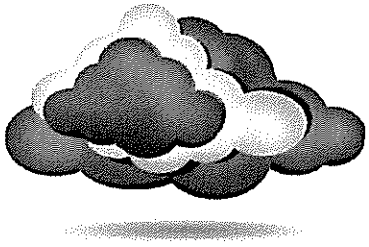
2

HRSA Ryan White HIV/AIDS Program
CENTER FOR QUALITY IMPROVEMENT & INNOVATION

Introduction to Data as an Assessment Tool

What are Data?

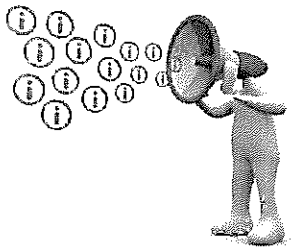
- Data (n) (plural): Facts or information used usually to calculate, analyze, or plan something



Source: http://www.merriam-webster.com/dictionary/data accessed on 04/05/14

Cultural Competency

- Data are the voice of the system . . .
- If you want to know how to ask questions or how to understand its answers, you need to know data



5

HRSA Ryan White HIV/AIDS Program
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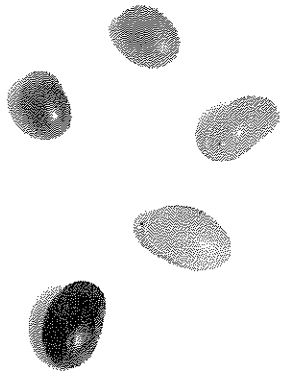
Types of Data

Quantitative Data - Counting Things:

5 Jelly Beans
or
1 Red Jelly Bean
1 Green Jelly Bean
1 Orange Jelly Bean
1 Pink Jelly Bean
1 Purple Jelly Bean



6

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Types of Data

Qualitative Data - Describing Things:

- There are red, green, orange, pink and purple Jelly Beans
- Each of the Jelly Beans is oval shaped and about the same size
- They all taste delicious

7

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Group Exercise

8

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Exercise: Bag of Data

- Step 1: Form a group.
- Step 2: Pick a person who will write on the poster paper
- Step 3: Identify five examples from your quantitative brainstorm
- Step 4: Identify five examples from your qualitative brainstorm
- Step 5: Identify one person to report back

9

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Debrief

- How do you see yourself using quantitative and qualitative data in your committee?

10

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Key Data Terms

11

UCLA Ryan White HIV/AIDS Program
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Key Data Term #1: **Data Set**

da·ta set
[data set]

1. a collection of related sets of information that is composed of separate elements but can be manipulated as a unit by a computer.

"all hospitals must provide a standard data set of each patient's details"

12

UCLA Ryan White HIV/AIDS Program
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Data Set: Diagnoses of HIV Infection

Table 1a. Diagnoses of HIV infection, by year of diagnosis and selected characteristics, 2012–2017—United States

	2012		2013		2014		2015		2016		2017	
	No.	Rate[a]	No.	Rate[a]	No.	Rate[a]	No.	Rate[a]	No.	Rate[a]	No.	Rate[a]
Age at diagnosis (yr)												
<13	241	0.5	184	0.3	160	0.3	140	0.3	130	0.2	99	0.2
13–14	50	0.6	43	0.5	32	0.4	25	0.3	25	0.3	25	0.3
15–19	1,919	9.0	1,687	8.0	1,727	8.2	1,740	8.2	1,700	8.0	1,711	8.1
20–24	7,174	31.8	7,054	30.9	7,370	32.2	7,276	32.1	6,868	30.7	6,354	28.7
25–29	6,459	30.2	6,653	30.6	7,187	32.7	7,596	33.9	7,930	34.6	7,691	32.9
30–34	5,458	26.1	5,202	24.4	5,451	25.3	5,457	25.2	5,662	25.9	5,614	25.6
35–39	4,161	21.3	3,964	20.2	4,241	21.3	4,253	21.0	4,224	20.3	4,315	20.3
40–44	4,448	21.1	3,925	18.8	3,790	18.4	3,417	16.9	3,254	15.6	3,256	15.2
45–49	4,290	19.6	3,923	18.5	3,610	17.3	3,325	16.0	3,098	14.8	2,964	14.1
50–54	3,157	14.1	2,959	13.1	2,899	12.9	3,009	13.5	2,879	13.2	2,677	12.5
55–59	1,924	9.3	2,010	9.5	1,933	9.0	1,874	8.6	1,885	8.6	1,805	8.6
60–64	1,049	5.9	1,095	5.9	973	5.2	999	5.2	1,078	5.5	1,056	5.4
≥65	820	1.9	850	1.9	831	1.8	852	1.8	845	1.7	864	1.7
Race/ethnicity												
American Indian/Alaska Native	172	7.4	147	6.3	182	7.7	189	8.0	230	9.6	212	8.8
Asian	797	5.1	792	4.9	923	5.5	941	5.4	972	5.4	942	5.1
Black/African American	18,196	46.9	17,326	44.3	17,503	44.4	17,453	43.7	17,269	42.9	16,890	41.1
Hispanic/Latino[b]	9,196	17.3	8,966	16.6	9,549	17.3	9,643	17.1	9,831	17.0	9,461	16.1
Native Hawaiian/Other Pacific Islander	51	9.8	47	8.8	44	8.1	74	13.3	41	7.2	57	9.9
White	11,041	5.6	10,621	5.4	10,581	5.3	10,403	5.3	10,117	5.1	10,048	5.1
Multiple races	1,727	28.8	1,620	26.2	1,415	22.2	1,261	19.2	1,129	16.7	871	12.6

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HRSA Ryan White HIV/AIDS Program
CENTER FOR QUALITY IMPROVEMENT & INNOVATION

Key Data Term #2: **Average**

av·er·age
['av(ə)rij]

1. a number expressing the central or typical value in a set of data, in particular the mode, median, or (most commonly) the mean, which is calculated by dividing the sum of the values in the set by their number.

"the housing prices there are twice the national average"

synonyms:
mean · median · mode · midpoint · center · norm · standard · rule

14

HRSA Ryan White HIV/AIDS Program
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Data Set: Clinic Satisfaction (1-10)

Respondent	Rating	Respondent	Rating
Deborah	9	Rose	9
Michele	6	Jane	7
Susan	9	Patricia	1
Judith	1	Robin	9
Mary	5	Erin	1

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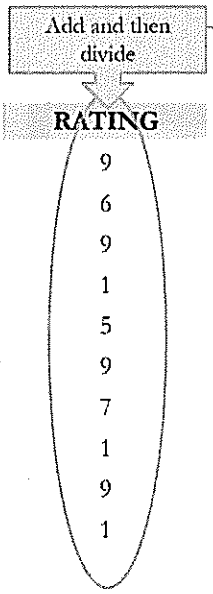

Average

- Add each of the numbers and divide by the total number of numbers
- They responded using a 1-10 scale and there were ten respondents, therefore 10 is the total number of numbers
  a) 9 + 6 + 9 + 1 + 5 + 9 + 7 + 1 + 9 + 1 = 57
  b) 57 / 10 = 5.7
- **5.7** is your Average

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Analyzing the Data …

- What if I told you that Deborah, Susan, Rose, and Robin were all long-term patients of the clinic?
- What if I told you that Judith, Patricia, and Erin were all newly enrolled patients?

Respondent	Rating
Deborah	9
Michele	6
Susan	9
Judith	1
Mary	5
Rose	9
Jane	7
Patricia	1
Robin	9
Erin	1

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Key Data Term #3: **Percent**

per·cent
[pər'sent]

1. one part in every hundred.

"a reduction of half a percent or so in price"

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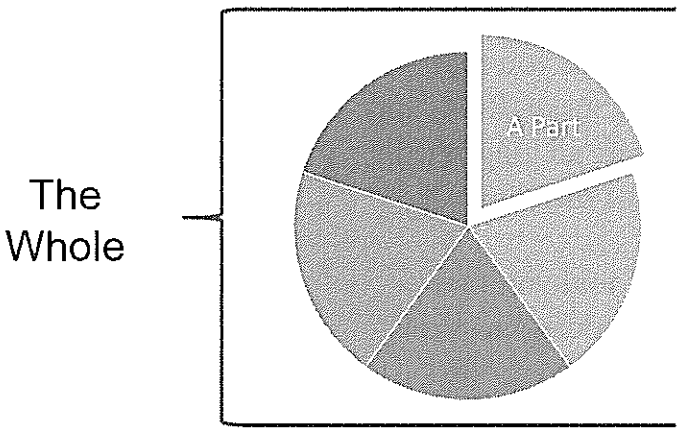
A percent is just a part of the whole.



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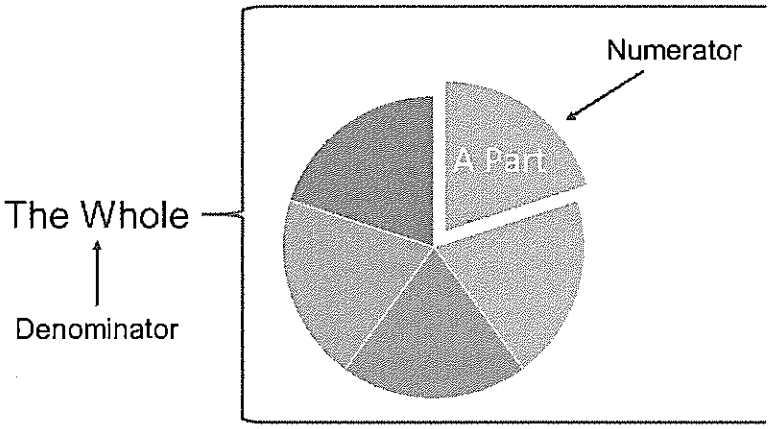
Numerator and Denominator



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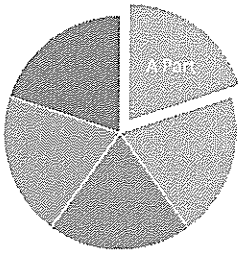
Question:

What percentage of the United States population was Black in 2017?



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Data Set: United States Population

Race/Ethnicity Category	Persons
White	192,336,100
Black	38,408,000
Hispanic	57,560,600
Asian	2,039,400
American Indian/Alaskan Native	17,651,200
Native Hawaiian/Other Pacific Islander	502,500
Two or More Races	8,524,700
TOTAL	317,022,500

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Step One

NUM ÷ DEN = N

Step Two

N × 100 = X

Step Three

X = % **Percent**

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Step One

10 ÷ 100 = 0.1

Step Two

0.1 × 100 = 10

Step Three

10 = 10% **Percent**

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Answer

- After dividing **38,408,000** by **317,022,500** and then multiplying by **100** you get **12**
- The answer is Blacks made up **12%** of the United States population in **2017**

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Question:

What percentage of new diagnoses of HIV occurred in Hispanic persons in 2016?

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Race/Ethnicity Category	2016 New Diagnoses
White	10,048
Black	16,690
Hispanic	**9,461**
Asian	942
American Indian/Alaskan Native	212
Native Hawaiian/Other Pacific Islander	57
Two or More Races	871
TOTAL	**38,281**

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Answer

- After dividing **9,461** by **38,281** and then multiplying by **100** you get **25**
- The answer is Hispanics represented **25%** of the new HIV diagnoses in 2016.

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We Have a Problem . . .

I got . . .

- A lot of people living with HIV
- A medium size urban center
- A higher percentage of the population living with HIV
- A huge impact on my city
- A need to accurately compare my problem to yours

You got . . .

- A lot of people living with HIV
- A Metropolis
- More actual persons living with HIV
- A huge impact on my city
- A need to accurately compare my problem to yours

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Data Term #4: **Rate**

rate

[rāt]

1. a measure, quantity, or frequency, typically one measured against some other quantity or measure.

"the rate of HIV infection in the Gay and Bisexual Community"

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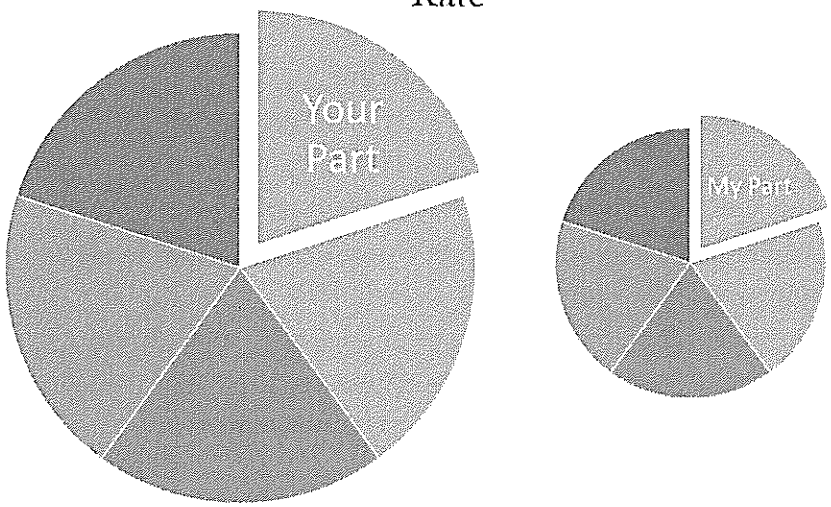
Rate



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Rank Total	Metropolitan Statistical Area (MSA)	New HIV Diagnoses 2016	MSA Population Estimate
1	Miami–Ft. Lauderdale–West Palm Beach, FL	2285	5,181,406
2	Atlanta–Sandy Springs–Roswell, GA	1523	4,759,375
3	Houston–The Woodlands–Sugar Land, TX	1469	5,440,741
4	Orlando–Kissimmee–Sanford, FL	620	2,052,980
5	Las Vegas–Henderson–Paradise, NV	461	1,786,822
6	New Orleans–Metairie, LA	409	1,062,338
7	Jacksonville, FL	327	1,238,636
8	Memphis, TN–MS–AR	302	1,098,182
9	Baton Rouge, LA	245	692,090
10	Jackson, MS	145	478,548

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https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-supplemental-report-vol-23-2.pdf
Population estimated by using the formula: (New Diagnoses * 100,000)/rate per 100,000 with data provided in citation 1

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Question:

What was the rate per 100,000 of new HIV diagnoses in the Baton Rouge Metropolitan Statistical Area in 2016?

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Why 100,000?

- To Compare
  - Not all cities have the same population so we standardize the population so we can compare.
- To Simplify
  - Such small numbers comparatively that you would end up with .05 of a person . . . How do we plan for that?

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Rate

Step One

The NEW DIAGNOSES in each area divided by the TOTAL POPULATION will give us a NUMBER

Step Two

Take that NUMBER and multiply by 100,000 to get the RATE

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Step One

NUM ÷ DEN = N

Step Two

N × 100,000 = X

Step Three

X = Rate per 100,000

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Answer

- After dividing **245** by **692,090** and then multiplying by **100,000** you get **35.4**
- The rate of new HIV Diagnoses in the Baton Rouge Metropolitan Statistical Area in 2016 was **35.4 per 100,000 persons**

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Skills Building

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Calculating Percents and Rates

- Step 1: Use a calculator and the Small Group Handout
- Step 2: Complete the Small Group Handout
  1. Calculate the percentage for each Racial and Ethnic Category as well as the percentage of New HIV Diagnoses
  2. Calculate the Rate for new HIV diagnoses for each of the ten Metropolitan Statistical Areas and rank them 1 through 10 (1 being the highest rate and ten being the lowest)
- Step 3: Discuss your findings with your small groups and be prepared to share back with the larger group

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2019 QUARTERLY REPORT
AFFECTED COMMUNITY COMMITTEE
(November 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: Done thru "Road 2 Sucess".

2. Continue to get a better understanding of the needs of transgender individuals through training, attending meetings of the transgender community and more.
   Ongoing

3. Assure participation by people living with HIV in all Council work products.
   Status: Most Members Partipated on other committees

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: Done

5. Recruit Council applicants throughout the year.
   Status: Done

6. Annually, review the status of committee activities identified in the current Comprehensive Plan.
   Status: Done.

Rodney Mills
Committee Chairperson

Nov 25th 2019
Date

Quality Improvement Committee Report

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

FY 2019 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**	**9,783,470**	**0**	**100,096**	**0**	**0**	**9,883,566**	**44.79%**	**9,883,566**	**0**		**5,648,146**	**57%**	**58%**
1.a	Primary Care - Public Clinic (a)	3,591,064	0	0	0		3,591,064	16.27%	3,591,064	0	3/1/2019	$1,935,432	54%	58%
1.b	Primary Care - CBO Targeted to AA (a) (e) (f)	940,447	0	25,032	0		965,479	4.38%	965,479	0	3/1/2019	$769,058	80%	58%
1.c	Primary Care - CBO Targeted to Hispanic (a) (e)	786,424	0	25,032	0		811,456	3.68%	811,456	0	3/1/2019	$725,521	89%	58%
1.d	Primary Care - CBO Targeted to White/MSM (a) (e)	1,023,797	0	25,032	0		1,048,829	4.75%	1,048,829	0	3/1/2019	$421,679	40%	58%
1.e	Primary Care - CBO Targeted to Rural (a) (e)	1,149,761	0	0	0		1,149,761	5.21%	1,149,761	0	3/1/2019	$603,684	53%	58%
1.f	Primary Care - Women at Public Clinic (a)	1,874,540	0	0			1,874,540	8.50%	1,874,540	0	3/1/2019	$954,208	51%	58%
1.g	Primary Care - Pediatric (a.1)	15,437	0				15,437	0.07%	15,437	0	3/1/2019	$5,400	35%	58%
1.h	Vision	402,000	0	25,000	0		427,000	1.94%	427,000	0	3/1/2019	$233,165	55%	58%
2	**Medical Case Management**	**2,535,802**	**0**	**50,000**	**-120,000**	**0**	**2,465,802**	**11.17%**	**2,465,802**	**0**		**930,490**	**38%**	**58%**
2.a	Clinical Case Management	488,656	0	0	0		488,656	2.21%	488,656	0	3/1/2019	$281,067	58%	58%
2.b	Med CM - Public Clinic (a)	482,722	0	0	0		482,722	2.19%	482,722	0	3/1/2019	$101,116	21%	58%
2.c	Med CM - Targeted to AA (a) (e)	321,070	0	16,666	0		337,736	1.53%	337,736	0	3/1/2019	$163,381	48%	58%
2.d	Med CM - Targeted to H/L (a) (e)	321,072	0	16,666	0		337,738	1.53%	337,738	0	3/1/2019	$57,710	17%	58%
2.e	Med CM - Targeted to W/MSM (a) (e)	107,247	0	16,668	0		123,915	0.56%	123,915	0	3/1/2019	$56,504	46%	58%
2.f	Med CM - Targeted to Rural (a)	348,760	0	0	-60,000		288,760	1.31%	288,760	0	3/1/2019	$131,293	45%	58%
2.g	Med CM - Women at Public Clinic (a)	180,311	0	0			180,311	0.82%	180,311	0	3/1/2019	$55,872	31%	58%
2.h	Med CM - Targeted to Pedi (a.1)	160,051	0	0	-60,000		100,051	0.45%	100,051	0	3/1/2019	$20,562	21%	58%
2.i	Med CM - Targeted to Veterans	80,025	0	0	0		80,025	0.36%	80,025	0	3/1/2019	$43,727	55%	58%
2.j	Med CM - Targeted to Youth	45,888	0	0			45,888	0.21%	45,888	0	3/1/2019	$19,260	42%	58%
3	**Local Pharmacy Assistance Program (a) (e)**	**2,657,166**	**500,000**	**125,126**	**0**	**0**	**3,282,292**	**14.88%**	**3,282,292**	**0**	3/1/2019	**$926,350**	**28%**	**58%**
4	**Oral Health**	**166,404**	**0**	**0**	**0**	**0**	**166,404**	**0.75%**	**166,404**	**0**	3/1/2019	**97,050**	**58%**	**58%**
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	3/1/2019	$97,050	58%	58%
5	**Mental Health Services (c)**	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**	**NA**	**$0**	**0%**	**0%**
6	**Health Insurance (c)**	**1,173,070**	**166,000**	**0**	**0**	**0**	**1,339,070**	**6.07%**	**1,339,239**	**-169**	3/1/2019	**$752,954**	**56%**	**58%**
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**	**-10,000**	**0**	**35,677**	**0.16%**	**35,677**	**0**	3/1/2019	**$15,306**	**43%**	**58%**
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**	**1.55%**	**341,395**	**0**	3/1/2019	**$191,208**	**56%**	**58%**
11	**Hospice Services**	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**	**NA**	**$0**	**0%**	**0%**
12	**Outreach Services**	**420,000**	**0**				**420,000**	**1.90%**	**420,000**	**0**	**3/1/2019**	**$145,782**	**35%**	**58%**
13	**Emergency Financial Assistance**	**450,000**	**0**	**0**	**0**	**0**	**450,000**	**2.04%**	**450,000**	**0**	**3/1/2019**	**$202,793**	**45%**	**58%**
14	**Referral for Health Care and Support Services (c)**	**0**	**0**	**0**			**0**	**0.00%**	**0**	**0**	NA	$0	**0%**	**0%**
15	**Non-Medical Case Management**	**1,231,002**	**0**	**100,000**	**-25,000**	**0**	**1,306,002**	**5.92%**	**1,306,002**	**0**		**865,013**	**66%**	**58%**
15.a	Service Linkage targeted to Youth	110,793	0	0	-10,000		100,793	0.46%	100,793	0	3/1/2019	$64,719	64%	58%
15.b	Service Linkage targeted to Newly-Diagnosed/Not-in-Care	100,000	0		-15,000		85,000	0.39%	85,000	0	3/1/2019	$61,703	73%	58%
15.c	Service Linkage at Public Clinic (a)	427,000	0	0	0		427,000	1.94%	427,000	0	3/1/2019	$271,213	64%	58%
15.d	Service Linkage embedded in CBO Pcare (a) (e)	593,209	0	100,000	0		693,209	3.14%	693,209	0	3/1/2019	$467,379	67%	58%
16	**Medical Transportation**	**424,911**	**0**	**0**	**0**	**0**	**424,911**	**1.93%**	**424,911**	**0**		**204,636**	**48%**	**58%**
16.a	Medical Transportation services targeted to Urban	252,680	0	0	0		252,680	1.15%	252,680	0	3/1/2019	$170,378	67%	58%
16.b	Medical Transportation services targeted to Rural	97,185	0	0	0		97,185	0.44%	97,185	0	3/1/2019	$34,258	35%	58%
16.c	Transportation vouchering (bus passes & gas cards)	75,046	0	0	0		75,046	0.34%	75,046	0	3/1/2019	$0	0%	0%
17	**Linguistic Services (c)**	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**	**NA**	$0	**0%**	**0%**
BES27516	**Total Service Dollars**	**19,228,897**	**666,000**	**375,222**	**-155,000**	**0**	**20,115,119**	**89.26%**	**20,115,288**	**-169**		**9,979,729**	**50%**	**58%**
	Grant Administration	**1,675,047**	**119,600**	**0**	**0**	**0**	**1,794,647**	**8.13%**	**1,794,647**	0	**N/A**	**627,328**	**35%**	**58%**
BES27517	HCPHES/RWGA Section	1,183,084	119,600	0		0	1,302,684	5.90%	1,302,684	0	N/A	$462,731	36%	58%
PC	RWPC Support*	491,963			0	0	491,963	2.23%	491,963	0	N/A	164,598	33%	58%

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

FY 2019 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	-119,600	0	0	0	375,400	1.70%	375,400	0	N/A	$84,702	23%	58%
		21,398,944	666,000	375,222	-155,000	0	22,285,166	99.09%	22,285,335	-169		10,691,759	48%	58%
								Unallocated	Unobligated					
	Part A Grant Award:	22,065,113	*Carry Over:*	465		*Total Part A:*	22,065,578	-219,588	-169					

		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)	16,702,984	666,000	275,222	-130,000	0	17,514,206	87.07%	8,561,505	85.79%
	Non-Core (may not exceed 25% of total service dollars)	2,525,913	0	100,000	-25,000	0	2,600,913	12.93%	1,418,224	14.21%
	Total Service Dollars (does not include Admin and QM)	19,228,897	666,000	375,222	-155,000	0	20,115,119		9,979,729	
	Total Admin (must be ≤ 10% of total Part A + MAI)	1,675,047	119,600	0	0	0	1,794,647	8.13%		
	Total QM (must be ≤ 5% of total Part A + MAI)	495,000	-119,600	0	0	0	375,400	1.70%		

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**	1,846,845	40,438	18,861	0	0	1,906,144	85.62%	1,906,144	0		1,155,275	61%	42%
1.b (MAI)	Primary Care - CBO Targeted to African American	934,693	20,219	9,430	0	0	964,342	43.32%	964,342	0	3/1/2019	$689,975	72%	42%
1.c (MAI)	Primary Care - CBO Targeted to Hispanic	912,152	20,219	9,431	0	0	941,802	42.30%	941,802	0	3/1/2019	$465,300	49%	42%
2	**Medical Case Management**	320,100	0	0	0	0	320,100	14.38%	320,100	0		$105,387	33%	42%
2.c (MAI)	MCM - Targeted to African American	160,050					160,050	7.19%	160,050	0	3/1/2019	$69,525	43%	42%
2.d (MAI)	MCM - Targeted to Hispanic	160,050					160,050	7.19%	160,050	0	3/1/2019	$35,862	22%	42%
	Total MAI Service Funds	2,166,945	40,438	18,861	0	0	2,226,244	100.00%	2,226,244	0		1,260,662	57%	42%
	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%
BEO27516	**Total MAI Funds**	2,166,945	40,438	18,861	0	0	2,226,244	100.00%	2,226,244	0		1,260,662	57%	42%
	MAI Grant Award	2,207,383	*Carry Over:*	0		*Total MAI:*	2,207,383							
	Combined Part A and MAI Orginial Allocation Total	23,565,889												

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

Prepared by: Ryan White Grant Administration

FY 2018 Ryan White Part A and MAI Service Utilization Report

RW PART A SUR- 2nd Quarter (6/1-8/31)

Priority	Service Category	Goal	Unduplicated Clients Served YTD	Male	Female	Trans gender	AA (non-Hispanic)	White (non-Hispanic)	Other (non-Hispanic)	Hispanic	0-12	13-19	20-24	25-34	35-44	45-49	50-64	65 plus
1	**Outpatient/Ambulatory Primary Care (excluding Vision)**	**6,467**	**4,210**	**71%**	**27%**	**1%**	**41%**	**15%**	**3%**	**41%**	**0%**	**0%**	**4%**	**24%**	**27%**	**14%**	**28%**	**2%**
1.a	Primary Care - Public Clinic (a)	2,350	2,098	68%	31%	1%	47%	10%	2%	41%	0%	0%	2%	15%	26%	16%	37%	4%
1.b	Primary Care - CBO Targeted to AA (a)	1,060	611	62%	35%	4%	100%	0%	0%	0%	0%	0%	6%	39%	28%	11%	14%	1%
1.c	Primary Care - CBO Targeted to Hispanic (a)	960	737	82%	16%	1%	0%	0%	0%	100%	0%	1%	8%	30%	31%	13%	18%	1%
1.d	Primary Care - CBO Targeted to White and/or MSM (a)	690	391	87%	13%	1%	0%	85%	15%	0%	0%	1%	4%	28%	21%	18%	27%	2%
1.e	Primary Care - CBO Targeted to Rural (a)	400	413	69%	30%	1%	42%	25%	1%	31%	0%	0%	7%	31%	27%	12%	21%	1%
1.f	Primary Care - Women at Public Clinic (a)	1,000	656	0%	100%	0%	58%	7%	2%	33%	0%	0%	1%	11%	29%	19%	35%	5%
1.g	Primary Care - Pediatric (a)	7	4	100%	0%	0%	25%	0%	0%	75%	25%	25%	50%	0%	0%	0%	0%	0%
1.h	Vision	1,600	747	73%	25%	1%	48%	12%	3%	37%	0%	0%	4%	23%	23%	14%	31%	5%
2	**Medical Case Management (f)**	**3,075**	**2,287**															
2.a	Clinical Case Management	600	494	77%	20%	2%	53%	15%	2%	31%	0%	1%	3%	29%	24%	9%	30%	4%
2.b	Med CM - Targeted to Public Clinic (a)	280	279	95%	4%	1%	67%	8%	2%	23%	0%	0%	1%	31%	22%	13%	30%	3%
2.c	Med CM - Targeted to AA (a)	550	536	66%	31%	2%	100%	0%	0%	0%	0%	0%	6%	36%	26%	11%	18%	2%
2.d	Med CM - Targeted to H/L(a)	550	180	79%	18%	3%	0%	0%	0%	100%	0%	1%	8%	28%	36%	7%	18%	1%
2.e	Med CM - Targeted to White and/or MSM (a)	260	187	83%	16%	1%	0%	92%	8%	0%	0%	0%	2%	22%	18%	20%	35%	4%
2.f	Med CM - Targeted to Rural (a)	150	327	68%	31%	0%	47%	29%	3%	20%	0%	0%	5%	26%	19%	11%	34%	4%
2.g	Med CM - Targeted to Women at Public Clinic (a)	240	116	0%	100%	0%	71%	8%	3%	19%	0%	0%	0%	12%	30%	17%	37%	3%
2.h	Med CM - Targeted to Pedi (a)	125	56	59%	41%	0%	70%	5%	2%	23%	55%	34%	11%	0%	0%	0%	0%	0%
2.i	Med CM - Targeted to Veterans	200	108	94%	6%	0%	71%	20%	1%	7%	0%	0%	0%	0%	5%	3%	61%	31%
2.j	Med CM - Targeted to Youth	120	4	75%	25%	0%	50%	25%	0%	25%	0%	0%	100%	0%	0%	0%	0%	0%
3	**Local Drug Reimbursement Program (a)**	**2,845**	**2,149**	**74%**	**23%**	**3%**	**46%**	**15%**	**2%**	**37%**	**0%**	**0%**	**4%**	**25%**	**27%**	**16%**	**26%**	**2%**
4	**Oral Health**	**200**	**162**	**67%**	**33%**	**0%**	**44%**	**33%**	**2%**	**21%**	**0%**	**0%**	**4%**	**17%**	**28%**	**12%**	**33%**	**5%**
4.a	Oral Health - Untargeted (d)	NA	NA															
4.b	Oral Health - Rural Target	200	162	67%	33%	0%	44%	33%	2%	21%	0%	0%	4%	17%	28%	12%	33%	5%
5	**Mental Health Services (d)**	**NA**	**NA**															
6	**Health Insurance**	**1,700**	**1,101**	**78%**	**21%**	**1%**	**44%**	**26%**	**3%**	**27%**	**0%**	**0%**	**1%**	**14%**	**17%**	**14%**	**44%**	**10%**
7	**Home and Community Based Services (d)**	**NA**	**NA**															
8	**Substance Abuse Treatment - Outpatient**	**40**	**8**	**88%**	**13%**	**0%**	**25%**	**38%**	**13%**	**25%**	**0%**	**0%**	**0%**	**13%**	**38%**	**38%**	**13%**	**0%**
9	**Early Medical Intervention Services (d)**	**NA**	**NA**															
10	**Medical Nutritional Therapy/Nutritional Supplements**	**650**	**289**	**78%**	**21%**	**0%**	**35%**	**26%**	**3%**	**36%**	**0%**	**0%**	**1%**	**10%**	**14%**	**15%**	**49%**	**11%**
11	**Hospice Services (d)**	**NA**	**NA**															
12	**Outreach**	**700**	**180**	**76%**	**22%**	**2%**	**59%**	**8%**	**1%**	**32%**	**0%**	**1%**	**8%**	**26%**	**22%**	**14%**	**27%**	**2%**
13	**Non-Medical Case Management**	**7,045**	**2,854**															
13.a	Service Linkage Targeted to Youth	320	74	78%	20%	1%	53%	4%	3%	41%	0%	19%	81%	0%	0%	0%	0%	0%
13.b	Service Linkage at Testing Sites	260	47	77%	23%	0%	53%	11%	6%	30%	0%	0%	0%	47%	28%	6%	11%	9%
13.c	Service Linkage at Public Clinic Primary Care Program (a)	3,700	1,489	66%	33%	1%	62%	10%	2%	27%	0%	0%	0%	16%	25%	14%	40%	4%
13.d	Service Linkage at CBO Primary Care Programs (a)	2,765	1,244	72%	26%	2%	50%	14%	2%	35%	1%	1%	6%	27%	26%	10%	25%	3%
14	**Transportation**	**2,850**	**962**															
14.a	Transportation Services - Urban	170	252	66%	33%	1%	61%	10%	3%	26%	0%	1%	3%	31%	23%	14%	25%	3%
14.b	Transportation Services - Rural	130	64	75%	23%	2%	39%	39%	2%	20%	0%	0%	3%	16%	22%	9%	47%	3%
14.c	Transportation vouchering	2,550	646															
15	**Linguistic Services (d)**	**NA**	**NA**															
16	**Emergency Financial Assistance (e)**	**NA**	**150**	**75%**	**23%**	**3%**	**46%**	**7%**	**2%**	**45%**	**0%**	**1%**	**3%**	**24%**	**31%**	**13%**	**26%**	**2%**
17	**Referral for Health Care - Non Core Service (d)**	**NA**	**NA**															
Net unduplicated clients served - all categories*		**12,941**	**8,782**	**73%**	**26%**	**1%**	**49%**	**15%**	**2%**	**33%**	**0%**	**1%**	**4%**	**22%**	**24%**	**13%**	**32%**	**4%**
Living AIDS cases + estimated Living HIV non-AIDS (from FY 18 App) (b)		**NA**	**28,225**	**60%**	**21%**		**39%**	**18%**	**3%**	**20%**	**0%**	**5%**		**15%**	**22%**	**25%**	**15%**	

Available Data As Of: 11/4/2019

FY 2018 Ryan White Part A and MAI Service Utilization Report

RW MAI Service Utilization Report - 2nd Quarter (06/01 - 08/31)

Priority	Service Category MAI unduplicated served includes clients also served under Part A	Goal	Unduplicated MAI Clients Served YTD	Male	Female	Trans gender	AA (non-Hispanic)	White (non-Hispanic)	Other (non-Hispanic)	Hispanic	0-12	13-19	20-24	25-34	35-44	45-49	50-64	65 plus
	Outpatient/Ambulatory Primary Care (excluding Vision)																	
1.b	Primary Care - MAI CBO Targeted to AA (g)	1,060	808	71%	27%	3%	100%	0%	0%	0%	0%	0%	7%	39%	25%	10%	17%	1%
1.c	Primary Care - MAI CBO Targeted to Hispanic (g)	960	492	84%	14%	1%	0%	0%	0%	100%	0%	1%	7%	27%	35%	13%	16%	1%
2	**Medical Case Management (f)**																	
2.c	Med CM - Targeted to AA (a)	1,060	443	62%	36%	2%	52%	14%	4%	30%	0%	2%	4%	40%	26%	12%	13%	2%
2.d	Med CM - Targeted to H/L(a)	960	238	82%	12%	6%	45%	15%	3%	36%	0%	6%	9%	30%	33%	6%	15%	0%

RW Part A New Client Service Utilization Report - 1st Quarter (03/01-05/31)

Report reflects the number & demographics of clients served during the report period who did not receive services during previous 12 months (3/1/18 - 2/28/19)

Priority	Service Category	Goal	Unduplicated New Clients Served YTD	Male	Female	Trans gender	AA (non-Hispanic)	White (non-Hispanic)	Other (non-Hispanic)	Hispanic	0-12	13-19	20-24	25-34	35-44	45-49	50-64	65 plus
1	**Primary Medical Care**	**2,100**	**446**	**72%**	**26%**	**2%**	**52%**	**12%**	**3%**	**33%**	**0%**	**2%**	**11%**	**31%**	**27%**	**12%**	**2%**	**15%**
2	**LPAP**	**1,200**	**99**	**62%**	**36%**	**2%**	**52%**	**14%**	**4%**	**30%**	**0%**	**2%**	**4%**	**40%**	**26%**	**12%**	**2%**	**13%**
3.a	Clinical Case Management	400	33	82%	12%	6%	45%	15%	3%	36%	0%	6%	9%	30%	**33%**	**6%**	0%	**15%**
3.b-3.h	Medical Case Management	1,600	270	71%	27%	1%	61%	11%	2%	26%	1%	3%	6%	33%	**26%**	**13%**	1%	**17%**
3.i	Medical Case Manangement - Targeted to Veterans	60	15	100%	0%	0%	60%	33%	7%	0%	0%	0%	0%	0%	**13%**	**0%**	40%	**47%**
4	**Oral Health**	**40**	**7**	**57%**	**43%**	**0%**	**43%**	**29%**	**0%**	**29%**	**0%**	**0%**	**14%**	**29%**	**14%**	**0%**	**14%**	**29%**
12.a. 12.c. 12.d.	**Non-Medical Case Management (Service Linkage)**	**3,700**	**559**	**70%**	**29%**	**1%**	**55%**	**15%**	**2%**	**28%**	**0%**	**2%**	**7%**	**24%**	**26%**	**12%**	**27%**	**3%**
12.b	**Service Linkage at Testing Sites**	**260**	**36**	**83%**	**17%**	**0%**	**50%**	**11%**	**6%**	**33%**	**0%**	**0%**	**19%**	**39%**	**19%**	**6%**	**11%**	**6%**

Footnotes:

(a) Bundled Category

(b) Age groups 13-19 and 20-24 combined together; Age groups 55-64 and 65+ combined together.

(d) Funded by Part B and/or State Services

(e) Total MCM served does not include Clinical Case Management

(f) CBO Pcare targeted to AA (1.b) and HL (1.c) goals represent combined Part A and MAI clients served

Available Data As Of: 11/4/2019

The Houston Regional HIV/AIDS Resource Group, Inc.
FY 1920 Ryan White Part B
Procurement Report
April 1, 2019 - March 31, 2020

Reflects spending through September 2019

Spending Target: 50.0%

Revised 11/20/19

Priority	Service Category	Original Allocation per RWPC	% of Grant Award	Amendment*	Contractual Amount	Amendment	Contractual Amount	Date of Original Procurement	Expended YTD	Percent YTD
4	Oral Health Care	$2,186,905	65%	$31,973	$2,218,878	$0	$2,218,878	4/1/2019	$1,035,191	47%
5	Health Insurance Premiums and Cost Sharing (1)	$1,040,351	31%	$0	$1,040,351	$0	$1,040,351	4/1/2019	$193,622	19%
8	Home and Community Based Health Services	$113,315	3%	$0	$113,315	$0	$113,315	4/1/2019	$65,040	57%
	Increased RWB Award added to OHS per Increase Scenario*	$0	0%	-$31,973	$0					
	Total Houston HSDA	3,340,571	100%	0	3,372,544	$0	$3,372,544		1,293,853	38%

Note: Spending variances of 10% of target will be addressed:

-1 HIP - Funded by Part A, B and State Services. Provider spends grant funds by ending dates Part A- 2/28; B-3/31; SS-8/31. No expenditures submitted - Focusing on spending State Services funds.

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 August 2019

Spending Target: 100.%

Revised 11/20/2019

Priority	Service Category	Original Allocation per RWPC	% of Grant Award	Amendments per RWPC	Contractual Amount	Amendment	Contractual Amount	Date of Original Procurement	Expended YTD	Percent YTD
5	**Health Insurance Premiums and Cost Sharing**	$979,694	52%	**$142,285**	$1,121,979	$41,715	$1,163,694	9/1/2018	$1,158,880	100%
6	**Mental Health Services (1)**	$300,000	16%	**$0**	$300,000	-$132,000	$168,000	9/1/2018	$162,744	97%
7	**EIS - Incarcerated**	$166,211	9%	**$0**	$166,211	$3,789	$170,000	9/1/2018	$170,000	100%
11	**Hospice (2)**	$359,832	19%		$359,832	-$107,500	$252,332	9/1/2018	$251,680	100%
15	**Linguistic Services (3)**	$68,000	4%		$68,000	-$8,450	$59,550	9/1/2018	$53,513	90%
	Increased award amount -Approved by RWPC for Health Insurance (a)	$0	0%	**-$142,285**						
	Total Houston HSDA	**1,873,737**	**100%**	**$0**	$2,016,022	-$202,446	$1,813,576		1,796,816	99%

Note TRG expended 99.4 % of its State Services funding which required TRG to move $ 200,000 to our rural HSDA's. 16,000 remained unspent

(1) Mental Health Services are under utilized for the last couple of years

(2) Hospice care has had lower than expected client turn out and agency has other grant funding. Service category has been reduced for next grant cycle during P&A

(3) Linguistic has had lower than expected client utilization.

(a) Reflect increase in State Services award and RWPC approval of increasing HIP category, plus an additional $ 40,000 in the category

* Final numbers will be presented after closeout period. TRG will move funds to other HSDAs to expend all grant funds to met the required 95% spent threshold.

2019-2020 Ryan White Part B Service Utilization Report
4/1/2019 - 9/30/2020 Houston HSDA (4816)
2nd Quarter

Revised 10/25/2019

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	*1,000*	1,796	80.77%	18.74%	5.00%	44.00%	43.93%	26.22%	26.83%	3.00%	0.00%	0.33%	2.24%	16.94%	19.98%	27.33%	24.94%	8.24%
Home & Community Based Health Services	*30*	22	77.27%	22.73%	0.00%	0.00%	68.18%	13.64%	18.18%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	45.45%	40.90%	13.63%
Oral Health Care	*2,500*	2,935	71.51%	27.21%	0.06%	1.21%	72.87%	22.21%	2.15%	2.74%	0.00%	0.25%	2.48%	17.88%	21.83%	26.40%	24.08%	7.08%
Unduplicated Clients Served By RW Part B Funds:	*NA*	4,753	114.78%	34.34%	2.53%	22.61%	92.49%	31.04%	23.58%	2.87%	0.00%	0.29%	2.36%	17.41%	20.91%	49.59%	44.96%	14.48%

Note: "HOME & COMMUNITY BASE HEALTH SERVICES" Calculations are under a different Category in CPCDMS. The Data appears under "DAY and RESPITE CARE".

Houston Ryan White Health Insurance Assistance Service Utilization Report

Period Reported: 09/01/2019-9/30/19

Revised: 11/7/2019

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	270	$15,261.78	208			*0*
Medical Deductible	41	$5,780.33	35			*0*
Medical Premium	526	$183,165.63	419			*0*
Pharmacy Co-Payment	939	$38,135.74	300			*0*
APTC Tax Liability	0	$0.00	0			*0*
Out of Network Out of Pocket	0	$0.00	0			*0*
ACA Premium Subsidy Repayment	3	$230.00	3	*NA*	*NA*	*NA*
Totals:	1779	$242,113.48	965	0	$0.00	

Comments: This report represents services provided under all grants.

Houston Ryan White Health Insurance Assistance Service Utilization Report

Period Reported: 09/01/2019-10/31/19

Revised: 11/7/2019

	Assisted			NOT Assisted		
Request by Type	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	385	$23,901.70	271			*0*
Medical Deductible	63	$9,374.99	56			*0*
Medical Premium	1151	$422,972.79	575			*0*
Pharmacy Co-Payment	262	$87,258.94	421			*0*
APTC Tax Liability	0	$0.00	0			*0*
Out of Network Out of Pocket	0	$0.00	0			*0*
ACA Premium Subsidy Repayment	7	$511.02	8	*NA*	*NA*	*NA*
Totals:	1868	$542,997.40	1331	0	$0.00	

Comments: This report represents services provided under all grants.

DEFINITIONS

Telehealth vs. Telemedicine

As of 11/2S/19

The U.S. Department of Health and Human Services Health Resources and Services Administration defines **telehealth** as "the use of electronic information and telecommunication technologies to support long-distance clinical health care, patient and professional health-related education, public health and health administration."

The State of Texas defines **telemedicine** as "medical care provided to a patient in a different location by a by a person with prescriptive authority."

Center for Connected Health Policy
The National Telehealth Policy Resource Center

State Telehealth Laws and Reimbursement Policies AT A GLANCE

Fall 2019

Telehealth policy trends continue to vary from state-to-state, with no two states alike in how telehealth is defined, reimbursed, or regulated. A general definition of telehealth used by CCHP is **the use of electronic technology to provide health care and services to a patient when the provider is in a different location.**

Medicaid Policy Trends

All 50 states and D.C. now reimburse for some type of live video telehealth services. Reimbursement for store-and-forward and remote patient monitoring (RPM) continues to lag behind. Fourteen state Medicaid programs reimburse for store-and-forward and twenty-one states reimburse for remote patient monitoring (RPM), with additional states having laws requiring Medicaid reimbursement for store-and-forward or RPM, yet no official written policies indicating that such policy has been implemented.

Many of the reimbursement policies that do exist continue to have restrictions and limitations, creating a barrier to utilizing telehealth to deliver services. One of the most common restrictions is a limitation on where the patient is located, referred to as the originating site. While most states have dropped Medicare's rural geographic requirement, many Medicaid programs have limited the type of facility that can serve as an originating site, often excluding a patient's home from eligibility. However, nineteen states do now explicitly allow the home to be an eligible originating site under certain circumstances.

49 states and the District of Columbia (D.C.) have a definition for telehealth, telemedicine or both.

14 Medicaid programs reimburse for S&F

50 states and D.C. reimburse for live video

22 Medicaid programs reimburse for RPM

19 states reimburse service to the home

Other Common Telehealth Restrictions

- The specialty that telehealth services can be provided for
- The types of services or CPT codes that can be reimbursed *(inpatient office, consult, etc.)*
- The types of providers that can be reimbursed *(e.g. physician, nurse, etc.)*

CENTER FOR CONNECTED HEALTH POLICY
The Federally Designated National Telehealth Policy Resource Center
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Center for Connected Health Policy
The National Telehealth Policy Resource Center

State Telehealth Laws and Reimbursement Policies
AT A GLANCE
Fall 2019

40
states and the District of Columbia have active laws

Private Payer Reimbursement

40 states and the District of Columbia have laws that govern private payer reimbursement of telehealth. States that passed new or revised private payer laws since Spring 2019 include Arizona, California, Georgia and Florida. Some laws require reimbursement be equal to in-person coverage, however most only require parity in covered services, not reimbursement amount. Not all laws mandate reimbursement.

Online Prescribing

Most states consider the use of only an online questionnaire as insufficient to establish the patient-provider relationship and prescribe medication. Some states allow telehealth to be used to conduct a physical exam, while others do not. Some states have relaxed requirements for prescribing controlled substances used in medication assisted therapy (MAT) as a result of the opioid epidemic.

More and more states are passing legislation directing healthcare professional boards to adopt practice standards for its providers who utilize telehealth. Medical and Osteopathic Boards often address issues of prescribing in such regulatory standards.

Often, internet/online questionnaires are not adequate; states may require a physical exam prior to a prescription

KANSAS passed a policy in 2018 extending to telehealth the same drug prescription laws and regulations that apply to in-person prescriptions.

WEST VIRGINIA explicitly allows practitioner to provide aspects of MAT through telehealth if within their scope of practice.

38
states and D.C. include some sort of informed consent

Consent

38 States and D.C. have a consent requirement in either Medicaid policy, law, or regulation. This number has not changed since Spring 2019.

Licensure

Nine state boards issue licenses related to telehealth allowing an out-of-state licensed provider to render services via telehealth. Licensure Compacts have become increasingly common. For example:

29
States, D.C. & Guam: Interstate Medical Licensure Compact

34
States: Nurse Licensure Compact

26
States: Physical Therapy Compact

12
States: Psychology Interjurisdictional Compact (PSYPACT)

CENTER FOR CONNECTED HEALTH POLICY
The Federally Designated National Telehealth Policy Resource Center • info@cchpca.org • 877-707-7172

This fact sheet was possible by Grant #G22RH30365 from the Office for the Advancement of Telehealth, Health Resources and Services Administration, DHHS.

TEXAS
Health and Human Services

Texas Department of State Health Services

Overview of Telemedicine and Telehealth in Texas Ryan White Program

[illegible], BSN, RN, DSHS Nurse Consultant

Introduction

- Key Terms
- Protected Health Information (PHI) Security
- Telehealth Models
- Telehealth &Telemedicine Ryan White Service Categories
- Benefits
- Myths
- Funding Options & Resources
- Questions

Key Terms

- Telemedicine- §111.001(4), Texas Occupations Code
- Telehealth- §111.001(3), Texas Occupations Code
- Distant site
- Originating site
- Facility fee

https://thesource.americantelemed.org/resources/telemedicine-glossary

PHI & Security

- The software system used by the distant site provider must allow secure authentication of the distant site provider and the client
- The physical environments of the client and the distant site provider must ensure that the client's PHI remains confidential
- Providers of telehealth or telemedicine medical services must maintain the confidentiality of PHI as required by Federal Register 42, Code of Federal Regulations (CFR) Part 2, 45 CFR Parts 160 and 164, Chapters 111 and 159 of the Texas Occupations Code, and other applicable federal and state law
  - https://www.hhs.gov/hipaa/for-professionals/security/laws-regulations/index.html
  - https://www.hhs.gov/hipaa/for-professionals/security/guidance/cybersecurity/index.html

Texas Medicaid Provider Procedures Manual, Telecommunications Services Handbook, Volume 2, October 2019)

PHI Security (continued)

- For Ryan White Providers-Texas Department of State Health Services Procedure Number 2016.01 must be followed when implementing health technology
  - https://www.dshs.texas.gov/hivstd/policy/procedures/2016-01.shtm
- All client health information generated or utilized during a telehealth or telemedicine medical service must be stored by the distant site provider in a client health record. If the distant site provider stores the patient health information in an electronic health record, the provider should use software that complies with Health Insurance Portability and Accountability Act (HIPAA) confidentiality and data encryption requirements, as well as with the United States Department of Health and Human Services (HHS) rules implementing HIPAA
  - https://www.healthit.gov/sites/default/files/pdf/privacy/privacy-and-security-guide.pdf
  - https://www.hipaajournal.com/hipaa-guidelines-on-telemedicine/

Texas Medicaid Provider Procedures Manual, Telecommunications Services Handbook, Volume 2, October 2019)

Telehealth & Telemedicine Models

Model	Details	Key Points
Traditional	• Healthcare services provided to a client who is not the same location or city as the provider • Patient is at a clinic or ASO	• Medical provider determines the site and technology requirements that are required to appropriately diagnose & treat a client, i.e. POC, Texas Document Cam • Patient presentation is optional • Visits with RW care provider ensure capacity • Consent is required
Direct to consumer/client	• Healthcare services provided to a client who is in not the same location or city as the provider • Provided to client in their home • Provided to client on smartphone or tablet	• Telemedicine can be provided in this manner • Mental health services allowed to be provided directly consumer • Security of client's home network • Encryption using smartphone or tablet • Many providers ask for a specialized consent
Specialty care	• Healthcare services provided to a client who is in not the same location or city as the provider • Client's PCP presents client	• Consent is required • Builds capacity of RW provider • Minimizes travel for client in resource low settings

Texas Ryan White Service Categories

Service Categories	Traditional Ryan White Program	State of Texas
Telemedicine	• Outpatient Ambulatory Health Services (OAHS) • PCN 16-02	• Outpatient Ambulatory Health Services • Mental health specialty
Telehealth	• Non Medical Case Management • PCN 16-02	• Mental health Future: • *Medical Case Management* • *Medical Nutrition Therapy* • *NMCM*

Benefits of Telemedicine & Telehealth

[illegible]	[illegible]	[illegible]	[illegible]
Medical Transportation Costs	*Provider travel also cited*	Patient satisfaction scores	*On their time, meet clients where they are*
Stigma associated with HIV care and Mental Healthcare (MH)	*No longer associated with going to the HIV or MH provider*	Potential for same day Medical appointments	*By decreasing the face-to-face visit schedule*
No shows	*Can be a function of childcare/travel or too busy*	Retention of clients	*Clients who have challenges with traditional visits*
Lack of access in rural settings	*Limited by bandwidth, see USAC/USDA on resources*	Client access	*Home, smort device, Non-traditional setting*

Common Myths

Myth	The Truth	Comments
An in-person visit is required to establish a patient provide relationship	Senate Bill 1107 Removed the requirement	Same standards that apply to an in-person visit also apply to telemedicine
Insurance will not pay the same as in-person visit	Provider reimbursement for telemedicine services must be in the same manner as in-person services. **Source:** *TX Admin. Code, Title 1 Sec. 355.7001. & TX Govt. Code Sec. 531.0217(d)*	A health plan may require a deductible, a copayment, or coinsurance for a covered health care service or procedure delivered as a telemedicine medical service or a telehealth service, **Source:** *TX Insurance Code Sec. 1455.004(b)*
A telemedicine provider cannot prescribe medicines for a client	Same standards and requirements as with an in-person setting, **Source:** *TX Occupations Code 111.005-008*	Treatment of chronic pain with scheduled drugs through use of telemedicine is prohibited, **Source:** *TX Admin. Code, Title 22, Part 9, Ch. 174.5*

Funding Options & Resources

- Universal Services Administrative Company (USAC): https://www.usac.org/rhc/healthcare-connect/default.aspx
- United States Department of Agriculture-Rural Development:, https://www.rd.usda.gov/programs-services/distance-learning-telemedicine-grants
- Use of 340B funds:
  - See www.fiscalhealht.hiv for technical assistance on the use and requirement for 340b funds
  - DSHS guidance from October 2019 Part B meeting
- Ryan White Part B & State Services Funds, work with Services Consultant to arrange funds in grant
- Texas-Telehealth Resource Center, *Resources only:* hardware cost, training, & workbook texlatrc@ttuhsc.edu
- Texas Medical Association (TMA): https://www.texmed.org/Telemedicine/
  - *Resources only*
  - Vendor evaluation tool
  - Contract evaluation
  - CME

Thank you!

Operations Committee Report

Williams, Victoria (County Judge's Office)

From: Angela Hawkins <afhawkins1964@gmail.com>
Sent: Tuesday, September 17, 2019 1:33 PM
To: Williams, Victoria (County Judge's Office)
Subject: Alternative Names for External Committee

Auxiliary Committee Representatives or Members
Fellow Members
Assistant Committee Members
Affiliate Committee Members

Draft

Houston Area HIV Services Ryan White Planning Council
Office of Support

2019 Project LEAP Final Report

Approved: Pending

Prepared by:
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Houston Area HIV Services Ryan White Planning Council
Office of Support
2019 Project LEAP Final Report

Table of Contents

Introduction

"Project LEAP" (*Learning, Empowerment, Advocacy and Participation*) is a locally defined HRSA-funded Service Category for the Houston EMA. Its purpose is to "increase the number and effectiveness of people living with HIV (**PLWH**) and affected others who can participate in organizations, councils, and committees dealing with the allocation of public funds for HIV-related prevention and care services," with an emphasis on increasing participation in the EMA's two local Planning Bodies, the Ryan White Planning Council (**RWPC**) and the Houston HIV Prevention Community Planning Group (**CPG**).

Project LEAP is currently designed as a weekly class spanning 16 weeks including classroom training, out-of-class time observation, and experiential community-based learning. On the 17th week, students are recognized through a graduation ceremony and encouraged to apply to RWP and CPG. Annually, the RWPC reviews and makes recommendations for the Project LEAP Service Definition based on program results and student needs. An External Advisory Panel consisting of representatives from the RWPC, CPG, and Project LEAP alumni also advises Project LEAP.

Beginning in 2012, the RWPC Office of Support (**OS**) assumed responsibility for planning, implementing, and evaluating Project LEAP, including student recruitment, syllabus design, and course facilitation. In its pilot year as an Office of Support project, 29 students enrolled in the program, and 24 students graduated (for an 83% graduation rate). Of graduates, 63% were consumers living with HIV, and 63% applied for either RWPC or CPG membership. Staff conducted the pilot was also conducted at a savings of over $38,000 compared to prior contracted providers.

This report summarizes results from the 2019 Project LEAP cohort, including the ways in which the 2019 syllabus met the objectives outlined in the RWPC-approved Service Definition, the extent of the program's achievement in increasing the knowledge and skills of PLWH and affected individuals, and lessons learned for future program implementation.

Obj. 1: Contact Hours Requirements

From the FY19 Project LEAP Service Definition:

Since 2013, Project LEAP has been designed to include multiple experiential community-based learning opportunities, including direct observations of Planning Body activities. To ensure each Project LEAP student has the same opportunity for community-based learning activities, the FY19 Project LEAP Service Definition requires contact hours for out-of-class time and service learning. The approved contact hours for Project LEAP are as follows:

- No more than two classes will be provided during the [program]
- Each class will include graduation and at least:
    1. 44 contact hours of classroom training;
    2. 6 hours of participation in RWPC or CPG meetings or activities; and
    3. 6 hours of participation in HIV-related community meetings and activities.

From the 2019 Project LEAP Syllabus:

- Two classes were held each week from April 3 – July 17, 2019 (**Figure 1**), including:
    1. 50 hours of classroom training;
    2. 12 hours of participation in RWPC or CPG meetings or activities; and participation in HIV-related community activities;
- For a total of 60 hours of instruction. This is 3 hours *more per class* than the Service Definition requirement.
- A graduation dinner and ceremony was held on July 24, 2019.

Figure 1: Project LEAP Contact Hours, 2019

	FY19 Service Definition (approved 02-14-19)	**2019 Project LEAP Syllabus** (conducted 4-3-19 through 7-17-19)	
Requirement	Number of Hours	Number of Hours	Method
Graduation	n/a	n/a	Graduation ceremony held 7-24-19
Classroom training	44	50	11 weekly classroom sessions conducted at 4 hours/session; 6 hours of classroom sessions before RWPC, CPG, and Steering Committee mtgs
PC/Community participation	12	12	Student attendance at 1 RWPC mtg (2 hrs), 1 CPG mtg (2 hrs), 1 Steering Committee mtg (2 hrs), 1 community mtg (2 hrs), and participation in 1 volunteer shift collecting Needs Assessment surveys (4 hrs)
Total per class	56	62	
Number of classes	≤2	2	
Total contact hours	56-112	124	

Obj. 1: Curriculum Requirements

FY19 Project LEAP Service Definition curriculum requirements met through curriculum:

1. Information on PrEP; & sources & purposes of HIV service funds in Houston EMA/HSDA

- ☑ Week #2 (4/10/19): Panel – Barriers to Reaching, Linking, & Retention in Care with Epidemiology Overview & Special Populations *(Meyer, Watley-Calloway, Martin, Sierra, Koroma, & Johnson)*
- ☑ Week #2 (4/10/19): Overview of HIV Care Funds & RW Program: HRSA to Council and Designing HIV Care Services: HTBMN (*Williams*)
- ☑ Week #3 (4/17/19): HIV Prevention Program: CDC to CPG Panel (*Campbell, Townsend & Vargas*)
- ☑ Week #4 (4/24/19): END HIV Houston (*Townsend*)
- ☑ Week #10 (6/5/19): Overview of Housing Opportunities for People with HIV/AIDS (*Barr*)
- ☑ Week #13 (6/26/19): PrEP (*Gibson*)
- ☑ Week #14 (7/3/19): Attendance at Steering Committee meeting (*Williams*)

2. Structure, functions, & procedures of the RWPC/CPG

- ☑ Week #1 (4/3/19): History of HIV in the Houston Area Interactive Exercise (*Vargas & Williams*)
- ☑ Week #2 (4/10/19): Overview of HIV Care Funds & RW Program: HRSA to Council and Designing HIV Care Services: HTBMN (*Williams*)
- ☑ Week #3 (4/17/19): PB & Jelly Exercise (Function of Policies & Procedures) (*Harbolt*)
- ☑ Week #7 (5/15/19): Conflict of Interest (*Williams*)
- ☑ Week #8 (5/23/19): Attendance at a CPG meeting
- ☑ Week #11 (6/13/19): Attendance at Ryan White Planning Council (RWPC) meeting
- ☑ Week #12 (6/19/19): Training and Exercise on the P&A Process (*Williams*)
- ☑ Week #12 (6/19/19): Organizing Graduation/Robert's Rules of Order Practice (*Williams*)
- ☑ Week #14 (7/3/19): RWPC and CPG Application Process (*Williams*)
- ☑ Week #16 (7/18/18): Project LEAP to Planning Body (*Oshingbade, Cruz, Pradia, & Fergus*)

3. Needs assessments; parliamentary procedures & meeting mgmt; presentation skills; RFP; accessing & utilizing resources/role models; organizational participation & conduct

- ☑ Week #1 (4/3/19): Introduction to Robert's Rules of Order (*Williams*)
- ☑ Week #3 (4/17/19): Community Needs Assessment (*Harbolt*)
- ☑ Week #3 (4/17/19): LEAP Project – Needs Assessment Survey Training (*Harbolt*)
- ☑ Week #4 (4/24/19): Robert's Rules of Order Exercise (*Williams*)
- ☑ Week #4 (4/24/19): Advocacy 101 (*Ray*)
- ☑ Week #5 (5/1/19): Leadership Skills and Team Building (*Alexander*)
- ☑ Week #7 (5/15/19): Epidemiology Profile and EIHA Strategy (*Harbolt*)
- ☑ Week #7 (5/15/19): The RFP Process (*Williams*)
- ☑ Week #9 (5/29/19): LEAP Special Study Project – Organize Class Presentation (*Harbolt*)
- ☑ Week #10 (6/5/19): Training on HIV Resources/Blue Book Treasure Hunt (*Beck & Williams*)
- ☑ Week #11 (6/13/19): LEAP Project –Presentation Practice (*Harbolt*)
- ☑ Week #11 (6/13/19): Presentation of LEAP Project to RWPC
- ☑ Week #13 (6/26/19): Community Meeting Report-Backs (*Williams*)

Ongoing: Weekly designation of meeting chairs, weekly practice with Robert's Rules and following meeting agendas, regular in-class small/large-group activities requiring student presentations

4. HIV-related Standards of Care, quality assurance methods, & HRSA service category definitions

- ☑ Week #2 (4/10/19): Designing HIV Care Services: HTBMN (*Williams*)
- ☑ Week #3 (4/17/19): HIV Care Continuum (*Harbolt*)
- ☑ Week #14 (7/3/19): Comprehensive HIV Planning (*Harbolt*)
- ☑ Week #14 (7/3/19): Training on Standards of Care and Performance Measures (*Harbolt*)

Obj. 2: Class Composition vs. Current HIV Prevalence

From the FY19 Project LEAP Service Definition:

- Identify and provide training to 20-30 PLWH, and no more than 10 affected others in order for them to receive the necessary skills and knowledge to participate in the decision-making process to fund and allocate public money to HIV-related services in the Houston EMA/HSDA.
- The race, ethnicity, and gender composition of the classes must reflect current local HIV prevalence data to the extent feasible.
- Endeavor to enroll individuals from groups that are disproportionally affected by HIV, including youth and transgender PLWH.

From the 2019 Project LEAP Cohort (**Figure 2**):

- T PLWH (19 of whom were Ryan White consumers) and 7 affected others were enrolled at the beginning of the 2019 Project LEAP program. No young adults (age 18-24) enrolled.
- Of graduating students, 15 were PLWH (75%), and five were affected (25%).
- Compared to HIV prevalence proportions for the Houston EMA, greater proportions of black, non-Hispanic (63% vs. 48%) and female students (41% vs. 25%) enrolled in the program.
- Two transgender students enrolled in the program and one graduated.

Figure 2: Project LEAP Class Composition, 2019

	EMA HIV Prevalence (as of 12/31/18)		2019 Project LEAP Enrollees (as of 4/4/19)		2019 Project LEAP PLWH Enrollees (as of 4/4/19)		2019 Project LEAP Graduates (as of 7/24/19)	
Race/Ethnicity	#	%	#	%	#	%	#	%
White, not Hispanic	5,109	18	5	19	4	22	5	25
Black, not Hispanic	14,044	48	17	63	14	78	11	55
Hispanic	8,493	29	4	15	*	*	3	15
Multiracial	1,025	4	1	4	*	*	1	5
Other/Unknown	407	1	0	0	0	0	0	0
Total	29,078	100	27	100	18	100	20	100
Sex at Birth	#	%	#	%	#	%	#	%
Male	21,829	75	14	52	12	63	12	60
Female	7,249	25	11	41	7	34	7	35
Transgender	n/a	n/a	2	7	*	*	1	5
Total	29,078	100	27	100	19	100	20	100
Age	#	%	#	%	#	%	#	%
13 – 24 years**	1,170	4	0	0	0	0	0	0
Total	1,170	4	0	0	0	0	0	0

*Data suppressed to maintain confidentiality

**Project LEAP youth enrollees and graduates reflect 18-24 years

Obj. 2: Course Completion

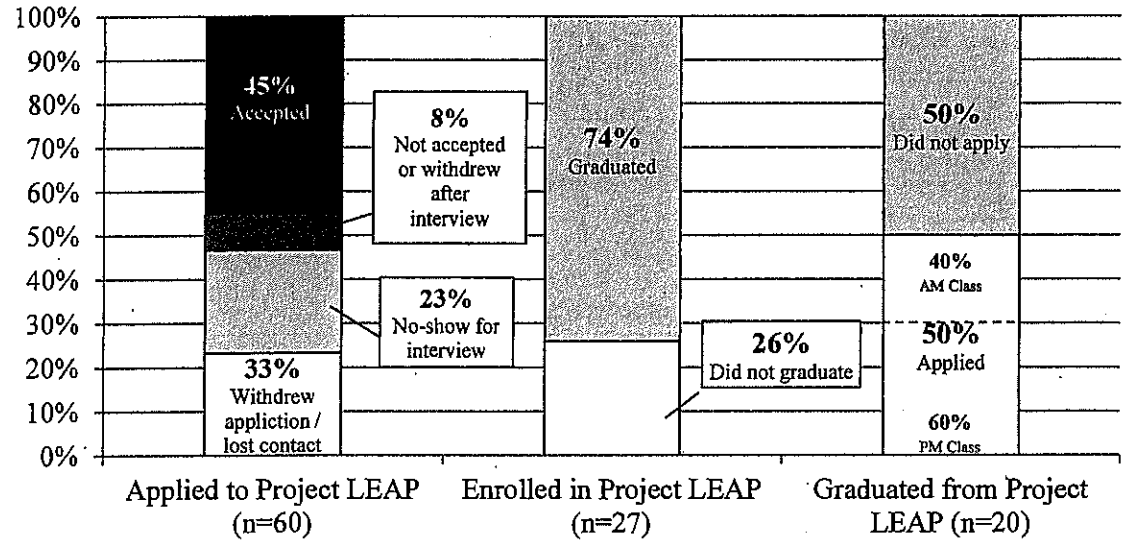
From the FY19 Project LEAP Service Definition:

- Identify and provide training to 20-30 PLWH, and no more than 10 affected others in order for them to receive the necessary skills and knowledge to participate in the decision-making process to fund and allocate public money to HIV-related services in the Houston EMA/HSDA.
- Establish realistic training schedules that accommodate varying health situations of participants.

From the 2019 Project LEAP Cohort (**Figures 3**):

- Sixty individuals applied for 2019 Project LEAP, and 14 applicants withdrew from the interview process or could not be contacted after they applied. The remaining 46 applicants had interviews scheduled. Fourteen applicants did not show up for their interviews, five applicants were interviewed but withdrew or were not accepted into the program, and 27 applicants were enrolled.
- Out of the 27 students enrolled, 20 graduated from the program, for a graduation rate of 74%, down from 86% in 2018. Reasons for attrition were changes in work schedule, needing to care for a family member, and conflicts with other priorities. Three students enrolled, but never attended class. Four students attended classes, but did not complete the course.
- Average weekly class size was 12 students for the morning class, and eight students for the evening class. Weeks involving off-site locations or alternate days/times correlated with higher absences. Eight students had perfect attendance.
- When asked about next steps after Project LEAP, 53% of graduates planned to apply to RWPC or an External Committee; 47% planned to apply to CPG, 16% planned to join a Community Advisory Board (**CAB**), 42% planned to join a Task Force, and 21% planned to sign up for PLWH advocacy training like the Positive Organizing Project.
- Ten students (or 50% of the graduating class) submitted applications to RWPC for PC (5) and/or External Committee (10) membership. One LEAP student was already serving on PC. As of October 2019, nine students applied to CPG.

Figure 3: Project LEAP Application, Enrollment, and Course Completion, 2019



Obj. 2: Pre/Post-Training Evaluation

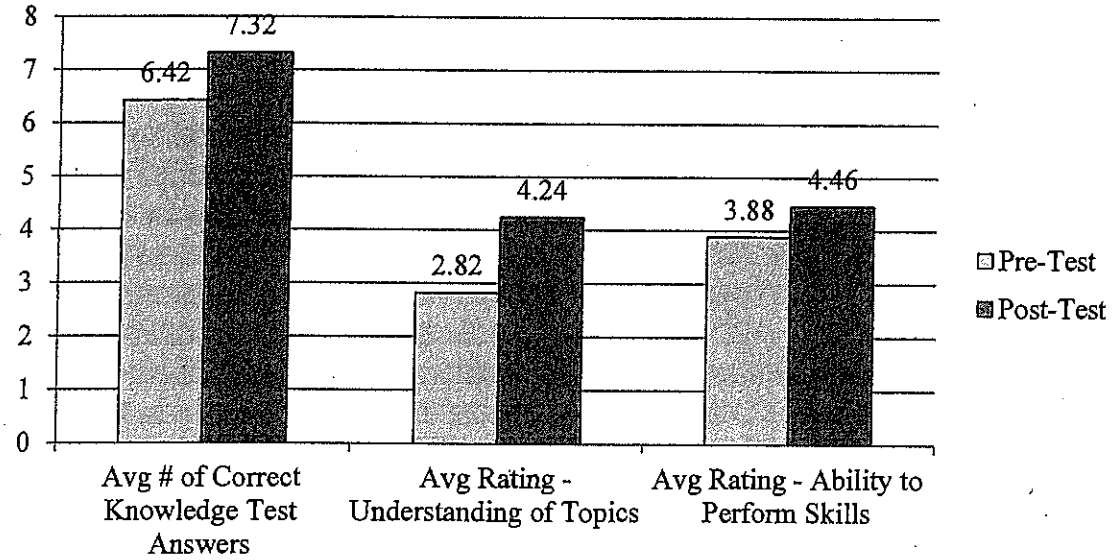
From the FY19 Project LEAP Service Definition:

- Conduct a pre-training evaluation to determine knowledge and beliefs concerning HIV disease and understanding of HIV-related funding processes.
- Conduct a post-training evaluation to measure change.

From the 2019 Project LEAP Cohort:

- A matched pre-training and post-training evaluation was conducted at Weeks 1 and 16. The evaluation tool (**See Attachment**) included the following:
  1. A 10-item fact-based multiple choice quiz specific to Service Definition topics measuring change in knowledge;
  2. A self-assessment of understanding of Service Definition topics (1 = "not well"; 5 = "very well") measuring self-assessed change in understanding; and
  3. A self-assessment of ability to perform the skills or activities required by the Service Definition (1 = "not well"; 5= "very well") measuring self-assessed change in skills.
- Nineteen students were evaluated at both pre and post with the following results (**Figure 4**):
  1. The average number of correct answers to the multiple choice knowledge assessment questions increased from 6.42 to 7.32, or a 14% increase in average knowledge scores.
  2. The average self-assessment rating of understanding increased from 2.82 to 4.24 (out of 5), or a 50% increase in self-assessed understanding.
  3. The average self-assessment rating of ability to perform skills or activities increased from 3.88 to 4.46 (out of 5), or a 15% increase in self-assessed skills.
  4. The greatest improvements occurred in: knowledge of the purpose of Standards of Care; understanding of structure and functions of the RWPC; and ability to access community resources.

Figure 4: Project LEAP Pre/Post-Training Evaluation Results, 2019



Obj. 2: Process Evaluation and Lessons Learned

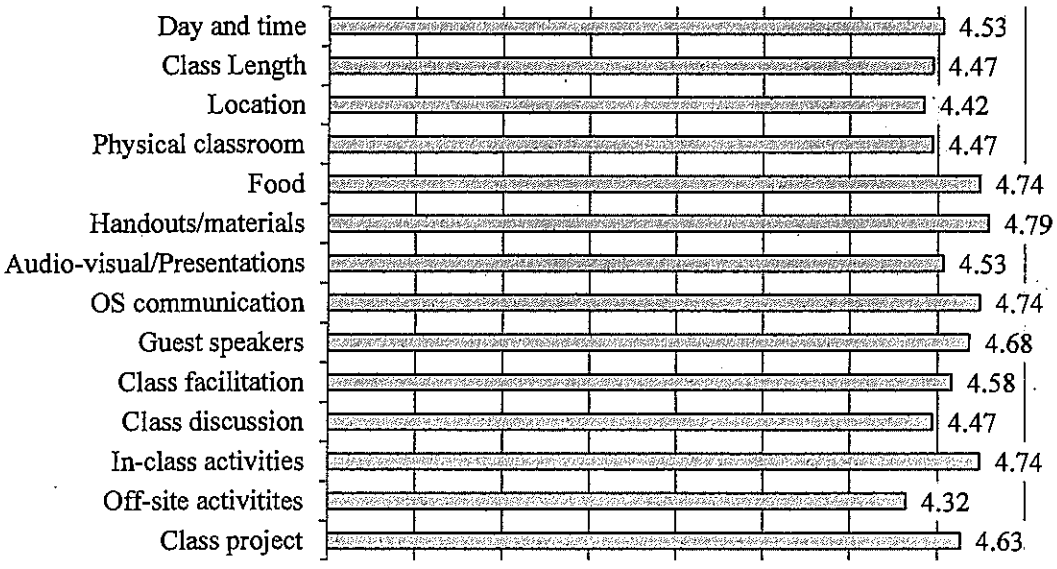
From the FY19 Project LEAP Service Definition:

- Enhance the participation of PLWH and affected persons participating in this project.
- Provide both lecture and hands-on experiential class activities to enable participants to maximize opportunities for learning.

From the 2019 Project LEAP Syllabus and Cohort:

- A variety of teaching methods was employed to meet the Service Definition:
  1. *Lectures*: included 24 guest speakers (in addition to three Office of Support staff/facilitators)
  2. *Hands-on activities*: 100% of classroom sessions included an interactive activity (e.g., Robert's Rules practice, Needs Assessment project development, team-building activities, group discussion, and report-back)
  3. *Experiential activities*: Graduation requirements included a class project, attendance at a community meeting, and a volunteer shift surveying for the Needs Assessment. Three weeks of class occurred at a RWPC, Committee, or CPG meeting.
- Staff assessed course instruction quality in each class.
  1. Students named their favorite part of class, and anything that could have been added, changed, or done differently. Staff reviewed this feedback and made adjustment as necessary.
  2. Students were also asked to rate the general quality of each class on a 5-point scale, with a rating of 1 indicating poor quality, and 5 indicating excellent quality. Overall, classes received an average rating of 4.77/5 - Excellent. The final class received an average rating of 4.93/5 - Excellent.
- Staff assessed course logistics quality at the end of the course. (**Figure 5**)
- Average ratings were highly favorable, with all course logistics elements rated "Very Good" (14%) or "Excellent" 86%). The highest rated logistics element handouts and materials provided with an average score of 4.79. Though still rated "Very Good", the logistics element with the lowest rating was off-site activities with an average score of 4.22

Figure 5: Project LEAP Logistics, Evaluation Ratings (1=Very Poor, 5=Excellent), 2019



Obj. 2: Process Evaluation and Lessons Learned (Con't)

- Staff measured general impressions of course quality at the end-point. As of the final Project LEAP 2019 class:
  1. 89% of students felt better able to be productive planning body members following Project LEAP.
  2. 100% of students were pleased with their decision to participate in Project LEAP and would recommend Project LEAP to someone else.
  3. 100% of students agreed or strongly agreed that Project LEAP made them more knowledgeable about HIV prevention and care services planning.

- Staff collected qualitative data at the end-point with an open-ended question inviting students to suggest ways of making Project LEAP even better in the future:
  1. Allow more time for questions and answers
  2. Recruit younger students (suggested ages 18-35); suggested offering a small incentive for attending the evening class or a ½ day class on Saturdays
  3. Add a session on HIV treatment regimens (different medication combinations, medication adherence, pricing, ADAP, potential new treatments in the pipeline like injectable or implant)
  4. Allow for class to attend more RWPC meetings

Remaining responses complimented the quality of the class, facilitators, and course content.

"It Has Given Me a Voice to Be Heard.": The Life-Changing Impact of Project LEAP

Near the end of the course, the 2019 Project LEAP students were asked to share the impact of the program had on their lives. The quotes were displayed in a presentation that played during the graduation ceremony. The following quotes convey sentiments shared by many of the students:

- As a long-term 30+ year survivor, Project L.E.A.P. has introduced me to the current face of PLHIV. I have gained invaluable insight, education and the necessary skills to help empower these faces to live the best of all possible lives.
- I have learned a lot about HIV, how to avoid HIV, how to take care of yourself and be careful.
- It has given me more understanding of the epidemic. It has made me appreciate science and research. It has made me appreciate humanity. It has made me want to give more to the society. It has given me a voice to be heard.
- Tikkun Olam (Hebrew) = Repairing a Broken World
- Project LEAP has been a wonderful prism to explore the complicated issues surrounding HIV and care in the Greater Houston area. It has been a blessed 17 weeks of building community with other passionate advocates and challenging ourselves to see the complexities of addressing the epidemic.
- LEAP gave me a lot of valuable information that I will take with me, but most of all it gave me a group of remarkable new friends that I will always be forever grateful for meeting.
- Project LEAP has been a combination of motivation, inspiration, education, exposure, gratitude, community and foundation. It has been a thought provoking program that makes me want to know more and do more for the HIV community. I am a proud leader!
- Project LEAP: Brought me knowledge and new friends.
- KNOWLEDGE - What can be done to help create change how change takes place at the RWPC; EMPOWERED - How to do things when to do things (proper way); DESIRE - Willingness to do something about the disease; STRENGTH - To stand up and say "I do matter, I am not just a number or statistic".
- I am grateful for the vast amount of HIV education and information. As a graduate of Project LEAP I will continue to be a positive role model who has lived with HIV for over 30 years.
- Knowledge from Project LEAP has been empowering making me realize that my voice counts.
- I am a voice for the voiceless.
- Project LEAP has empowered me to become an HIV activist in the community by using my voice to end new HIV transmission and linked PLHIV into care.
- An opportunity to learn what Ryan White does for the Houston area.
- I want to thank Ryan White, visiting agencies and all the presenters for sharing. The more knowledge we acquire the greater outcomes in the future.
- I am so glad that I made a decision to become part of Project LEAP class. The knowledge I have gained is incredible. Project LEAP has granted me the chance to stop being apart on the sideline of the HIV field, I am ready to be an actual and formal advocate
- Being a Long Term survivor: I know how hard it is to get and stay connected. My goal is to "Help others" with the connection process. Project LEAP has given me the tools to do Just That. Thanks Project LEAP!

"It Has Given Me a Voice to Be Heard.": The Life-Changing Impact of Project LEAP

Continued

- I'm learning more about health and things that I was confused with. I'm not anymore and I learn a lot with Ms. Tori and Ms. Amber and the speakers!
- The Project LEAP program has been informative. All the way from where it started and where we are now and the challenges that have been overcome by people who were passionate, dedicated advocates to the cause.

Budget Information and Comparison

Original Cost of the Program:	$ 52,000
2019 Cost of the Program:	$ 14,407
Total Savings:	**$ 37,593**

2019 Expenses:

Supplies	$ 635
Facilities Rental	399
Speaker Fees	300
Student Reimbursement	4,293
Mileage	3,873
Dependent care	420
Meals and Snacks	8,133
Staff Mileage	0
Miscellaneous (graduation shirts)	647
TOTAL	**$14,407**

See next page for Project LEAP Budget Comparison, 2012 – 2019

Project LEAP Budget Comparison, 2012 – 2019

Item	2012 Expenses	2013 Expenses	2014 Expenses	2015 Expenses	2016 Expenses	2017 Expenses	2018 Expenses	2019 Expenses
Supplies	$ 1,182	$ 1,159	$ 523	$ 638	$ 493	$ 466	$ 873	$ 635
Facilities Rental	268	875	318	274	1,158	724	364	399
Speaker Fees	0	0	0	0	100	100	100	300
Student Reimbursement Transportation Dependent Care	 3,294 560	 3,178 705	 4,878 0	 1,031 0	 1,242 0	 4,525* 0	 3,488 0	 3,873 420
Food	7,844	5,897	7,553	4091	3,734	6,989	7,295	8,133
Staff Mileage	200	25	20	20	20	0	0	0
Miscellaneous	630	858	809	301	494	1,020	1,144	420
TOTAL	**$13,978**	**$12,697**	**$14,100**	**$6,355****	**$7,241****	**$13,824**	**$13,264**	**$14,407**

****IMPORTANT**: Please note that 2015 and 2016 expenses are significantly less than in previous years because there were no evening classes.

Acknowledgments

Project LEAP 2019 was a collaboration of the:

Houston Area HIV Services Ryan White Planning Council and the Houston Health Department Bureau of HIV/STD & Viral Hepatitis Prevention

Project LEAP 2019 was made possible by the following individuals:

Project LEAP Advisory Committee

Rosalind Belcher, Co-Chair
Crystal Starr, Co-Chair

Mona Cartwright-Biggs
Bobby Cruz
Johnny Deal
Ronnie Galley
Eddie Givens
Kelvin Harris
Tiffany Jones
Denis Kelly
Rodney Mills
John Poole
Tana Pradia
Isis Torrente

Guest Speakers

Mike Alexander
MLA Consulting

Melody Barr
Houston Department of Housing & Community Development

Samantha Bowen
Ryan White Grant Administration

W. Jeffrey Campbell
Governmental Co-Chair, Community Planning Group; Houston Health Department

Bobby Cruz
Member, Ryan White Planning Council

Ahmier Gibson
Legacy Community Health

Angela F. Hawkins
Member, Ryan White Planning Council

Nettie Johnson
Baylor Teen Health Clinic

Sha'Terra Johnson-Fairley, LMSW
The Resource Group

Kathryn Fergus
Member, Community Planning Group; AIDS Healthcare Foundation

Juma Koroma
Legacy Community Health

Kevin Martin
AIDS Foundation Houston

Jeffrey Meyer, MD, MPH
Houston Health Department

Scot More
Houston Coalition for the Homeless

John Nechman
Katine & Nechman L.L.P.

Cecilia Oshingbade
Founder, Living Without Limits Living Large

Tana Pradia
Secretary, Ryan White Planning Council
Member, Community Planning Group

Venita Ray
Positive Women's Network

Gloria Sierra
Member, Ryan White Planning Council
Texas Children's Hospital

Paul Simmons, MSN, NP-C
Legacy Community Health

Crystal Townsend
Community Co-Chair, Community Planning Group; The Resource Group

Steven Vargas
Community Co-Chair Elect, Community Planning Group;; Association for the Advancement of Mexican Americans

Desmond Watley-Calloway
AIDS Foundation Houston

Lou Weaver
Equality Texas

Office of Support Staff

Tori Williams, Director
Amber Harbolt, Health Planner
Diane Beck, Council Coordinator
Rodriga Avila, Assistant Coordinator

HHD Staff

Marlene McNeese, Assistant Director
Cathy Wiley, Training Administrator

Attachments

- FY19 Project LEAP Service Definition (approved 02-14-19)
- 2019 Project LEAP Course Overview
- 2019 Pre/Post-Training Evaluation Forms

Service Category Title: Grant Administration - Project LEAP

Unit of Service Definition:
1 unit of service = 1 class hour of training to Project L.E.A.P. participants. No other costs may be billed to the contract issued for Project LEAP.

GOAL: Agency will increase the number and effectiveness of People Living With HIV (PLWH) and the affected community who can participate in organizations, councils and committees dealing with the allocation of public funds for HIV-related prevention and care services, through an effort known as "Project LEAP" (Learning, Empowerment, Advocacy and Participation). Enrollment should include 20 to 30 persons who are living with HIV. No more than 10 individuals are to be enrolled in the training program who are affected by HIV. The race, ethnicity and gender composition of the classes must reflect current local HIV prevalence data to the extent feasible. Agency will prioritize to enroll individuals from groups that are disproportionally affected by HIV disease, including youth and transgender persons living with HIV, in Project LEAP.

Project LEAP will increase the knowledge, participation and efficacy of PLWH and affected participants through a training program specifically developed to provide PLWH and affected persons with the knowledge and skills necessary to become active, informed, and empowered members of HIV planning bodies and other groups responsible for the assessment of HIV-related prevention and service needs in the Houston EMA/HSDA. The primary focus of training is to prepare participants to be productive members of local HIV planning bodies, with an emphasis on planning activities conducted under the auspices of the Houston Ryan White Planning Council (RWPC).

Each class provided during the term of this agreement will include graduation and at least:

A. 44 contact hours of classroom training;

B. 6 hours of participation in Ryan White Planning Council and/or Committee related activities; and

C. 6 hours of participation in HIV-related community activities.

There will be no more than 2 classes at 56 hours per class. The Council-approved minimum outline for the training curriculum includes: HIV funding sources, general and specific operational procedures of HIV-related planning bodies, information regarding assessment of the needs of PLWH in the Houston EMA/HSDA, a general understanding of an RFP process, organizational case studies and mentoring, presentation skills, knowledge related to accessing services, overview of HIV-related quality assurance (QA) processes and parliamentary procedure/meeting management skills.

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their participation, limited to transportation, childcare, and meals. Agency agrees to provide Harris County Public Health (HCPH)/Ryan White Grant Administration (RWGA) and the Houston RWPC with written reports and project summaries as requested by Harris County and in a form acceptable to Harris County, regarding the progress and outcome of the project.

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Objective 1: Agency will identify and provide training to at least 20 persons who are living with HIV and no more than 10 affected individuals in order for them to receive the necessary skills and knowledge to participate in the decision-making process to fund and allocate public money to HIV-related services in the Houston EMA/HSDA. The following training curriculum shall be provided:

1. Information on PrEP and the sources and purposes of HIV service funds in the Houston EMA/HSDA;
2. The structure, functions, policies and procedures of the Houston HIV Health Services Planning Council (Ryan White Planning Council/RWPC) and the Houston HIV Prevention Community Planning Group (CPG);
3. Specific training and skills building in needs assessments, parliamentary procedures and meeting management procedures, presentation skills, a general understanding of an RFP process, accessing and utilizing support resources and role models, and competence in organizational participation and conduct; and
4. Specific training on HIV-related Standards of Care, quality assurance methods and HRSA service category definitions.

Objective 2: Agency will enhance the participation of the people living with HIV and affected persons in the decision-making process by the following documented activities:

1. Establishing realistic training schedule(s) which accommodate varying health situations of those selected participants;
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3. Conducting a post-training evaluation to measure the change in participants knowledge and beliefs concerning HIV disease and understanding of HIV-related funding processes in the Houston area;

4. Providing reimbursement of allowable expenses to help defray costs of the individual's participation, limited to transportation, child care, and meals; and
5. Providing both lecture and hands-on experiential class activities to enable participants to maximize opportunities for learning.

Objective 3: Agency will encourage cooperation and coordination among entities responsible for administering public funds for HIV-related services by:

1. Involving HCPH/RWGA, The Houston Regional HIV/AIDS Resource Group (TRG) and other administrative agencies for public HIV care and prevention funds in curriculum development and training activities;
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   - Review the final report for the Project in order to highlight the successes and brainstorm/problem solve around issues identified in the report. The results of the review will be sent to the Ryan White Operations Committee and the next Advisory Panel.
3. Collaborating with the Project LEAP External Advisory Panel during the initial 60 days of the Contract term. The criteria developed and utilized will, to the maximum extent possible, ensure participants selected represent the groups most affected by HIV disease, consistent with current HIV epidemiological data in the Houston EMA/HSDA, including youth (ages 18-24) and transgender persons living with HIV.

Agency will provide RWGA with the attached matrix and chart 21 and 14 days before the first class and again the day after the first class demonstrating that the criteria established by the Project LEAP External Advisory Panel was met. The matrix must be approved by RWGA 14 days before the first class.

Council approved: 02-14-19

EXAMPLE

Recommended Project LEAP Class of 2018

Candidate	M	F	T	HIV+	Non-Aligned HIV+	W	B	H	Youth Age 18 – 19	Youth Age 20 – 24
1	X			X	X	X				
2		X		X			X		X	
3		X					X			X
4		X		X	X			X		X
5	X					X				
6	X			X	X		X			
7	X			X	X	X				
Totals	4	3		5	4	3	3	1	1	2

	EMA HIV/AIDS prevalence as of 12/31/10*		PC Members as of 09/01/11		Non-Aligned Consumers on PC	
Race/Ethnicity	No.	%	No.	%	No.	%
White, not Hispanic	5,605	26.85%	7	19.44%	4	25.00%
Black, not Hispanic	10,225	48.98%	19	52.78%	8	50.00%
Hispanic	4,712	22.57%	10	27.78%	4	25.00%
Other	333	01.60%	0	00.00%	0	0.00%
Total*	20,875	100%	36	100%	16	100%
Gender	Number	Percentage	No.	%	No.	%
Male	15,413	73.83%	21	58.33%	11	68.75%
Female	5,462	26.17%	15	41.67%	5	31.25%
Total*	20,875	100%	36	100%	16	100%

*Data are estimated cases adjusted for reporting delay. The sum total of estimates for each category may not match the EMA totals due to rounding.

Houston Area HIV Services Ryan White Planning Council
Office of Support

Project L.E.A.P. 2019 Course Overview

**Class will take place at an alternate location, day, and/or time*

Course Key: Classroom | Guest Speaker | In-Class Activity | Off-Site Class | Group Project | Deadline | Graduation

Week	Date	Topics	Key
1	April 3 Room 416	• Overview of Project LEAP • Housekeeping, Logistics, and Ground Rules • Student Introductions and Expectations • HIV, TB and Hepatitis • Introduction to Robert's Rules of Order • The History of HIV in the Houston Area	
2	April 10 Room 416	• Epidemiology Overview • Panel: Barriers to Reaching, Linking & Retention in Care, focusing on African Americans, Hispanics, MSM and Youth • Overview of HIV Care Funds • From HRSA to Council: Overview of the Ryan White Program • Designing HIV Care Services: How to Best Meet the Need	
3	April 17 Room 416	• HIV Prevention Programs: CDC to CPG • Needs Assessment and the Continuum of Care • LEAP Special Study Project –Survey skills training • Policies and Procedures: the PB&J Exercise	
4	April 24 Room 416	• Robert's Rules of Order Exercise • END HIV Houston Plan • Advocacy 101	
5	May 1 Room 416	• Leadership and Presentation Skills Building	
6	May 8	Participate in Data Collection at a Survey Site – no class	
7	May 15 Room 416	• Health Literacy • Introduction to Transgender Topics • General Overview: Epi Report and EIIHA Strategy • Conflict of Interest and the RFP Process • Prepare for CPG Meeting	

Course Key: Classroom Guest Speaker In-Class Activity Off-Site Class Group Project Deadline Graduation

Week	Date	Topics	Key
8	May 22 (Keep Room 416)	Attend the HIV Prevention Community Planning Group (CPG) Meeting • LEAP Special Study Surveys Due	
9	May 29 Room 416	• LEAP Special Study Project – analyze data, prepare class presentation • The Criminalization of HIV	
10	June 5 Room 416	• Homelessness and HIV • Housing Opportunities for Persons with AIDS (HOPWA) • Blue Book Treasure Hunt • LEAP Special Study Project –practice presentation	
11	**THURSDAY** June 13 Room 532	Attend the RWPC Meeting and Present the Class Special Study Project	
12	June 19 Room 416	• Plan for LEAP Graduation – Student photos • Priority and Allocations Exercise	
13	June 26 Room 416	• Intimate Partner Violence & HIV • Plan for LEAP Graduation – Order shirts • Community Meeting Report-Backs • Student Choice: PrEP	
14	**BOTH CLASSES 10am** July 3 Room 416	• Ryan White Standards of Care & Performance Measures • Council and CPG Application Process/Forms • Community Meeting Report-Backs • Steering Committee Meeting	
15	July 10	Attend a Community Meeting – no class	
16	July 17 Room 416	• From Project LEAP to Planning Body: Panel of Planning Body and C.A.B. Members • Word Cloud Review • Mock Interviews • Course Wrap-Up	
17	July 24	Graduation Dinner and Ceremony	

Houston Area HIV Services Ryan White Planning Council
Office of Support
Project L.E.A.P. 2019 *Knowledge Assessment*

The purpose of this questionnaire is to measure your understanding of core Project L.E.A.P. topics and skills *before* the course begins. You will complete the same questionnaire at the end of the course. We will then compare both questionnaires. This comparison helps us know how well we did in reaching our goal to help your Project L.E.A.P. class improve its HIV Community Planning knowledge, skills, and abilities.

Today's Date: 04/03/2019

First Name: _____ **Last Name:** _____

***Please know that the only reason we need your name on this form is to match it to the questionnaire you will complete at the end of the course. Your name will not be used for any other reason.*

Please rate how well you currently understand each of the following topics:

I understand...	Very Well	Quite Well	Fairly Well	A Little	Not at All
The sources and purposes of HIV care, treatment, and support services funding	☐	☐	☐	☐	☐
The structure and function of the Houston Ryan White Planning Council (RWPC)	☐	☐	☐	☐	☐
The structure and function of the Houston HIV Prevention Community Planning Group (CPG)	☐	☐	☐	☐	☐
HRSA service category definitions for HIV care, treatment, and support	☐	☐	☐	☐	☐
HIV-related Standards of Care and quality assurance methods	☐	☐	☐	☐	☐

Please rate how well you can currently perform each of the following skills or activities:

I can...	Very Well	Quite Well	Fairly Well	A Little	Not at All
Read and understand needs assessments	☐	☐	☐	☐	☐
Use Robert's Rules of Order	☐	☐	☐	☐	☐
Engage in public speaking and give presentations	☐	☐	☐	☐	☐
Access community resources	☐	☐	☐	☐	☐
Serve as a role model	☐	☐	☐	☐	☐
Work in a group setting	☐	☐	☐	☐	☐

1. **What is the purpose of the Ryan White HIV Program?** *Select one:*
   - Ⓐ To provide routine HIV testing in all health care settings
   - Ⓑ To provide emergency and/or transitional housing for People Living with HIV
   - Ⓒ To provide HIV-related care, treatment, and support services for those who may not have sufficient resources to manage their HIV
   - Ⓓ To lobby for new state and local legislation regarding HIV

2. **What federal agency funds the Ryan White HIV Program?** *Select one:*
   - Ⓐ Centers for Disease Control and Prevention (CDC)
   - Ⓑ Health Resources and Services Administration (HRSA)
   - Ⓒ U.S. Department of Housing and Urban Development (HUD)
   - Ⓓ Office of National HIV/AIDS Policy (ONAP)

3. **What federal agency funds HIV prevention activities in states and cities?** *Select one:*
   - Ⓐ Centers for Disease Control and Prevention (CDC)
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   - Ⓒ U.S. Department of Housing and Urban Development (HUD)
   - Ⓓ Office of National HIV/AIDS Policy (ONAP)

4. **Which Houston Ryan White Planning Council document contains data on consumer-reported HIV care needs?** *Select one:*
   - Ⓐ Assessment of the Administrative Mechanism
   - Ⓑ Epidemiologic Profile
   - Ⓒ "Blue Book" Resource Guide
   - Ⓓ Community Needs Assessment

5. **What is the main responsibility of the Houston Ryan White Planning Council?** *Select one:*
   - Ⓐ To manage Ryan White A, B, and State Services contracts
   - Ⓑ To give feedback and recommendations on HIV testing and prevention activities
   - Ⓒ To design and attach Ryan White A, B, and State Services funding to HIV care and treatment services
   - Ⓓ To raise community awareness of HIV

6. **Which of the following is a Conflict of Interest?** *Select one:*
   - Ⓐ A Council member votes on a motion for a service that they could potentially gain from personally, professionally, or financially
   - Ⓑ A Council member votes on a motion for a service that they use
   - Ⓒ A Council member serves on an HIV Task Force
   - Ⓓ A Council member used to work for a funded agency several years ago

7. **In the Houston Area, what do the Administrative Agents do?** *Select one:*
   - Ⓐ Provide direct services to Ryan White consumers
   - Ⓑ Distribute HIV care funds by contracting with agencies that provide direct services to Ryan White consumers
   - Ⓒ Bring tasty snacks to all the meetings
   - Ⓓ Provide support to the Planning Council

8. **Which of the following is an activity of the Houston Ryan White Planning Council (RWPC)?** *Select one:*
   - Ⓐ Assessing the needs of People Living with HIV
   - Ⓑ Allocating Ryan White HIV Program dollars
   - Ⓒ Maintaining a Comprehensive Plan
   - Ⓓ All of the above

9. **Which organization provides HIV/STD prevention education and testing, and supports to the Houston HIV Prevention Community Planning Group (CPG)?** *Select one:*
   - Ⓐ Ryan White Grants Administration (RWGA)
   - Ⓑ Houston Health Department (HHD)
   - Ⓒ Houston Regional HIV/AIDS Resource Group (TRG)
   - Ⓓ Texas Department of Health and Human Services (DSHS)

10. **What is the purpose of a Standard of Care, as it relates to HIV services?** *Select one:*
    - Ⓐ To determine whether an agency gets funding from Ryan White
    - Ⓑ To set the minimum level of quality for HIV services
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11. **Take a deep breath, and give yourself a pat on the back! You did marvelously.** ☺

Houston Area HIV Services Ryan White Planning Council
Office of Support
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Today's Date: 07/17/2019

First Name: _____ **Last Name:** _____

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DRAFT

Advisory Committee approved: 11-11-19

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DRAFT

Advisory Committee approved: 11-11-19

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3		X					X			X
4		X		X	X			X		X
5	X					X				
6	X			X	X		X			
7	X			X	X	X				
Totals	4	3		5	4	3	3	1	1	2

	EMA HIV/AIDS prevalence as of 12/31/10*		PC Members as of 09/01/11		Non-Aligned Consumers on PC	
Race/Ethnicity	**No.**	**%**	**No.**	**%**	**No.**	**%**
White, not Hispanic	5,605	26.85%	7	19.44%	4	25.00%
Black, not Hispanic	10,225	48.98%	19	52.78%	8	50.00%
Hispanic	4,712	22.57%	10	27.78%	4	25.00%
Other	333	01.60%	0	00.00%	0	0.00%
Total*	**20,875**	**100%**	**36**	**100%**	**16**	**100%**
Gender	**Number**	**Percentage**	**No.**	**%**	**No.**	**%**
Male	15,413	73.83%	21	58.33%	11	68.75%
Female	5,462	26.17%	15	41.67%	5	31.25%
Total*	**20,875**	**100%**	**36**	**100%**	**16**	**100%**

*Data are estimated cases adjusted for reporting delay. The sum total of estimates for each category may not match the EMA totals due to rounding.

DRAFT

2020 Project LEAP Student Selection Guidelines

The following guidelines will be used by the Office of Support to select students for the 2020 Project LEAP cohort. They are presented in order of priority:

1. As outlined in the 2020 Service Definition for Project LEAP:

    a. The Office of Support shall enroll 20 to 30 persons who are living with HIV prior to the commencement of the training program. No more than 10 affected individuals are to be included in the training program. Preference will be given to non-aligned (non-conflicted) consumers of Ryan White HIV Program services in the Houston EMA and high risk applicants.

    b. Selected students shall be representative of the demographics of current HIV prevalence in the Houston EMA, with particular attention to sex, race/ethnicity, and the special populations of young adults (age 18 - 24) and people who are transgender and/or gender non-conforming.

~~2. Not a prior Project LEAP applicant.~~

2. If the applicant is a prior LEAP graduate, they may be selected for the 2020 cohort if they have not been appointed to the Planning Council following LEAP participation and if space in the class is available.

3. Be available for the 2020 Project LEAP class schedule.

4. Have the ability to commit to Project LEAP expectations in regards to class participation, activities, and homework assignments.

5. Demonstrate an interest in planning HIV services in the Houston EMA. Students should have an understanding of the expected roles of Project LEAP graduates in local HIV prevention and care services planning.

6. Demonstrate an interest in volunteerism, advocacy, and other types of community involvement. If possible, have a history of past volunteerism, advocacy, and/or community involvement.

7. Demonstrated interpersonal skills consistent with successful participation in Project LEAP, such as ability/willingness to work in a team, effective communication skills, etc.

MAKING ROOM AT THE TABLE: RECRUITING, RETAINING AND ENGAGING YOUTH AND YOUNG ADULTS

Michelle: Page 1 — Okay everyone, hello, and welcome to today's webinar. Recruiting, retaining, and engaging youth and young adult. My name is Michelle Dawson, and I am a technical assistant's coordinator for the planning chat project.

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Michelle: Page 13 — Thank you so much. I think those are really excellent strategies, and can help planning councils be really successful and grow in this area. We do know that there are some different models of youth engagement, or young adult engagement, that have been employed by different jurisdictions. They all have benefits and challenges that are associated with them. Some jurisdictions have youth subcommittees, some have separate youth councils that are equal to the regular planning council. Other jurisdictions have youth and young adult as part of their full membership. An innovative idea is to offer sort of an at-large membership, prior to full membership, as a sort of trial run for involvement. But what we want to ensure, though, is that all different types of models of youth and young adult engagement, is that the youth and young adults are actually involved. It's important that whatever the model, it should be used in a way that amplifies the voice and needs of young adults and not as a way to limit or moderate that influence.

MAKING ROOM AT THE TABLE: RECRUITING, RETAINING AND ENGAGING YOUTH AND YOUNG ADULTS

Michelle: Okay everyone, hello, and welcome to today's webinar. Recruiting, retaining, and engaging youth and young adult. My name is Michelle Dawson, and I am a technical assistant's coordinator for the planning chat project.

Michelle: Before we get started, we want to go through some technical details. First, you're all in listen only mode. But we do encourage to communicate with each other and ask lots of questions using the chat box. You can submit your questions at any time during the call, or during the question period at the end. Our presenters, along with the planning chat staff, will take as many of your questions as we can at the end of today's session. If you think of a question after the webinar, that's fine too. You can always email questions to us at planning chat at JSI dot com.

Michelle: The easiest way to listen to our webinar is through your computer. If you can't hear well, check to make sure your computer audio is turned on. If you still can't hear us, or if you're experiencing sound delay, try refreshing your screen. You can also mute your computer audio, and call in using your telephone number that you see on the screen. You'll need to use the passcode which is also listed on the screen. And this will be copied in to the chat as well.

Michelle: So we'll start out today with a welcome, some introductions, and our objectives. Then we'll move into a discussion of the state of planning councils and planning bodies with regard to youth and young adult involvement. We'll provide strategies that you can use to recruit and retain youth and young adults, and how to achieve and maintain intergenerational harmony. We'll be taking questions through the chat box throughout the webinar. And we'll aggregate them for response at the end.

Michelle: So by the end of today's webinar, you'll be able to understand the value of a multi-generational planning council or planning body. Identify strategies to recruit youth and young adults to your planning council or planning body. Identify strategies to engage and retain youth and young adults in planning council, planning body activities. And identify strategies for multi-generational harmony in planning council and planning body operations.

Michelle: So first I'd like to take a moment to acknowledge our HRSA/HAB colleagues, who make all of this good work possible. Stephen Young is the director of the division of Metropolitan HIV/AIDS programs in HRSA/HAB. And Lenwood Green is a project officer at the division of Metropolitan HIV/AIDS programs in HRSA/HAB. And we'd like to thank them and all their colleagues at HRSA for their continued support of the planning chat project, and the Ryan White HIV/AIDS program, Part A planning councils and planning bodies.

Michelle: As you know, these webinars are put on by the planning chat project. And planning chat builds the capacity of the Ryan White HIV/AIDS program Part A planning councils or planning bodies across the United States. And our goal is to help planning councils and planning bodies meet their legislative requirements, strengthen consumer engagement, and increase involvement of community providers and HIV service delivery planning. We conduct lots of webinars, which are all archived on our planning chat website, which you'll hear about later. As well as post lots of resources for you all to use. And you can access all of that at our website, which we'll talk about a bit later.

Michelle: Joining me today as a presenter is Mr. Venton Hill-Jones. Mr. Hill-Jones is the founder and chief executive officer of the Southern Black Policy and Advocacy network. Venton has worked with some of the nation's leading public policy organizations and academic institutions, responding to HIV and other health disparities, including AIDS United, National Black Justice Coalition, National Black Gay Men's Advocacy Coalition, and the University of California San Francisco Center for AIDS Prevention Studies. In these roles, he's worked to advance public policy and building effective coalitions. Venton currently serves as the chairman of the Dallas HIV taskforce, and is an appointed member of the Ryan White planning council of the Dallas area. Venton has a long history of successfully initiating innovative and effective new initiatives and non profit organizations, and his extensive background has led him to serve as an expert consultant on mobilizing black and LGBT communities, HIV/AIDS, and other health disparities for community based organizations, health departments, federal and state government entities throughout the United States. So thank you for joining us today.

Michelle: I also want to take a moment to call out some people in organizations who provided insights and strategies that informed the development of today's

presentation. Danielle [Griffin 00:45:52] of Thrive SF, Trina Scott of the Kaiser Family Foundation, and the Austin Department of Health.

Michelle: So let's get started. We know that today, youth ages 13 to 24 make up a substantial proportion of new HIV diagnoses in the United States and its territories. Despite knowing this, youth are least likely to be successfully linked to or retained in care, or to have achieved [inaudible 00:46:25] suppression. Thus, in addition to information and tools to help them reduce their risk of acquiring HIV, make healthy choices, and get in staying care if they have HIV, we need to have youth and young adults involved. But, how do we do that? How do we ensure that prevention and treatment services are accessible to youth and young adults, and that youth and young adults are well served when they get there?

Michelle: So who is a youth or young adult? For the purposes of today's conversation, we're going to talk about youth and young adults, that is, everyone between the ages of 13 and 35. And I know, that's a huge range. But this is because these are the folks who are not really engaged with planning councils and planning bodies. And so this is the group that we really need to be working to engage. And so you see here on your screen that often we see typical descriptions of young people being adolescent, 13 to 19 years. Young adults 20-24. But today, we're really kind of talking about youth 13-19, and young adult being 20-35.

Michelle: So let's get started by putting ourselves in the mindset of a young person. We're going to take a quick look at the worldview of an 18 year old person. We'll talk about some of the things that are true for an 18 year old person, who was born in 2001. And this list is a subset of the annual Marist Mindset List.

Michelle: So to start, for an 18 year old, September 11th has always been a historical event. Nearly half of their generation is composed of people of color. The Mars Odyssey has always been checking the water supply on Mars. Only two thirds of their generation identify as exclusively heterosexual. They've witnessed two African American secretaries of state, the election of a black president, Disney's first black princess, and the rise of the Black Lives Matter movement. There have always been smart watches. And they have never known a world without HIV. So, what we're going to do now is take a minute to think about what our planning councils look like. Now that we've thought about what the worldview of an 18 year old might be, and how that might be different from our own. Let's get an idea of your jurisdiction's planning council planning body leadership. In

the poll, tell us into what age group your youngest planning council or planning body co-chair falls. If you don't know for sure, that's okay. Just give us your best estimate.

Michelle: Okay, I'm seeing the answers come in. And what I'm seeing here is actually a pretty good distribution. But really seeing that for most of the people who wrote in, let's see, over ... about 70 percent of you, your youngest planning council or planning body co-chair falls in their 30's, 40's, 50's, or 70's. So that says something. And we should be thinking about that as we move through today's presentation. I'll share these results.

Michelle: So what we see is that the planning council planning body membership and leadership are generally older. And we looked at some of the data from the six jurisdictions with the highest percentage of youth and young adult members, and only two of those six memberships had more than 30 percent of their members be younger than 39 years old.

Michelle: So why does this matter? One might say that older folks have more experience, or are more experienced with the policies, procedures, and goals of the planning council, and are therefore able to more efficiently conduct business. The concern is that a homogenous planning council or planning body is not reflective of the epidemic in the community. One of the concerns is that if your planning council or planning body is not reflective of the people with HIV in your community and all of the different ways in which people are diverse, then the planning council or planning body might not have a complete understanding of the facilitators and gaps in care.

Michelle: For example, people aging with HIV and people who are young or newly infected with HIV, will have very different experiences in their life and in their care needs. And we need to be sure that we're meeting these diverse needs. And a diverse, representative planning council and planning body helps us to do that. Diverse planning council and planning bodies provide community memory and community experience. More tenured planning council and planning body members can remind newer members of the need for continued consumer involvement in and leadership of care priorities. Planning councils also need young people to help keep up the energy of the planning council. To continue its work. And to get an idea for what a newer generation is thinking, and the challenges and facilitators that they're experiencing. But to be successful, they need longer term members to train them and support them. I'm going to hand it

over to Venton right now, to talk a little bit about other ways that youth and young adults are important.

Venton: Thank you so much, Michelle. I think one very important point that you mentioned is just the need to ensure that not only youth are represented on the council, but diverse populations of young people. Particularly in this moment, as many jurisdictions are creating [inaudible 00:53:24] epidemic plans to talk about and highlight strategies to end the HIV epidemic by 2030. The voices of young people really have to be a part of that plan. And we have to make sure that we understand that key populations, particularly young people, African American and Latinx communities, we cannot end the HIV/AIDS epidemic without bringing the voices and the needs of diverse parts of these communities.

Venton: And definitely, a generalization to young people, as you mentioned at the beginning of the presentation, acknowledging the gaps of the definition of young people. And making sure that we have 18 year olds represented. We also make sure that we have people in their young twenties and their older twenties represented. But also, the conversation around the thirties. Because in some circles, even in the thirties, young thirties, are still counted as young people. So how do we have this conversation and ensure that there's earnest investment in those voices to make sure that any plans that are created represent the needs of populations that are critical in ending the epidemic in the next ten years.

Michelle: Thanks so much. So as Venton just said, it's really imperative that planning councils and planning bodies be reflective of the epidemic in order to effectively fulfill their tasks and obligations. As we know, planning councils are tasked with determining service needs, establishing priorities for allocation of funds, providing guidance to the recipients on how to best meet priorities, and helping to ensure coordination of Ryan White HIV/AIDS program and other services, including prevention.

Michelle: So, not only is it required for planning councils and planning body membership to be reflective of the community, it's essential to the success of their core tasks. If we aren't successful in this, we could be missing the needs of an important portion of our community.

Michelle: So now that we understand the state that we need to get to, which is a planning council and planning body that's diverse in age, we want to know how we get youth and young adults to the planning council and planning body. The first

strategy is that your planning council and planning body needs to determine that recruitment and retention of youth and young adults to the planning council or planning body is a priority. This is going to take intentional effort, and active involvement of the youth and young adults as a means by which to ensure representation and needs, needs to be an intrinsic value of the planning council. To actualize this priority, we recommend that you set a realistic goal for recruitment of youth and young adults. Track your progress to that goal over time. When you're tracking, be sure to monitor not just the number that you recruited, but how they were recruited, which recruitment strategies were successful, and which were not. And your planning council can use this information to hone and improve your recruitment efforts in the future.

Michelle: Once you've made the intentional decision to actively recruit youth and young adults to the planning council or planning body, you should take some time to consider what you're currently doing. Your current recruitment strategies. Understanding where you are can often be the first step in knowing where to go next. So take a critical eye to your recruitment materials. Who develops them? Were youth and young adults involved in the design or development? In what way were they involved? What do they look like? Are they black and white, are they colorful? Are there photos or images? Who is in those photos and images? What is the medium of your recruitment materials? Are they videos, are they clips, are they flyers, are they memes? Are they something else? Where do you advertise? Are you posting to social media? If so, what platforms? Are you going to youth serving organizations? Do you participate in the local pride parade? Do you go to schools or colleges or universities?

Michelle: What language are you using? Is it jargon? Is it wellness oriented? Who are you referring to, who are you talking about? When do you recruit? Are you recruiting during business hours, after hours, on weekends? Who does the recruitment? Are the people conducting outreach and recruitment youth or young adults, or are they older? Are they members of the planning council or planning body? And then, once we've thought about all those things, we need to think about ways that we could improve. And things that you could do to change what you're doing, or think about the things that are successful and could be enhanced.

Michelle: So what could we change? In order to get a different outcome, you will need to make changes to how things are done. And this is why we talked about

recruiting youth and young adults as requiring intentionality. To the extent possible, we want to empower and support youth and young adults currently involved in planning council and planning body activities and operations to guide these efforts. Allow them to think about and select the language that's going to be used in recruitment tools. Many youth and young adults are more responsive to language that places HIV services in the context of broader health and wellness, rather than language that's kind of traditionally been used. For example, consumer or behaviorally based language like MSM.

Michelle: Consider the epidemic in your area. Who is at the greatest risk for HIV in your community? And do the images, if you have any, that you use for planning council or planning body recruitment reflect that reality?

Michelle: So you might ask, where do I find the young people? Where do I find them to recruit them? This is a great question. And it's one that's perhaps best answered by the youth or young people that you have involved in your planning council or planning body now. But in the absence of current involvement, or in addition to their suggestions, your planning council or planning body might consider conducting outreach at or with youth serving organizations, at LGBTQ centers at local colleges or universities, in high school health classes with permission, of course. And at events held by youth and young adults. In short, it's recommended to go to their events, go to where they are, rather than expecting them to come to your events. Meet them in their comfort zone, and find ways to bridge the gaps between where they are, and where you'd like them to be, which is involved in your planning council or planning body.

Michelle: So how do I talk to young people? Once we found the young people, you should endeavor to use language comfortable for and familiar to youth and young people. For example, many planning councils and planning bodies and experts in youth and young adults with HIV tell us that young people are uncomfortable with consumer, as in consumer services, the consumer language often used by planning councils and planning bodies. And so I think now Venton is going to take some time to talk to us about tailoring conversations to different audiences.

Venton: Yes. One important key item to really take into conversations and understanding recruitment for young people, is to know that young people are not just people living with HIV when it comes to recruitment on councils. They are young professionals who work for the organizations that are within the

council's jurisdiction. There are young people that also work in other industries and various areas of their career and also their lives. So we have to make sure that we're not just, again, when we're talking about this consumer language, not just using language that identifies a young person only coming from a perspective of one that is living with HIV, and making sure that we're very [inaudible 01:02:09] that we're bringing them for their experience, and to be able to really build their leadership in order to ultimately take leadership positions and leadership roles within jurisdictions on planning councils and planning bodies.

Michelle: Excellent. Thank you. So another strategy is to frame planning council and planning body involvement in relation to the values that they already hold and already care about. For example, many youth and young adults care deeply about health and wellness. And by framing involvement with the planning council and planning body in terms of improving community health and wellness, rather than focusing recruitment language around HIV, which is kind of a singular issue, you could reach a broader audience.

Michelle: Another strategy would be to link planning council and planning body involvement and service coordination role to social justice and community activism. Both of which are really important to many youth and young people.

Michelle: And these strategies, they serve to show that you don't necessarily need to change your identity or what you're doing. But you just might need to change how you're framing what it is that you're doing, in order to bring new people to the table.

Michelle: Recruiting youth and young adults to planning councils and planning bodies can be challenging. If you have very few or no youth or young adults on your planning council or planning body, you might not really know where to go to start to find or to talk to youth. Additionally, youth and young adults' stage of life can make it difficult or challenging for them to feel like they can make a long term commitment, such as the one that many planning councils and planning body membership requires. We know that sometimes it's a long term commitment to membership. At least for a year or maybe more.

Michelle: So for example, perhaps you're 28 and you work a regular job, and a second job. You don't have the flexibility in your roles to make meetings during business hours. And you might have a small child to take care of at home after your shift.

Or perhaps you're 17 and in high school, and need to attend classes during the day, and you don't know where you'll be next year after you graduate high school. Or, if you're a consumer, your ability to participate in the planning council or planning body could be directly related to the things in your life that affect your ability to engage or stay in care. You might be experiencing homelessness, or housing instability. And planning council involvement is not contributing directly to your ability to overcome these challenges, which would be your ability to change that.

Michelle: Administrators and organizations are paid to attend, often. But consumer members are not. And so, I'd like to hand it over to Venton to talk a little bit more about the challenges of being a young person on the planning council.

Venton: Yes, thank you Michelle. I think that every point that you made is definitely considerations. Also, understanding that the work of the planning council and planning body is intense if you are an active member, because by being an active member, the work on the council doesn't just begin and end with attending the monthly council meetings or the committee meetings that may take place. It's also understanding the documents that you are asked to give feedback, give votes, and give voice to. And making sure that young people and all new members that are brought on, are adequately trained to be able to give the level of feedback needed to be able to engage in that process. And unfortunately, for many, just having the information at the meeting to be able to glance over and vote at, is not sufficient to be able to have that level of participation.

Venton: So again with young people, we have to make sure that there's an understanding that there's a need to invest so that young people can be active and be able to contribute at that level.

Michelle: Thank you so much. Another challenge faced by planning councils and planning bodies, and it's a little bit related to what I alluded to before, is that youth and young adults today often perceive their life experience, their expertise as a young person with HIV, as intellectual property. And they want to be appropriately compensated for their time and expertise. Planning councils and planning bodies are made up of volunteers. That could be another challenge that we have to work to overcome. And later in the seminar, we'll go through some of the strategies to help overcome these challenges.

Michelle: So once you get youth and young adults interested in being involved in planning council and planning body work, and get them to a planning council planning body meeting, how do planning councils and planning bodies engage them, so that they're effectively retained as a part of planning council and planning body?

Michelle: The reason we need to talk about engagement and retention is that recruitment can only be as successful as engagement and retention. If you recruit a number of youth or young adults to your planning council, but they attend only one meeting, and then never return, you've really not made a difference in the operation of the planning council or planning body. And you'll need to recruit over and over again. You kind of get stuck in this cycle of continuous recruitment. We should always be recruiting, but we're not able to capitalize on any growth or movement that we had.

Michelle: So that's why in the next few slides, we'll go through strategies for recruitment, as well as engagement and retention, because they're often interchangeable. If you recruit a young person, and they have a meaningful experience, they'll tell their friends and their colleagues about it. And then you're using young adult involvement and engagement will grow.

Michelle: So we get young people to the table. What do we do once they're there? First, we recommend finding and engaging a youth and young adult champion. That is, a person who wants to spearhead young adult and youth recruitment and engagement efforts. If possible, your champion should be a young person, because youth and young adults know other youth and young adults. And as we mentioned earlier, kind of use language that frames HIV in the context of health and wellness.

Michelle: We might encourage flexibility in meeting attendance, and consider permitting alternate forms of attendance, such as video conference or teleconference. And we know that there are local guidelines around this, but we might want to consider the accessibility and flexibility that would come with these options. And also consider changing your meeting times to be more accessible, and limiting the amount of meetings that we might have to attend.

Michelle: And now Venton has some more strategies for success. And if you just want to let me know when to switch, I can do that.

Venton: Okay. Next slide please. Ultimately, we have to think differently about how the work around recruiting young people is done. And so, once area is look at opportunities for engaging young people as interns or staff for your administrative agencies. In this way, you are getting youth and young adults interested, as well as involved in planning council operations, in a way that works for them. And may perhaps lead to membership in the planning council, and also to recruit their friends that they may know.

Venton: If you're going to hire young people or young adult people, be sure to pay them an appropriate wage whenever possible. If it's not possible, we have to look for ways to compensate them for their time and experience. And so, for example, when you are in a volunteer capacity, what are ways that can be promoted to find for volunteer or community service hours, or school credit for their activity?

Venton: In the end, I think it's important to just realize that a person's time and experience are their intellectual property. And intellectual property has value. We have to incentivize and engage [inaudible 01:11:40] with the planning council by encouraging the young people and young adults that you want to be involved to possibly be a part of a project that could be able to work on behalf of the council, and support their attendance at conferences such as the United States Conference on AIDS, or a faith conference on addressing HIV.

Venton: The end product though, of this project, can be something that benefits the planning council or the community that the youth or the young adult represents. And that they can also be a part of a young person's professional portfolio that can also lead to possible legislation or changes in policies, or being a part of videos or media projects that can really be able to highlight the voices of young people in local communities. Next slide please.

Venton: And also, another strategy is to offer specialized training before planning council events. Such as ways to describe ... excuse me, I think that ... oh excuse me, I had some notes. One thing is to look at specialized training before events, and being able to describe what activities are before going into meetings, and also giving context that when activities are occurring, and also if there are any procedural steps that they need to know or follow in order to complete the activity. Planning council meetings can be challenging, and oftentimes the conver ... [inaudible 01:13:22] can also be used as intensive, that the meeting could be boring. So we have to make sure that we better understand what the

planning council is doing. And how to make sure that we make the experiences more interesting and meaningful to our membership. And therefore, improving engagement of the young person that you want involved.

Venton: Specialized trainings can help break down language or jargon barriers that can oftentimes confuse new members. And the language that planning councils and planning bodies use can be exclusive language that is very unfamiliar ... that the message, it's surrounded in policy that's oftentimes very unfamiliar to young people. So it's very important that that's taken into consideration, as you talk about involvement of young people. Next slide.

Venton: And so, when youth or young adults become more involved in planning councils, it is important that intentional efforts be made towards making sure that a young person feels empowered to speak up for themselves, and also those that they represent on planning council bodies, or working with the planning council or administrative agencies.

Venton: One way to encourage this is to have a young person serve as one of the co-chairs of the planning council or committee. And by elevating a young person to this role, you are amplifying their voice, highlighting their value, as well as encouraging other people to get involved in the council in a meaningful way. And to prepare young people for roles such as co-chairs, the planning council may want to offer leadership training that can take place, again, either before meetings, or also on other days that that's convenient for young people. And you'll know that when you have conversations with them in community.

Venton: And having these trainings can also help other people prepare for these roles, and also build transferable skills for other aspects of a young person's life, career, and investment in ending this epidemic. And when young people ultimately show interest in, or become involved in the planning council, we have to find ways for them to be meaningfully involved. Their time, their investment in the planning council, needs to feel of value to them and to the planning council. It's important that we don't just have them joining meetings for the sake of filling the slot, or checking the box. We have to find ways that they can apply their skills, and also their interests, to advance the goals of the planning council and planning body. And that's ultimately to improve the lives of those living with HIV, or ultimately to, depending upon the body that you're involved with, also prevent the additional transmission of HIV to new individuals.

Venton: And so for example, one planning council noted that some of their young people used their video production skills to make a planning council improvement video. That's ultimately, projects like that help put young people in decision making roles. And this doesn't necessarily mean that you should immediately become a co-chair. But there are decision making roles outside of those, that the young person decides where to conduct outreach or recruitment activities. Like I mentioned earlier, the possibility of serving as a committee chair, and also another option is to start a youth or young adult committee or caucus, that allows them to discuss how this community is best served as well as recruit other young people to be able to raise their voice for the needs of young people and young adults. So I'll turn it back over to Michelle.

Michelle: Thank you so much. I think those are really excellent strategies, and can help planning councils be really successful and grow in this area. We do know that there are some different models of youth engagement, or young adult engagement, that have been employed by different jurisdictions. They all have benefits and challenges that are associated with them. Some jurisdictions have youth subcommittees, some have separate youth councils that are equal to the regular planning council. Other jurisdictions have youth and young adult as part of their full membership. An innovative idea is to offer sort of an at-large membership, prior to full membership, as a sort of trial run for involvement. But what we want to ensure, though, is that all different types of models of youth and young adult engagement, is that the youth and young adults are actually involved. It's important that whatever the model, it should be used in a way that amplifies the voice and needs of young adults and not as a way to limit or moderate that influence.

Michelle: When we're successful in engaging and retaining youth and young adults in the planning council or planning body activities, we'll have a multi-generational planning council and planning body. And like any multi-generational work environment, there are some great synergies and benefits, but there are also challenges. And together, the generations can create and excel.

Michelle: And so, there are some strategies that you can see here, that can help your planning council and planning body to work together to achieve your common goals in a harmonious way. And these are some general strategies often employed in multi-generational workplaces, but are very applicable to planning councils and planning bodies. And the first is of course to establish respect.

Understand and accept that generations are different than yours. Think about what your planning council and planning body members do to build and show mutual respect to each other, particularly people from different generations. And if you have ideas on how this is happening in your planning council, how you're establishing respect, do tell us in the chat. We'd love to hear that, and I know that your colleagues would love to hear that as well.

Michelle: To the extent possible, be flexible and accommodating with regards to people's schedules, their time, commitments, and desires. And if you have ideas about the types of policies, protocols, and commitments that you might need to be flexible with in your planning council, or might want to think about being flexible with, go ahead and tell us in the chat, so that it can help start other groups thinking about what they might need to think about with their own planning councils.

Michelle: You want to avoid stereotyping. Instead of assuming the worst about a person or their generation, fight unconscious bias, and accept individuals based on their merits, rather than kind of typical members of a generation.

Michelle: By demonstrating willingness to listen to or adopt new ideas, and by working collaboratively, you can change perceptions and attitudes. And we want to think about the assumptions that planning council bodies and planning council members might be making about other generations, and what those things that we might need to check, in order to work together productively. One example, I think that Venton mentioned a little bit earlier is an assumption that a young person is ... might have limited knowledge or experience in HIV, when in fact a young person could very well be a young professional working in HIV. And doesn't necessarily want to be treated the same as if they were a 13 year old student. So we need to be mindful that just because a person is younger than you doesn't necessarily mean that they don't have knowledge and experience.

Michelle: We want to learn from one another. Each person has skills and experience to bring to the table, and the planning council is stronger than any individual alone. So we want to focus on amplifying a person's strengths, rather than thinking about how they're different from you. And so you want to think about who is on your planning council? What are their strengths? What do youth and young adults bring to the table? I know that Venton mentioned earlier, somebody brought video production skills to the table. That's excellent. And so couple that

with a more tenured representative's knowledge and experience with the planning council, and together you can create something amazing.

Michelle: You might want to tailor your communication style to the needs of different planning council or planning body members. If you're just sticking with one mode of communication you risk alienating people. So if you're only communicating by telephone call, you might be alienating people who strongly prefer texting. If you write really informally, you risk alienating people who prefer a more formal means of communication. So you want to think about the changes that you can make to your communications. Both internally to your planning council, and externally, so make them accessible to younger audiences.

Michelle: Also, we want to make sure that we're not overlooking how similar generations are, rather than dwelling on differences. Many generations value feeling engaged, they value fair play, building a better quality of life and a better service coordination for people living with HIV and AIDS in your jurisdiction. Being respected. We want to look for inter-generational common ground. And so one of the best ways that you can do this is to show your planning council and planning body members, and potential members, the common values that you have. Which are trying to improve life and wellness for people in your community. That is a uniting force. And that can really bring everyone together. Because we're all trying to do the same thing. We might have different ways of getting there, or different ways of talking about it, but we're all trying to do the same thing.

Michelle: So we want to know, what types of assistance would be beneficial to help your planning council and planning body implement the strategies that you've heard here today? I you want to tell us in the chat, we'd love to have that information so that we can help support you. Because we know that this has probably brought up some new thoughts for you. I'll give you a moment to respond.

Michelle: I'm loving seeing these things come in through the chat. I'm hearing that you're interesting in sample guidance, hearing from other planning councils, so I'm hoping that everybody will share in the chat, and I'm really hopeful to see that folks will share their success stories. And if people wanted to share them with us, we can find ways to communicate that back out. You can always reach us at our planning chat email.

Michelle: Okay. So I'll let you guys keep responding in the chat, because I'm really enjoying seeing what you're talking about. But in the meantime, I want to take some time to thank you for joining us today. I would like to encourage you if you have any other questions, we've been aggregating your question and answers as we go, and so if you have anymore, please chat them in, and we'll do our best to respond to them. While you're thinking about any questions that you have, I'd like to mention that today's webinar was recorded and will be archived on our target HIV page, which is target HIV dot org slash planning hyphen chat, with two T's. All participants in today's call will also receive an email when it's posted, so you can share with your colleagues. And all of our tools are also posted on that page. It's definitely a great place to go for resources. You can also find us by going to the target HIV website homepage, and looking through the topic library there.

Michelle: Okay so I'm going to take a minute to look through these Q and A questions, and make sure that we get your questions answered. Okay so I'll start with the first question. How do you justify to other planning council or planning body members that don't get incentives, while other members such as youth do? And so, I think that one of the things that I would say is that we aren't necessarily incentivizing with monetary, though if you're employing folks, it's always best practice to pay people. But can you find ways to be creative about incentive? Can you find a way to create some sort of ... that the youth or young adult could create some sort of deliverable that they could use? If they're creating a documentary, they have that, that's on their resume, that they can show that and take it somewhere else, resume building opportunities. Something with a defined end product that can be taken and built somewhere else.

Michelle: You might offer leadership training. That's a transferable skill. Or conference attendance. And so, we want to think about ways to incentivize, or just even calling them incentives. Things that you might have done anyway, but really finding a way to repackage that so that it is understandable as such. Because we know that there are limitations on what you can and can't do. And perception of eligibility.

Michelle: There is a question, another question. How can you prepare longstanding members to be more open minded to bringing in new members? And so, I would say that you really need to bring this back to the roles and responsibilities of the planning council. Planning councils and planning bodies need to be

representative of and reflective of their communities. Without bringing in new members, particularly youth and young adult members, you're not able to confidently say that you're meeting the needs of everyone.

Michelle: And this is also, you could also frame this as saying, this is not a change in what we're doing. It's not a change in the mission. We're just finding new ways to be friendlier to new generations, so that we can meet the evolving needs of the people in our community. And a recognition that different people in our community have different needs that we need to be meeting. And we need to have their voice in order to do that. That's very consistent with the messaging and the goals of planning councils and planning bodies. And so if we really bring it back to what is the purpose of the planning council and the planning body? There should be a recognition that this is important and possible.

Michelle: And so then there was a question: can people under 18 years old serve as planning council or planning body members? And I could hand this over to our HRSA colleagues. Let me ... but I can also, let me see if I can do that, if he's willing. Lenny you're unmuted now. Would you like to respond to this question?

Lenny: Repeat the question.

Michelle: Oh yeah. Can people less than 18 years old serve as planning council members?

Lenny: There is no real legal issue in regards to that. There may be some local concerns when you get to someone maybe 16 or under, or considered a minor status, about parental guidance or consent. But in regards to Ryan White, we welcome the youth input. So we would try our best to work as closely as we can with ensuring that parents are involved or are aware that there's participation by minors. But we really don't speak to that. There's a lot of local issues that may step in there. So we would always default to that.

Michelle: Thank you so much for that.

Michelle: Okay, and then I see we have another question about framing HIV as a part of health and wellness, and linking to other concepts and ideas that are a part of the milieu of what is going on in the world right now. And so I would just say that this is something, it's just a strategy, I would recommend you talk to the young people in your community and think about what are the things that planning councils and planning bodies, what are they associated with? Is it a

part of ... are there things that are maybe more tangible, or at least a little bit more present in the lives of young people than a planning council or planning body, which they might not know about.

Michelle: And so health and wellness is certainly something that youth and young adults are thinking about often. And so we want to be thoughtful about saying, oh, this is a way that you can be involved with improving the health of your community. This is a way that you can be involved in your community. And so kind of reframing from a really narrow focus on HIV, into a broader, bringing you into a new broad landscape that people might be more familiar with, and more comfortable with. And I do think there were some other folks who wanted to respond to that, so I'm going to open that up.

Lenny: Hi this is Lenny. One of the things that we can also look at is disparities in general. We find that oftentimes, some of the social issues or the economic issues that drive diabetes, high blood pressure, a good portion of these health concerns are based in disparity, also drive our HIV concerns. So when you look at it holistically, if you couch this in a wellness program, and accept it just from HIV [inaudible 01:34:50], it also tends to reduce the initial stigma that some folks may have with approaching a conversation about HIV for fear of unintentional disclosure. So there's many ways you can look at this, and incorporating it into other wellness activity is one of those ways. So it's something to give some food for thought, or some consideration to.

Michelle: Thank you so much. And I'd just like to remind you, if you have more questions, you can go ahead and chat those in. And I'm loving to see all these different ... I'm loving the answers that are coming in, and the things that you're chatting to each other, because really showing that this is an area that you all want to grow in and improve in, and really help build your planning council in this area. And so I'm really pleased to see that.

Michelle: As you're taking another moment to ask anymore questions that you have, I'd like to again remind you that you can download slides, recording, and all of our past webinars from our planning chat website. Slides from today will be available, along with the recording in the future. And all of that will be available on the planning chat site.

Michelle: Okay, well I'm not seeing anymore questions come in. So I'm just going to say thank you all so much for attending today. Be sure to visit our website to sign up

for our mailing list. Download tools and resources. View archived webinars and more. And please to take a moment to complete the evaluation when that comes to you. We really do use those, and would love to see what you think and how we can improve.

Michelle: Of course you can always contact us at planning chat at JFI dot com. I do think that the evaluation link is going to go out in the chat, but if it doesn't, you'll receive it later. Thank you so much, and I hope you all have a great day.

SLATE OF NOMINEES

As of Thursday, November 7, 2019 the following people have been nominated as officers for the 2020 Ryan White Planning Council:

Chair:

Allen Murray
Tana Pradia
Carol Suazo

Vice Chair:

Ronnie Galley
Tana Pradia

Secretary:

Tony Crawford
Tana Pradia

Members Eligible to Run for Chair of the 2020 Ryan White Planning Council

(as of 10-24-19)

According to Council Policy 500.01 regarding election of officers: "Ryan White Part A, B and State Services funded providers/employees/subcontractors/Board Members and/or employees/subcontractors of the Grantees for these entities shall not be eligible to run for office of Chair of the Ryan White Planning Council. Candidates will have served as an appointed member of the RWPC for the preceding twelve (12) months and, if needed, have been reappointed by the CEO. One of the three officers must be a self-identified HIV positive person. " Nominations for all three positions: Council Chair, Vice Chair and Secretary, must be submitted to the Director of the Office of Support before the end of the November Steering Committee or at the December Council meeting, which is the day of the election.

Eligible To Run for Chair (* must be reappointed):

Veronica Ardoin
Rosalind Belcher*
Tony Crawford
Bobby Cruz*
Johnny Deal
Ronnie Galley*
Gregory Hamilton
Angela F. Hawkins
Melvin Joseph
Arlene Johnson
Tom Lindstrom
Holly Renee McLean
Rodney Mills*
Allen Murray*
John Poole
Tana Pradia
Gloria Sierra*
Crystal Starr
Carol Suazo
Bruce Turner*

Not Eligible To Run for Chair

Ahmier Gibson-conflicted (Legacy Community Health)
Allison Hesterman-employee (Tx. Dept. of State Health Services)
Dawn Jenkins-conflicted (Harris Health Systems)*
Daphne Jones-conflicted (City of Houston)*
J. Hoxi Jones-employee (Tx. Health & Human Serv.)*
Denis Kelly-conflicted (Avenue 360)
Niquita Moret-conflicted (City of Houston)
Matilda Padilla-conflicted (AIDS Healthcare Foundation)
Faye Robinson-conflicted (City of Houston)*
Pete Rodriguez-employee (HRSA)
Imran Shaikh-conflicted (City of Houston)

QUALIFICATIONS FOR ALLEN MURRAY

Nominee for Chair, Ryan White Planning Council

2005-2011	Served on the Michigan HIV/AIDS Council where I was a member of several committees.
2013	Moved to Houston
2014	Graduated from Project LEAP Graduated from the Positive Organizing Project – Houston (POP+)
2015	Became an external member of the Ryan White Comprehensive HIV Planning Committee
2016 - Present	Appointed to the Houston Ryan White Planning Council. Served on a number of committees and co-chaired the Affected Community and Operations Committees. Currently, the Chair of the Operations Committee.
2017 and 2019	Very active as an HIV advocate in both Texas legislative sessions
2019	Became an active ally for Positive Women's Network Organizing Power 2020. I was the only cis-male at the conference. The women went out of their way to make me feel welcome.

RONNIE G. GALLEY

ronniegalley@sbcglobal.net

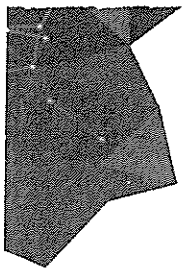
Thank you, I accept the nomination for Vice Chair for Houston Ryan White Planning Council 2020. Based on my 2019 Attendance record, I have no expectations of not meeting the 2020 attendance.

I am a 34 year retiree U S Postmaster from Beaumont TX area. I have supervised over 100 employees in Houston and managed supervisors, letter carriers, and clerks in Beaumont-Port Arthur-Orange area.

I am a 2017 Project LEAP graduate. I have volunteered on several outreach programs, such as Road 2 Success, Miss Utopia, and other workshops.

QUALIFICATIONS:

- Evaluation Workgroup
- Steering Committee
- Planning Council member
- Operations Co-Chair
- Affective Committee Vice Chair
- Quality Improvement Vice Chair
- Project LEAP Advisory Committee
- Project LEAP Recruitment Committee
- Project Path Committee
- HIV & Aging Coalition



LOGO&NAME

Secretary Position

I am Tony Crawford and I am applying for the position of Secretary of Ryan White Planning Council / Houston, Texas.

This will be my first attempt to sit as an officer and have true responsibility and accountability. I am a graduate of the Ryan White Planning Council class of 2018. I have volunteered and participated to help my fellow members involved with the project to end the HIV epidemic growth in the Houston area. I am on two committees; Quality Improvement Committee and Affected Community Committee.

This is an opportunity to grow, learn and become an active member of an organization which I believe in and have witnessed the beneficiary results of its determined task to end the lack of education of people living with HIV and attaining a zero growth of HIV cases in the Houston area.