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

AGENDA

12 noon, Thursday, April 2, 2020

Meeting Location: Online or via phone
Zoom Meeting ID: 499 715 637
To join via phone: (346) 248-7799

I. Call to Order — Tana Pradia, Chair, RW 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 and Steven Vargas, Co-Chairs

Item: Needs Assessment Data for How to Best Meet the Need
Recommended Action: FYI**:** The Needs Assessment Group (NAG) and the Committee each met online on March 26th to review and approve Needs Assessment data used in the *How to Best Meet the Need* Process. Please see the attached presentation outlining the data approved.

Recommended Action: **Motion:** Approve the attached Needs Assessment introduction, Chapters 1-2, and Service-Specific Fact Sheets for use in the How to Best Meet the Need process

Item: FY 2021 EIIHA Plan
Recommended Action: **Motion:** In order to meet HRSA grant application deadlines, request the Planning Council to allow the Comprehensive HIV Planning Committee to have final approval of the FY 2021 EIIHA Plan target populations, provided that:

- The FY 2021 EIIHA Plan is developed through a collaborative process that includes stakeholders from prevention and care, community members, and consumers; and

- The recommended FY 2021 EIIHA Plan target populations are distributed to Planning Council members for input prior to final approval from the Comprehensive HIV Planning Committee.

B. Affected Community Committee — Veronica Ardoin and Rodney Mills, Co-Chairs

Item: Training: *How To Best Meet the Need* Process
Recommended Action: FYI: Although the Committee did not meet in March, members received the training materials for the *How To Best Meet the Need* process and a time when they could call Tori to walk through the information via conference call.

C. Quality Improvement Committee — Denis Kelly and Pete Rodriguez, Co-Chairs

Item: Information about Consumer Experiences in Care
Recommended Action: FYI: See the attached chart, which describes reports that provide information on consumer experiences in care.

Item: Criteria Used to Determine the FY 2021 Service Categories
Recommended Action: **Motion:** Approve the attached criteria which will be used to determine the FY 2021 Ryan White Part A and Part B and State Services service categories.

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

- Summary of Ryan White Clinical Care Chart Review Findings
- 2018 Chart Review Packet regarding:
  1. Primary Care
  2. Case Management
  3. Oral Health – Rural Target
  4. Vision Care

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

- Health Insurance Program report DSHS – dated 03/02/20

Item: Proposed Idea Forms
Recommended Action: **Motion:** Approve the 2020 Criteria and form for reviewing Proposed Ideas.

Item: Tentative FY 2021 How To Best Meet the Need Schedule
Recommended Action: FYI: See the attached, tentative schedule for the FY 2020 How To Best Meet the Need process.

D. Priority and Allocations Committee — Bobby Cruz and Allen Murray, Co-Chairs

No report.

E.	Operations Committee No report.	Ronnie Galley and Carol Suazo, Co-Chairs
IV.	Report from Office of Support	Tori Williams, Director
V.	Report from Ryan White Grant Administration	Carin Martin, Manager
VI.	Report from The Resource Group	Sha'Terra Johnson-Fairley, Health Planner
VII.	Announcements	
VIII.	Adjournment	

HOUSTON AREA HIV SERVICES RYAN WHITE PLANNING COUNCIL
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STEERING COMMITTEE

MINUTES

12 noon, Thursday, March 5, 2020
2223 W. Loop South, Suite 240; Houston, Texas 77027

MEMBERS PRESENT	MEMBERS ABSENT	OTHERS PRESENT
Tana Pradia, Chair	Carol Suazo, excused	*Ryan White Grant Administration*
Allen Murray, Vice Chair	Pete Rodriguez, excused	Carin Martin
Crystal Starr, Secretary vis phone		
Veronica Ardoin		*The Resource Group*
Rodney Mills		Sha'Terra Johnson-Fairley
Daphne L. Jones		
Steven Vargas		*Office of Support*
Ronnie Galley		Tori Williams
Bobby Cruz		Amber Harbolt
Denis Kelly		Diane Beck

Call to Order: Tana Pradia, Chair, called the meeting to order at 12:06 p.m.

During the opening remarks, Pradia thanked everyone who is helping to recruit Project LEAP applicants. We have found some excellent applicants this year so it should be another good year for the program. She thanked Galley for taking on the important job of coordinating the tables at agencies and the volunteers who staff the tables. We could not have Project LEAP without all of our dedicated efforts.

She also thanked Galley and Murray for working with Williams and herself to orient new Affiliate Committee members. The training went well and hopefully the new committee members are getting comfortable with their committees. Please be on the lookout for new members and help them to feel welcome and part of the team.

She then called for a Moment of Reflection.

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

Adoption of the Agenda: ***Motion #1:*** *it was moved and seconded (Jones, Galley) to adopt the agenda with one change, move the Report from Ryan White Grant Administration to before Reports from Committees.* **Motion carried.**

Approval of the Minutes: ***Motion #2:*** *it was moved and seconded (Starr, Jones) to approve the February 6, 2020 minutes.* **Motion carried.**

Public Comment and Announcements: None.

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

Reports from Committees
Comprehensive HIV Planning Committee: Steven Vargas, Co-Chair, reported on the following:
Epidemiologic Supplement Report: ***Motion #3:*** *Approve the attached 2020 Epidemiologic Supplement report, with formatting changes to come from the Houston Health Department (HHD).* **Motion carried.**

Houston Ending the Epidemic (EHE) Draft Plan: Beau Mitts, Crystal Townsend, Carin Martin, and Amber Harbolt presented information about the strategies to create a local plan to end the HIV epidemic in Houston, and asked the Committee and audience members for input and consensus. Additional presentations were provided to the END HIV Houston Coalition on 2/26/20 and the Community Planning Group on 2/27/20. Please see the attached presentation.

Motion #4: *As the 2017-2021 Comprehensive Plan and the Roadmap to End HIV in Houston expire, concur with the development of one unified local EHE plan to serve as both the joint Comprehensive/Integrated Plan and the new Roadmap.* **Motion carried.**

Motion #5: *Accept the attached EHE planning timeline.* **Motion carried.**

Motion #6: *Support an EHE planning structure that is a mix of the best parts of the two options presented, with additional feedback from the END HIV Houston Coalition and the Community Planning Group, to be decided by the EHE Steering Committee.* **Motion carried.**

2020 Houston Medical Monitoring Project Questions: Please see the attached proposed 2020 Houston Medical Monitoring Project Local Questions. Any feedback or suggestions may be submitted directly to Osaro Mgbere at Osaro.Mgbere@houstontx.gov.

Committee Vice Chair: Denis Kelly was elected as vice chair for the 2020 Comprehensive HIV Planning Committee.

Affected Community Committee: Rodney Mills, Co-Chair, reported on the following:
Committee Orientation: All committees dedicated the first portion of their February meeting to general orientation, which included a review of the purpose of the committee, requirements, such as the Open Meetings Act training deadline, work products, meeting dates and more. The Affected Community Committee also reviewed the Purpose of the Planning Council and Public Hearings, and role played questions that members might receive while staffing a booth at a health fair, see attached.

HIV Molecular Surveillance Training: The National Alliance of State and Territorial AIDS Directors (NASTAD) is developing training on HIV Molecular Surveillance. They have asked the Affected Community Committee if they would go through a brief summary of the training and then fill out a survey that critiques the training. All members of the Council are welcome to attend the training, which will take place at 12 noon on Monday, March 23 in room 101. See attached email from Vargas of comments he received from Venita Ray.

2020 Community Events: See the attached list of 2020 Community Events.

Greeters for 2020 Council Meetings: See the attached list of Greeters.

Committee Vice Chair: Ronnie Galley was elected as vice chair of the Affected Community Committee.

Quality Improvement Committee: Denis Kelly, Co-Chair, reported on the following:
Reports from Administrative Agent – Part B/SS: See the attached reports from the Part B/State Services Administrative Agent:

- FY19 Procurement Report – Part A & MAI, dated 02/18/20
- FY19 Service Utilization Report – Part A & MAI, dated 03/02/20
- Clinical Quality Management Quarterly Report, 11/15/19

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

- How To Read TRG Reports 2020
- FY 19/20 Procurement Reports Part B – dated 01/21/20
- FY 19/20 Procurement Reports DSHS – dated 01/24/20
- FY 2018/29 Service Utilization Report DSHS – dated 01/08/20
- Health Insurance Program Reports – dated 01/08/20 & 02/05/20
- 2019 Chart Review Packet regarding:
  1. Early Intervention Services – Incarcerated
  2. Home and Community Based Services
  3. Hospice Services
  4. Mental Health Services
  5. Oral Health Care Services
  6. Referral for Healthcare Services – ADAP
- TRG Consumer Engagement Feedback Results 2019

Committee Vice Chair: Crystal Starr was elected as vice chair of the Quality Improvement Committee.

Priority and Allocations Committee: Bobby Cruz, Co-Chair, reported on the following:
FY 2021 Priority Setting Process: ***Motion #7:*** *Approve the attached FY 2021 Priority Setting Process.* **Motion carried.**

2020 Guiding Principles and Criteria: ***Motion #8:*** *Approve the attached 2020 Guiding Principles and Decision Making Criteria.* **Motion carried.**

2020 Policy for Addressing Unobligated and Carryover Funds: ***Motion #9:*** *Approve the attached FY 2019 Policy for Addressing Unobligated and Carryover Funds.* **Motion carried.**

Committee Vice Chair: Josh Mica was elected as vice chair of the Priority and Allocations Committee.

Operations Committee: Ronnie Galley, Co-Chair, reported on the following:
2020 Council Orientation Evaluation Results: See the attached evaluation results of the 2020 Council Orientation.

Future Council Orientations: See the attached Public Comment from Steven Vargas suggesting that the Council and CPG combine their annual Orientations. The Operations Committee will be discussing this public comment at their March 17, 2020 meeting. If members have comments on this subject, please provide public comment at the meeting, or submit it in writing to the Office of Support so it can be included in the discussion.

Committee Vice Chair: Crystal Starr was elected as vice chair of the Operations Committee.

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

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

Announcements: Vargas said that the NMAC BLOC grant is now available in Spanish. Representatives from NMAC will be in Houston in June.

Kelly advised all to be cautious about the COVID-19 outbreak, especially those who are living with HIV and/or older.

Pradia said that there is an article about the Houston Ending the Epidemic planning process on thebody.com.

Adjournment: The meeting adjourned at 1:14 p.m.

Submitted by:

_____

Tori Williams, Director Date

Approved by:

_____

Committee Chair Date

2020 Steering Committee Voting Record for Meeting Date 03/05/20

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

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

MEMBERS	**Motion #1** Agenda **Carried**				**Motion #2** Minutes **Carried**				**Motion #3** 2020 Epi Supplement **Carried**			
	Absent	**Yes**	**No**	**Abstain**	**Absent**	**Yes**	**No**	**Abstain**	**Absent**	**Yes**	**No**	**Abstain**
Tana Pradia, Chair				**C**				**C**				**C**
Allen Murray, Vice Chair		**X**				**X**				**X**		
Crystal Starr, Secretary		**X**				**X**				**X**		
Rodney Mills, Aff		**X**				**X**				**X**		
Daphne L. Jones, Comp		**X**				**X**				**X**		
Ronnie Galley, Op		**X**				**X**				**X**		
Bobby Cruz, PA		**X**				**X**				**X**		
Denis Kelly, QI		**X**				**X**				**X**		
Non-voting members at the meeting:												
Veronica Ardoin, Aff												
Steven Vargas, Comp												
Absent members:												
Carol Suazo, Op												
Pete Rodriguez, QI												

MEMBERS	**Motion #4** Joint Comp/ Integrated/EHE Plan **Carried**				**Motion #5** EHE Planning Timeline **Carried**				**Motion #6** Support EHE Planning Structure **Carried**			
	Absent	**Yes**	**No**	**Abstain**	**Absent**	**Yes**	**No**	**Abstain**	**Absent**	**Yes**	**No**	**Abstain**
Tana Pradia, Chair				**C**				**C**				**C**
Allen Murray, Vice Chair		**X**				**X**				**X**		
Crystal Starr, Secretary		**X**				**X**				**X**		
Rodney Mills, Aff		**X**				**X**				**X**		
Daphne L. Jones, Comp		**X**				**X**				**X**		
Ronnie Galley, Op		**X**				**X**				**X**		
Bobby Cruz, PA		**X**				**X**				**X**		
Denis Kelly, QI		**X**				**X**						**X**
Non-voting members at the meeting:												
Veronica Ardoin, Aff												
Steven Vargas, Comp												
Absent members:												
Carol Suazo, Op												
Pete Rodriguez, QI												

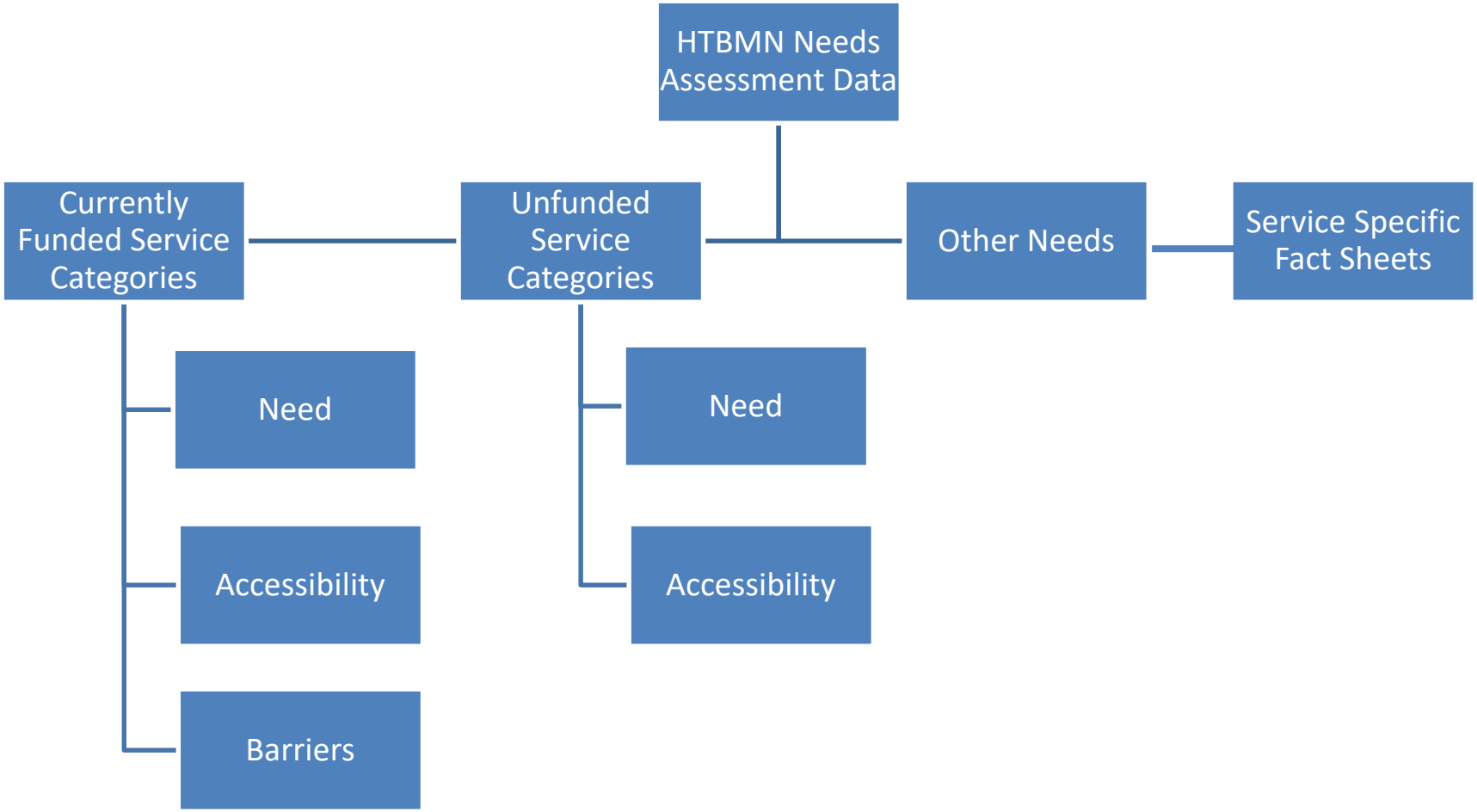
MEMBERS	**Motion #7** FY21 Priority Setting Process **Carried**				**Motion #8** 2020 Principles & Criteria **Carried**				**Motion #9** 2020 Policy for Addressing Unobligated & Carryover Funds **Carried**			
	Absent	**Yes**	**No**	**Abstain**	**Absent**	**Yes**	**No**	**Abstain**	**Absent**	**Yes**	**No**	**Abstain**
Tana Pradia, Chair				**C**				**C**				**C**
Allen Murray, Vice Chair		**X**				**X**						**X**
Crystal Starr, Secretary		**X**				**X**				**X**		
Rodney Mills, Aff		**X**				**X**				**X**		
Daphne L. Jones, Comp		**X**				**X**				**X**		
Ronnie Galley, Op		**X**				**X**				**X**		
Bobby Cruz, PA		**X**				**X**				**X**		
Denis Kelly, QI		**X**				**X**				**X**		
Non-voting members at the meeting:												
Veronica Ardoin, Aff												
Steven Vargas, Comp												
Absent members:												
Carol Suazo, Op												
Pete Rodriguez, QI												

Comprehensive HIV Planning Committee Report

2020 Needs Assessment Data for How to Best Meet the Need

March 23, 2020

Analysis Structure



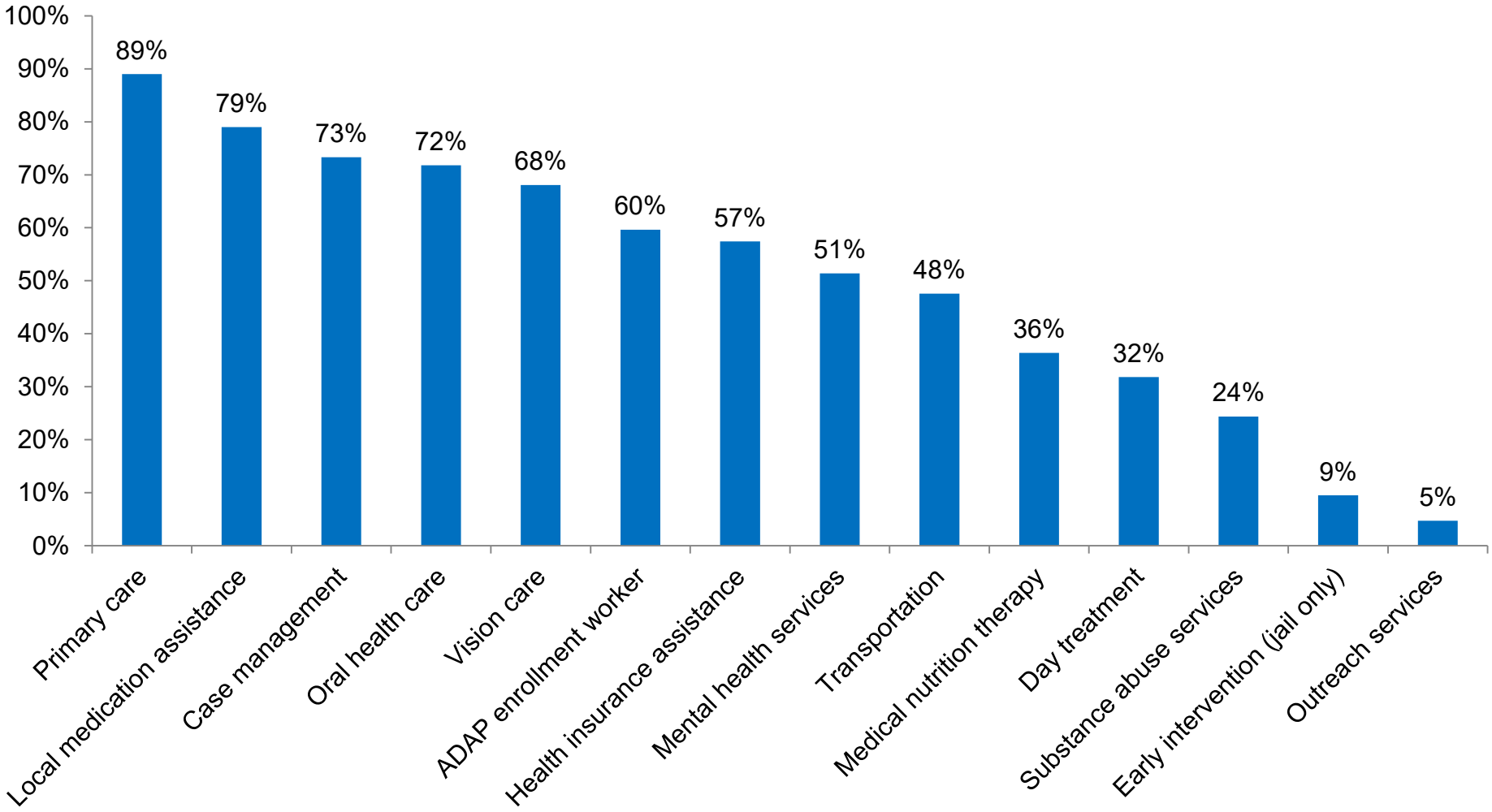
Currently Funded in the Houston EMA/HSDA through RW Part A/B or State Services:

- Primary care
  - Includes vision care
- HIV medication assistance
  - LPAP
  - EFA
- Health insurance assistance
- Oral health care
- Case management
  - Medical/clinical case management
  - Service linkage
- Outpatient alcohol or drug treatment
- Mental health
- Day Treatment
- Hospice (unranked)
- Nutritional supplements
- Language translation
- Transportation
- Outreach services
- ADAP enrollment worker
- Pre-discharge planning (EIS)

Currently Funded Services: Need

GRAPH 1-Ranking of Funded HIV Services in the Houston Area, By Need, 2020

Definition: Percent of needs assessment participants stating they needed the funded service in the past 12 months, regardless of service accessibility.



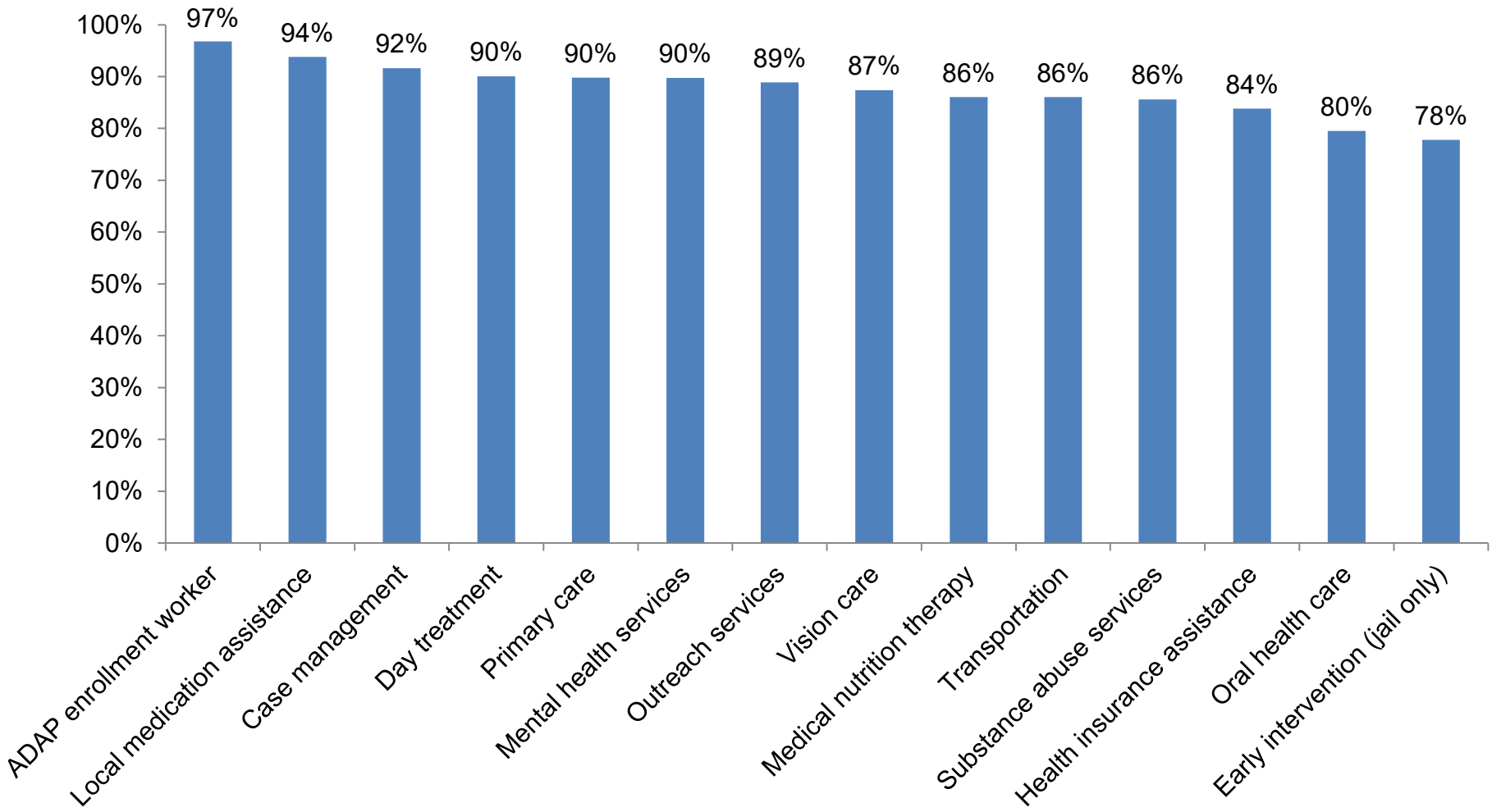
Currently Funded Services: Need

- **Most needed medical service:** Primary care
- **Most needed support service:** Mental health services
- **Greatest changes between 2016 and 2020:**
  - Need decreased the most for case management (↓9 percentage points) and primary care (↓5 percentage points)
  - Need increased the most for local medication assistance and outreach services (↑5 percentage points each)

Currently Funded Services: Accessibility

GRAPH 2-Ranking of Funded HIV Services in the Houston Area, By Accessibility, 2020

Definition: Of needs assessment participants stating they needed the funded service in the past 12 months, the percent stating it was easy to access the service.



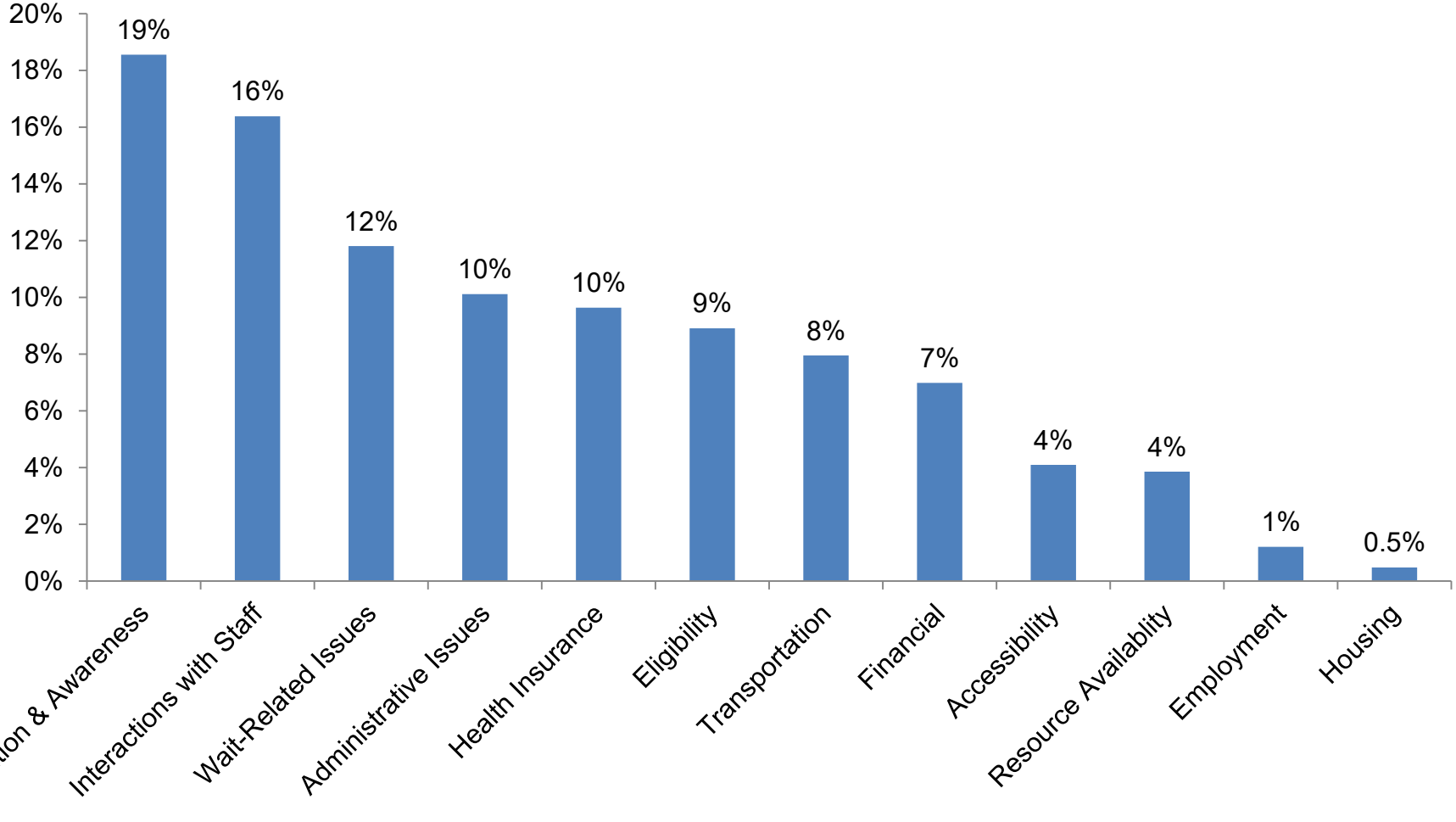
Currently Funded Services: Accessibility

- **Most accessible medical service:** Local medication assistance
- **Most accessible support service:** ADAP enrollment worker
- **Greatest changes between 2016 and 2020:**
  - Accessibility decreased the most for early intervention services (↓7 percentage points)
  - Accessibility increased the most for local medication assistance (↑5 percentage points each)

Currently Funded Services: Barriers

GRAPH 3-Ranking of Types of Barriers to Funded HIV Services in the Houston Area, 2020

Definition: Percent of times each barrier type was reported by needs assessment participants, regardless of funded service, when difficulty accessing needed funded services was reported.



Currently Funded Services: Barriers

- **Barrier type reported most often:** Education and awareness
- **Barrier type reported least often:** Housing
- **Greatest changes between 2016 and 2020:**
  - Barrier reports decreased the most wait-related issues (↓3 percentage points)
  - Barrier reports increased the most for interactions with staff (↑3 percentage points each)

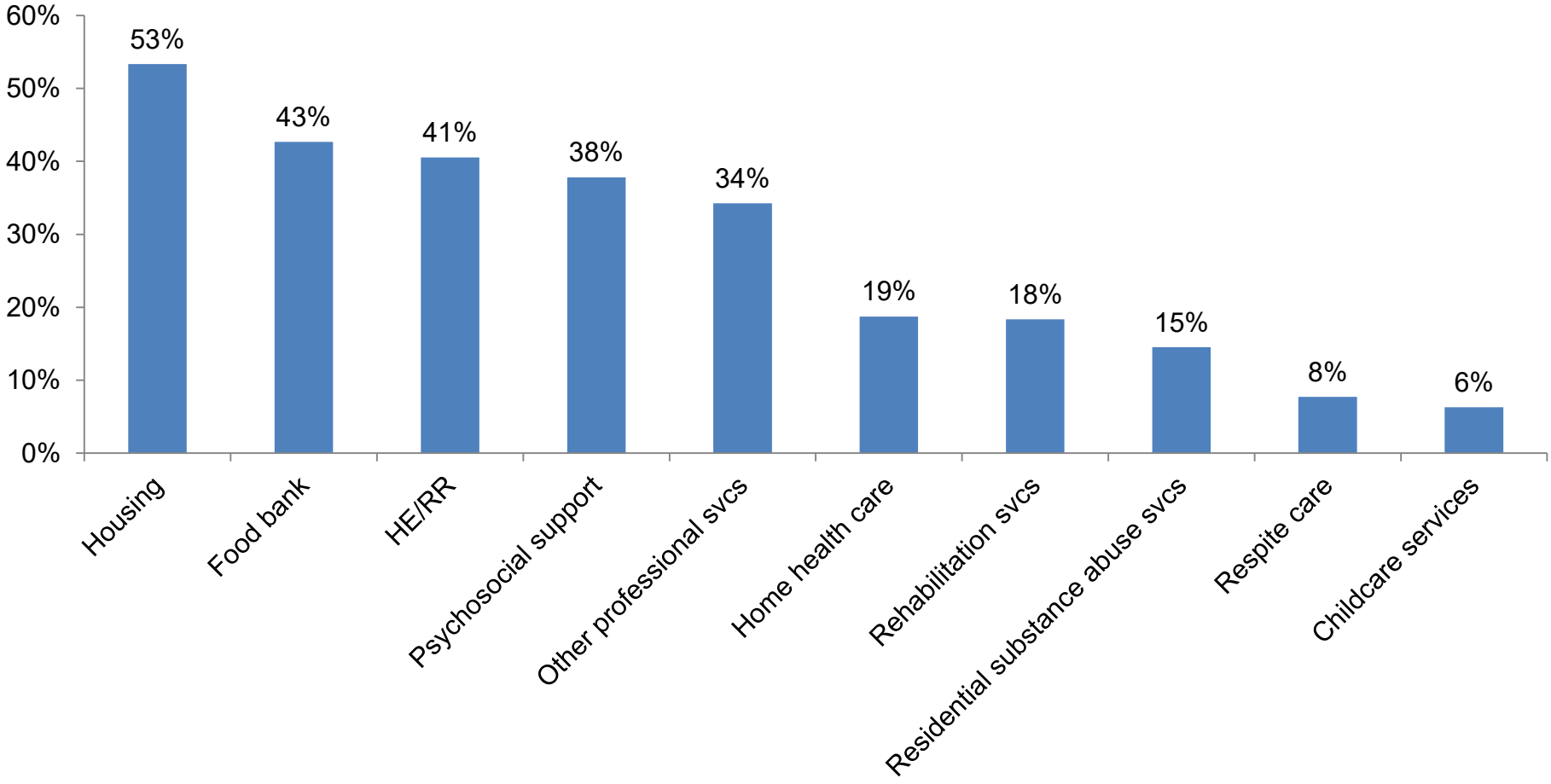
Unfunded Services:

- Home health care
- Child care services
- Food bank
  - Food bank services
  - Home delivered meals
- Health education/risk reduction
- Housing
- Other professional services
  - Legal services
  - Permanency Planning
  - Tax preparation
- Psychosocial support services
  - Online support/groups
  - In person support/groups
- Rehabilitation
- Respite care
- Residential alcohol or drug treatment

Unfunded Services: Need

GRAPH 4-Ranking of Unfunded HIV Services in the Houston Area, By Need, 2020

Definition: Percent of needs assessment participants stating they needed the unfunded service in the past 12 months, regardless of service accessibility.



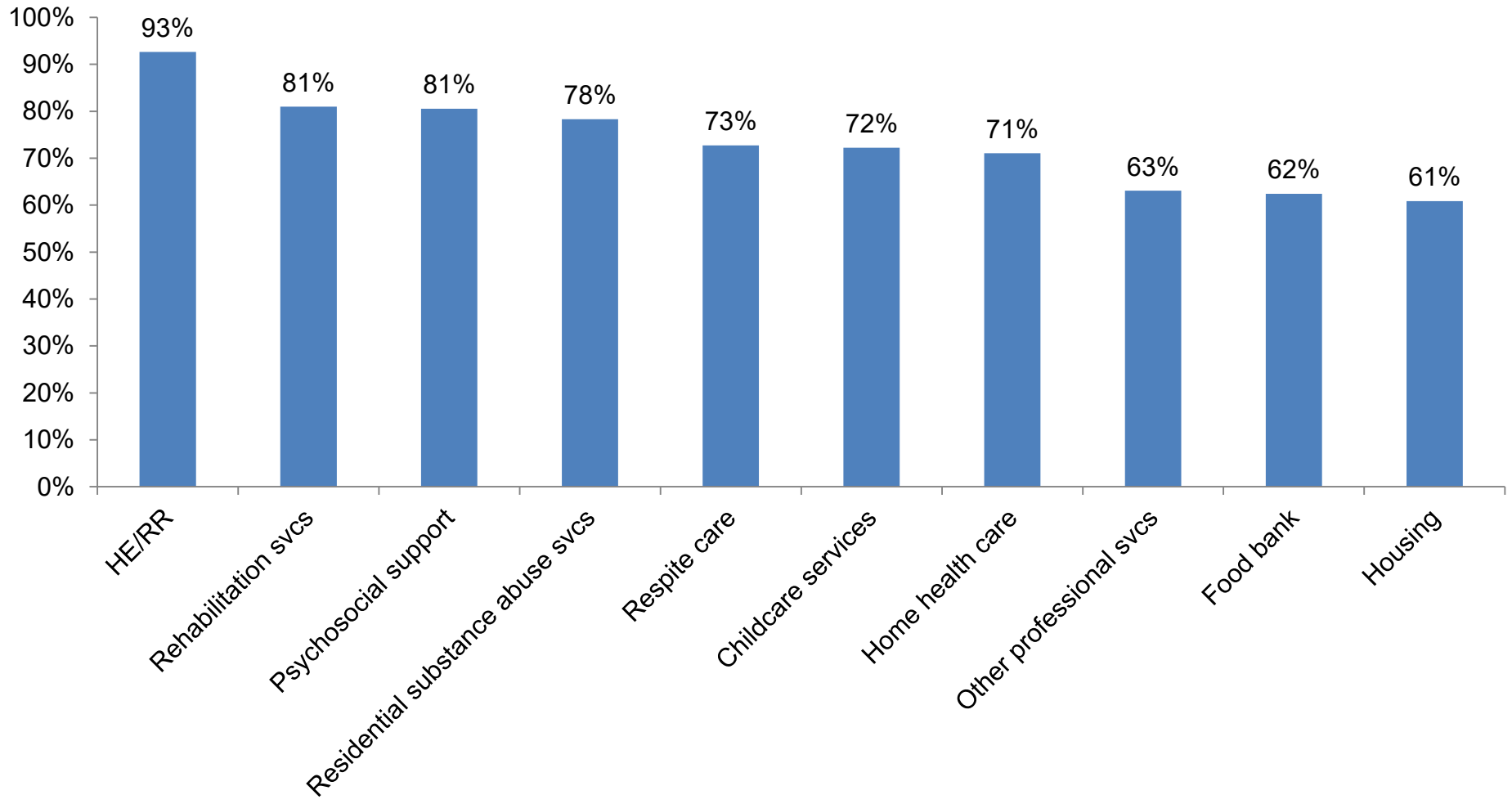
Unfunded Services: Need

- **Most needed unfunded medical service:** Home health care
- **Most needed unfunded support service:** Housing
- **Greatest need within unfunded service subcategories:**
  - Food bank: 69% indicated need for traditional food bank
  - Psychosocial support services: 89% indicated need for in-person support/groups
  - Other professional services: 66% indicated need for legal services

Unfunded Services: Accessibility

GRAPH 5-Ranking of Unfunded HIV Services in the Houston Area, By Accessibility, 2020

Definition: Of needs assessment participants stating they needed the unfunded service in the past 12 months, the percent stating it was easy to access the service



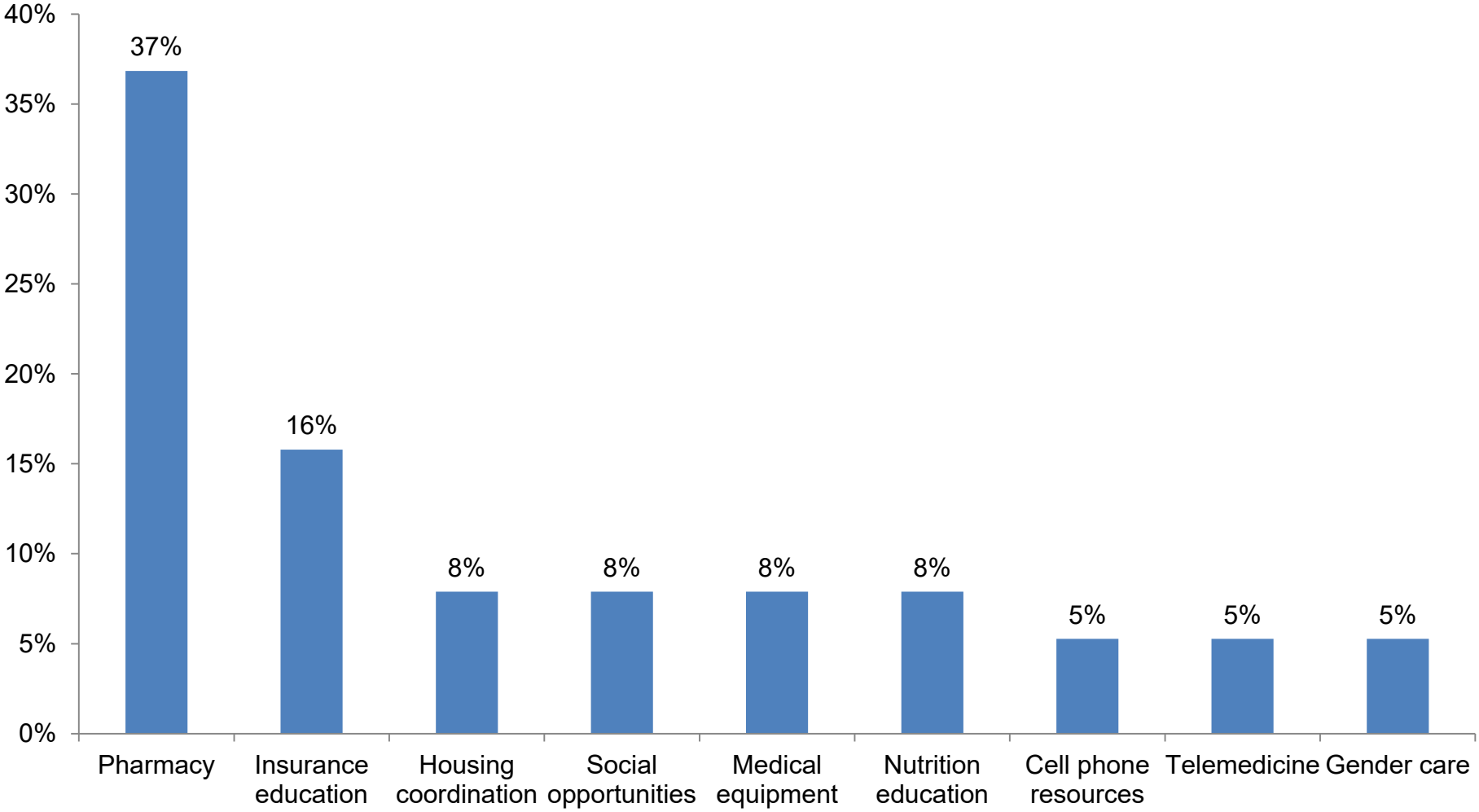
Unfunded Services: Accessibility

- **Most accessible unfunded medical service:** Home health care
- **Most accessible unfunded support service:** Rehabilitation services
- **Least accessible unfunded support service:** Housing

Other Needs

GRAPH 6-Other Needs for HIV Services in the Houston Area, 2020

Definition: Percent of write-in responses by type for the survey question, "What other kinds of services do you need to help you get your HIV medical care?"



Other Needs

- **Pharmacy**
  - These include expanded pharmacy services such as medication delivery and automatic refills
- **Insurance education**
  - These include education on how health insurance works, how to use health insurance, and how to get coverage for dental/vision services

Service-Specific Fact Sheets

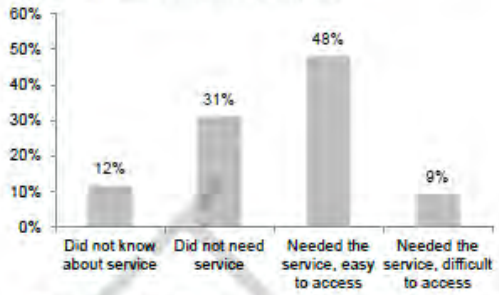
HEALTH INSURANCE ASSISTANCE

Health insurance assistance, also referred to as *health insurance premium and cost-sharing assistance*, provides financial assistance to persons living with HIV (PLWH) with third-party health insurance coverage (such as private insurance, ACA Qualified Health Plans, COBRA, or Medicare) so they can obtain or maintain health care benefits. This includes funding for premiums, deductibles, Advanced Premium Tax Credit liability, and co-pays for both medical visits and medication.

(**Graph 1**) In the 2016 Houston HIV Care Services Needs Assessment, 57% of participants indicated a need for *health insurance assistance* in the past 12 months. 48% reported the service was easy to access, and 9% reported difficulty. 12% stated that they did not know the service was available.

(**Table 1**) When barriers to *health insurance assistance* were reported, the most common barrier types were eligibility and financial (each 23%). Eligibility barriers reported include not meeting eligibility requirements, and redundant or complex processes for meeting/renewing eligibility, while financial barriers reported include inability to afford the service.

GRAPH 1-Health Insurance Assistance, 2020



(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *health insurance assistance*, this analysis shows the following:

- No difference in service accessibility by sex at birth.
- More white PLWH found the service accessible than other race/ethnicities.
- More PLWH age 18 to 24 found the service accessible than other age groups.
- In addition, more transgender, homeless, MSM, and rural PLWH found the service difficult to access when compared to all participants.

TABLE 1-Top 5 Reported Barrier Types for Health Insurance Assistance, 2020

	No.	%
1. Eligibility (EL)	9	23%
2. Financial (F)	9	23%
3. Health Insurance Coverage (I)	7	18%
4. Administrative (AD)	5	13%
5. Education and Awareness (EA)	4	10%

TABLE 2-Health Insurance Assistance, by Demographic Categories, 2020

	Sex (at birth)		Race/ethnicity				Age		
Experience with the Service	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	12%	9%	15%	13%	8%	12%	0%	12%	11%
Did not need service	30%	34%	43%	29%	32%	12%	14%	30%	34%
Needed, easy to access	48%	48%	40%	48%	50%	58%	81%	47%	49%
Needed, difficult to access	9%	9%	3%	9%	10%	15%	5%	12%	6%

TABLE 3-Health Insurance Assistance, by Selected Special Populations, 2020

Experience with the Service	Homeles[a]	MSM[b]	Out of Care[c]	Recently Released[d]	Rural[e]	Transgender[f]
Did not know about service	21%	11%	16%	25%	17%	13%
Did not need service	32%	30%	42%	25%	23%	25%
Needed, easy to access	34%	47%	42%	43%	49%	33%
Needed, difficult to access	13%	12%	0%	8%	11%	29%

[a]Persons reporting current homelessness [b]Men who have sex with men [c]Persons with no evidence of HIV care for 12 mo.
[d]Persons released from incarceration in the past 12 mo. [e]Non-Houston/Harris County residents [f]Persons with discordant sex assigned at birth and current gender

DRAFT

2020 Houston HIV Care Services Needs Assessment

DRAFT

A collaboration of:
Houston Area HIV Services Ryan White Planning Council
Houston HIV Prevention Community Planning Group
Harris County Public Health, Ryan White Grant Administration
Houston Health Department, Bureau of HIV/STD and Viral Hepatitis Prevention
Houston Regional HIV/AIDS Resource Group, Inc.
Harris Health System
People Living with HIV in the Houston Area and Ryan White HIV/AIDS Program Consumers

Approval: Pending

DRAFT

Chapter 1: Demographics

PARTICIPANT COMPOSITION

The following summary of the geographic, demographic, socio-economic, and other composition characteristics of individuals who participated in the 2020 Houston HIV Care Services Needs Assessment provides both a "snapshot" of who is living with HIV in the Houston Area today as well as context for other needs assessment results.

(**Table 1**) Overall, 95% of needs assessment participants resided in Harris County at the time of data collection. The majority of participants were male (66%), African American/Black (63%), and heterosexual (57%). Over half (60%) were age 50 or over, with a median age of 50-54.

The average unweighted household income of participants was $13,493 annually, with the majority living below 100% of federal poverty (**FPL**). A majority of participants (63%) was not working at the time of survey, with 39% collecting disability benefits and 16% unemployed and seeking employment, and 9% retired. Most participants paid for healthcare using Medicaid/Medicare or assistance through Harris Health System (Gold Card).

TABLE 1-Select Participant Characteristics, Houston Area HIV Needs Assessment, 2020

	No.	%		No.	%		No.	%
County of residence			Age range (median: 50-54)			Sex at birth		
Harris	545	94.9%	13 to 17	0	-	Male	384	65.8%
Fort Bend	10	41.7%	18 to 24	17	2.9%	Female	200	34.2%
Liberty	3	0.5%	25 to 34	50	8.6%	Intersex	0	-
Montgomery	7	1.2%	35 to 49	160	27.6%	Transgender	22	3.9%
Other	9	1.6%	50 to 54	105	18.1%	Non-binary / gender fluid	8	1.4%
			55 to 64	161	27.8%	Currently pregnant*	4	2.0%
			65 to 74	79	13.6%	*All currently pregnant respondents reported being in care. The denominator is all respondents reporting female sex at birth		
			75+	8	1.4%			
			Youth (13 to 27)	17	2.9%			
			Seniors (≥50)	353	59.9%			
Primary race/ethnicity			Sexual orientation			Health insurance		
White	78	13.6%	Heterosexual	329	56.8%	Private insurance	53	9.1%
African American/Black	343	59.8%	Gay/Lesbian	176	30.4%	Medicaid/Medicare	388	66.7%
Hispanic/Latino	122	21.3%	Bisexual/Pansexual	52	9.0%	Harris Health System	168	30.1%
Asian American	4	0.7%	Other	22	3.8%	Ryan White Only	138	23.7%
Other/Multiracial	27	4.7%	MSM	238	40.5%	None	11	1.9%
Residency			Yearly income (average: $13,493)			Employment		
Born in the U.S.	511	87.8%	Federal Poverty Level (FPL)			Disabled	263	38.9%
Lived in U.S. > 5 years	58	10.0%	Below 100%	191	67.3%	Unemployed and seeking work	105	15.5%
Lived in U.S. < 5 years	8	1.4%	100%	54	19.0%	Employed (PT)	59	8.7%
In U.S. on visa	1	0.2%	150%	16	5.6%	Retired	59	8.7%
Prefer not to answer	4	0.7%	200%	15	5.3%	Employed (FT)	53	7.8%
			250%	2	0.7%	Self Employed	19	2.8%
			≥300%	6	2.1%	Other	118	17.5%

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(**Table 2**) Certain subgroups of PLWH have been historically underrepresented in HIV data collection, thereby limiting the ability of local communities to address their needs in the data-driven decision-making processes of HIV planning. To help mitigate underrepresentation in Houston Area data collection, efforts were made during the 2020 needs assessment process to *oversample* PLWH who were also members of groups designated as "special populations" due to socio-economic circumstances or other sources of disparity in the HIV service delivery system.

The results of these efforts are summarized in Table 2.

TABLE 2-Representation of Special Populations, Houston Area HIV Needs Assessment, 2020

	No.	%
Young adult (18-24 years)	17	2.9%
Adult age 50+ years	353	59.9%
Homeless	65	11.1%
Unstably Housed	159	29.0%
People who inject drugs (PWID)*	47	8.2%
Male-male sexual contact (MSM)	238	40.5%
Out of care (last 12 months)	24	4.3%
Recently released from incarceration	65	11.6%
Rural (non-Harris County resident)	29	5.1%
Women of color	194	33.2%
Transgender	22	3.8%

*Includes self-administered medications, insulin, steroids, hormones, silicone, or drugs.

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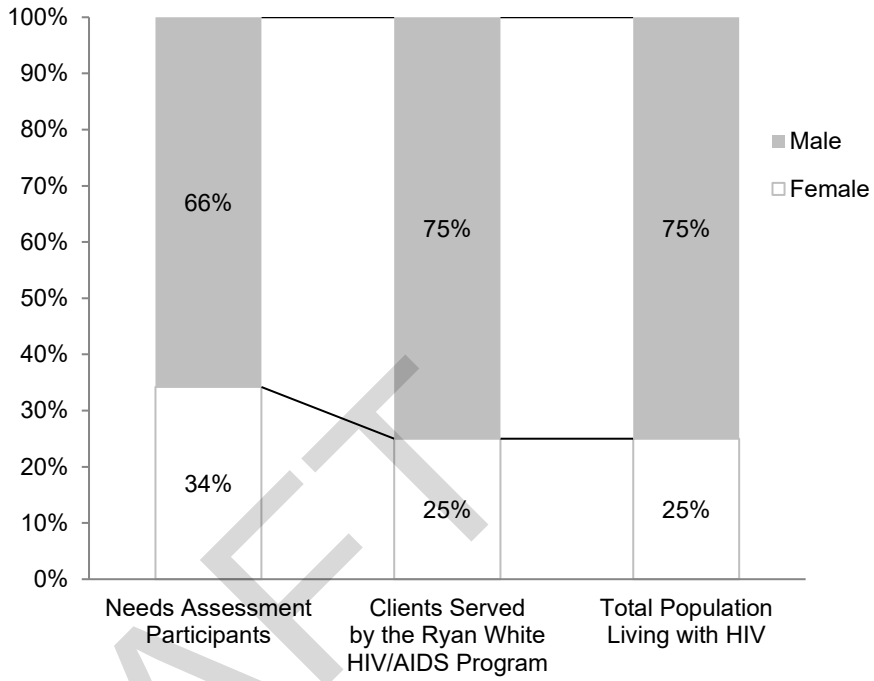
COMPARISON OF NEEDS ASSESSMENT PARTICIPANTS TO HIV PREVALENCE

HIV needs assessments generate information about the needs and service barriers of persons living with HIV (**PLWH**) in a specific geographic area to assist planning bodies and other stakeholders with designing HIV services that best meet those needs. As it is not be feasible to survey every PLWH in the Houston area, multiple administrative and statistical methods are used to generate a sample of PLWH that are reliably representative of *all* PLWH in the area. The same is true in regards to assessing the needs of clients of the Ryan White HIV/AIDS Program.

GRAPH 1-Needs Assessment Participants Compared to Ryan White HIV/AIDS Program Clients[a] and Total HIV Diagnosed Population[b] in the Houston EMA, by Sex at Birth, 2018



[a]Source: CPCDMS as of 12/31/18, Total number of clients served by the Ryan White HIV/AIDS Program Part A, the Minority AIDS Initiative (MAI), Part B, and State Services (State of Texas matching funds). Accessed 4/1/19.
[b]Source: Texas eHARS. Living HIV cases as of 12/31/18.

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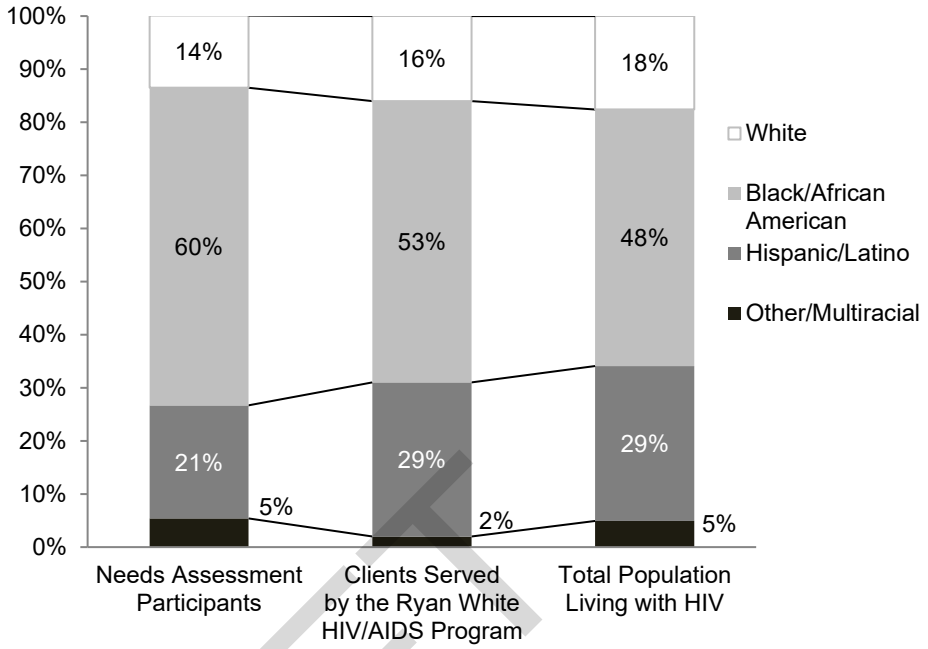
As such, awareness of participant representation compared to the composition of both Ryan White HIV/AIDS Program clients and the total HIV diagnosed population is beneficial when reviewing needs assessment results to document actions taken to mitigate any disproportional results.

(**Graph 1**) In the 2020 Houston HIV Care Services Needs Assessment males (sex at birth) comprised 66% of participants but 75% of all Ryan White clients, and all PLWH in the Houston Eligible Metropolitan Area (**EMA**). This indicates that male PLWH were underrepresented in the needs assessment sample, while female PLWH were overrepresented.

(**Graph 2**) Analysis of race/ethnicity composition also shows disproportionate representation between participants, all Ryan White clients, and all PLWH in the Houston EMA. Black/African American participants were overrepresented at 60% of participants when compared to the proportions of Black/African American Ryan White clients and PLWH. Conversely, White PLWH and Hispanic/Latino PLWH were slighly underrepresented in the needs assessment.

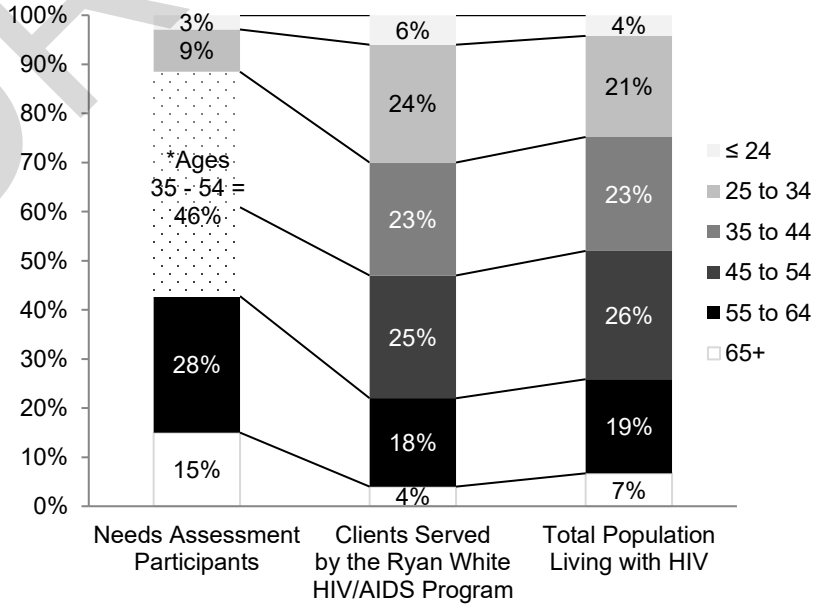
GRAPH 2- Needs Assessment Participants Compared to Ryan White HIV/AIDS Program Clients[a] and Total HIV Diagnosed Population[b] in the Houston EMA, by Race/Ethnicity, 2018



[a]Source: CPCDMS as of 12/31/18, Total number of clients served by the Ryan White HIV/AIDS Program Part A, the Minority AIDS Initiative (MAI), Part B, and State Services (State of Texas matching funds). Accessed 4/1/19.
[b]Source: Texas eHARS. Living HIV cases as of 12/31/18

(**Graph 3**) As referenced in Table 1, 60% of the total needs assessment sample was comprised of individuals age 50 and over. An analysis of age range shows that more needs assessment participants were older than Ryan White clients and PLWH in the Houston EMA. Among needs assessment participants, 28% were ages 55 to 64 and 15% age 65 years and over. Compared to Ryan White clients, 18% were ages 55 to 64 and 4% were 65 and over. Among all PLWH 19% and 7% were in these age groups, respectively. No adolescents (those age 13 to 17) were surveyed. This suggests that youth and young adult PLWH (those age 13 to 24) are generally underrepresented in the needs assessment, while older adults (those age 55 and above) are overrepresented.

GRAPH 3- Needs Assessment Participants Compared to Ryan White HIV/AIDS Program Clients[a] and Total HIV Diagnosed Population[b] in the Houston EMA, by Age[c], 2018



[a]Source: CPCDMS as of 12/31/18, Total number of clients served by the Ryan White HIV/AIDS Program Part A, the Minority AIDS Initiative (MAI), Part B, and State Services (State of Texas matching funds). Accessed 4/1/19.
[b]Source: Texas eHARS. Living HIV cases as of 12/31/18
[c]Excludes ages0-12
*Age ranges 35-44 and 45-54 combined due to differences in question structuring.

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Weighting the Sample

Needs assessment data were statistically weighted by sex at birth, primary race/ethnicity, and age group using current HIV prevalence for the Houston EMA (2018) *prior to* the analysis of results related to service needs and barriers. This was done because the demographic composition of 2020 Houston HIV Care Services Needs Assessment participants was *not* comparable to the composition of all PLWH in the Houston EMA. As such, the results presented in the remaining Chapters of this document are proportional for these three demographic categories only. Appropriate statistical methods were applied throughout the process in order to produce an accurately weighted sample, including a three-level stratification of prevalence data and subsequent data weighting syntax. Voluntary completion on the survey and non-applicable answers comprise the missing or invalid survey entries and are excluded in the statistical analysis; therefore, denominators will further vary across results. All data management and quantitative analysis, including weighting, was performed in IBM© SPSS© Statistics (v. 22). Qualitative analysis was performed in QSR International© NVivo 10.

Sources:

Texas Department of State Health Services (TDSHS) eHARS data through 12-31-2018.

University of Illinois, Applied Technologies for Learning in the Arts and Sciences (ATLAS), Statistical & GIS Software Documentation & Resources, SPPS Statistics 20, Post-stratification weights, 2009.

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INTRODUCTION

What is an HIV needs assessment?

An HIV needs assessment is a process of collecting information about the needs of people living with HIV (**PLWH**) in a specific geographic area. The process involves gathering data *from multiple sources* on the number of HIV cases, the number of PLWH who are not in care, the needs and service barriers of PLWH, and current resources available to meet those needs. This information is then analyzed to identify what services are needed, what barriers to services exist, and what service gaps remain.

Special emphasis is placed on gathering information about the need for services funded by the Ryan White HIV/AIDS Program and on the socio-economic and behavioral conditions experienced by PLWH that may influence their need for and access to services both today and in the future.

In the Houston Area, data collected directly from PLWH in the form of a *survey* are the principal source of information for the HIV needs assessment process. Surveys are administered every three years to a representative sample of PLWH residing in the Houston Area.

How are HIV needs assessment data used?

Needs assessment data are integral to the information base for HIV services planning, and they are used in almost every decision-making process of the Ryan White Planning Council (**RWPC**), including setting priorities for the allocation of funds, designing services that fit the needs of local PLWH, developing the comprehensive plan, and crafting the annual implementation plan. The community also uses needs assessment data for a variety of *non*-Council purposes, such as in writing funding applications, evaluation and monitoring, and the improvement of services by individual providers.

In the Houston Area, HIV needs assessment data are used for the following purposes:

- Ensuring the consumer point-of-view is infused into all of the data-driven decision-making activities of the Houston Area RWPC.
- Revising local service definitions for HIV care, treatment, and support services in order to best meet the needs of PLWH in the Houston Area.
- Setting priorities for the allocation of Ryan White HIV/AIDS Program funds to specific services.
- Establishing goals for and then monitoring the impact of the Houston Area's comprehensive plan for improving the HIV prevention and care system.
- Determining if there is a need to target services by analyzing the needs of particular groups of PLWH.
- Determining the need for special studies of service gaps or subpopulations that may be otherwise underrepresented in data sources.
- By the Planning Council, other Planning Bodies, specific Ryan White HIV/AIDS Program Parts, providers, or community partners to assess needs for services.

Needs assessment data are specifically mandated for use during the Planning Council's *How to Best Meet the Need*, Priority & Allocations, and Comprehensive HIV Planning processes.

Because surveys are administered every three years, results are used in RWPC activities for a three year period. Other data sources produced during interim years of the cycle, such as epidemiologic data and estimates of unmet need, are used to provide additional context for and to better understand survey results.

Sources:

2020 Houston Area HIV Needs Assessment Group (NAG), Analysis Workgroup, Principles for the 2020 Needs Assessment Analysis. Approved 08-19-19.

U.S. Department of Health and Human Services, Health Resources and Services Administration, HIV/AIDS Bureau, Ryan White HIV/AIDS Program Part A Manual Revised 2013. Section XI, Ch 3: Needs Assessment.

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METHODOLOGY

Needs Assessment Planning

Planning the 2020 Houston Area HIV Care Services Needs Assessment was a collaborative process between HIV prevention and care stakeholders, the Houston Area planning bodies for HIV prevention and care, all Ryan White HIV/AIDS Program Parts, and individual providers and consumers of HIV services. To guide the overall process and provide specific subject matter expertise, a series of Needs Assessment-related Workgroups reconvened under the auspices of the Ryan White Planning Council (**RWPC**):

- The Needs Assessment Group (**NAG**) provided overall direction to the needs assessment process. As such, the NAG consisted of voting members from each collaborating partner and from the following workgroups.
- The Epidemiology Workgroup developed the consumer survey sampling plan, which aimed at producing a representative sample of surveys.
- The Survey Workgroup developed the survey instrument and consent language.
- The Analysis Workgroup determined how survey data should be analyzed and reported in order to serve as an effective tool for HIV planning.

In total, 38 individuals in addition to staff participated in the planning process, of which at least 45% were people living with HIV (**PLWH**).

Survey Sampling Plan

Staff calculated the 2020 Houston Area HIV Care Services Needs Assessment sample size based on current total HIV prevalence for the Houston Eligible Metropolitan Area (**EMA**) (2017), with a 95% confidence interval, at both 3% and 4% margin of error. Respondent composition goals were proportional to demographic and geographic representation in total prevalence. Desired sample sizes for funded-agency representation were proportional to total client share for the most recent complete calendar year (2018). Efforts were also taken to over-sample out-of-care consumers and members of special populations. Regular reports of select respondent characteristics were provided to NAG, the Comprehensive HIV Planning Committee, and RWPC during survey administration to assess real-time progress toward attainment of sampling goals and to make sampling adjustments when necessary.

Survey Tool

Data for the 2020 Houston Area HIV Care Services Needs Assessment were collected using a 54-question paper or electronic survey of open-ended, multiple choice, and scaled questions addressing nine topic areas (in order):

- HIV services, needs, and barriers to care
- Communication with HIV medical providers
- HIV diagnosis history
- HIV care history including linkage to care
- Non-HIV co-occurring health concerns (incl. mental health)
- Substance use
- Housing, transportation, and social support
- Financial resources
- Demographics
- HIV prevention activities

The Survey Workgroup determined topics and questions, restructuring and expanding the 45-question 2016 needs assessment survey. Subject matter experts were also engaged to review specific questions. Consistency with the federally-mandated HIV prevention needs assessment for the Houston Area was assured through participation of Houston Health Department staff during the survey development process and alignment of pertinent questions such as those designed to gather demographic information and HIV prevention knowledge and behaviors. A cover sheet explained the purpose of the survey, risks and benefits, planned data uses, and consent. A double-sided tear-sheet of emergency resources and HIV service grievance/complaint process information was also attached, and liability language was integrated within the survey.

Data Collection

Surveys for the 2020 Houston Area HIV Care Services Needs Assessment were administered (1) in pre-scheduled group sessions at Ryan White HIV/AIDS Program providers, HIV Prevention providers, housing facilities, support groups, Harris County community centers, and specific community locations and organizations serving special populations; and (1) online via word of mouth, print, and social media advertising. Staff contacts at each physical location were responsible for session promotion and participant recruitment. Out-of-care consumers were recruited through flyers, word of mouth, print advertisement, and staff promotion.

Inclusion criteria were an HIV diagnosis and residency in counties in the greater Houston Area. Participants were self-selected and self-identified according to these criteria. Surveys were self-administered in English, Spanish, and large-print formats, with staff and bilingual interpreters available for verbal interviewing.

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Participation was voluntary, anonymous, and monetarily incentivized; and respondents were advised of these conditions verbally and in writing. Most surveys were completed in 30 to 40 minutes. Surveys were reviewed on-site by trained staff, interns, and interpreters for completion and translation of written comments; completed surveys were also logged in a centralized tracking database.

In total, 589 consumer surveys were collected from April 2019 to February 2020 during 47 survey sessions at 27 survey sites and online.

Data Management

Data entry for the current Houston Area HIV Care Services Needs Assessment was performed by trained staff and contractors at the RWPC Office of Support using simple numerical coding. Skip-logic questions were entered based on first-order responses; and affirmative responses only were entered for "check-all" questions. Additional variables were recoded during data entry and data cleaning. Surveys that could not be accurately entered by staff ere eliminated. Data are periodically reviewed for quality assurance, and a line-list level data cleaning protocol was applied prior to analysis. When data entry and cleaning are complete, a data weighting syntax will be created and applied to the sample for: sex at birth, primary race/ethnicity, and age group based on a three-level stratification of current HIV prevalence for the Houston EMA (2018). Missing or invalid survey entries will be excluded from analysis per variable; therefore, denominators vary across results. Also, proportions will not calculated with a denominator of the total number of completed surveys for every variable due to missing or "check-all" responses. Data entry for the 2020 Houston Area HIV Care Services Needs Assessment was performed by trained staff and contractors at the RWPC Office of Support using simple numerical coding. Skip-logic questions were entered based on first-order responses; and affirmative responses only were entered for "check-all" questions. Additional variables were recoded during data entry and data cleaning. Surveys that could not be accurately entered by staff or that were found to be duplicates were eliminated (n=11). Data were periodically reviewed for quality assurance, and a line-list level data cleaning protocol was applied prior to analysis. In addition, a data weighting syntax was created and applied to the sample for: sex at birth, primary race/ethnicity, and age group based on a three-level stratification of current HIV prevalence for the Houston EMA (2018), producing a total weighted sample size of 589 (8% in Spanish). Missing or invalid survey entries are excluded from analysis per variable; therefore, denominators vary across results. Also, proportions are not calculated with a denominator of 589 surveys for every variable due to missing or "check-all" responses. All data management and analysis was performed in IBM© SPSS© Statistics (v. 22) and QSR International© NVivo 10.

Limitations

The 2020 Houston Area HIV Care Services Needs Assessment produced data that are unique because they reflect the first-hand perspectives and lived experiences of PLWH in the Houston Area. However, there are limitations to the generalizability, reliability, and accuracy of the results that should be considered during their interpretation and use. These limitations are summarized below:

- *Convenience Sampling*. Multiple administrative methods were used to survey a representative sample of PLWH in the Houston Area proportional to geographic, demographic, transmission risk, and other characteristics. Despite extensive efforts, respondents were not randomly selected, and the resulting sample is not proportional to current HIV prevalence. To mitigate this bias, data were statistically weighted for sex at birth, primary race/ethnicity, and age group using current HIV prevalence for the Houston EMA (2018). Results presented from Chapters 2 through the end of this report are proportional for these three demographic categories only. Similarly, the majority of respondents were Ryan White HIV/AIDS Program clients at the time of data collection, but may have received services outside the program that are similar to those currently funded. Therefore, it not possible to determine if results reflect non-Ryan White systems.
- *Margin of Error*. Staff met the minimum sampling plan goal of at least 588 valid surveys for a margin of error of 4.00%, based on a 95% confidence interval. This indicates that 95% of the time, the quantitative results reported this document are anticipated to be correct by a margin of 4 percentage points. For this reason, results reported in this document are statistically significant, generalizable, and are suitable for planning purposes to draw general conclusions about the overall needs and experiences of people living with HIV in the Houston area.
- *Reporting Bias*. Survey participants were self-selected and self-identified, and the answers they provided to survey questions were self-reported. Since the survey tool was anonymous, data could not be corroborated with medical or other records. Consequently, results

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should not be used as empirical evidence of reported health or treatment outcomes. Other data sources should be used if confirmation of results is needed.

- *Instrumentation*. Full data accuracy cannot be assured due to variability in comprehension and completeness of surveys by individual respondents. Though trained staff performed real-time quality reviews of each survey, there were missing data as well as indications of misinterpretation of survey questions. It is possible that literacy and language barriers contributed to this limitation as well.
- *Data management*. The use of both staff and contractors to enter survey data could have produced transcription and transposition errors in the dataset. A line-list level data cleaning protocol was applied to help mitigate errors.

Data presented here represent the most current repository of *primary* data on PLWH in the Houston Area. With these caveats in mind, the results can be used to describe the experiences of PLWH in the Houston Area and to draw conclusions on how to best meet the HIV service needs of this population.

Sources:

Houston Area HIV Needs Assessment Group (NAG), Epidemiology Workgroup, 2019 Survey Sampling Principles and Plan, Approved 03-18-19.

Texas Department of State Health Services (DSHS) eHARS data through 12-31-2018, extracted as of spring 2020.

University of Illinois, Applied Technologies for Learning in the Arts and Sciences (ATLAS), Statistical & GIS Software Documentation & Resources, SPPS Statistics 20, Post-stratification weights, 2009.

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BACKGROUND

The Houston Area

Houston is the fourth largest city in the U.S., the largest city in the State of Texas, and as well as one of the most racially and ethnically diverse major American metropolitan area. Spanning 600 square miles, Houston is also the least densely populated major metropolitan area. Houston is the seat of Harris County, the most populous county in the State of Texas and the third most populous in the country. The United States Census Bureau estimates that Harris County has almost 4.7 million residents, around half of which live in the city of Houston.

Beyond Houston and Harris County, local HIV service planning extends to four geographic service areas in the greater Houston Area:

- *Houston/Harris County* is the geographic service area defined by the Centers for Disease Control and Prevention (**CDC**) for HIV prevention. It is also the local reporting jurisdiction for HIV surveillance, which mandates all laboratory evidence related to HIV/AIDS performed in Houston/Harris County be reported to the local health authority.
- The *Houston Eligible Metropolitan Area* (**EMA**) is the geographic service area defined by the Health Resources and Services Administration (**HRSA**) for the Ryan White HIV/AIDS Program Part A and Minority AIDS Initiative (**MAI**). The Houston EMA includes six counties: Chambers, Fort Bend, Harris, Liberty, Montgomery, and Waller.
- The *Houston Health Services Delivery Area* (**HSDA**) is the geographic service area defined by the Texas Department of State Health Services (**TDSHS**) for the Ryan White HIV/AIDS Program Part B and the Houston Area's HIV service funds from the State of Texas. The HSDA includes the six counties in the EMA listed above plus four additional counties: Austin, Colorado, Walker, and Wharton.
- The *Houston Eligible Metropolitan Statistical Area* (**EMSA**) is the geographic service area defined by U.S. Department of Housing and Urban Development (**HUD**) for the Housing Opportunities for People with AIDS (**HOPWA**) program. The EMSA consists of the six counties in the EMA listed above plus Austin, Brazoria, Galveston, and San Jacinto Counties.

Together, these geographic service areas encompass 13 counties in southeast Texas, spanning from the Gulf of Mexico into the Texas Piney Woods.

HIV in the Houston Area

In keeping with national new HIV diagnosis trends, the number of new cases of HIV in the Houston Area has remained relatively stable; HIV-related mortality has steadily declined, and the number of people living with HIV has steadily increased. According to current disease surveillance data, there are 29,078 diagnosed people living with HIV in the Houston EMA (**Table 1**). The majority are male (75%), over the age of 45 (52%), and have MSM transmission risk (58%), while almost half are Black/African American (48%).

TABLE 1-Diagnosed People Living with HIV in the Houston EMA, 2018[a]

	#	%
Total	29,078	100.0%
Sex at Birth		
Male	21,829	75.1%
Female	7,249	24.9%
Race/Ethnicity		
White	5,109	17.6%
Black/African American	14,044	48.3%
Hispanic/Latino	8,493	29.2%
Other/Multiracial	1432	4.9%
Age		
0 - 12	54	0.2%
13 - 24	1,170	4.0%
25 - 34	5,986	20.6%
35 - 44	6,752	23.2%
45 - 54	7,594	26.1%
55 - 64	5,580	19.2%
65+	1,942	6.7%
Transmission Risk[b]		
Male-male sexual contact (MSM)	16,818	57.8%
Person who injects drugs (PWID)	2,256	7.8%
MSM/PWID	1,192	4.1%
Sex with Male/Sex with Female	8,455	29.1%
Perinatal transmission	340	1.2%
Adult other	17	0.1%

[a]Source: Texas eHARS, Diagnosed PLWH in the Houston EMA between 1/1/2018 and 12/31/2018

[b]Cases with unknown risk have been redistributed based on historical patterns of risk ascertainment and reclassification.

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The CDC ranks the Houston Area (specifically, the Houston-Baytown-Sugarland, TX statistical area) 10th highest in the nation for new HIV diagnoses and 11th in cases of progressed/Stage 3 HIV (formerly known as AIDS). In February 2019, the U.S. Department of Health and Human Services (**HHS**) launched the cross-agency initiative *Ending the HIV Epidemic: A Plan for America* with an overarching goal to reduce new HIV transmission in the U.S. by 90% by 2030. This initiative identified Harris County as a priority county due to the high rate and number of new HIV diagnoses, and plans to introduce additional resources, technology, and technical assistance to support local HIV prevention and treatment activities. Of the 29,078 diagnosed PLWH in the Houston Area, 75% are in medical care for HIV, but only 59% have a suppressed viral load.

HIV Services in the Houston Area

Both governmental agencies and non-profit organizations provide HIV services in the Houston Area through direct HIV services provision and/or function as Administrative Agents which contract to direct service providers. The goal of HIV care in the Houston Area is to create a seamless system that supports people at risk for or living with HIV with a full array of educational, clinical, mental, social, and support services to prevent new infections and support PLWH with high-quality, life-extending care. In addition, two local HIV Planning Bodies provide mechanisms for those living with and affected by HIV to design prevention and care services. Each of the primary sources in the Houston Area HIV service delivery system is described below:

- Comprehensive HIV prevention activities in the Houston Area are provided by the Houston Health Department (**HHD**), a directly-funded CDC grantee, and the Texas Department of State Health Services (**DSHS**). Prevention activities include health education and risk reduction, HIV testing, disease investigation and partner services, linkage to care for newly diagnoses and out of care PLWH. The Houston Area HIV Prevention Community Planning Group provides feedback and to HHD in its design and implementation of HIV prevention activities.
- The Ryan White HIV/AIDS Program Part A and MAI provide core medical and support services for HIV-diagnosed residents of the Houston EMA. These funds are administered by the Ryan White Grant Administration of Harris County Public Health. The Houston Area Ryan White Planning Council designs Part A and MAI funded services for the Houston EMA.
- The Ryan White HIV/AIDS Program Parts B, C, D, and State Services provide core medical and support services for HIV-diagnosed residents of the Houston HSDA, with special funding provided to meet the needs of women, infants, children, and youth. The Houston Regional HIV/AIDS Resource Group (**TRG**) administers these funds. The Ryan White Planning Council also designs Part B and State Services for the Houston HSDA. Additional programs supported by TRG include reentry housing through HOPWA funds and support of the grassroots END HIV Houston coalition.
- HOPWA provides grants to community organizations to meet the housing needs of low-income persons living with HIV. HOPWA services include assistance with rent, mortgage, and utility payments, case management, and supportive housing. These funds are administered by the City of Houston Housing and Community Development for the Houston EMSA.

Together, these key agencies, the direct service providers that they fund, and the two local Planning Bodies ensure the greater Houston Area has a seamless system of prevention, care, treatment, and support services that best meets the needs of people at risk for or living with HIV.

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Sources:

Centers for Disease Control and Prevention, *Diagnoses of HIV Infection in the United States and Dependent Areas, 2018*; vol. 30. Published November 2015. Accessed 03/06/2020. Available at: www.cdc.gov/hiv/topics/surveillance/resources/reports/.

U.S. Census Bureau, American FactFinder. Houston (city), Texas and Harris (county), Texas Accessed: 03/03/2020. Available at: https://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml

U.S. Department of Health and Human Services, *Ending the HIV Epidemic: A Plan for America*. February 2019.

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Chapter 2:
Service Needs and Barriers

OVERALL SERVICE NEEDS AND BARRIERS

As payer of last resort, the Ryan White HIV/AIDS Program provides a spectrum of HIV-related services to people living with HIV (**PLWH**) who may not have sufficient resources for managing HIV. The Houston Area HIV Services Ryan White Planning Council identifies, designs, and allocates funding to locally-provided HIV care services. Housing services for PLWH are provided through the federal Housing Opportunities for People with AIDS (**HOPWA**) program through the City of Houston Housing and Community Development Department and for PLWH recently released from incarceration through the Houston Regional HIV/AIDS Resource Group (**TRG**). The primary function of HIV needs assessment activities is to gather information about the need for and barriers to services funded by the local Houston Ryan White HIV/AIDS Program, as well as other HIV-related programs like HOPWA and the Houston Health Department's (**HHD**) prevention program.

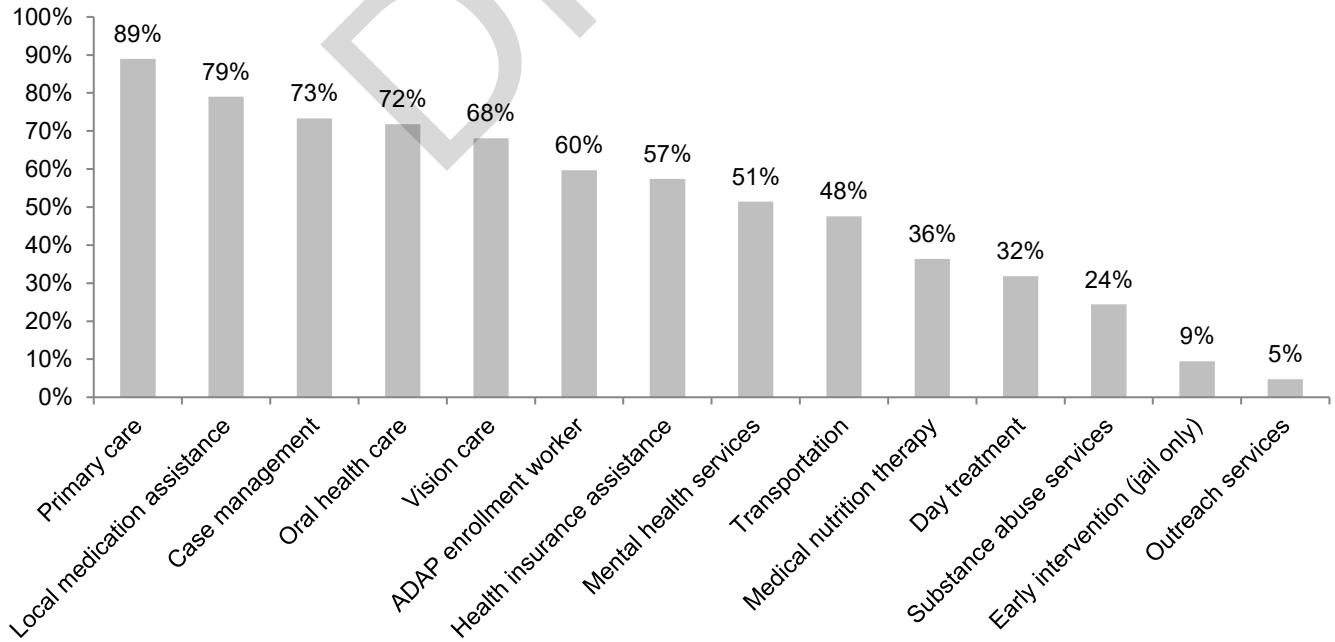
Overall Ranking of Funded Services, by Need

At the time of survey, 17 HIV core medical and support services were funded through the Houston Area Ryan White HIV/AIDS Program. Participants of the 2020 Houston HIV Care Services Needs Assessment were asked to indicate which of these funded services they needed in the past 12 months.

(**Graph 1**) All funded services except hospice and linguistics were analyzed and received a ranking of need. Emergency financial assistance was merged with local medication assistance, and non-medical case management was merged with medical case management. At 89%, primary care was the most needed funded service in the Houston Area, followed by local medication assistance at 79%, case management at 73%, oral health care at 72%, and vision care at 68%. Primary care had the highest need ranking of any core medical service, while ADAP enrollment worker received the highest need ranking of any support service. Compared to the last Houston Area HIV needs assessment conducted in 2016, need ranking decreased for most services. The percent of needs assessment participants reporting need for a particular service decreased the most for case management and primary care, while the percent of those indicating a need for local medication assistance and early intervention services increased from 2016.

GRAPH 1-Ranking of HIV Services in the Houston Area, By Need, 2020

Definition: Percent of needs assessment participants stating they needed the service in the past 12 months, regardless of service accessibility.
Denominator: 569-573 participants, varying between service categories



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Overall Ranking of Funded Services, by Accessibility

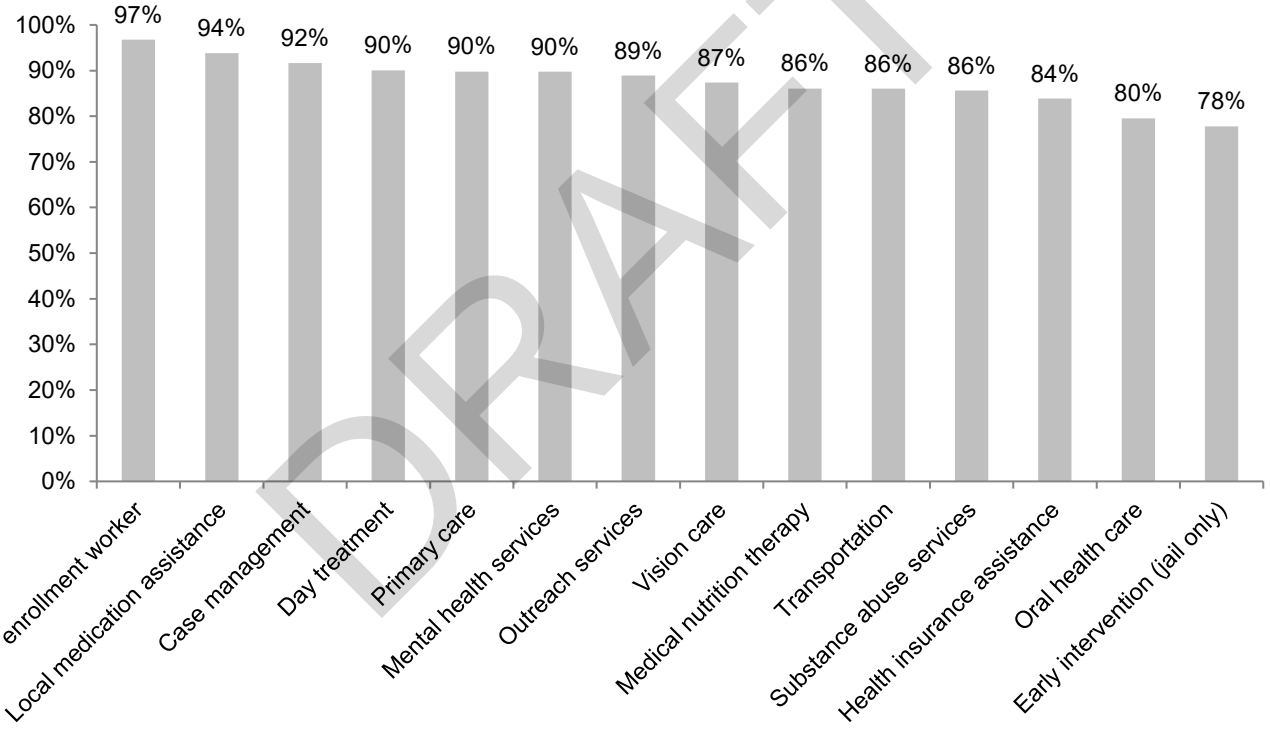
Participants were asked to indicate if each of the funded Ryan White HIV/AIDS Program services they needed in the past 12 months was easy or difficult for them to access. If difficulty was reported, participants were then asked to provide a brief description on the barrier experienced. Results for both topics are presented below.

(**Graph 2**) All funded services except hospice and linguistics were analyzed and received a ranking of accessibility. The most accessible service was ADAP enrollment worker at 97% ease of access, followed by local medication assistance at 94% and case management at 92%. Local medication assistance had the highest accessibility ranking of any core medical service, while ADAP enrollment worker received the highest accessibility ranking of any support service. Compared 2016 needs assessment, reported accessibility on remained stable on average. The greatest increase in percent of participants reporting ease of access was observed in local medication assistance, while the greatest decrease in accessibility was reported for early intervention services.

GRAPH 2-Ranking of HIV Services in the Houston Area, By Accessibility, 2020

Definition: Of needs assessment participants stating they needed the service in the past 12 months, the percent stating it was easy to access the service.

Denominator: 569-573 participants, varying between service categories



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Overall Ranking of Barriers Types Experienced by Consumers

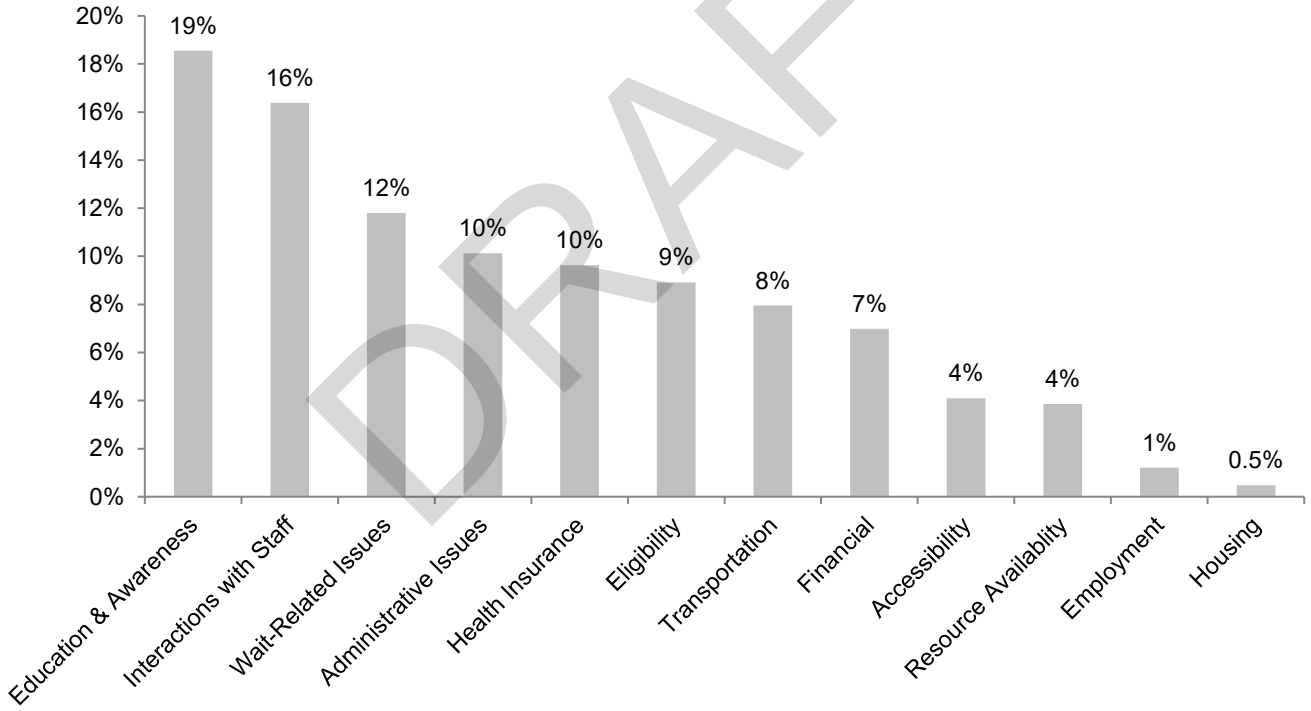
Since the 2016 Houston Area HIV Needs Assessment, participants who reported *difficulty* accessing needed services have been asked to provide a brief description of the barrier or barriers encountered, rather than select from a list of pre-selected barriers. In 2016, staff used recursive abstraction to categorize participant descriptions into 39 distinct barriers, then grouped together into 12 nodes, or barrier types. This categorization schema was applied to reported barriers in the 2020 survey.

(**Graph 3**) Overall, fewer barriers were reported in 2020 (415 barrier reports) than in previous 2016 needs assessment (501 barrier reports), despite the increase in sample size in 2020. Across all funded services, the barrier types reported most often related to service education and awareness issues (19% of all reported barriers); interactions with staff (16%), wait-related issues (12%); administrative issues (10%); and issues relating to health insurance coverage (10%). Housing issues (homelessness or intimate partner violence) were reported least often as barriers to funded services (1%). Between the 2016 and 2020 HIV needs assessments, the percentage of barriers relating to interactions with staff increased by 3 percentage points, while wait-related issues decreased by 3 percentage points.

For more information on barrier types reported most often by service category, please see the Service-Specific Fact Sheets.

GRAPH 3-Ranking of Types of Barriers to HIV Services in the Houston Area, 2018

Definition: Percent of times each barrier type was reported by needs assessment participants, regardless of service, when difficulty accessing needed services was reported.
Denominator: 415 barrier reports



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Descriptions of Barriers Encountered

All funded services were reported to have barriers, with an average of 35 reports of barriers per service. Participants reported the least barriers for Linguistic Services (one barrier) and the most barriers for Oral Health Care (90 barriers). In total, 415 reports of barriers across all services were indicated in the sample.

(**Table 1**) Within education and awareness, knowledge of the availability of the service and where to go to access the service accounted for 81% of barriers reported. Being put on a waitlist accounted for a majority (56%) of wait-related barriers. Poor communication and/or follow up from staff members when contacting participants comprised a majority (53%) of barriers related to staff interactions. Forty-five percent (45%) of eligibility barriers related to participants being told they did not meet eligibly requirements to receive the service while redundant or complex processes for renewing eligibility accounted for an additional 39% of eligibility barriers. Among administrative issues, long or complex processes required to obtain services sufficient to create a burden to access comprised most (57%) of the barriers reported.

A majority of health insurance-related barriers occurred because the participant was under-insured or experiencing coverage gaps for needed services or medications (55%) or they were uninsured (25%). The largest proportion (91%) of transportation-related barriers occurred when participants had no access to transportation. Inability to afford the service accounted for all barriers relating to participant financial resources. Services being offered at an inaccessible distance accounted for most (76%) of accessibility-related barriers, though it is noteworthy that low or no literacy accounted for 12% of accessibility-related barriers. Receiving resources that were insufficient to meet participant needs accounted for most resource availability barriers. Intimate partner violence accounted for both reports of housing-related barriers. Instances in which the participant's employer did not provide sufficient sick/wellness leave for attend appointments comprised most (80%) employment-related barriers.

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TABLE 1-Barrier Proportions within Each Barrier Type, 2020					
Education & Awareness	%	Wait-Related Issues	%	Interactions with Staff	%
Availability (Didn't know the service was available)	51%	**Waitlist** (Put on a waitlist)	56%	**Communication** (Poor correspondence/ Follow up from staff)	53%
Definition (Didn't know what service entails)	2%	**Unavailable** (Waitlist full/not available resulting in client not being placed on waitlist)	22%	**Poor Treatment** (Staff insensitive to clients)	13%
Location (Didn't know where to go [location or location w/in agency])	30%	**Wait at Appointment** (Appointment visits take long)	12%	**Resistance** (Staff refusal/ resistance to assist clients)	6%
Contact (Didn't know who to contact for service)	16%	**Approval** (Long durations between application and approval)	10%	**Staff Knowledge** (Staff has no/ limited knowledge of service)	19%
				Referral (Received service referral to provider that did not meet client needs)	10%
Eligibility	%	Administrative Issues	%	Health Insurance	%
Ineligible (Did not meet eligibility requirements)	45%	**Staff Changes** (Change in staff w/o notice)	10%	**Uninsured** (Client has no insurance)	25%
Eligibility Process (Redundant process for renewing eligibility)	39%	**Understaffing** (Shortage of staff)	7%	**Coverage Gaps** (Certain services/medications not covered)	55%
Documentation (Problems obtaining documentation needed for eligibility)	16%	**Service Change** (Change in service w/o notice)	7%	**Locating Provider** (Difficulty locating provider that takes insurance)	18%
		Complex Process (Burden of long complex process for accessing services)	57%	**ACA** (Problems with ACA enrollment process)	3%
		Dismissal (Client dismissal from agency)	7%		
		Hours (Problem with agency hours of operation)	12%		
Transportation		Financial	%	Accessibility	%
No Transportation (No or limited transportation options)	91%	**Financial Resources** (Could not afford service)	100%	**Literacy** (Cannot read/difficulty reading)	12%
Providers (Problems with special transportation providers such as Metrolift or Medicaid transportation)	9%			**Spanish Services** (Services not made available in Spanish)	0%
				Released from Incarceration (Restricted from services due to probation, parole, or felon status)	12%
				Distance (Service not offered within accessible distance)	76%
Resource Availability	%	Housing	%	Employment	%
Insufficient (Resources offered insufficient for meeting need)	81%	**Homeless** (Client is without stable housing)	0%	**Unemployed** (Client is unemployed)	20%
Quality (Resource quality was poor)	19%	**IPV** (Interpersonal domestic issues make housing situation unsafe)	100%	**Leave** (Employer does not provide sick/wellness leave for appointments)	80%

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NEEDS AND ACCESSIBILITY FOR UNFUNDED SERVICES

The Ryan White HIV/AIDS Program allows funding of 13 core medical services and 15 support services, though only 17 of these services were funded in the Houston area at the time of survey. For this first time, the 2020 Houston Area HIV Needs Assessment collected data on the need for and accessibility to services that are allowable under Ryan White, but not currently funded in the Houston area. While these services are not funded under Ryan White, other funding sources in the community may offer them.

Overall Ranking of Unfunded Services, by Need

Participants of the 2020 Houston HIV Care Services Needs Assessment were asked to indicate which of allowable but currently unfunded services they needed in the past 12 months.

(**Graph 4**) At 53%, housing was the most needed unfunded service in the Houston Area, followed by food bank at 43%, health education/risk reduction at 41%, psychosocial support services at 38%, and other professional services at 34%. Of participants indicating a need for food bank, 69% reported needing services from a food bank, 6% reported needing home delivered meals, and 25% indicated need for both types of food bank service. Among participants indicating a need for psychosocial support services, 89% reported needing an in-person support group, 3% reported needing an online support group, and 8% indicated need for both types of psychosocial support.

Home health care had the highest need ranking of any unfunded core medical service, while housing received the highest need ranking of any unfunded support service.

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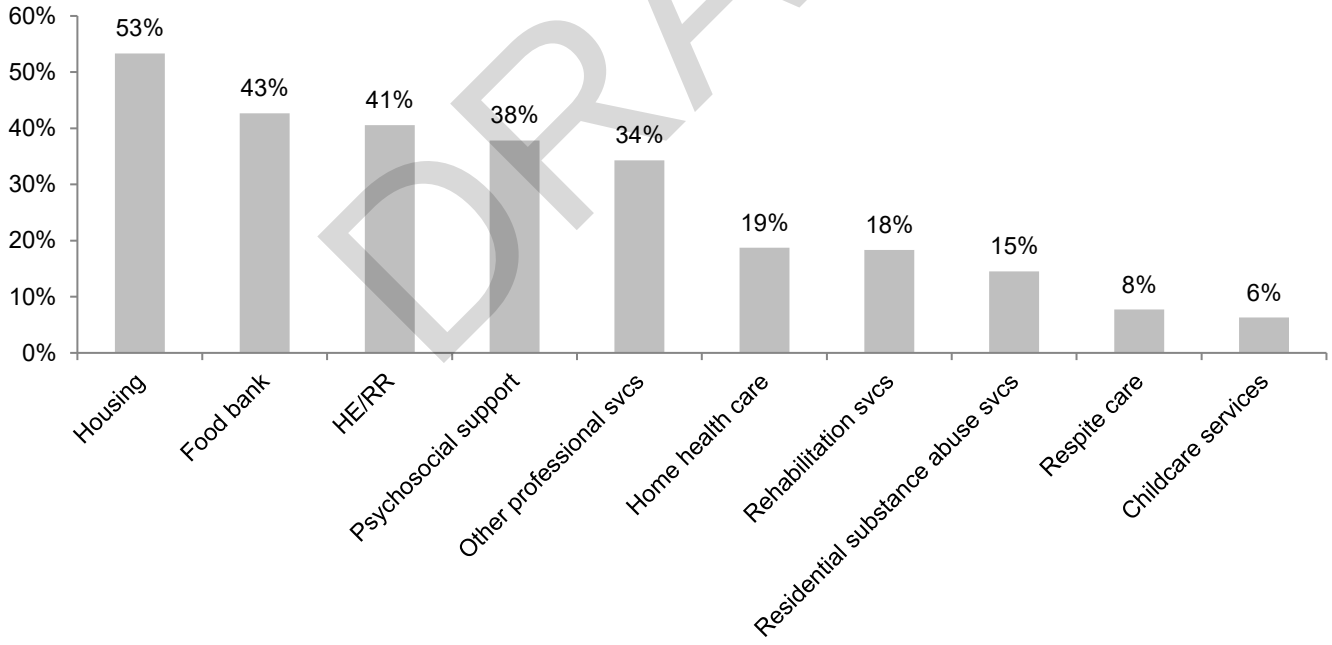
GRAPH 4-Ranking of Unfunded HIV Services in the Houston Area, By Need, 2020

Definition: Percent of needs assessment participants stating they needed the unfunded service in the past 12 months, regardless of service accessibility.

Denominator: 569-572 participants, varying between service categories



Overall Ranking of Unfunded Services, by Accessibility

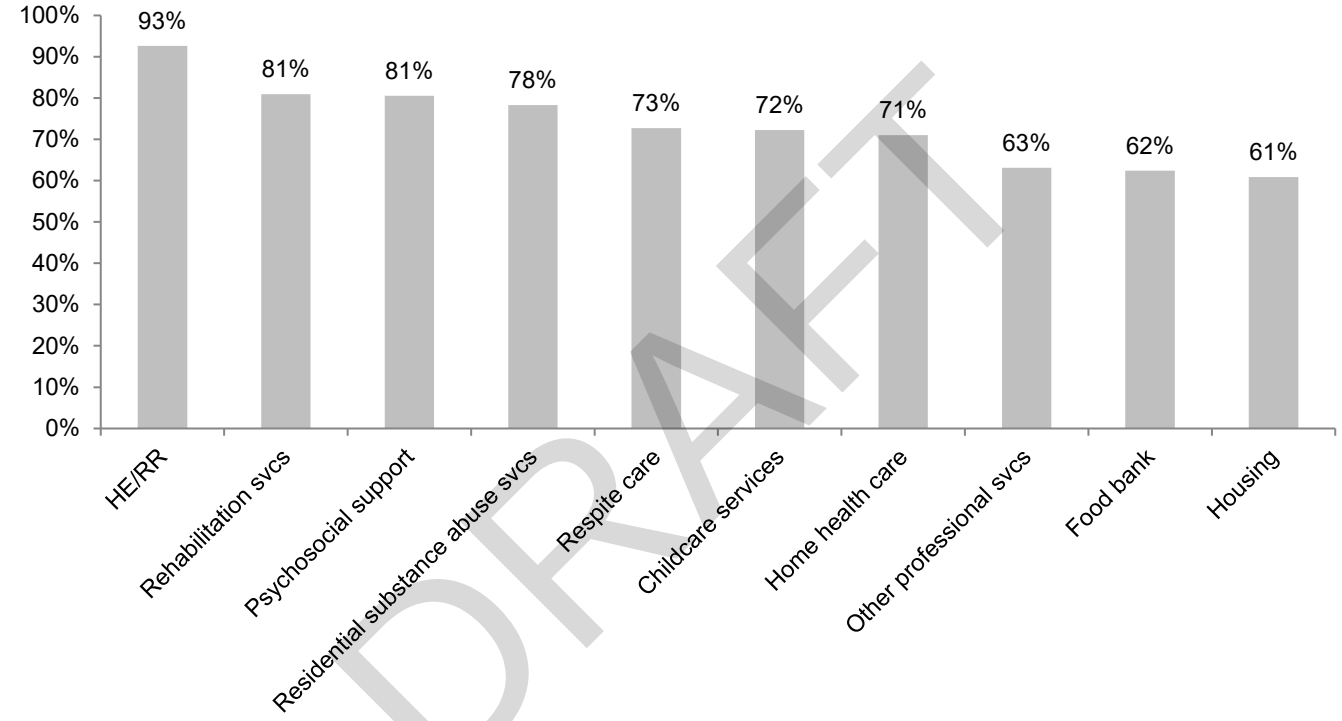
Participants were asked to indicate if each of the unfunded HIV services they needed in the past 12 months was easy or difficult for them to access.

(**Graph 5**) The most accessible unfunded service was health education/risk reduction at 93% ease of access, followed by rehabilitation services at 81%, psychosocial support services at 81%, residential substance abuse services at 78%, and respite care at 73%. The least accessible needed unfunded services was housing at 61%. Home health care had the highest accessibility ranking of any core medical service, while rehabilitation services received the highest accessibility ranking of any support service.

GRAPH 5-Ranking of Unfunded HIV Services in the Houston Area, By Accessibility, 2020

Definition: Of needs assessment participants stating they needed the unfunded service in the past 12 months, the percent stating it was easy to access the service.

Denominator: 569-572 participants, varying between service categories



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Other Identified Needs

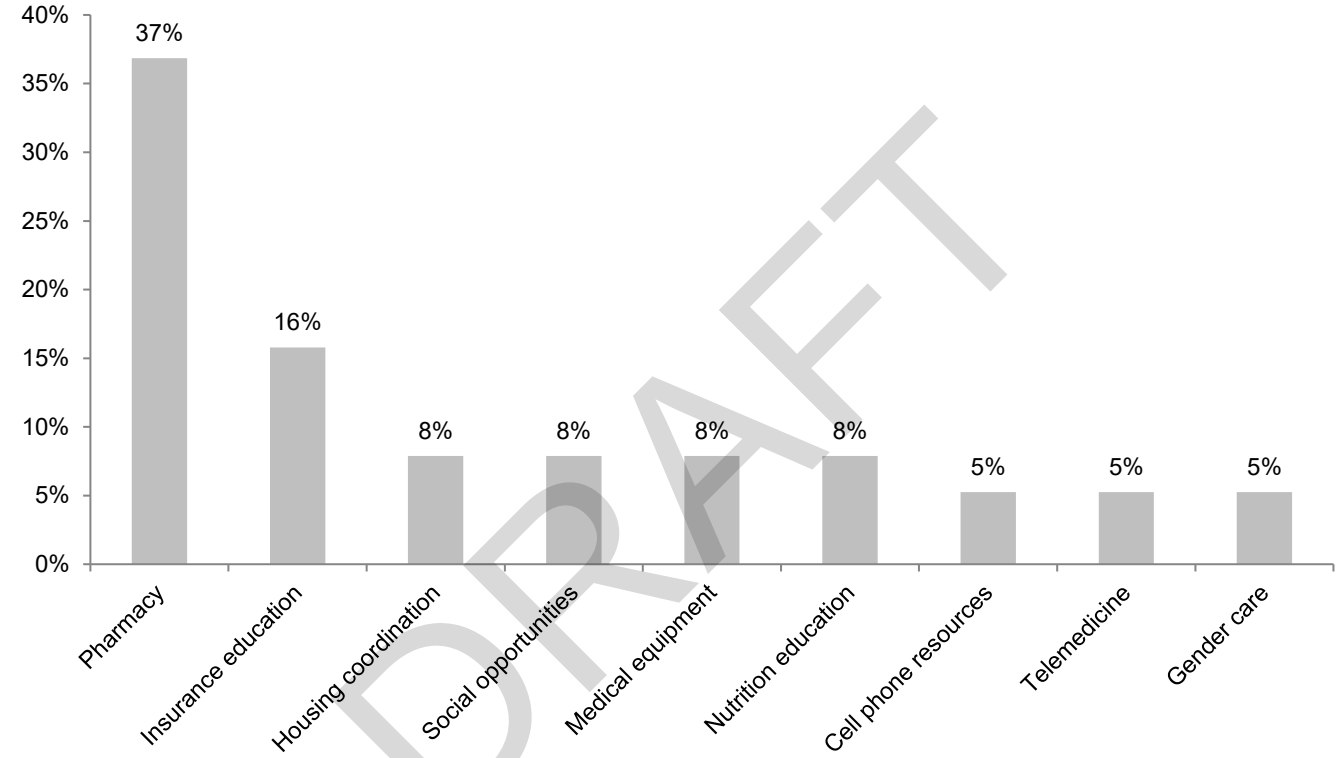
In addition to the allowable HIV services listed above, participants were also encouraged to write-in other types of needed services to gauge any new or emerging service needs in the community.

(**Graph 6**) Participants identified nine additional needs not otherwise described in funded and unfunded services above. The most common identified needs related to pharmacy, such as having medications delivered and automatic refills, at 37%. This was followed by insurance education at 16%, and housing coordination, social opportunities, coverage for medical equipment, and nutrition education, each at 8%.

GRAPH 6-Other Needs for HIV Services in the Houston Area, 2020

Definition: Percent of write-in responses by type for the survey question, "What other kinds of services do you need to help you get your HIV medical care?"

Denominator: 38 write-in responses



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Service-Specific Fact Sheets

ADAP ENROLLMENT WORKER

AIDS Drug Assistance Program (ADAP) enrollment worker, technically referred to as *referral for health care and support,* describes a service that helps people living with HIV (PLWH) access medication coverage by ensuring the efficient and accurate submission of ADAP applications to the Texas HIV Medication Program (THMP). ADAP enrollment workers meet with all potential new ADAP enrollees, explain ADAP program benefits and requirements, assist clients with the submission of complete, accurate ADAP applications, and submit annual re-certifications.

(**Graph 1**) In the 2020 Houston HIV Care Services Needs Assessment, 60% of participants indicated a need for *ADAP enrollment worker* in the past 12 months. 58% reported the service was easy to access, and 2% reported difficulty. 12% stated they did not know the service was available.

(**Table 1**) When barriers to *ADAP enrollment worker* were reported, the most common barrier type was education and awareness (30%). Education and awareness barriers reported include lack of knowledge about service availability and who to contact to access the service.

GRAPH 1-ADAP Enrollment Worker, 2020

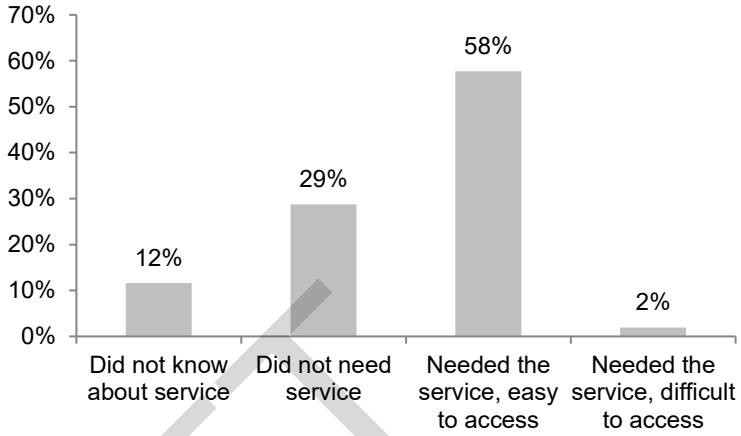

TABLE 1-Top 3 Reported Barrier Types for ADAP Enrollment Worker, 2020

	No.	%
1. Education and Awareness (EA)	3	30%
2. Administrative (AD)	2	20%
3. Eligibility (EL)	2	20%

(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *ADAP enrollment worker*, this analysis shows the following:

- More females than males found the service accessible.
- More Hispanic/Latino PLWH found the service accessible than other race/ethnicities.
- More PLWH age 18 to 24 found the service accessible than other age groups.

In addition, more out of care, rural, and homeless PLWH found the service difficult to access when compared to all participants.

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TABLE 2-ADAP Enrollment Worker, by Demographic Categories, 2020

	Sex (at birth)		Race/ethnicity				Age		
Experience with the Service	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	12%	9%	8%	13%	12%	4%	12%	9%	8%
Did not need service	28%	31%	32%	36%	20%	12%	28%	31%	32%
Needed, easy to access	57%	58%	57%	50%	66%	77%	57%	58%	57%
Needed, difficult to access	2%	1%	3%	2%	1%	8%	2%	1%	3%

TABLE 3-ADAP Enrollment Worker, by Selected Special Populations, 2020

Experience with the Service	Homeless[a]	MSM[b]	Out of Care[c]	Recently Released[d]	Rural[e]	Transgender[f]
Did not know about service	8%	6%	0%	5%	0%	18%
Did not need service	7%	12%	0%	0%	3%	9%
Needed, easy to access	76%	71%	100%	89%	91%	64%
Needed, difficult to access	10%	11%	0%	5%	6%	9%

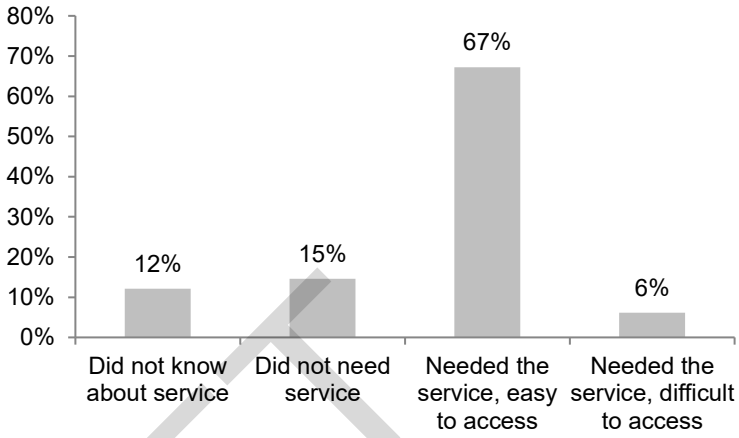
[a]Persons reporting current homelessness [b]Men who have sex with men [c]Persons with no evidence of HIV care for 12 mo.
[d]Persons released from incarceration in the past 12 mo. [e]Non-Houston/Harris County residents [f]Persons with discordant sex assigned at birth and current gender

CASE MANAGEMENT

Case management, technically referred to as *medical case management, clinical case management, or service linkage*, describes a range of services that help connect persons living with HIV (PLWH) to HIV care, treatment, and support services and to retain them in care. Case managers assess client needs, develop service plans, and facilitate access to services through referrals and care coordination. Case management also includes treatment readiness and adherence counseling.

(**Graph 1**) In the 2020 Houston HIV Care Services Needs Assessment, 73% of participants indicated a need for *case management* in the past 12 months. 67% reported the service was easy to access, and 6% reported difficulty. 12% stated they did not know the service was available.

GRAPH 1-Case Management, 2020



(**Table 1**) When barriers to *case management* were reported, the most common barrier type was interactions with staff (37%). Staff interaction barriers reported include poor correspondence or follow up, poor treatment, limited staff knowledge of services, and service referral to provider that did not meet client needs.

TABLE 1-Top 4 Reported Barrier Types for Case Management, 2020

	No.	%
1. Interactions with Staff (S)	13	37%
2. Education and Awareness (EA)	8	8%
3. Administrative (AD)	6	8%
4. Wait (4)	2	2%

(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *case management*, this analysis shows the following:

- More females than males found the service accessible.
- More white PLWH found the service accessible than other race/ethnicities.
- More PLWH age 50+ found the service accessible than other age groups.

In addition, more out of care, transgender, recently released from incarceration, and homeless PLWH found the service difficult to access when compared to all participants.

TABLE 2-Case Management, by Demographic Categories, 2020

	Sex (at birth)		Race/ethnicity				Age		
Experience with the Service	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	17%	7%	10%	11%	15%	4%	5%	15%	9%
Did not need service	59%	68%	22%	14%	13%	8%	29%	12%	17%
Needed, easy to access	20%	23%	64%	68%	66%	81%	52%	67%	69%
Needed, difficult to access	4%	3%	4%	7%	6%	8%	14%	6%	5%

TABLE 3-Case Management, by Selected Special Populations, 2020

Experience with the Service	Homeless[a]	MSM[b]	Out of Care[c]	Recently Released[d]	Rural[e]	Transgender[f]
Did not know about service	10%	13%	13%	11%	37%	17%
Did not need service	13%	18%	16%	8%	9%	13%
Needed, easy to access	68%	63%	58%	71%	51%	58%
Needed, difficult to access	10%	6%	13%	11%	3%	13%

[a]Persons reporting current homelessness [b]Men who have sex with men [c]Persons with no evidence of HIV care for 12 mo.
[d]Persons released from incarceration in the past 12 mo. [e]Non-Houston/Harris County residents [f]Persons with discordant sex assigned at birth and current gender

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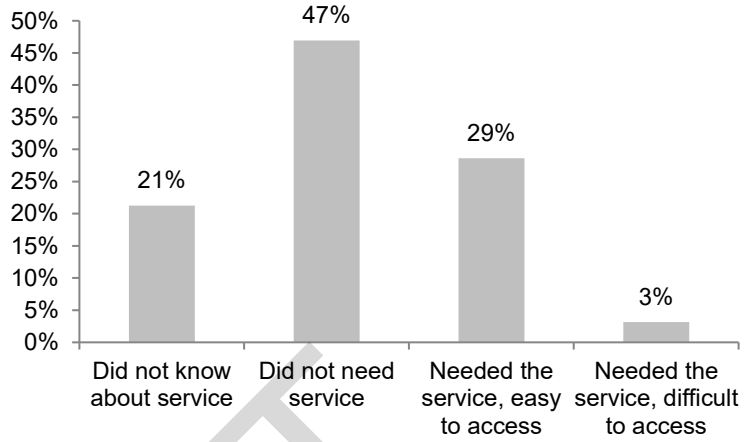
DAY TREATMENT

Day treatment, technically referred to as *home and community-based health services*, provides therapeutic nursing, support services, and activities for persons living with HIV (PLWH) at a community-based location. This service does not currently include in-home health care, in-patient hospitalizations, or long-term nursing facilities.

(**Graph 1**) In the 2020 Houston HIV Care Services Needs Assessment, 32% of participants indicated a need for *day treatment* in the past 12 months. 29% reported the service was easy to access, and 3% reported difficulty. 21% stated that they did not know the service was available.

GRAPH 1-Day Treatment, 2020



(**Table 1**) When barriers to *day treatment* were reported, the most common barrier type was education and awareness (25%). Education and awareness barriers reported include lack of knowledge about service availability and where to access the service.

TABLE 1-Top 3 Reported Barrier Types for Day Treatment, 2020

	No.	%
1. Education and Awareness (EA)	3	25%
2. Administrative (AD)	2	17%
3. Wait (W)	2	17%

(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services For *day treatment*, this analysis shows the following:

- More females than males found the service accessible.
- More other/multiracial PLWH found the service accessible than other race/ethnicities.
- More PLWH age 18 to 24 found the service accessible than other age groups.
- In addition, more transgender and homeless PLWH found the service difficult to access when compared to all participants.

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TABLE 2- Day Treatment, by Demographic Categories, 2020

	Sex (at birth)		Race/ethnicity				Age		
Experience with the Service	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	22%	18%	18%	24%	20%	19%	14%	26%	15%
Did not need service	46%	50%	69%	49%	40%	42%	38%	45%	51%
Needed, easy to access	28%	29%	12%	24%	38%	31%	52%	25%	32%
Needed, difficult to access	3%	2%	1%	3%	2%	4%	0%	4%	1%

TABLE 3- Day Treatment, by Selected Special Populations, 2020

Experience with the Service	Homeless[a]	MSM[b]	Out of Care[c]	Recently Released[d]	Rural[e]	Transgender[f]
Did not know about service	27%	24%	23%	31%	26%	28%
Did not need service	29%	49%	52%	30%	66%	36%
Needed, easy to access	35%	24%	26%	38%	9%	20%
Needed, difficult to access	8%	3%	0%	2%	0%	16%

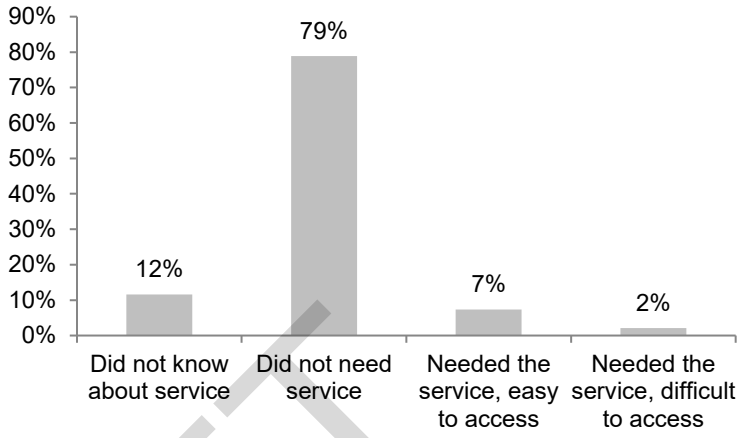
[a]Persons reporting current homelessness [b]Men who have sex with men [c]Persons with no evidence of HIV care for 12 mo.
[d]Persons released from incarceration in the past 12 mo. [e]Non-Houston/Harris County residents [f]Persons with discordant sex assigned at birth and current gender

EARLY INTERVENTION (JAIL ONLY)

Early intervention services (EIS) refers to the provision of HIV testing, counseling, and referral in the Ryan White HIV/AIDS Program setting. In the Houston Area, the Ryan White HIV/AIDS Program funds EIS to persons living with HIV (PLWH) who are incarcerated in the Harris County Jail. Services focus on post-incarceration care coordination to ensure continuity of primary care and medication adherence post-release.

(**Graph 1**) In the 2020 Houston Area HIV needs assessment, 9% of participants indicated a need for *early intervention services* in the past 12 months. 7% reported the service was easy to access, and 2% reported difficulty. 12% stated that they did not know the service was available.

GRAPH 1-Early Intervention (Jail Only), 2020



(**Table 1**) When barriers to *early intervention services* were reported, the most common barrier type was interactions with staff (67%). Interactions with staff barriers reported include poor correspondence or follow up, poor treatment, and service referral to provider that did not meet client needs.

TABLE 1-Top 4 Reported Barrier Types for Early Intervention (Jail Only), 2020

	No.	%
1. Interactions with Staff (S)	6	67%
2. Education and Awareness (EA)	3	33%

(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *early intervention services*, this analysis shows the following:

- More females than males found the service accessible.
- More Hispanic/Latino PLWH found the service accessible than other race/ethnicities.
- More PLWH age 18 to 24 found the service accessible than other age groups.
- In addition, more recently released, homeless, transgender, and MSM PLWH found the service difficult to access when compared to all participants.

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TABLE 2-Early Intervention (Jail Only), by Demographic Categories, 2020

	Sex (at birth)		Race/ethnicity				Age		
Experience with the Service	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	13%	8%	5%	12%	12%	12%	5%	12%	11%
Did not need service	77%	84%	83%	78%	81%	31%	86%	77%	82%
Needed, easy to access	8%	7%	8%	9%	5%	38%	5%	9%	6%
Needed, difficult to access	2%	1%	4%	2%	1%	19%	0%	3%	1%

TABLE 3-Early Intervention (Jail Only), by Selected Special Populations, 2020

Experience with the Service	Homeless[a]	MSM[b]	Out of Care[c]	Recently Released[d]	Rural[e]	Transgender[f]
Did not know about service	13%	14%	6%	15%	14%	4%
Did not need service	66%	79%	87%	43%	80%	83%
Needed, easy to access	16%	5%	6%	31%	6%	8%
Needed, difficult to access	5%	3%	0%	11%	0%	4%

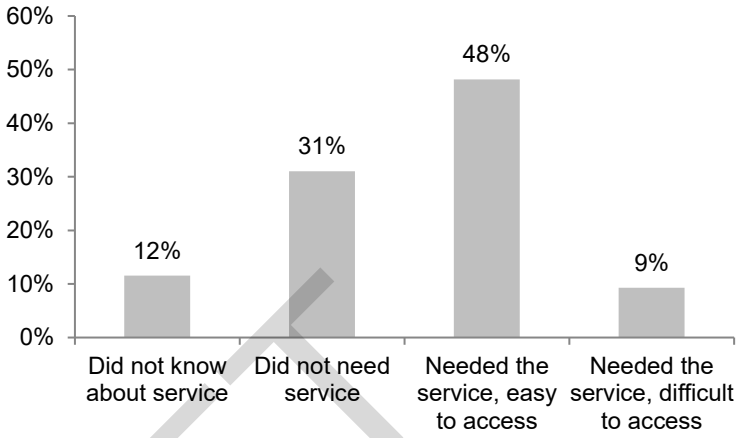
[a]Persons reporting current homelessness [b]Men who have sex with men [c]Persons with no evidence of HIV care for 12 mo.
[d]Persons released from incarceration in the past 12 mo. [e]Non-Houston/Harris County residents [f]Persons with discordant sex assigned at birth and current gender

HEALTH INSURANCE ASSISTANCE

Health insurance assistance, also referred to as *health insurance premium and cost-sharing assistance*, provides financial assistance to persons living with HIV (PLWH) with third-party health insurance coverage (such as private insurance, ACA Qualified Health Plans, COBRA, or Medicare) so they can obtain or maintain health care benefits. This includes funding for premiums, deductibles, Advanced Premium Tax Credit liability, and co-pays for both medical visits and medication.

(**Graph 1**) In the 2016 Houston HIV Care Services Needs Assessment, 57% of participants indicated a need for *health insurance assistance* in the past 12 months. 48% reported the service was easy to access, and 9% reported difficulty. 12% stated that they did not know the service was available.

GRAPH 1-Health Insurance Assistance, 2020



(**Table 1**) When barriers to *health insurance assistance* were reported, the most common barrier types were eligibility and financial (each 23%). Eligibility barriers reported include not meeting eligibility requirements, and redundant or complex processes for meeting/renewing eligibility, while financial barriers reported include inability to afford the service.

TABLE 1-Top 5 Reported Barrier Types for Health Insurance Assistance, 2020

	No.	%
1. Eligibility (EL)	9	23%
2. Financial (F)	9	23%
3. Health Insurance Coverage (I)	7	18%
4. Administrative (AD)	5	13%
5. Education and Awareness (EA)	4	10%

(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *health insurance assistance,* this analysis shows the following:

- No difference in service accessibility by sex at birth.
- More white PLWH found the service accessible than other race/ethnicities.
- More PLWH age 18 to 24 found the service accessible than other age groups.
- In addition, more transgender, homeless, MSM, and rural PLWH found the service difficult to access when compared to all participants.

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TABLE 2-Health Insurance Assistance, by Demographic Categories, 2020

	Sex (at birth)		Race/ethnicity				Age		
Experience with the Service	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	12%	9%	15%	13%	8%	12%	0%	12%	11%
Did not need service	30%	34%	43%	29%	32%	12%	14%	30%	34%
Needed, easy to access	48%	48%	40%	48%	50%	58%	81%	47%	49%
Needed, difficult to access	9%	9%	3%	9%	10%	15%	5%	12%	6%

TABLE 3-Health Insurance Assistance, by Selected Special Populations, 2020

Experience with the Service	Homeles[a]	MSM[b]	Out of Care[c]	Recently Released[d]	Rural[e]	Transgender[f]
Did not know about service	21%	11%	16%	25%	17%	13%
Did not need service	32%	30%	42%	25%	23%	25%
Needed, easy to access	34%	47%	42%	43%	49%	33%
Needed, difficult to access	13%	12%	0%	8%	11%	29%

[a]Persons reporting current homelessness [b]Men who have sex with men [c]Persons with no evidence of HIV care for 12 mo.
[d]Persons released from incarceration in the past 12 mo. [e]Non-Houston/Harris County residents [f]Persons with discordant sex assigned at birth and current gender

HOSPICE

Hospice is end-of-life care for persons living with HIV (PLWH) who are in a terminal stage of illness (defined as a life expectancy of 6 months or less). This includes room, board, nursing care, mental health counseling, physician services, and palliative care.

(**Graph 1**) In the 2020 Houston HIV Care Services Needs Assessment, 8% of participants indicated a need for *hospice* in the past 12 months. 7% reported the service was easy to access, and 1% reported difficulty. 17% stated that they did not know the service was available.

(**Table 1**) Only two barriers were reported for hospice. This number is too small to detect any pattern in service barriers for hospice.

GRAPH 1-Hospice, 2020

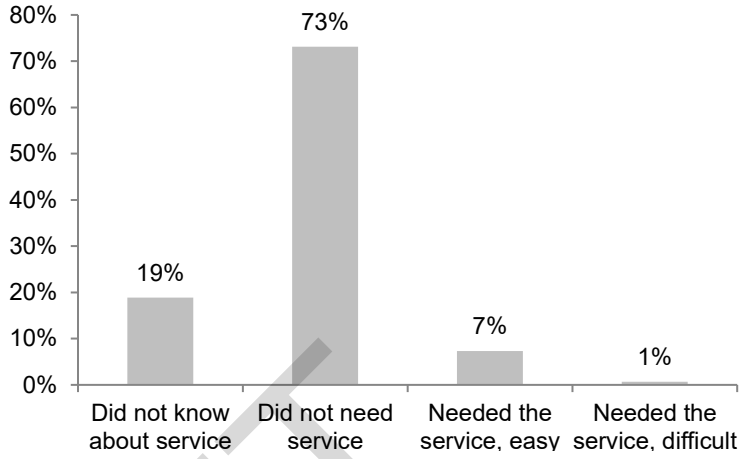

TABLE 1- Reported Barrier Types for Hospice, 2020

		No.	%
1.	Health Insurance Coverage (I)	1	50%
2.	Transportation (T)	1	50%

(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *hospice*, this analysis shows the following:

- More females than males found the service accessible.
- More White, Hispanic/Latino, and other/multiracial PLWH found the service accessible than Black/African American PLWH.
- More PLWH age 50+ found the service accessible than other PLWH age 25 to 49.
- In addition, more MSM PLWH found the service difficult to access when compared to all participants.

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TABLE 2-Hospice, by Demographic Categories, 2020

	Sex (at birth)		Race/ethnicity				Age		
Experience with the Service	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	20%	15%	10%	18%	23%	23%	10%	23%	13%
Did not need service	72%	78%	87%	76%	65%	65%	95%	67%	80%
Needed, easy to access	8%	5%	3%	5%	11%	12%	0%	9%	6%
Needed, difficult to access	0%	1%	0%	1%	0%	0%	0%	1%	0%

TABLE 3- Hospice, by Selected Special Populations, 2020

Experience with the Service	Homeless[a]	MSM[b]	Out of Care[c]	Recently Released[d]	Rural[e]	Transgender[f]
Did not know about service	19%	8%	26%	27%	11%	36%
Did not need service	68%	54%	61%	63%	83%	64%
Needed, easy to access	13%	33%	13%	11%	6%	0%
Needed, difficult to access	0%	1/%	0%	0%	0%	0%

[a]Persons reporting current homelessness [b]Men who have sex with men [c]Persons with no evidence of HIV care for 12 mo.
[d]Persons released from incarceration in the past 12 mo. [e]Non-Houston/Harris County residents [f]Persons with discordant sex assigned at birth and current gender

LOCAL HIV MEDICATION ASSISTANCE

Local HIV medication assistance, technically referred to as the *Local Pharmacy Assistance Program (LPAP)*, provides HIV-related pharmaceuticals to persons living with HIV (PLWH) who are not eligible for medications through other payer sources, including the state AIDS Drug Assistance Program (ADAP).

(**Graph 1**) In the 2020 Houston HIV Care Services Needs Assessment, 79% of participants indicated a need for *local HIV medication assistance* in the past 12 months. 74% reported the service was easy to access, and 5% reported difficulty. 6% stated that they did not know the service was available.

(**Table 1**) When barriers to *local HIV medication assistance* were reported, the most common barrier type was eligibility (25%). Eligibility barriers reported include redundant or complex processes for meeting/renewing eligibility, problems obtaining documentation needed for eligibility and not meeting eligibility requirements.

GRAPH 1-Local HIV Medication Assistance, 2020

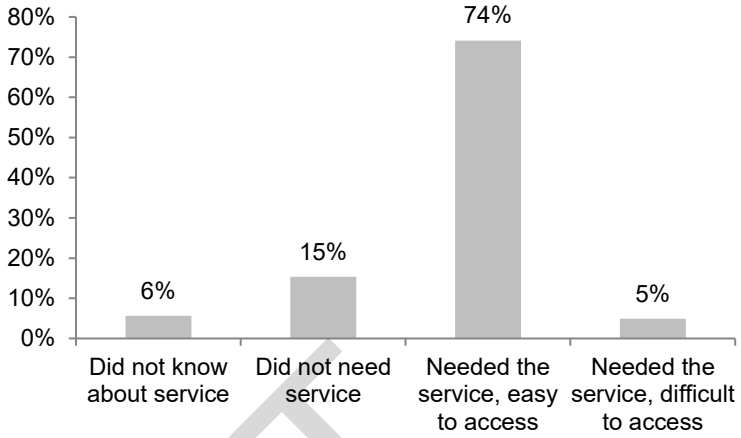


TABLE 1-Top 5 Reported Barrier Types for Local HIV Medication Assistance, 2020

	No.	%
1. Eligibility (EL)	7	25%
2. Administrative (AD)	4	14%
3. Education and Awareness (EA)	4	14%
4. Health Insurance Coverage (I)	4	14%
5. Interactions with Staff (S)	3	11%

(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *local HIV medication assistance*, this analysis shows the following:

- More males than females found the service accessible.
- More White PLWH than other race/ethnicities found the service accessible.
- More PLWH age 50+ found the service accessible than other age groups.
- In addition, homeless, MSM, rural, and transgender PLWH found the service difficult to access when compared to all participants.

DRAFT

TABLE 2-Local HIV Medication Assistance, by Demographic Categories, 2020

	Sex (at birth)		Race/ethnicity				Age		
Experience with the Service	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	7%	2%	1%	5%	7%	8%	0%	6%	6%
Did not need service	16%	12%	29%	17%	10%	4%	14%	15%	16%
Needed, easy to access	73%	79%	69%	72%	76%	88%	81%	73%	75%
Needed, difficult to access	4%	7%	1%	5%	6%	4%	5%	6%	3%

TABLE 3-Local HIV Medication Assistance, by Selected Special Populations, 2020

Experience with the Service	Homeless[a]	MSM[b]	Out of Care[c]	Recently Released[d]	Rural[e]	Transgender[f]
Did not know about service	11%	6%	10%	6%	6%	8%
Did not need service	15%	17%	20%	8%	17%	46%
Needed, easy to access	68%	71%	70%	83%	71%	42%
Needed, difficult to access	6%	6%	0%	3%	6%	4%

[a]Persons reporting current homelessness [b]Men who have sex with men [c]Persons with no evidence of HIV care for 12 mo.
[d]Persons released from incarceration in the past 12 mo. [e]Non-Houston/Harris County residents [f]Persons with discordant sex assigned at birth and current gender

MEDICAL NUTRITION THERAPY

Medical nutrition therapy provides nutrition supplements and nutritional counseling to persons living with HIV (PLWH) outside of a primary care visit by a licensed registered dietician based on physician recommendation and a nutrition plan. The purpose of such services can be to address HIV-associated nutritional deficiencies or dietary needs as well as to mitigate medication side effects.

(**Graph 1**) In the 2020 Houston HIV Care Services Needs Assessment, 36% of participants indicated a need for *medical nutrition therapy* in the past 12 months. 31% reported the service was easy to access, and 5% reported difficulty. 29% stated that they did not know the service was available.

(**Table 1**) When barriers to *medical nutrition therapy* were reported, the most common barrier type was education and awareness (35%) Education and awareness barriers reported include lack of knowledge about service availability, what the service entails, and who to contact to access the service.

GRAPH 1-Medical Nutrition Therapy, 2020

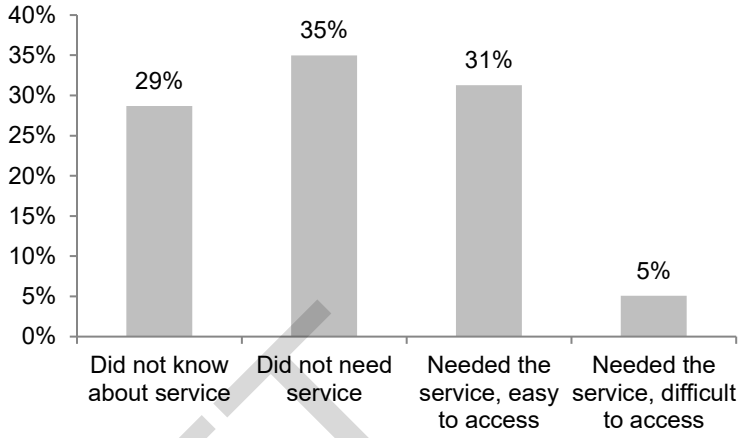


TABLE 1-Top 3 Reported Barrier Types for Medical Nutrition Therapy, 2020

	No.	%
1. Education and Awareness (EA)	8	35%
2. Eligibility (EL)	6	26%
3. Interactions with Staff (S)	4	17%

(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *medical nutrition therapy*, this analysis shows the following:

- More female than males found the service accessible.
- More Hispanic/Latino PLWH than other race/ethnicities found the service accessible.
- More PLWH age 18 to 24 found the service accessible than other age groups.
- In addition, more homeless PLWH found the service difficult to access when compared to all participants.

DRAFT

TABLE 2-Medical Nutrition Therapy, by Demographic Categories, 2020

	Sex (at birth)		Race/ethnicity				Age		
Experience with the Service	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	29%	28%	24%	28%	31%	27%	19%	35%	20%
Did not need service	35%	33%	36%	35%	36%	27%	71%	30%	39%
Needed, easy to access	31%	33%	36%	31%	31%	38%	10%	29%	37%
Needed, difficult to access	5%	6%	4%	6%	2%	12%	0%	6%	4%

TABLE 3-Medical Nutrition Therapy, by Selected Special Populations, 2020

Experience with the Service	Homeless[a]	MSM[b]	Out of Care[c]	Recently Released[d]	Rural[e]	Transgender[f]
Did not know about service	29%	31%	35%	41%	43%	17%
Did not need service	37%	36%	45%	28%	40%	54%
Needed, easy to access	24%	29%	16%	30%	17%	29%
Needed, difficult to access	10%	4%	3%	2%	0%	0%

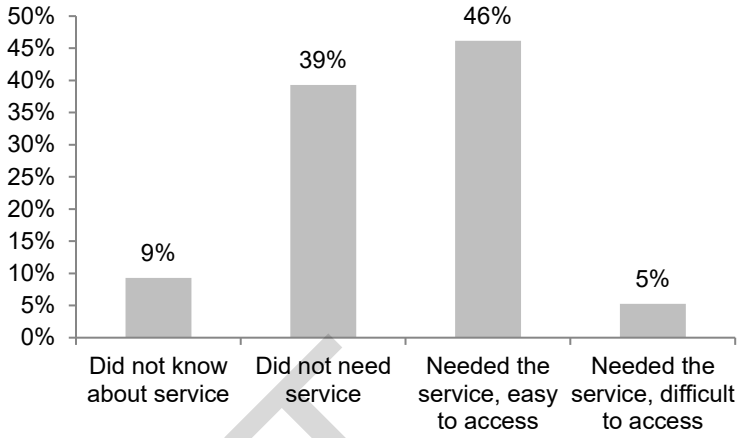
[a]Persons reporting current homelessness [b]Men who have sex with men [c]Persons with no evidence of HIV care for 12 mo.
[d]Persons released from incarceration in the past 12 mo. [e]Non-Houston/Harris County residents [f]Persons with discordant sex assigned at birth and current gender

MENTAL HEALTH SERVICES

Mental health services, also referred to as *professional mental health counseling*, provides psychological counseling services for persons living with HIV (PLWH) who have a diagnosed mental illness. This includes group or individual counseling by a licensed mental health professional in accordance with state licensing guidelines.

(**Graph 1**) In the 2020 Houston HIV Care Services Needs Assessment, 51% of participants indicated a need for *mental health services* in the past 12 months. 46% reported the service was easy to access, and 5% reported difficulty. 9% stated that they did not know the service was available.

GRAPH 1-Mental Health Services, 2020



(**Table 1**) When barriers to *mental health services* were reported, the most common barrier types were administrative, and education and awareness (each 22%). Administrative barriers reported include staff changes, hours of operation, client dismissal from the agency, and understaffing. Education and awareness barriers reported include lack of knowledge about service availability, where to go to access the service, and who to contact to access the service.

TABLE 1-Top 5 Reported Barrier Types for Mental Health Services, 2020

	No.	%
1. Administrative (AD)	7	22%
2. Education and Awareness (EA)	7	22%
3. Health Insurance Coverage (I)	4	13%
4. Interactions with Staff (S)	3	9%
5. Transportation (T)	3	9%

(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *mental health services*, this analysis shows the following:

- More males than females found the service accessible.
- More Hispanic/Latino PLWH found the service accessible than other race/ethnicities.
- More PLWH age 18 to24 found the service accessible than other age groups.
- In addition, more recently released, rural, and homeless PLWH found the service difficult to access when compared to all participants.

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TABLE 2-Mental Health Services, by Demographic Categories, 2020

	Sex (at birth)		Race/ethnicity				Age		
Experience with the Service	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	11%	5%	6%	10%	11%	12%	5%	12%	6%
Did not need service	39%	39%	35%	40%	42%	19%	43%	36%	44%
Needed, easy to access	46%	47%	47%	45%	45%	54%	52%	46%	45%
Needed, difficult to access	4%	8%	12%	5%	2%	12%	0%	5%	5%

TABLE 3-Mental Health Services, by Selected Special Populations, 2020

Experience with the Service	Homeless[a]	MSM[b]	Out of Care[c]	Recently Released[d]	Rural[e]	Transgender[f]
Did not know about service	16%	9%	7%	11%	11%	8%
Did not need service	38%	38%	63%	25%	57%	54%
Needed, easy to access	39%	48%	30%	49%	17%	33%
Needed, difficult to access	7%	5%	0%	14%	11%	4%

[a]Persons reporting current homelessness [b]Men who have sex with men [c]Persons with no evidence of HIV care for 12 mo.
[d]Persons released from incarceration in the past 12 mo. [e]Non-Houston/Harris County residents [f]Persons with discordant sex assigned at birth and current gender

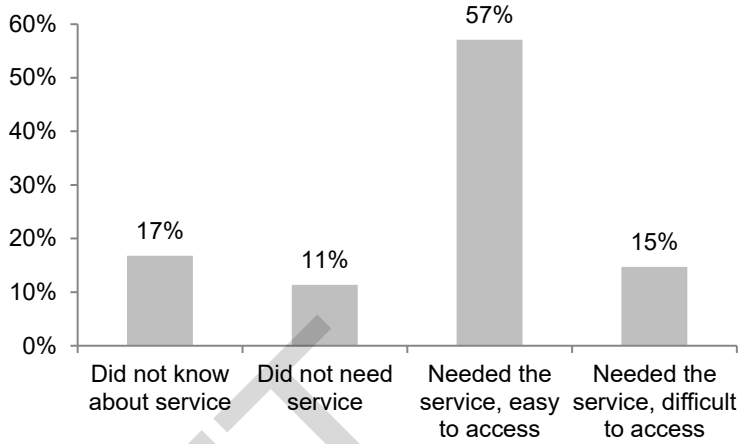
ORAL HEALTH CARE

Oral health care, or *dental services*, refers to the diagnostic, preventative, and therapeutic services provided to persons living with HIV (PLWH) by a dental health care professional (such as a dentist or hygienist). This includes examinations, periodontal services (such as cleanings and fillings), extractions and other oral surgeries, restorative dental procedures, and prosthodontics (or dentures).

(**Graph 1**) In the 2020 Houston HIV Care Services Needs Assessment, 72% of participants indicated a need for *oral health care* in the past 12 months. 57% reported the service was easy to access, and 15% reported difficulty. 17% stated that they did not know the service was available.

(**Table 1**) When barriers to *oral health care* were reported, the most common barrier type was wait-related issues (35%). Wait-related barriers reported include placement on a waitlist, long waits at appointments, and being told to call back as a wait list was full/unavailable. Of note, at least seven participants reported unprompted that their provider stated Ryan White does not cover prosthodontics, and that the participants would need to pay several hundred dollars out of pocket for treatment. Administrative agent and agency staff were notified immediately to resolve this issue.

GRAPH 1-Oral Health Care, 2020



(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *oral health care*, this analysis shows the following:

- More males than females found the service accessible.
- More Hispanic/Latino PLWH found the service accessible than other race/ethnicities.
- More PLWHA age 18 to 24 found the service accessible than other age groups.
- In addition, more out of care, recently released, and MSM found the service difficult to access when compared to all participants.

TABLE 1-Top 5 Reported Barrier Types for Oral Health Care, 2020

	No.	%
1. Wait (W)	20	22%
2. Interactions with Staff (S)	16	18%
3. Health Insurance Coverage (I)	12	13%
4. Education and Awareness (EA)	11	12%
5. Administrative (AD)	9	10%

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TABLE 2-Oral Health Care, by Demographic Categories, 2020

	Sex (at birth)		Race/ethnicity				Age		
Experience with the Service	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	18%	12%	6%	19%	19%	15%	24%	22%	8%
Did not need service	11%	12%	22%	12%	8%	4%	14%	9%	14%
Needed, easy to access	57%	59%	49%	55%	63%	54%	52%	52%	65%
Needed, difficult to access	14%	17%	22%	14%	10%	27%	10%	17%	12%

TABLE 3-Oral Health Care, by Selected Special Populations, 2020

Experience with the Service	Homeless[a]	MSM[b]	Out of Care[c]	Recently Released[d]	Rural[e]	Transgender[f]
Did not know about service	34%	15%	34%	20%	9%	8%
Did not need service	6%	10%	9%	11%	20%	13%
Needed, easy to access	45%	59%	34%	50%	69%	67%
Needed, difficult to access	15%	16%	22%	19%	3%	13%

[a]Persons reporting current homelessness [b]Men who have sex with men [c]Persons with no evidence of HIV care for 12 mo.
[d]Persons released from incarceration in the past 12 mo. [e]Non-Houston/Harris County residents [f]Persons with discordant sex assigned at birth and current gender

OUTREACH SERVICES

Outreach services are provided for people living with HIV (PLWH) who have missed primary medical care appointments without rescheduling, and who may have other risk factors for falling out of care. The goal of *outreach services* is to support retention in care. Services are field-based, and include assistance with medical appointment setting and accessing supportive services, advocating on behalf of clients to decrease service gaps and remove barriers to services, and helping clients develop and utilize independent living skills and strategies.

(**Graph 1**) In the 2020 Houston HIV Care Services Needs Assessment, 5% of participants indicated a need for *outreach services* in the past 12 months. 4% reported the service was easy to access, and 1% reported difficulty. 9% stated that they did not know the service was available.

(**Table 1**) When barriers to *outreach services* were reported, the most common barrier type was interactions with staff (71%). Interactions with staff barriers reported include poor correspondence or follow up.

GRAPH 1-Outreach Services, 2020

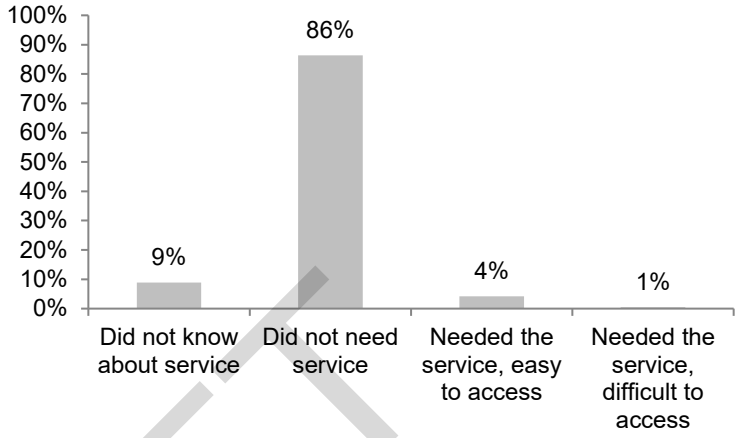


TABLE 1-Top Reported Barrier Type for Outreach Services, 2020

	No.	%
1. Interactions with Staff (S)	5	71%

(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *outreach services,* this analysis shows the following:

- More males than females found the service accessible.
- More Black/African American and Hispanic/Latino PLWH found the service accessible than other race/ethnicities.
- More PLWH age 50+ found the service accessible than other age groups.
- In addition, more homeless, MSM, recently released, and transgender PLWH found the service difficult to access when compared to all participants.

DRAFT

TABLE 2-Outreach Services, by Demographic Categories, 2020

	Sex (at birth)		Race/ethnicity				Age		
Experience with the Service	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	22%	17%	22%	19%	22%	23%	57%	25%	11%
Did not need service	42%	40%	57%	45%	33%	38%	24%	34%	53%
Needed, easy to access	34%	40%	17%	34%	42%	38%	19%	37%	34%
Needed, difficult to access	3%	2%	4%	2%	2%	0%	5%	3%	1%

TABLE 3-Outreach Services, by Selected Special Populations, 2020

Experience with the Service	Homeless[a]	MSM[b]	Out of Care[c]	Recently Released[d]	Rural[e]	Transgender[f]
Did not know about service	23%	23%	20%	28%	26%	21%
Did not need service	28%	42%	37%	30%	37%	42%
Needed, easy to access	37%	32%	43%	39%	37%	35%
Needed, difficult to access	12%	3%	0%	3%	0%	2%

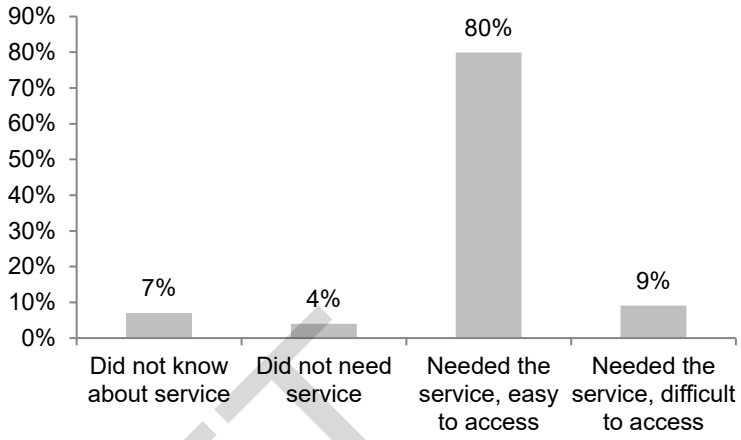
[a]Persons reporting current homelessness [b]Men who have sex with men [c]Persons with no evidence of HIV care for 12 mo.
[d]Persons released from incarceration in the past 12 mo. [e]Non-Houston/Harris County residents [f]Persons with discordant sex assigned at birth and current gender

PRIMARY HIV MEDICAL CARE

Primary HIV medical care, technically referred to as *outpatient/ambulatory medical care*, refers to the diagnostic and therapeutic services provided to persons living with HIV (PLWH) by a physician or physician extender in an outpatient setting. This includes physical examinations, diagnosis and treatment of common physical and mental health conditions, preventative care, education, laboratory services, and specialty services as indicated.

(**Graph 1**) In the 2020 Houston HIV Care Services Needs Assessment, 89% of participants indicated a need for *primary HIV medical care* in the past 12 months. 80% reported the service was easy to access, and 90% reported difficulty. 7% stated that they did not know the service was available.

GRAPH 1-Primary HIV Medical Care, 2020



(**Table 1**) When barriers to *primary HIV medical care* were reported, the most common barrier type was transportation (26%). Transportation barriers reported include having no or limited transportation options, and having problems with special transportation providers such as Metrolift or Medicaid transportation

TABLE 1-Top 5 Reported Barrier Types for Primary HIV Medical Care, 2020

	No.	%
1. Transportation (T)	11	26%
2. Education and Awareness (EA)	8	19%
3. Interactions with Staff (S)	8	19%
4. Eligibility	4	9%
5. Wait (W)	4	9%

(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *primary HIV medical care*, this analysis shows the following:

- More females than males found the service accessible.
- More White PLWH found the service accessible than other race/ethnicities.
- More PLWH age 50+ found the service accessible than other age groups.
- In addition, more rural, out of care, and MSM PLWH found the service difficult to access when compared to all participants.

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TABLE 2-Primary HIV Medical Care, by Demographic Categories, 2020

	Sex (at birth)		Race/ethnicity				Age		
Experience with the Service	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	8%	4%	1%	5%	12%	0%	0%	9%	5%
Did not need service	4%	4%	9%	3%	3%	0%	0%	2%	8%
Needed, easy to access	92%	85%	86%	83%	74%	92%	76%	79%	83%
Needed, difficult to access	9%	8%	4%	8%	12%	8%	24%	11%	5%

TABLE 3-Primary HIV Medical Care, by Selected Special Populations, 2020

Experience with the Service	Homeless[a]	MSM[b]	Out of Care[c]	Recently Released[d]	Rural[e]	Transgender[f]
Did not know about service	10%	9%	19%	9%	3%	13%
Did not need service	2%	5%	10%	2%	0%	13%
Needed, easy to access	82%	77%	55%	83%	71%	75%
Needed, difficult to access	6%	10%	16%	6%	26%	0%

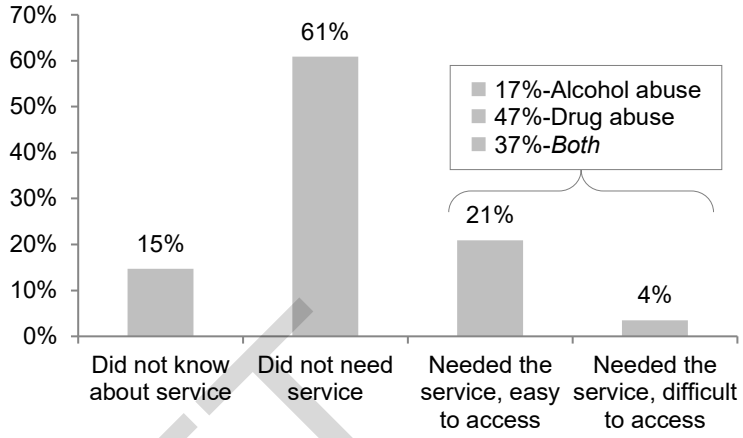
[a]Persons reporting current homelessnes [b]Men who have sex with men [c]Persons with no evidence of HIV care for 12 mo.
[d]Persons released from incarceration in the past 12 mo. [e]Non-Houston/Harris County residents [f]Persons with discordant sex assigned at birth and current gender

SUBSTANCE ABUSE SERVICES

Substance abuse services, also referred to as *outpatient alcohol or drug abuse treatment*, provides counseling and/or other treatment modalities to persons living with HIV (PLWH) who have a substance use disorder concern in an outpatient setting and in accordance with state licensing guidelines. This includes services for alcohol use and/or use of legal or illegal drugs.

(**Graph 1**) In the 2020 Houston HIV Care Services Needs Assessment, 24% of participants indicated a need for *substance abuse services* in the past 12 months. 21% reported the service was easy to access, and 4% reported difficulty. 15% stated they did not know the service was available. When analyzed by type of substance concern, 17% of participants cited alcohol, 47% cited drugs, and 37% cited both.

GRAPH 1-Substance Abuse Services, 2020



(**Table 1**) When barriers to *substance use services* were reported, the most common barrier type was education and awareness (46%). Education and awareness barriers reported include lack of knowledge about service availability

TABLE 1-Top 2 Reported Barrier Types for Substance Abuse Services, 2020

	No.	%
1. Education and Awareness (EA)	4	46%
2. Transportation (T)	2	18%

(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *substance abuse services,* this analysis shows the following:

- More females than males found the service accessible.
- More other/multiracial PLWH found the service accessible than other race/ethnicities.
- More PLWH age 50+ found the service accessible than other age groups.
- In addition, more recently released and homeless PLWH found the service difficult to access when compared to all participants.

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TABLE 2-Substance Abuse Services, by Demographic Categories, 2020

	Sex (at birth)		Race/ethnicity				Age		
Experience with the Service	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	17%	7%	12%	12%	18%	19%	43%	15%	12%
Did not need service	59%	68%	69%	63%	58%	58%	43%	59%	65%
Needed, easy to access	20%	23%	16%	21%	21%	23%	10%	22%	21%
Needed, difficult to access	4%	3%	3%	5%	2%	0%	5%	4%	2%

TABLE 3-Substance Abuse Services, by Selected Special Populations, 2020

Experience with the Service	Homeless[a]	MSM[b]	Out of Care[c]	Recently Released[d]	Rural[e]	Transgender[f]
Did not know about service	13%	18%	16%	15%	23%	8%
Did not need service	55%	60%	61%	44%	71%	71%
Needed, easy to access	20%	18%	23%	24%	6%	17%
Needed, difficult to access	12%	3%	0%	18%	0%	4%

[a]Persons reporting current homelessness [b]Men who have sex with men [c]Persons with no evidence of HIV care for 12 mo.
[d]Persons released from incarceration in the past 12 mo. [e]Non-Houston/Harris County residents [f]Persons with discordant sex assigned at birth and current gender

TRANSPORTATION

Transportation services provides transportation to persons living with HIV (PLWH) to locations where HIV-related care is received, including pharmacies, mental health services, and substance abuse services. The service can be provided in the form of public transportation vouchers (bus passes), gas vouchers (for rural clients), taxi vouchers (for emergency purposes), and van-based services as medically indicated.

(**Graph 1**) In the 2020 Houston HIV Care Services Needs Assessment, 48% of participants indicated a need for *transportation services* in the past 12 months. 41% reported the service was easy to access, and 7% reported difficulty. 15% stated they did not know the service was available. When analyzed by type transportation assistance sought, 81% of participants needed bus passes, 17% needed van services, and 11% needed both forms of assistance.

(**Table 1**) When barriers to *transportation services* were reported, the most common barrier type was education and awareness (24%). Transportation barriers reported include lack of knowledge about service availability and where to go to access the service.

GRAPH 1-Transportation Services, 2020

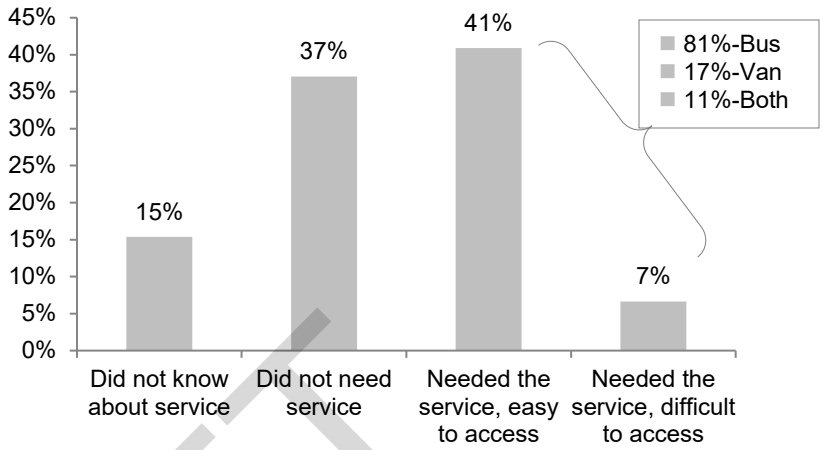


TABLE 1-Top 5 Reported Barrier Types for Transportation Services, 2020

	No.	%
1. Education and Awareness (EA)	7	24%
2. Resource Availability (R)	5	17%
3. Transportation (T)	5	17%
4. Eligibility (EL)	3	10%
5. Financial (F)	3	10%

(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *transportation services,* this analysis shows the following:

- More males than females found the service accessible..
- More Hispanic/Latino PLWH found the service accessible than other race/ethnicities.
- More PLWH age 18 to 24 found the service accessible than other age groups.
- In addition, more homeless, out of care, and recently released PLWH found the service difficult to access when compared to all participants.

DRAFT

TABLE 2-Transportation Services, by Demographic Categories, 2020

	Sex (at birth)		Race/ethnicity				Age		
Experience with the Service	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	17%	10%	5%	14%	8%	12%	43%	20%	7%
Did not need service	38%	35%	51%	32%	81%	31%	14%	38%	37%
Needed, easy to access	39%	47%	36%	49%	9%	38%	43%	35%	50%
Needed, difficult to access	6%	8%	8%	5%	1%	19%	5%	7%	7%

TABLE 3-Transportation Services, by Selected Special Populations, 2020

Experience with the Service	Homeless[a]	MSM[b]	Out of Care[c]	Recently Released[d]	Rural[e]	Transgender[f]
Did not know about service	7%	19%	30%	12%	14%	8%
Did not need service	28%	38%	17%	21%	71%	32%
Needed, easy to access	51%	37%	40%	59%	14%	16%
Needed, difficult to access	15%	6%	13%	8%	0%	4%

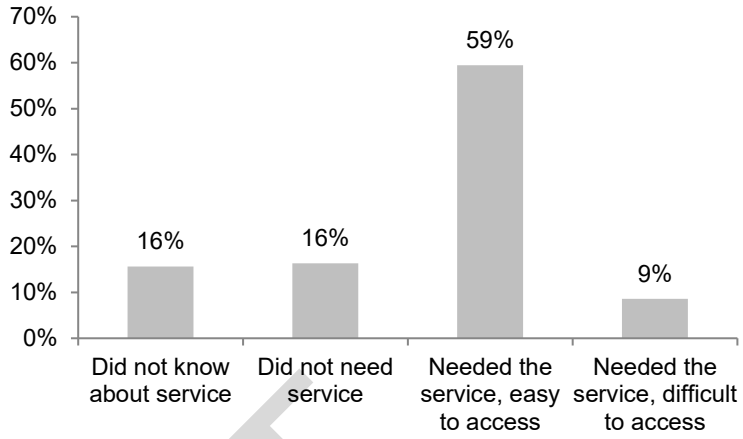
[a]Persons reporting current homelessness [b]Men who have sex with men [c]Persons with no evidence of HIV care for 12 mo.
[d]Persons released from incarceration in the past 12 mo. [e]Non-Houston/Harris County residents [f]Persons with discordant sex assigned at birth and current gender

VISION CARE

Vision care, technically a subcategory of primary HIV medical care, provides optometric/ophthalmologic treatment, vision screening, and glasses to people living with HIV (PLWH). This does not include fitting of contact lenses.

(**Graph 1**) In the 2020 Houston HIV Care Services Needs Assessment, 68% of participants indicated a need for *vision care* in the past 12 months. 59% reported the service was easy to access, and 9% reported difficulty. 16% stated they did not know the service was available.

GRAPH 1-Vision Care, 2020



(**Table 1**) When barriers to *vision care* were reported, the most common barrier type was wait-related issues. Wait-related barriers reported include scheduling appointments 2-3 months out, placement on a waitlist, being told to call back as a wait list was full/unavailable, and long waits at appointments.

TABLE 1-Top 5 Reported Barrier Types for Vision Care, 2020

	No.	%
1. Wait (W)	15	34%
2. Health Insurance Coverage (I)	8	18%
3. Education and Awareness (EA)	6	14%
4. Financial (F)	4	9%
5. Interactions with Staff (S)	3	7%

(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *vision care,* this analysis shows the following:

- More males than females found the service accessible.
- More Black/African American PLWH found the service accessible than other race/ethnicities.
- More PLWH age 50+ found the service accessible than other age groups.
- In addition, more homeless and out of care PLWH found the service difficult to access when compared to all participants.

TABLE 2-Vision Care, by Demographic Categories, 2020

	Sex (at birth)		Race/ethnicity				Age		
Experience with the Service	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	17%	10%	12%	15%	15%	15%	14%	21%	8%
Did not need service	16%	18%	19%	21%	11%	4%	62%	15%	15%
Needed, easy to access	60%	58%	60%	56%	65%	69%	14%	56%	69%
Needed, difficult to access	7%	14%	9%	8%	9%	15%	14%	9%	8%

TABLE 3-Vision Care, by Selected Special Populations, 2020

Experience with the Service	Homeless[a]	MSM[b]	Out of Care[c]	Recently Released[d]	Rural[e]	Transgender[f]
Did not know about service	20%	17%	10%	28%	6%	20%
Did not need service	16%	13%	10%	16%	20%	24%
Needed, easy to access	51%	63%	70%	47%	66%	56%
Needed, difficult to access	13%	7%	10%	9%	6%	0%

[a]Persons reporting current homelessness [b]Men who have sex with men [c]Persons with no evidence of HIV care for 12 mo.
[d]Persons released from incarceration in the past 12 mo. [e]Non-Houston/Harris County residents [f]Persons with discordant sex assigned at birth and current gender

DRAFT

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.

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

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.

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

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

Committee Chairperson **Date**

Affected Community Committee Report

Steps to Participate in the
2020 Ryan White *How To Best Meet the Need* Process

What is *How To Best Meet the Need*?
It is defining the HRSA approved service categories so that they "best meet the needs" of our local community.

The Ryan White Planning Council is responsible for planning the organization and delivery of HIV services, specifically in the areas of outpatient medical care, case management and comprehensive treatment services. Each year, the Planning Council reviews and refines its service definitions in preparation for the next funding cycle which begins March 1st of the following year. The purpose of each workgroup is to review specific service category definitions and make recommendations as needed to improve service delivery and effectiveness.

In 2020:

Step 1: Sign up with Rod or Diane in the Office of Support to attend trainings on:
- The process used by the various workgroups - **12 noon, March 23th**
- The documents used to justify changes made to service definitions - **1:30 pm, April 9th**

Step 2: Determine the criteria to be used to select FY 2021 service categories. **2 pm, March 17th**

Step 3: Pick up materials for the workgroups – **any time on or after April 9th**

Step 4: Workgroups take place. At the workgroups, participants are invited to:
- Introduce themselves and state their conflict of interest
- Staff explains their role in the process
- The Administrative Agent provides general information
- The Office of Support staff provides general information
- Each service definition is discussed and recommended changes are made
- The financial eligibility for the service is made

Step 5: Workgroup recommendations are moved forward to the Quality Improvement Committee where additional changes can be made to the definitions. **2 pm, Tues. May 19th**

Step 6: There is a Public Hearing where the service definitions are presented to the public. **7 pm, Tues., May 26th, City Annex, 900 Bagby St, downtown Houston.**

Step 7: Service definitions and recommended changes move forward to the Steering Committee at **12 noon on June 4th.** Changes made to services are final only after the Council has approved the FY 2020 service definitions at **12 noon on June 11th**.

March 1, 2021: Changes made to FY 2021 service categories take effect.

Quality Improvement Committee Report

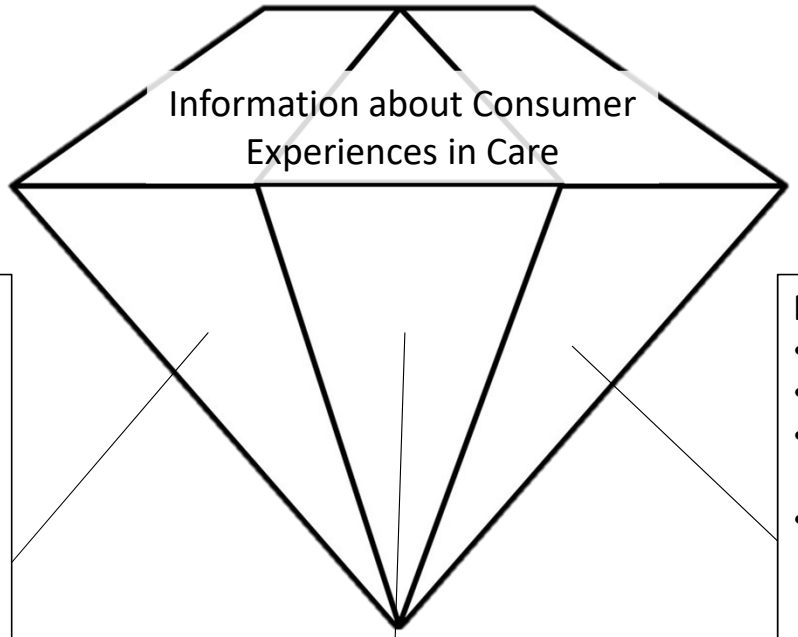


Chart reviews

- Collected by the AAs
- Gathered from a sample of medical charts
- Examines quality of care within the provision of particular services
- Answers the questions "Are RW consumers receiving services that meet Standards of Care and medical guidelines?"
- Can be tied to a specific provider, but presented to Council either de-identified or at the system level

Client Satisfaction Surveys

- Collected by the AAs
- Reported directly from consumer
- Examines client satisfaction within the provision of particular services
- Answer the question: "Are RW consumers satisfied with the quality of care they are receiving?"
- Can be tied to a specific provider, but presented to Council either de-identified or at the system level

Needs Assessment / Special Studies

- Collected by Office of Support
- Reported directly from consumer
- Examines the system of services in relation to need and accessibility*
- Answers the question: "What services do PLWH need to stay in medical care, and are those services accessible?"
- Not tied to any specific provider

*Also assesses service needs of those not in care

Service Category	**Is this a core service?** If no, how does the service support access to core services & support clients achieving improved outcomes?	**How does this service assist individuals *not in care** to access primary care?** *EIIHA: Early Identification of Individuals with HIV/AIDS seeks to identify the status-unaware and link them into care *Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months *Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	**Documentation of Need** (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Special Studies and surveys, etc.) Which populations experience disproportionate need for and/or barriers to accessing this service?	**Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate funding or the need to fill in a gap.** (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	**Justify the use of Ryan White Part A, Part B and State Services funds for this service.** **Is this a duplicative service or activity?**	**Service Efficiency** Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified?	**Recommendation(s)**
Part 1: Services offered by Ryan White Part A, Part B, and State Services in the Houston EMA/HSDA as of 03-19-19							
Ambulatory/Outpatient Primary Medical Care (incl. Vision):							
CBO, Adult – Part A, Including LPAP, MCM & Svc Linkage (Includes OB/GYN) *See below for Public Clinic, Rural, Pediatric, Vision*	✔ Yes ___No	☐ EIIHA ☐ Unmet Need ☐ Continuum of Care		Covered under QHP? ✔ Yes ___No			

‡ Service Category for Part B/State Services only.

Harris County Public Health
Building a Healthy Community

Ryan White Part A, Houston EMA FY18-19 Clinical Care Chart Review Summary of Findings

Chart Reviews Conducted

- Primary Care
- Vision
- Oral Health Care- Rural Target

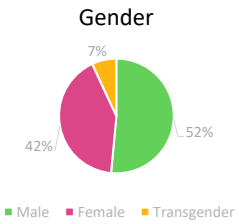
- Review period was March 1, 2018 - February 28, 2019

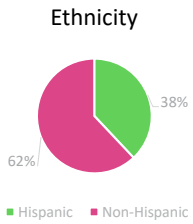
p. 5

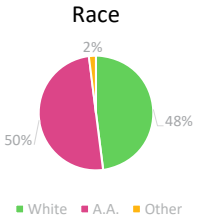
Harris County Public Health
HCPH Priority Public Health Issues for 2013-2018
Selected for the magnitude of the issue and our ability to make progress in Harris County
Chronic Disease | Food Safety | Emergency Preparedness | Environmental Health | Infectious Diseases | Injury | Social, Mental, and Emotional Wellbeing

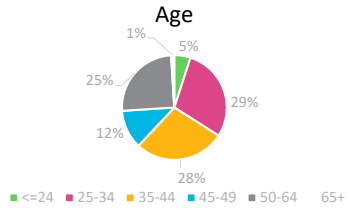
Primary Care Chart Review

- 635 charts reviewed
- Each sample was determined to be comparable to the racial, ethnic, and age demographics of each site's overall primary care population
- Female and Transgender clients were oversampled to adequately capture performance data for these populations









Primary Care Measures

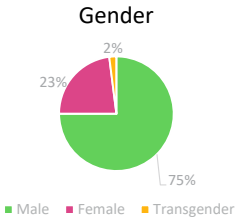
Performance Measures	FY17 Rate	FY18 Rate	Change	Goal
Viral Load Suppression	85.5%	87.8%	↑	90%
ART Prescription	98.7%	99.4%	–	95%
PCP Prophylaxis	93%	93.9%	–	100%
Viral Load Monitoring	98%	98.3%	–	90%
HIV Drug Resistance Testing	71.4%	75%	↑	85%
Influenza Vaccination	53.5%	62.9%	↑	65%
Lipid Screening	88.8%	89.9 %	–	90%
Tuberculosis Screening	67.2%	71%	↑	75%
Cervical Cancer	82.5%	81.6%	–	75%
STI Testing	77.6%	78.9%	–	65%
Hepatitis B Screening	87.1%	90.9%	↑	95%

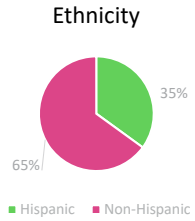
Primary Care Measures

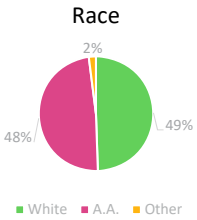
Performance Measures	FY17 Rate	FY18 Rate	Change	Goal
Hepatitis B Vaccination	51.4%	49.3%	↓	55%
Hepatitis C Screening	92.8%	95.1%	↑	95%
HIV Risk Counseling	90.7%	83.9%	↓	85%
Pneumococcal	83.4%	83.1%	–	90%
Mental Health Screening	96.4%	98.1%	–	95%
Tobacco Screening	100%	98.7%	–	100%
Smoking Cessation Counseling	55.7%	67.8%	↑	100%
Substance Use Screening	99.1%	99.4%	–	95%
Syphilis Screening	92.4%	94.8%	↑	85%

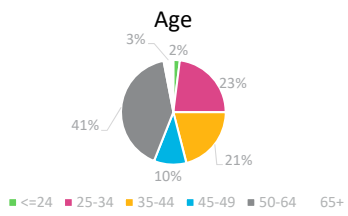
Vision Care Chart Review

- 150 charts reviewed
- Each sample was determined to be comparable to the racial, ethnic, gender and age demographics of each site's overall vision care population









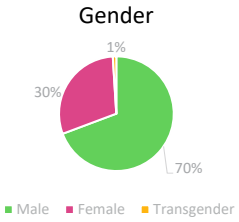
Vision Chart Review

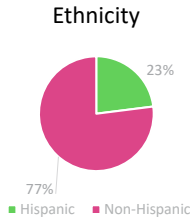
Performance Measure	2018
CD4 & VL	83%
Primary Care Provider	87%
Medication Allergies	100%
Medical History	100%
Current Medications	100%
Reason for Visit	100%
Ocular History	100%
Complete Eye Exam	100%
Dilated Fundus Exam	94%

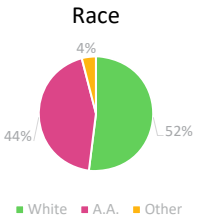
Performance Measure	2018
Internal Eye Exam	100%
Diagnosis Documented	100%
Treatment Plan Documented	100%
Visual Acuity Test	100%
Refraction Test	100%
External Structures Observed	100%
Glaucoma Test	100%
Cytomegalovirus (CMV) Screening	100%

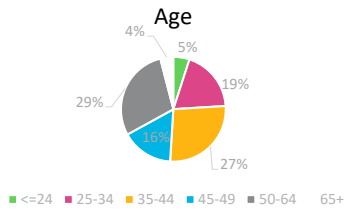
Vision Care Chart Review

- 75 charts reviewed
- Each sample was determined to be comparable to the racial, ethnic, gender and age demographics of each site's overall vision care population









Oral Health-Rural Chart Review

Performance Measure	2018
Primary Care Provider	97%
Medical/Dental Health History*	100%
Medical History 6 month update	96%
Vital Signs	100%
Current Medications	100%
CBC Documented	92%
Antibiotic Prophylaxis Given	0%

Performance Measure	2018
Oral Health Education*	99%
Hard Tissue Exam	96%
Soft Tissue Exam	96%
Periodontal Screening*	97%
X-Rays Present	99%
Treatment Plan*	99%

*HIV/AIDS Bureau (HAB) Performance Measures

Questions

Harris County Public Health
Building a Healthy Community
HCPH Priority Public Health Issues for 2013-2018
Selected for the magnitude of the issue and our ability to make progress in Harris County

Umair A. Shah, M.D., M.P.H.
Executive Director

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Public Health
Building a Healthy Community

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Primary Care Chart Review Report FY 2018

Ryan White Part A Quality Management Program – Houston EMA

October 2019

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HCPH is the local public health agency for the Harris County, Texas jurisdiction. It provides a wide variety of public health activities and services aimed at improving the health and well-being of the Harris County community.

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PREFACE

EXPLANATION OF PART A QUALITY MANAGEMENT

In 2018, the Houston Eligible Metropolitan Area (EMA) awarded Part A funds for adult Outpatient Ambulatory Medical Services to five organizations. Approximately 13,000 unduplicated individuals living with HIV receive Ryan White-funded services at these organizations.

Harris County Public Health (HCPH) must ensure the quality and cost effectiveness of primary medical care. The medical services chart review is performed to ensure that the medical care provided adheres to current evidence-based guidelines and standards of care. The Ryan White Grant Administration (RWGA) Project Coordinator for Clinical Quality Improvement (PC/CQI) performed the medical services review.

Introduction

On March 25, 2018, the RWGA PC/CQI commenced the evaluation of Part A funded Primary Medical Care Services funded by the Ryan White Part A grant. This grant is awarded to HCPH by the Health Resources and Services Administration (HRSA) to provide HIV-related health and social services to people living with HIV. The purpose of this evaluation project is to meet HRSA mandates for quality management, with a focus on:

- evaluating the extent to which primary care services adhere to the most current United States Department of Health and Human Services (DHHS) HIV treatment guidelines;
- provide statistically significant primary care utilization data including demographics of individuals receiving care; and,
- make recommendations for improvement.

A comprehensive review of client medical records was conducted for services provided between 3/1/18 and 2/28/19. The guidelines in effect during the year the patient sample was seen, *Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents Living with HIV* were used to determine degree of compliance. The current treatment guidelines are available for download at: http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf. The initial activity to fulfill the purpose was the development of a medical record data abstraction tool that addresses elements of the guidelines, followed by medical record review, data analysis and reporting of findings with recommendations.

Tool Development

The PC/CQI worked with the Clinical Quality Improvement (CQI) committee to develop and approve data collection elements and processes that would allow evaluation of primary care services based on the *Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents Living with HIV, 2017* that were developed by the Panel on Antiretroviral Guidelines for Adults and Adolescents convened by the DHHS. In addition, data collection elements and processes were developed to align with the Health Resources and Services Administration (HRSA), HIV/AIDS Bureau's (HAB) HIV/AIDS Clinical Performance Measures for Adults & Adolescents. These measures are designed to serve as indicators of quality care. HAB measures are available for download at: http://hab.hrsa.gov/deliverhivaidscare/habperformmeasures.html. An electronic database was designed to facilitate direct data entry from patient records. Automatic edits and validation screens were included in the design and layout of the data abstraction program to "walk" the nurse reviewer through the process and to facilitate the accurate collection, entering and validation of data. Inconsistent information, such as reporting GYN exams for men, or opportunistic infection prophylaxis for patients who do not need it, was considered when designing validation functions. The PC/CQI then used detailed data validation reports to check certain values for each patient to ensure they were consistent.

Chart Review Process

All charts were reviewed by a Master's-level registered nurse experienced in identifying documentation issues and assessing adherence to treatment guidelines. The collected data for each site was recorded directly into a preformatted computerized database. The data collected during this process is to be used for service improvement.

If documentation on a particular element was not found, a "no data" response was entered into the database. For some data elements, the reviewer looked for documentation that the requisite test/assessment/vaccination was performed, e.g., lipid screening or pneumococcal vaccination. Other data elements required that several questions be answered in an "if, then" format. For example, if a Pap smear was abnormal, then was a colposcopy performed? This logic tree type of question allows more in-depth assessment of care and a greater ability to describe the level of quality. Using another example, if only one question is asked, such as "was a mental health screening done?" the only assessment that can be reported is how many patients were screened. More questions need to be asked to evaluate quality and the appropriate assessment and treatment, e.g., if the mental health screening was positive, was the client referred? If the client accepted a referral, were they able to access a Mental Health Provider?

The specific parameters established for the data collection process were developed from national HIV care guidelines.

Tale 1. Data Collection Parameters

Review Item	Standard
Primary Care Visits	Primary care visits during review period, denoting date and provider type (MD, NP, PA, other). There is no standard of care to be met per se. Data for this item is strictly for analysis purposes only
Annual Exams	Dental and Eye exams are recommended annually
Mental Health	A Mental Health screening is recommended annually screening for depression, anxiety, and associated psychiatric issues
Substance Abuse	Clients should be screened for substance abuse potential annually and referred accordingly

Tale 1. Data Collection Parameters (cont.)	
Review Item	Standard
Antiretroviral Therapy (ART) adherence	Adherence to medications should be documented at every visit with issues addressed as they arise
Lab	Viral Load Assays are recommended every 3-6 months. Clients on ART should have a Lipid Profile annually (minimum recommendations)
STD Screen	Screening for Syphilis, Gonorrhea, and Chlamydia should be performed at least annually for clients at risk
Hepatitis Screen	Screening for Hepatitis B and C are recommended at initiation to care. At risk clients not previously immunized for Hepatitis A and B should be offered vaccination.
Tuberculosis Screen	Screening is recommended at least once since HIV diagnosis, either PPD, IGRA or chest X-ray.
Cervical Cancer Screen	Women are assessed for at least one PAP smear during the previous three years
Immunizations	Clients are assessed for annual Flu immunizations and whether they have ever received pneumococcal vaccination.
HIV Risk Counseling	Clients are screened for behaviors associated with HIV transmission and risk reduction discussed
Pneumocystis jirovecii Pneumonia (PCP) Prophylaxis	Labs are reviewed to determine if the client meets established criteria for prophylaxis

The Sample Selection Process

The sample population was selected from a pool of 7,541 clients (adults age 18+) who accessed Part A primary care (excluding vision care) and had at least two visits, at least 90 days apart, between 3/1/18 and 2/28/19. The medical charts of 635 clients were used in this review, representing 8.4% of the pool of unduplicated clients. The number of clients selected at each site is proportional to the number of primary care clients served there. Three caveats were observed during the sampling process. In an effort to focus on women living with HIV health issues, women were over-sampled, comprising 41.7% of the sample population. Second, providers serving a relatively small number of clients were over-sampled in order to ensure sufficient sample sizes for data analysis. Finally, transgender clients were oversampled in order to collect data on this sub-population.

In an effort to make the sample population as representative of the Part A primary care population as possible, the EMA's Centralized Patient Care Data Management System (CPCDMS) was used to generate the lists of client codes for each site. The demographic

make-up (race/ethnicity, gender, age) of clients who accessed primary care services at a particular site during the study period was determined by CPCDMS. A sample was then generated to closely mirror that same demographic make-up.

Characteristics of the Sample Population

Due to the desire to over sample for female clients, the review sample population is not generally comparable to the Part A population receiving outpatient primary medical care in terms of race/ethnicity, gender, and age. No medical records of children/adolescents were reviewed, as clinical guidelines for these groups differ from those of adult patients. Table 2 compares the review sample population with the Ryan White Part A primary care population as a whole.

Table 2. Demographic Characteristics of Clients During Study Period 3/1/18-2/28/19

	Sample		**Ryan White Part A Houston EMA**	
Gender	Number	Percent	Number	Percent
Male	329	51.8%	5,551	73.6%
Female	265	41.7%	1,867	24.8%
Transgender Male to Female	41	6.5%	121	1.6%
Transgender Female to Male	0	0%	2	0%
TOTAL	**635**		**7,541**	
Race				
Asian	8	1.3%	101	1.3%
African-Amer.	317	49.9%	3,777	50.1%
Pacific Islander	0	0%	5	.1%
Multi-Race	2	.3%	48	.6%
Native Amer.	2	.3%	25	.3%
White	306	48.2%	3,585	47.5%
TOTAL	**635**		**7,541**	
Hispanic				
Non-Hispanic	393	61.9%	4,774	63.3%
Hispanic	242	38.1%	2,767	36.7%
TOTAL	**635**		**7,541**	
Age				
<=24	21	3.3%	370	4.9%
25-34	164	25.8%	2,215	29.4%
35-44	185	29.1%	2,096	27.8%
45-49	86	13.5%	912	12.1%
50-64	172	27.1%	1,840	25.4%
65 and older	7	1.1%	105	1.4%
Total	**635**		**7,541**	

Report Structure

In November 2013, the Health Resource and Services Administration's (HRSA), HIV/AIDS Bureau (HAB) revised its performance measure portfolio[1]. The categories included in this report are: Core, All Ages, and Adolescents/Adult. These measures are intended to serve as indicators for use in monitoring the quality of care provided to patients receiving Ryan White funded clinical care. In addition to the HAB measures, several other primary care performance measures are included in this report. When available, data and results from the two preceding years are provided, as well as comparison to EMA goals. Performance measures are also depicted with results categorized by race/ethnicity.

[1] http://hab.hrsa.gov/deliverhivaidscare/habperformmeasures.html Accessed November 10, 2013

Findings

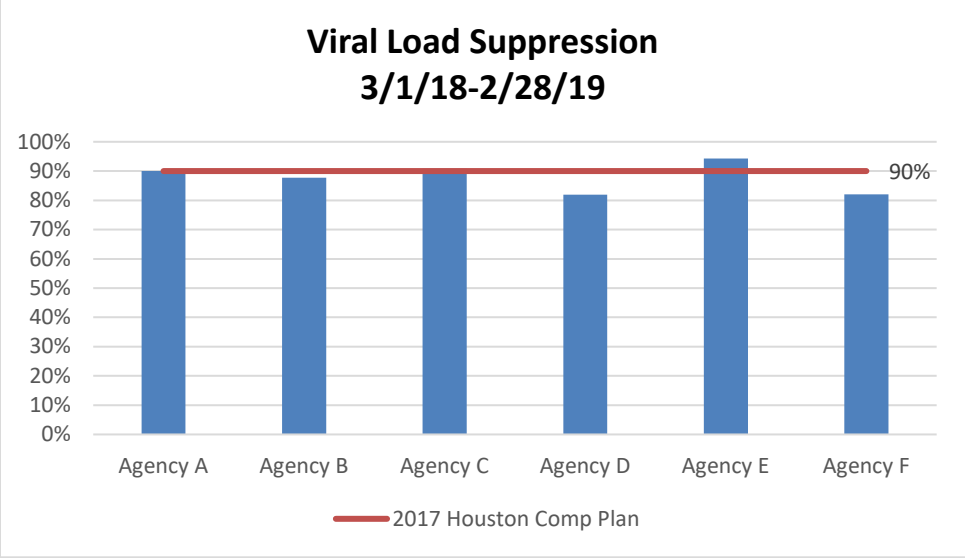
Core Performance Measures

Viral Load Suppression

- Percentage of clients living with HIV with viral load below limits of quantification (defined as <200 copies/ml) at last test during the measurement year

	2016	2017	2018
Number of clients with viral load below limits of quantification at last test during the measurement year	544	535	553
Number of clients who: • had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year, and • were prescribed ART for at least 6 months	615	626	630
Rate	**88.5%**	**85.5%**	**87.8%**
	2.1%	**-3%**	**2.3%**

2018 Viral Load Suppression by Race/Ethnicity			
	Black	Hispanic	White
Number of clients with viral load below limits of quantification at last test during the measurement year	252	214	78
Number of clients who: • had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year, and • were prescribed ART for at least 6 months	287	242	91
Rate	**87.8%**	**88.4%**	**85.7%**



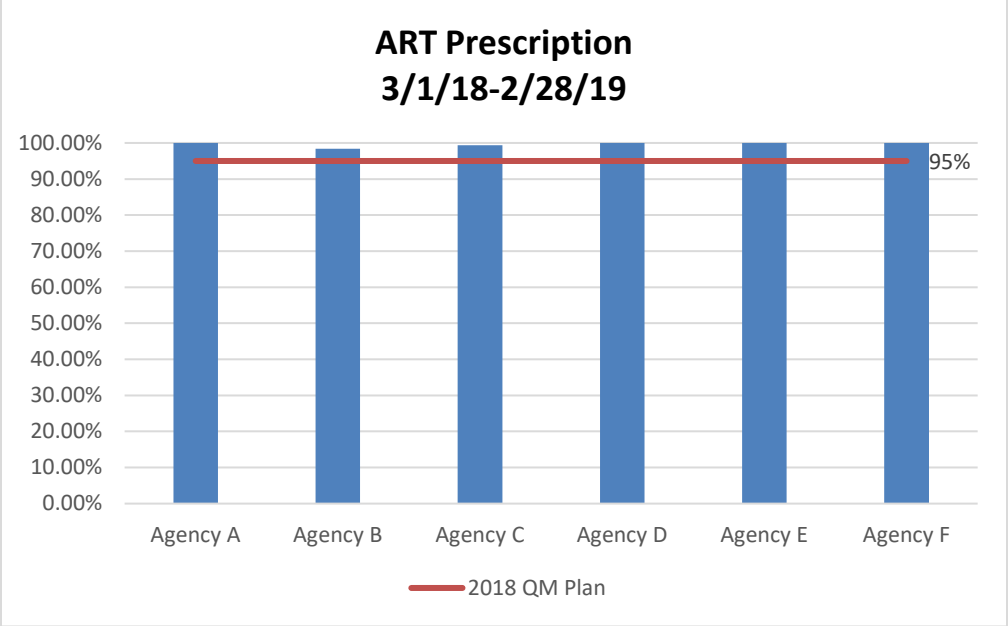
ART Prescription

- Percentage of clients living with HIV who are prescribed antiretroviral therapy (ART)

	2016	2017	2018
Number of clients who were prescribed an ART regimen within the measurement year	620	627	631
Number of clients who: • had at least two medical visit with a provider with prescribing privileges, i.e. MD, PA, NP in the measurement year	635	635	635
Rate	**97.6%**	**98.7%**	**99.4%**
Change from Previous Years Results	**1.1%**	**1.1%**	**.7%**

- Of the 4 clients not on ART, none had a CD4 <200, 3 were long-term non-progressors, and 1 refused

2018 ART Prescription by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who were prescribed an ART regimen within the measurement year	288	242	91
Number of clients who: • had at least two medical visit with a provider with prescribing privileges, i.e. MD, PA, NP in the measurement year	292	242	91
Rate	**98.6%**	**100%**	**100%**

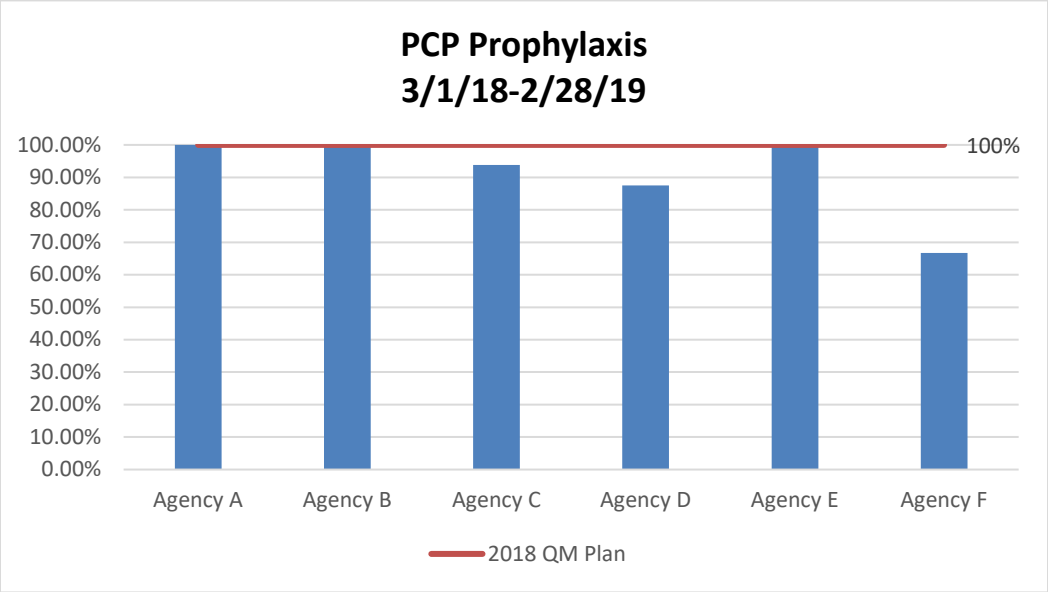


PCP Prophylaxis

- Percentage of clients living with HIV and a CD4 T-cell count below 200 cells/mm^3 who were prescribed PCP prophylaxis

	2016	2017	2018
Number of clients with CD4 T-cell counts below 200 cells/mm^3 who were prescribed PCP prophylaxis	48	53	62
Number of clients who: • had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year, and • had a CD4 T-cell count below 200 cells/mm^3, or any other indicating condition	48	57	66
Rate	**100%**	**93%**	**93.9%**
Change from Previous Years Results	**7%**	**-7%**	**.9%**

2018 PCP Prophylaxis by Race/Ethnicity			
	Black	Hispanic	White
Number of clients with CD4 T-cell counts below 200 cells/mm^3 who were prescribed PCP prophylaxis	30	21	11
Number of clients who: • had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least once in the measurement year, and • had a CD4 T-cell count below 200 cells/mm^3, or any other indicating condition	33	22	11
Rate	**90.9%**	**95.5%**	**100%**



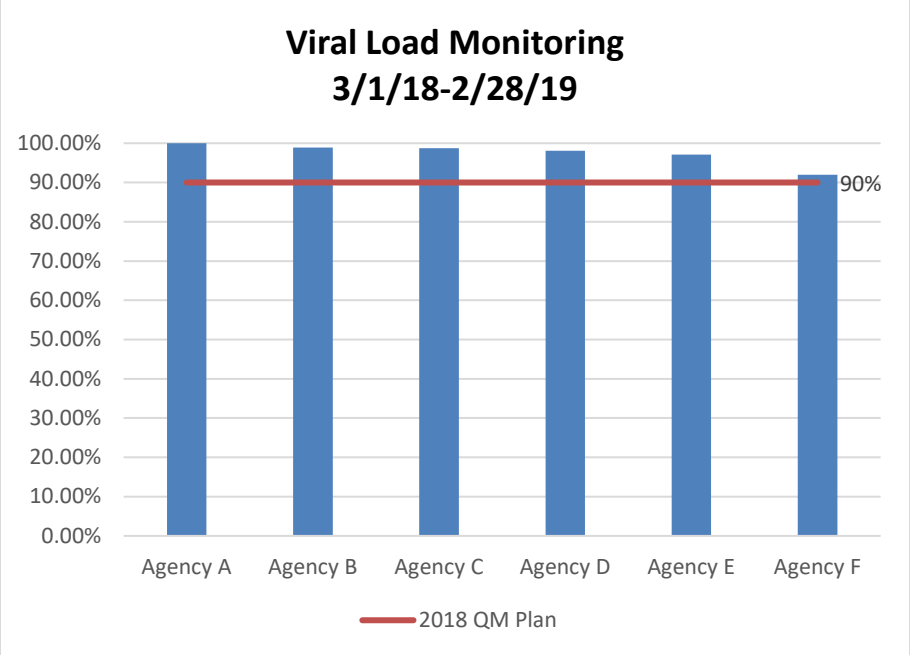
All Ages Performance Measures

Viral Load Monitoring

- Percentage of clients living with HIV who had a viral load test performed at least every six months during the measurement year

	2016	2017	2018
Number of clients who had a viral load test performed at least every six months during the measurement year	601	622	624
Number of clients who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year	635	635	635
Rate	**94.6%**	**98%**	**98.3%**
Change from Previous Years Results	**1.7%**	**3.4%**	**.3%**

2018 Viral Load by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who had a viral load test performed at least every six months during the measurement year	284	239	91
Number of clients who had a medical visit with a provider with prescribing privileges1, i.e. MD, PA, NP at least twice in the measurement year	292	242	91
Rate	**97.3%**	**98.8%**	**100%**



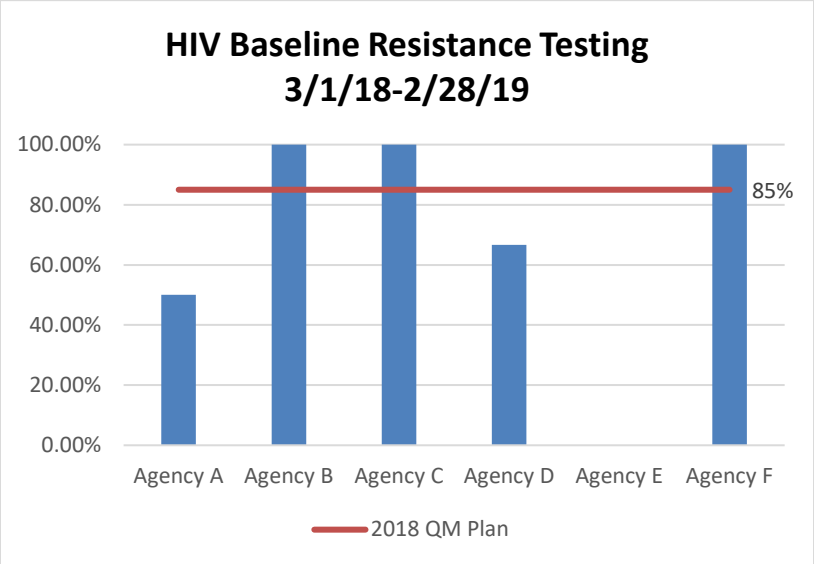
HIV Drug Resistance Testing Before Initiation of Therapy

- Percentage of clients living with HIV who had an HIV drug resistance test performed before initiation of HIV ART if therapy started in the measurement year

	2016	2017	2018
Number of clients who had an HIV drug resistance test performed at any time before initiation of HIV ART	9	5	6
Number of clients who: • had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year, and • were prescribed ART during the measurement year for the first time	13	7	8
Rate	**69.2%**	**71.4%**	**75%**
Change from Previous Years Results	**-.8%**	**2.2%**	**3.6%**

2018 Drug Resistance Testing by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who had an HIV drug resistance test performed at any time before initiation of HIV ART	1	2	3
Number of clients who: • had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year, and • were prescribed ART during the measurement year for the first time	2	3	3
Rate	**50%**	**66.7%**	**100%**

*Agency E did not have any clients that met the denominator



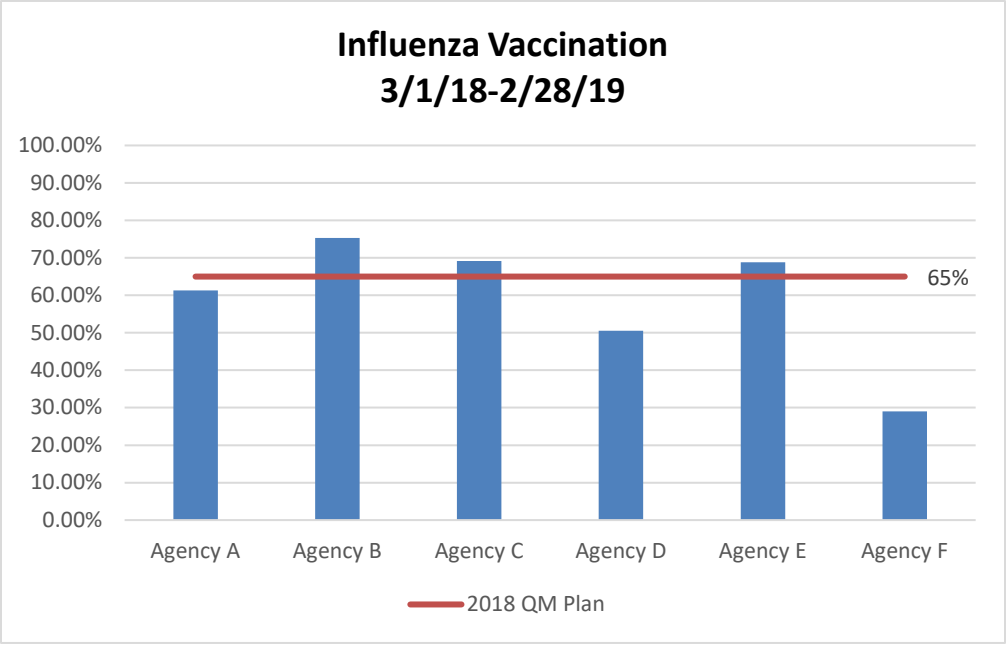
Influenza Vaccination

- Percentage of clients living with HIV who have received influenza vaccination within the measurement year

	2016	2017	2018
Number of clients who received influenza vaccination within the measurement year	312	310	336
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement period	588	579	534
Rate	**53.1%**	**53.5%**	**62.9%**
Change from Previous Years Results	**-3.2%**	**.4%**	**9.4%**

- The definition excludes from the denominator medical, patient, or system reasons for not receiving influenza vaccination

2018 Influenza Screening by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who received influenza vaccination within the measurement year	124	145	61
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	233	210	81
Rate	**53.2%**	**69%**	**75.3%**

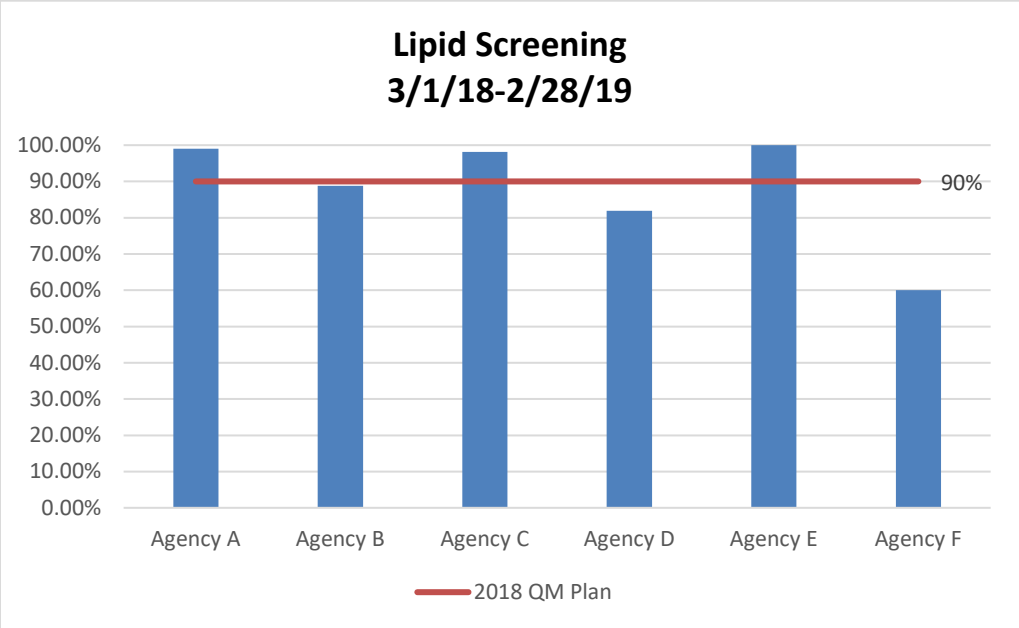


Lipid Screening

- Percentage of clients living with HIV on ART who had fasting lipid panel during measurement year

	2016	2017	2018
Number of clients who: • were prescribed ART, and • had a fasting lipid panel in the measurement year	551	557	567
Number of clients who are on ART and who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	620	627	631
Rate	**88.9%**	**88.8%**	**89.9%**
Change from Previous Years Results	**.5%**	**-.1%**	**1.1%**

2018 Lipid Screening by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who: • were prescribed ART, and • had a fasting lipid panel in the measurement year	256	219	82
Number of clients who are on ART and who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	288	242	91
Rate	**88.9%**	**90.5%**	**90.1%**

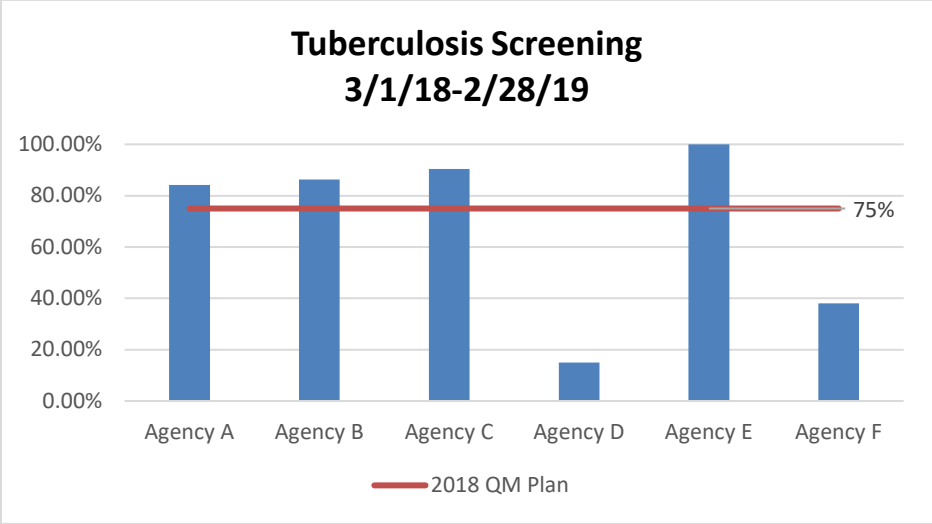


Tuberculosis Screening

- Percent of clients living with HIV who received testing with results documented for LTBI with any approved test (tuberculin skin test [TST] or interferon gamma release assay [IGRA]) since HIV diagnosis

	2016	2017	2018
Number of clients who received documented testing for LTBI with any approved test (tuberculin skin test [TST] or interferon gamma release assay [IGRA]) since HIV diagnosis	382	375	401
Number of clients who: • do not have a history of previous documented culture-positive TB disease or previous documented positive TST or IGRA; and • had a medical visit with a provider with prescribing privileges at least twice in the measurement year.	571	558	565
Rate	**66.9%**	**67.2%**	**71%**
Change from Previous Years Results	**-.2%**	**.3%**	**3.8%**

2018 TB Screening by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who received documented testing for LTBI with any approved test (tuberculin skin test [TST] or interferon gamma release assay [IGRA]) since HIV diagnosis	177	164	57
Number of clients who: • do not have a history of previous documented culture-positive TB disease or previous documented positive TST or IGRA; and • had a medical visit with a provider with prescribing privileges at least once in the measurement year.	269	208	84
Rate	**65.8%**	**78.8%**	**67.9%**



Adolescent/Adult Performance Measures

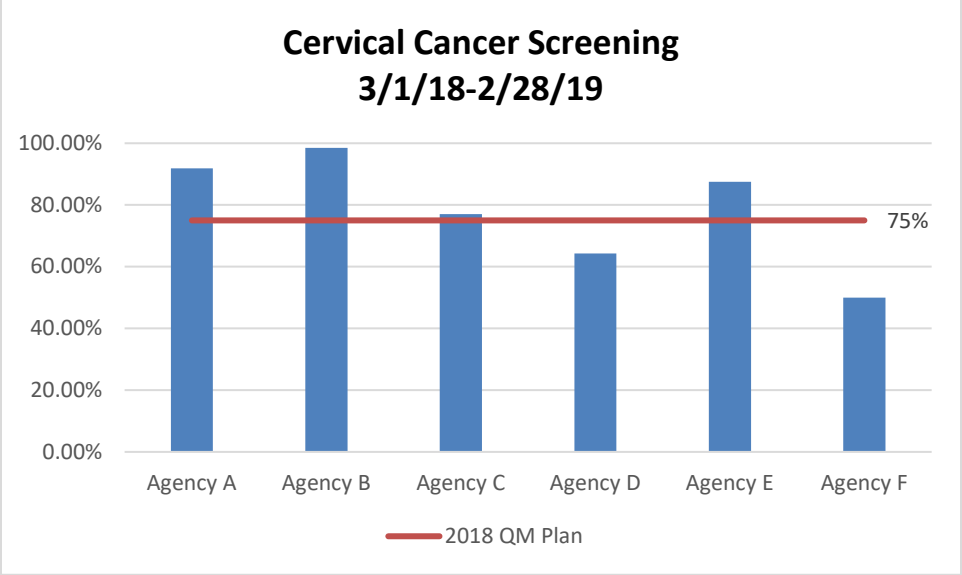
Cervical Cancer Screening

- Percentage of women living with HIV who have Pap screening results documented in the previous three years

	2016	2017	2018
Number of female clients who had Pap screen results documented in the previous three years	229	226	199
Number of female clients: • for whom a pap smear was indicated, and • who had a medical visit with a provider with prescribing privileges at least twice in the measurement year*	286	274	244
Rate	**80.1%**	**82.5%**	**81.6%**
Change from Previous Years Results	**11.9%**	**2.4%**	**-.9%**

- 20.6% (41/199) of pap smears were abnormal

2018 Cervical Cancer Screening Data by Race/Ethnicity			
	Black	Hispanic	White
Number of female clients who had Pap screen results documented in the previous three years	97	94	8
Number of female clients: • for whom a pap smear was indicated, and • who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	115	112	15
Rate	**84.3%**	**83.9%**	**53.3%**



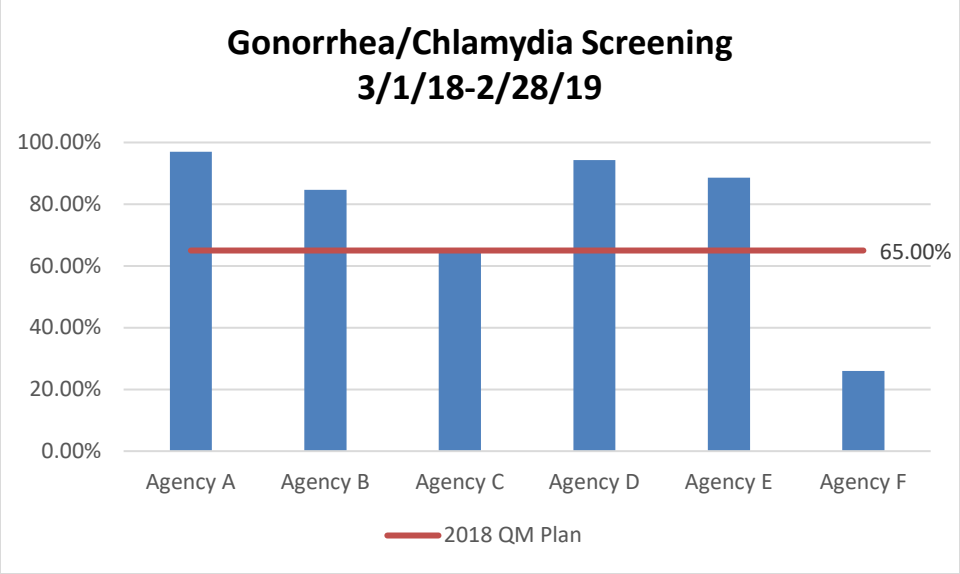
Gonorrhea/Chlamydia Screening

- Percent of clients living with HIV at risk for sexually transmitted infections who had a test for Gonorrhea/Chlamydia within the measurement year

	2016	2017	2018
Number of clients who had a test for Gonorrhea/Chlamydia	463	493	501
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	635	635	635
Rate	**72.9%**	**77.6%**	**78.9%**
Change from Previous Years Results	**3.3%**	**4.7%**	**1.3%**

- 19 cases of chlamydia and 16 cases of gonorrhea were identified

2018 GC/CT by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who had a serologic test for syphilis performed at least once during the measurement year	232	199	61
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	292	242	91
Rate	**79.5%**	**82.2%**	**67%**



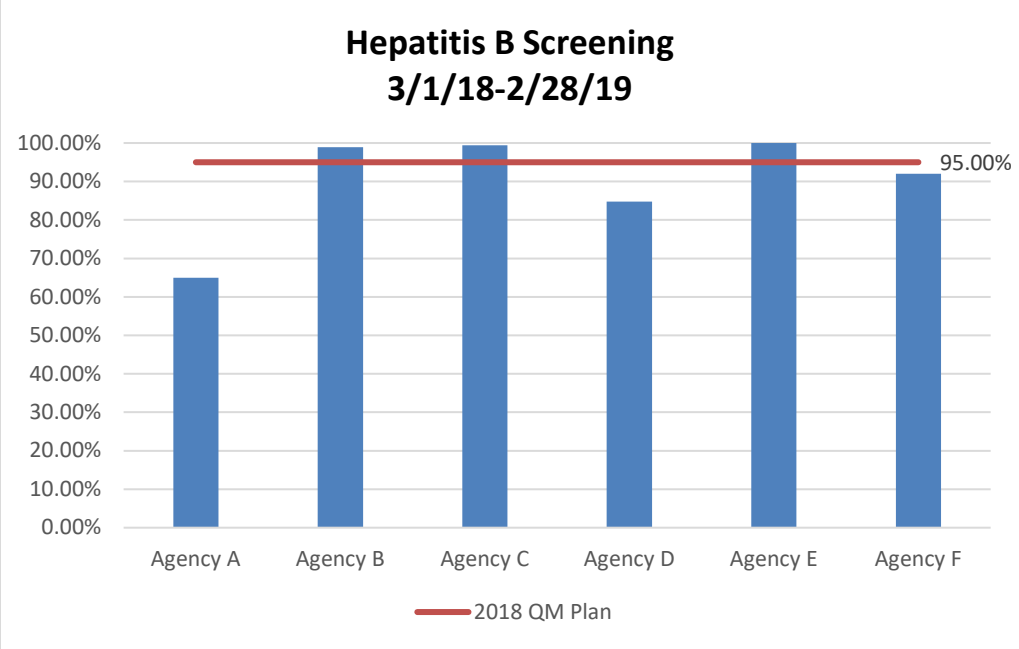
Hepatitis B Screening

- Percentage of clients living with HIV who have been screened for Hepatitis B virus infection status

	2016	2017	2018
Number of clients who have documented Hepatitis B infection status in the health record	610	553	577
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	635	635	635
Rate	**96.1%**	**87.1%**	**90.9%**
Change from Previous Years Results	**-3.7%**	**-9%**	**3.8%**

- 2.2% (14/635) were Hepatitis B positive

2018 Hepatitis B Screening by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who have documented Hepatitis B infection status in the health record	266	220	81
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	292	242	91
Rate	**91.1%**	**90.9%**	**89%**

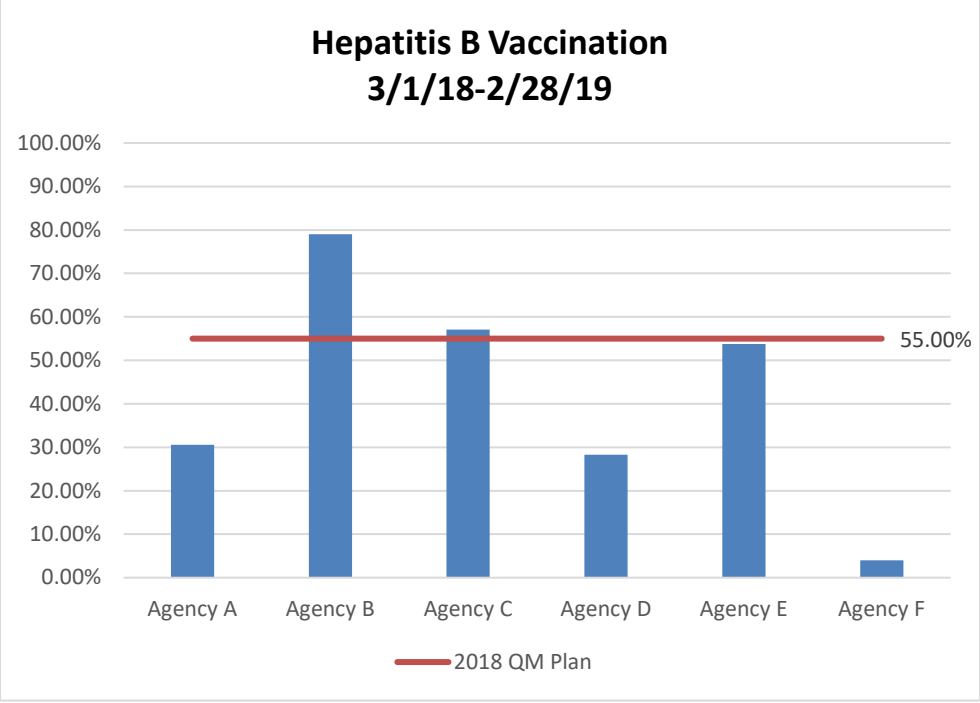


Hepatitis B Vaccination

- Percentage of clients living with HIV who completed the vaccination series for Hepatitis B

	2016	2017	2018
Number of clients with documentation of having ever completed the vaccination series for Hepatitis B	179	196	171
Number of clients who are Hepatitis B Nonimmune and had a medical visit with a provider with prescribing privileges at least twice in the measurement year	322	381	347
Rate	**55.6%**	**51.4%**	**49.3%**
Change from Previous Years Results	**-4.3%**	**-4.2%**	**-2.1%**

2018 Hepatitis B Vaccination by Race/Ethnicity			
	Black	Hispanic	White
Number of clients with documentation of having ever completed the vaccination series for Hepatitis B	60	89	21
Number of clients who are Hepatitis B Nonimmune and had a medical visit with a provider with prescribing privileges at least twice in the measurement year	136	160	50
Rate	**44.1%**	**55.6%**	**42%**



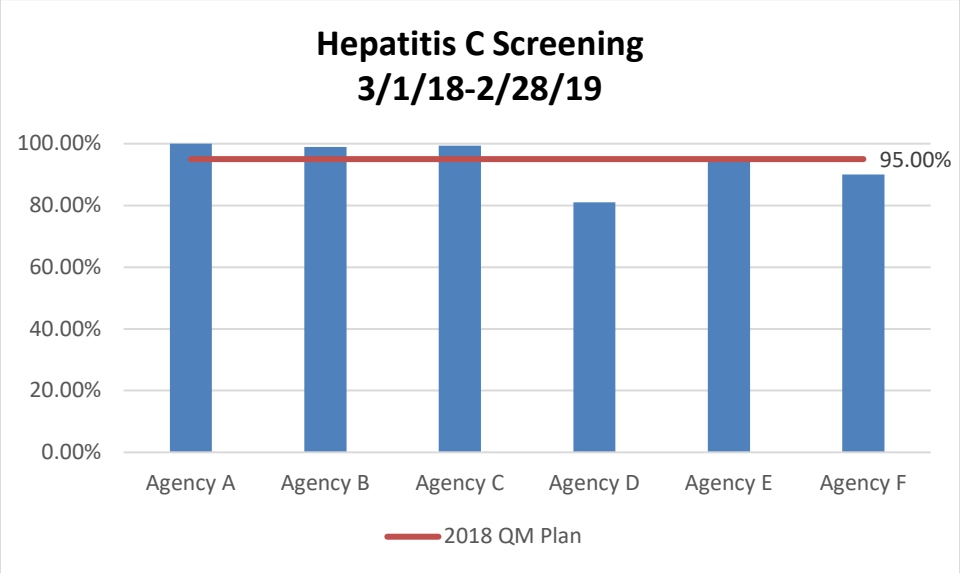
Hepatitis C Screening

- Percentage of clients living with HIV for whom Hepatitis C (HCV) screening was performed at least once since diagnosis of HIV

	2016	2017	2018
Number of clients who have documented HCV status in chart	629	589	604
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	635	635	635
Rate	**99.1%**	**92.8%**	**95.1%**
Change from Previous Years Results	**-.6%**	**-6.3%**	**2.3%**

- 7.2% (46/635) were Hepatitis C positive, including 11 acute infections only and 19 cures

2018 Hepatitis C Screening by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who have documented HCV status in chart	273	234	87
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	292	242	91
Rate	**93.5%**	**96.7%**	**95.6%**

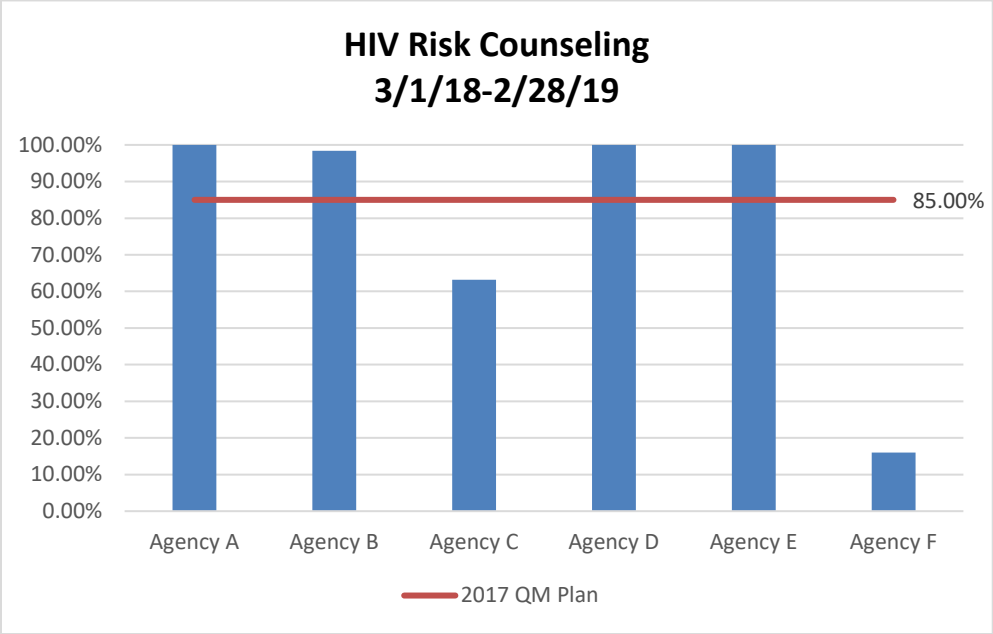


HIV Risk Counseling

- Percentage of clients living with HIV who received HIV risk counseling within measurement year

	2016	2017	2018
Number of clients, as part of their primary care, who received HIV risk counseling	441	576	533
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	635	635	635
Rate	**69.4%**	**90.7%**	**83.9%**
Change from Previous Years Results	**-1.9%**	**21.3%**	**-6.8%**

2018 HIV Risk Counseling by Race/Ethnicity			
	Black	Hispanic	White
Number of clients, as part of their primary care, who received HIV risk counseling	246	211	69
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	292	242	91
Rate	**84.2%**	**87.2%**	**75.8%**

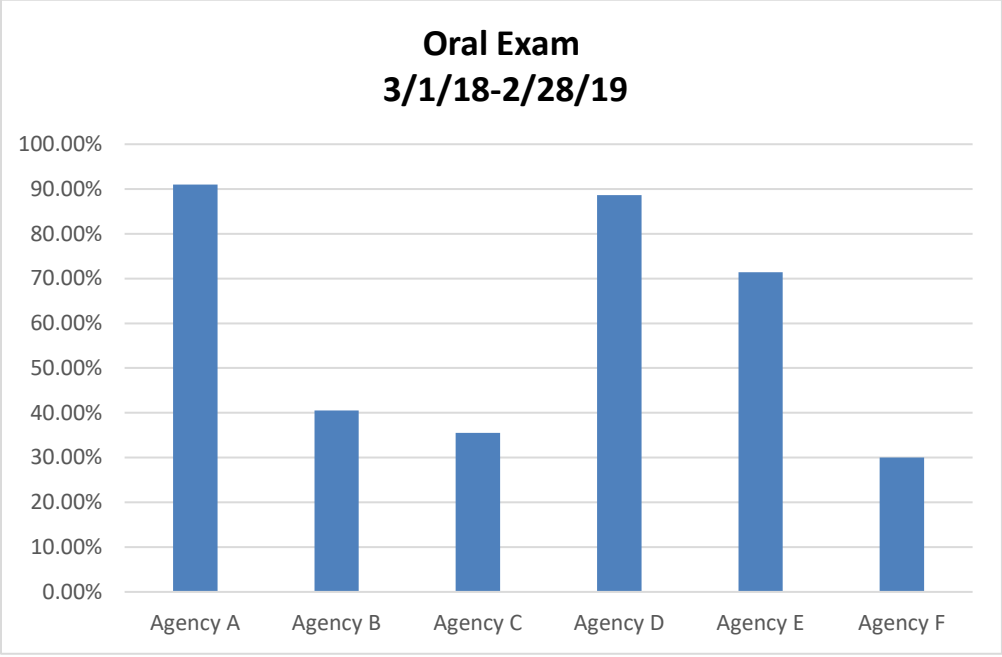


Oral Exam

- Percent of clients living with HIV who were referred to a dentist for an oral exam or self-reported receiving a dental exam at least once during the measurement year

	2016	2017	2018
Number of clients who were referred to a dentist for an oral exam or self-reported receiving a dental exam at least once during the measurement year	327	272	355
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	635	635	635
Rate	**51.5%**	**42.8%**	**55.9%**
Change from Previous Years Results	**-2%**	**-8.7%**	**13.1%**

2018 Oral Exam by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who were referred to a dentist for an oral exam or self-reported receiving a dental exam at least once during the measurement year	165	142	44
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	292	242	91
Rate	**56.5%**	**58.7%**	**48.4%**



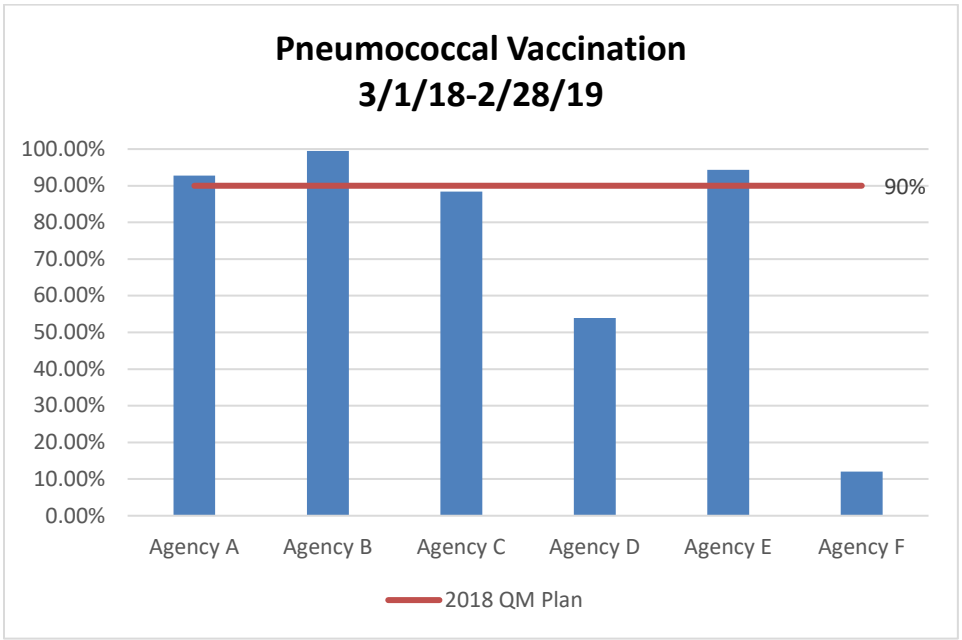
Pneumococcal Vaccination

- Percentage of clients living with HIV who ever received pneumococcal vaccination

	2016	2017	2018
Number of clients who received pneumococcal vaccination	534	514	507
Number of clients who: • had a CD4 count > 200 cells/mm3, and • had a medical visit with a provider with prescribing privileges at least twice in the measurement period	616	616	610
Rate	**86.7%**	**83.4%**	**83.1%**
Change from Previous Years Results	**-1.1%**	**-3.3%**	**-.3%**

- 330 clients (65.1%) received both PPV13 and PPV23 (FY17- 60.5%, FY16- 49.4%)

2018 Pneumococcal Vaccination by Race/Ethnicity			
	Black	Hispanic	White
Number of clients who received pneumococcal vaccination	224	204	70
Number of clients who: • had a CD4 count > 200 cells/mm3, and had a medical visit with a provider with prescribing privileges at least twice in the measurement period	282	233	85
Rate	**79.4%**	**87.6%**	**82.4%**

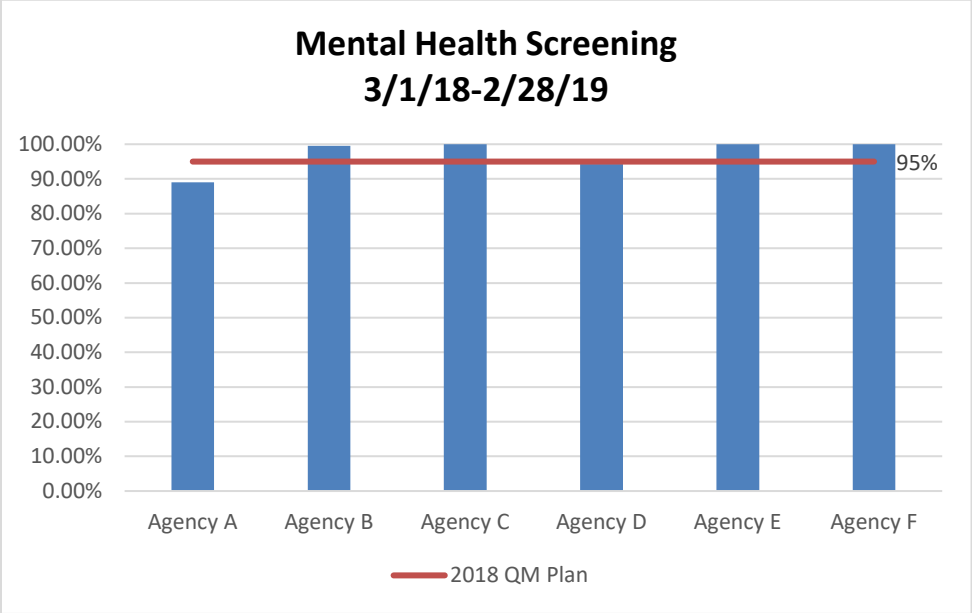


Preventative Care and Screening: Mental Health Screening

- Percentage of clients living with HIV who have had a mental health screening

	2016	2017	2018
Number of clients who received a mental health screening	558	612	623
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement period	635	635	635
Rate	**87.9%**	**96.4%**	**98.1%**
Change from Previous Years Results	**-4.4%**	**8.5%**	**1.7%**

- 24.3% (154/635) had mental health issues. Of the 75 who needed additional care, 66 (88%) were either managed by the primary care provider or referred; 8 clients refused a referral.

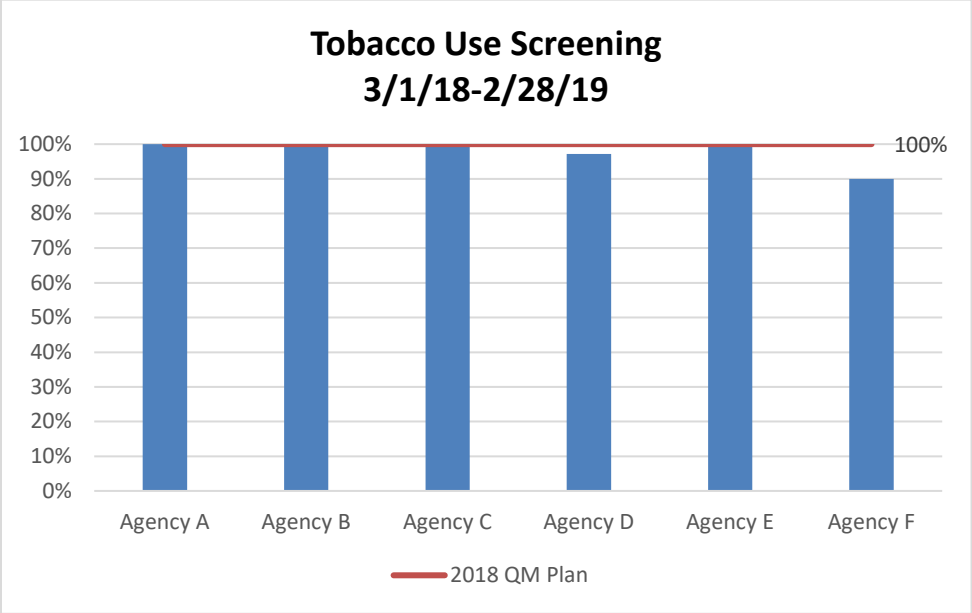


Preventative Care and Screening: Tobacco Use: screening & cessation intervention

- Percentage of clients living with HIV who were screened for tobacco use one or more times with 24 months and who received cessation counseling if indicated

	2016	2017	2018
Number of clients who were screened for tobacco use in the measurement period	631	635	627
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement period	635	635	635
Rate	**99.4%**	**100%**	**98.7%**
Change from Previous Years Results	**-.6%**	**.6%**	**-1.3%**

- Of the 627 clients screened, 177 (28.2%) were current smokers.
- Of the 177 current smokers, 120 (67.8%) received smoking cessation counseling, and 13 (7.3%) refused smoking cessation counseling



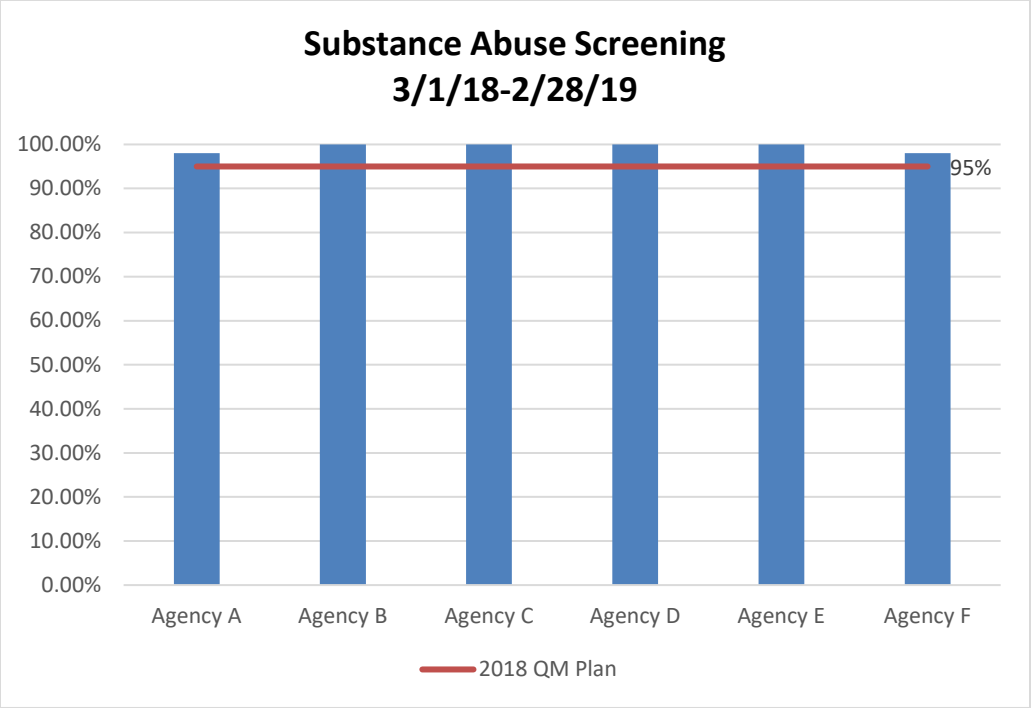
Substance Use Screening

- Percentage of clients living with HIV who have been screened for substance use (alcohol & drugs) in the measurement year*

	2016	2017	2018
Number of new clients who were screened for substance use within the measurement year	626	629	631
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement period	635	635	635
Rate	**98.6%**	**99.1%**	**99.4%**
Change from Previous Years Results	**-.1%**	**.5%**	**.3%**

*HAB measure indicates only new clients be screened. However, Houston EMA standards of care require medical providers to screen all clients annually.

- 5.4% (34/635) had a substance use disorder. Of the 34 clients who needed referral, 27 (79.4%) received one, and 6 (17.6%) refused.

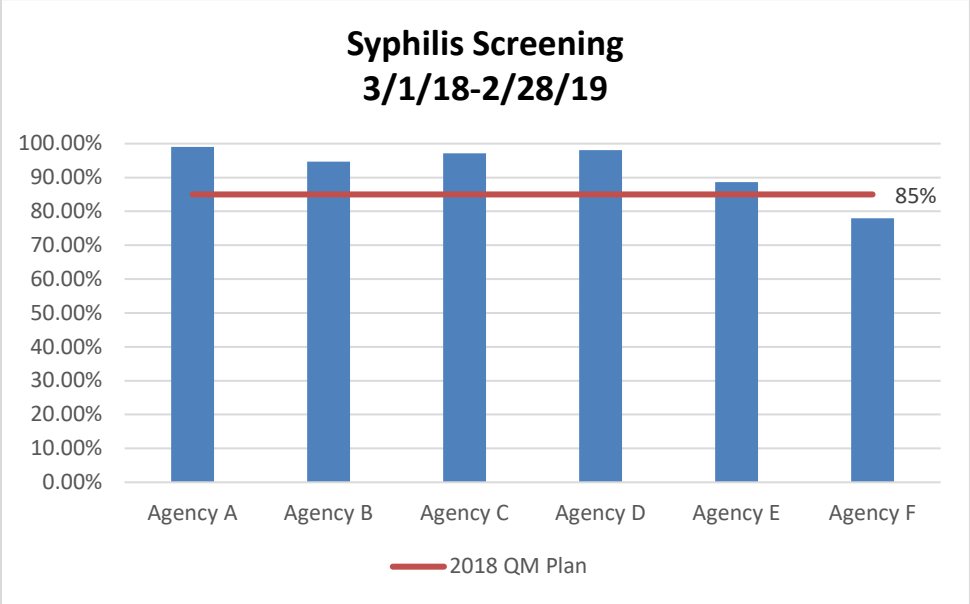


Syphilis Screening

- Percentage of clients living with HIV who had a test for syphilis performed within the measurement year

	2016	2017	2018
Number of clients who had a serologic test for syphilis performed at least once during the measurement year	597	587	602
Number of clients who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	635	635	635
Rate	**94%**	**92.4%**	**94.8%**
Change from Previous Years Results	**-.3%**	**-1.6%**	**2.4%**

- 7.9% (50/635) new cases of syphilis diagnosed

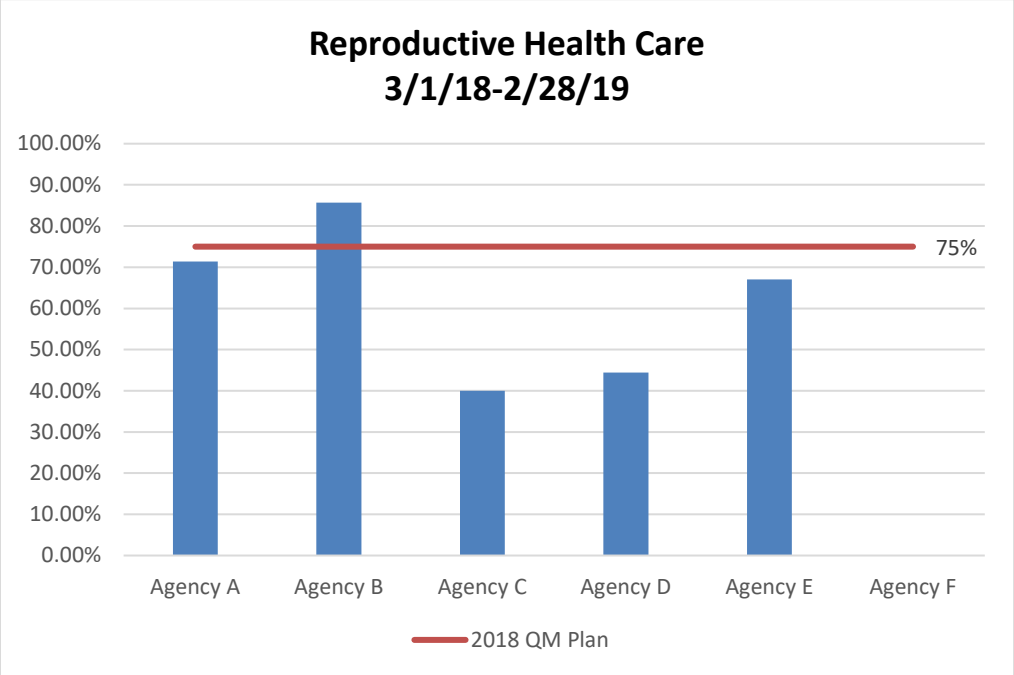


Other Measures

Reproductive Health Care

- Percentage of reproductive-age women living with HIV who received reproductive health assessment and care (i.e, pregnancy plans and desires assessed and either preconception counseling or contraception offered)

	2016	2017	2018
Number of reproductive-age women who received reproductive health assessment and care	34	22	29
Number of reproductive-age women who: • did not have a hysterectomy or bilateral tubal ligation, and • had a medical visit with a provider with prescribing privileges at least twice in the measurement period	63	63	54
Rate	**54%**	**34.9%**	**53.7%**
Change from Previous Years Results	**4.7%**	**-19.1%**	**18.8%**

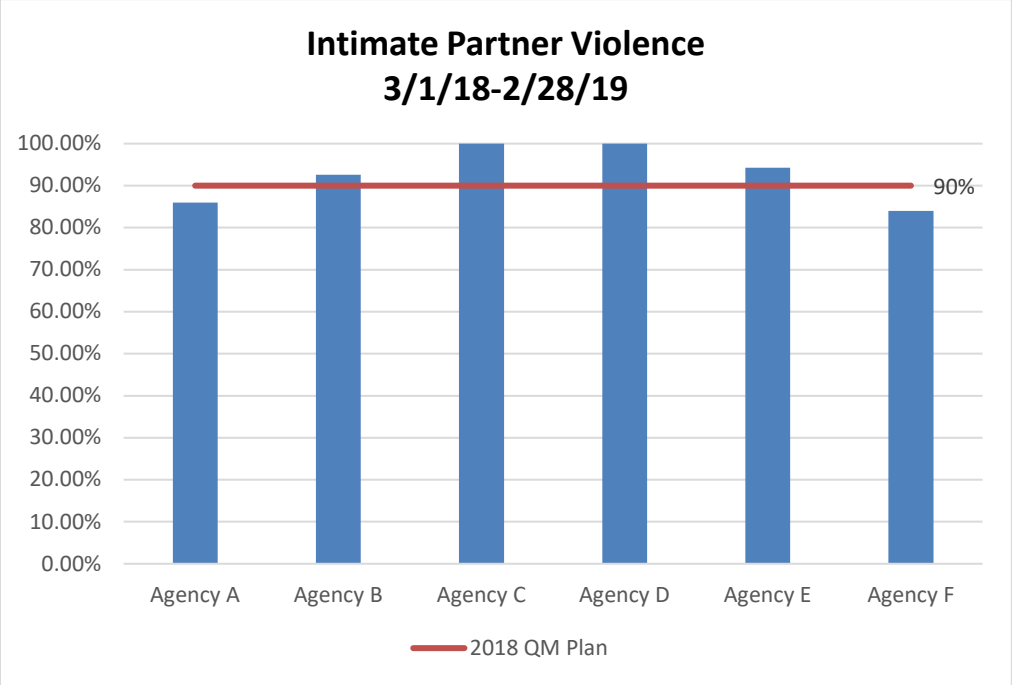


Intimate Partner Violence Screening

- Percentage of clients living with HIV who received screening for current intimate partner violence

	2016	2017	2018
Number of clients who received screening for current intimate partner violence	520	499	592
Number of clients who: • had a medical visit with a provider with prescribing privileges at least twice in the measurement period	635	635	635
Rate	**81.9%**	**78.6%**	**93.2%**
	-7.7%	**-3.3%**	**14.6%**

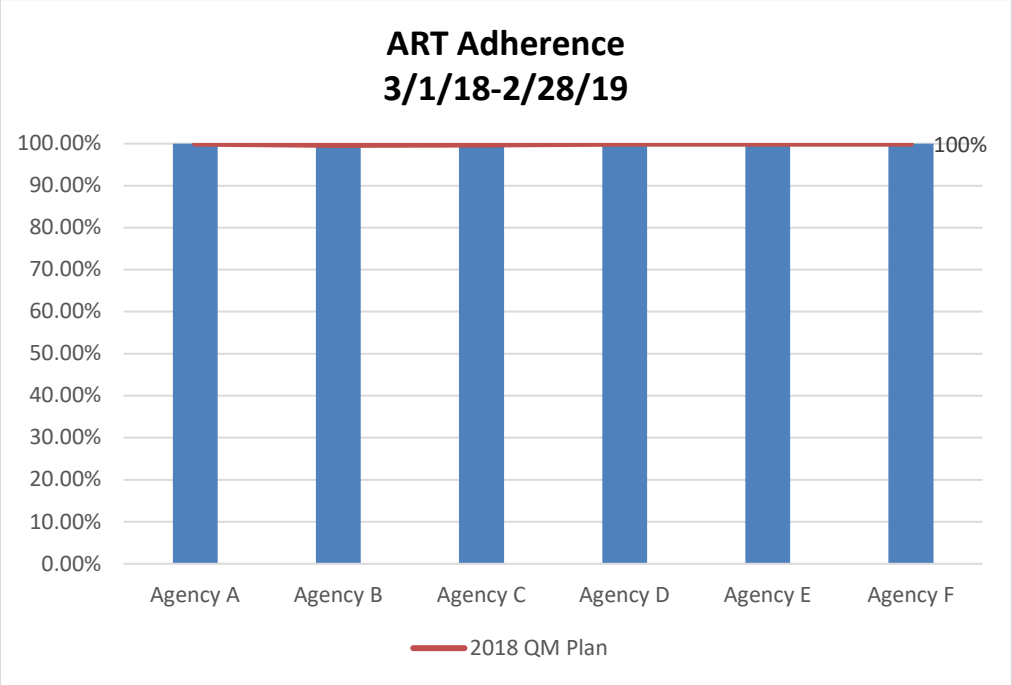
* 3/635 screened positive



Adherence Assessment & Counseling

- Percentage of clients living with HIV on ART who were assessed for adherence at least once per year

	Adherence Assessment		
	2016	2017	2018
Number of clients, as part of their primary care, who were assessed for adherence at least once per year	617	627	631
Number of clients on ART who had a medical visit with a provider with prescribing privileges at least twice in the measurement year	620	627	631
Rate	**99.5%**	**100%**	**100%**
Change from Previous Years Results	**.5%**	**.5%**	**0%**



ART for Pregnant Women

- Percentage of pregnant women living with HIV who are prescribed antiretroviral therapy (ART)

	2016	2017	2018
Number of pregnant women who were prescribed ART during the 2nd and 3rd trimester	3	3	3
Number of pregnant women who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year	3	3	3
Rate	**100%**	**100%**	**100%**
Change from Previous Years Results	**0%**	**0%**	**0%**

Primary Care: Diabetes Control

- Percentage of clients living with HIV and diabetes who maintained glucose control during measurement year

	2016	2017	2018
Number of diabetic clients whose last HbA1c in the measurement year was <8%	51	48	35
Number of diabetic clients who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year	70	74	67
Rate	**72.9%**	**64.9%**	**52.2%**
Change from Previous Years Results	**15.5%**	**-8%**	**-12.7%**

- 635/635 (100%) of clients where screened for diabetes and 67/635 (10.6%) were diagnosed diabetic

Primary Care: Hypertension Control

- Percentage of clients living with HIV and hypertension who maintained blood pressure control during measurement year

	2016	2017	2018
Number of hypertensive clients whose last blood pressure of the measurement year was <140/90	133	166	145
Number of hypertensive clients who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year	180	206	180
Rate	**73.9%**	**80.6%**	**80.6%**
Change from Previous Years Results	**-1.8%**	**6.7%**	**0%**

- 145/635 (22.8%) of clients were diagnosed with hypertension

Primary Care: Breast Cancer Screening

- Percentage of women living with HIV, over the age of 41, who had a mammogram or a referral for a mammogram, in the previous two years

	2016	2017	2018
Number of women over age 41 who had a mammogram or a referral for a mammogram documented in the previous two years	133	150	141
Number of women over age 41 who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year	180	171	164
Rate	**73.9%**	**87.7%**	**86%**
Change from Previous Years Results	**-1.8%**	**13.8%**	**-1.7%**

Primary Care: Colon Cancer Screening

- Percentage of clients living with HIV, over the age of 50, who received colon cancer screening (colonoscopy, sigmoidoscopy, or fecal occult blood test) or a referral for colon cancer screening

	2016	2017	2018
Number of clients over age 50 who had colon cancer screening or a referral for colon cancer screening	82	93	127
Number of clients over age 50 who had a medical visit with a provider with prescribing privileges, i.e. MD, PA, NP at least twice in the measurement year	152	151	160
Rate	**53.9%**	**61.6%**	**79.4%**
Change from Previous Years Results	**3.2%**	**7.7%**	**17.8%**

Conclusions

The Houston EMA continues to demonstrate high quality clinical care. Overall, performance rates were comparable to the previous year. However, Viral Load Suppression has slightly increased, as has Influenza Vaccination, Intimate Partner Violence Screening, and Reproductive Health Care. HIV Risk Counseling experienced a decrease in performance. While some measures still demonstrate racial and ethnic disparities, the gap appears to be closing for other measures, including Viral Load Suppression. Eliminating racial and ethnic disparities in care are a priority for the EMA, and will continue to be a focus for quality improvement.

Harris County
Public Health
Building a Healthy Community

Ryan White Part A
Quality Management Program- Houston EMA
Case Management Chart Review FY 18
Ryan White Grant Administration

CUMMULATIVE SUMMARY, DE-IDENTIFIED

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Table of Contents

Overview

Each year, the Ryan White Grant Administration Quality Management team conducts chart review in order to continuously monitor case management services and understand how each agency implements workflows to meet quality standards for their funded service models. This process is a supplemental complement to the programmatic and fiscal audit of each program, as it helps to provide an overall picture of quality of care and monitor quality performance measures.

A total of 609 medical case management client records were reviewed across seven of the ten Ryan White-Part A funded agencies, including a non-primary care site that provides Clinical Case Management services. The dates of service under review were March 1, 2018- February 28, 2019. The chart review was conducted by the Project Coordinator for Quality Management Development, a Licensed Master Social Worker on the Ryan White Grant Administration team. The sample selection process and data collection tool are described in subsequent sections.

Case Management is defined by the Ryan White legislation as a, "range of client-centered services that link clients with health care, psychosocial, and other services," including coordination and follow-up of medical treatment and "adherence counseling to ensure readiness for and adherence to HIV complex treatments." Case Managers assist clients in navigating the complex health care system to ensure coordination of care for the unique needs of People Living With HIV. Continuous assessment of need and the development of individualized service plans are key components of case management. Due to their training and skill sets in social services, human development, psychology, social justice, and communication, Case Managers are uniquely positioned to serve clients who face environmental and life issues that can jeopardize their success in HIV treatment, namely, mental health and substance abuse, poverty and access to stable housing and transportation, and poor social support networks.

Ryan White Part-A funds three distinct models of case management: Medical Case Management, Non-Medical Case Management (or Service Linkage Work), and Clinical Case Management, which must be co-located in an agency that offers Mental Health treatment/counseling and/or Substance Abuse treatment. Some agencies are also funded for Outreach Services, which complement Case Management Services and are designed to locate and assist clients who are on the cusp of falling out of care in order to re-engage and retain them back into care.

While traditional, community-based case management models tend to provide intensive, individualized assistance to a limited and defined number of clients on a social worker's "case load," case management in this time and place resembles more of a "revolving door" model. This evolution is not unique to the Ryan White system of care. The National Association of Social Workers has identified this transformation of case management in the health care setting as a growing challenge for medical social workers[1]. Social workers have become sought out by health care institutions in order to add professionals to their practice who specialize in holistic, person-centered approaches. However, as the health care system itself changes, the role of a medical case managers has adapted to include the more administrative tasks that are necessary for managed care facilitates and reimbursement models to function.

In practical terms, this means that case managers are now more often performing tasks that registered nurses, benefits specialists, and medical assistants are equally skilled to perform, such as scheduling and reminders, basic health education, and insurance or coverage navigation. While it is clear that these are invaluable functions in the HIV treatment setting, it is a distinct shift away from the type of psychosocial work that social workers are trained to do, such as supportive counseling, task-centered motivational change, service planning and intensive follow-up, and accompaniment through the social services system. Unfortunately, as the HIV epidemic shifts to disproportionately impact low-income, marginalized communities with lower social capital and higher incidence of mental health concerns, this the exact type of professional help that is sorely underutilized in HIV care.

[1] National Association of Social Workers. (2016). *NASW Standards for Social Work Practice in Health Care Settings*.

While this description is certainly not true of all agencies or client records reviewed, the data presented in this year's chart review paints an overall picture of a case management system that is characterized by in-the-moment, on-demand requests, rather than ongoing contact at regular intervals. More than half of the clients in the sample (56%) had 3 or less interactions from a case manager within the review year and less than 11% of the medical case management clients received two "care plans" within the year. These findings are consistent with last year's review, in which the previous chart abstractor noted that, "the Ryan White Standards of Care seem to presume much more intense and frequent contact between case manager and client than is actually happening in practice."

At the individual agency level, there are many noteworthy and innovative practices that were highlighted throughout the chart review process and quality management site interviews. For example, a lead case manager at one agency regular conducts chart review on the next day's patients in order to brief and essentially "pre-round" with the medical provider on their patient list. Another agency engages clients in their own assessments by having the patient self-administer the form so that it may be used as a conversation starter and way to build rapport, rather than a "cold interview" technique. Yet another agency has adapted their physical clinic layout to utilize a "pod" model in which at least one medical case manger and one service linkage worker is assigned to a provider, which functionally and closely resembles a case load model. One agency has an entirely separate benefits department that handles eligibility and enrollment for coverage programs, freeing up that responsibility from the case management team. All of these practices highlight opportunities and strengths within our Ryan White system for case management to continue as a value-added service for People Living with HIV.

The Tool

A copy of the Case Management Chart Review tool is available in the Appendix of this report.

The Case Management Chart Review tool is a pen and paper form designed to standardize data collection and analysis across agencies. The purpose of the tool is to capture information and quantify services that can present an overall picture of the quality of case management services provided within the Ryan White Part-A system of care. This way, strengths and areas of improvement can be identified and continuously monitored.

This tool has been developed with input from case management providers and previous chart abstractors and continues to be refined to prompt a more detailed chart review process. Since the tool and sample collection method continue to be revised each year, a retrospective comparison is not offered in this report, though previous reports are available upon request.

The coversheet of the chart abstraction tool captures basic information about the client, including their demographics, most recent appointments and lab results, and any documented psychological, medical, or social issues or conditions that would be documented in their medical record.

The content of the second sheet focuses on coordination of case management services. There is space for the chart abstractor to record what type of worker assisted the client (Medical Case Manager, Service Linkage Worker, Outreach Worker or Clinical Case Manager) and what types of services were provided. Any notes about case management closure are recorded, as well as any assessments or service plans or documented reasons for the absence of assessments or service plans.

The chart abstraction tool was also reviewed by the Ryan White Grant Administration Quality Management team, the supervisors of the case management staff at each agency, and a Clinical Quality Improvement committee convened by Ryan White Grant Administration.

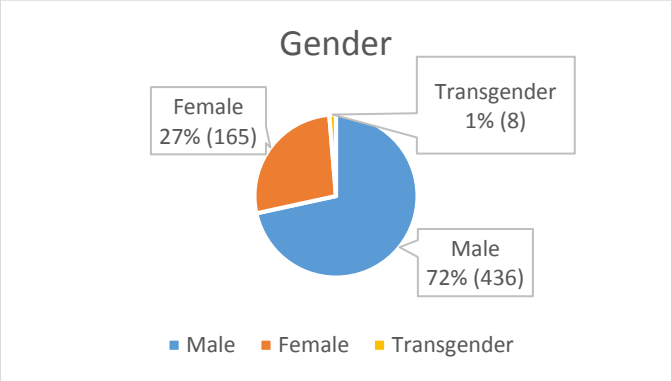
The Sample

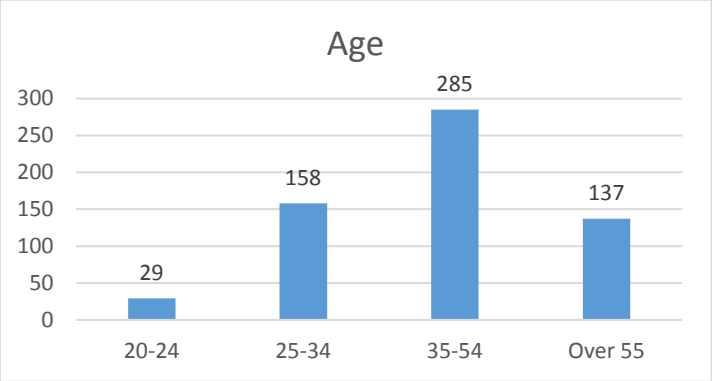
In order to conduct a thorough and comprehensive review, a total of 609 client records were reviewed across seven agencies for the 2018-2019 grant year. This included sixty (60) Clinical Case Management charts at a non-primary care site. In this Case Management Chart Review Report, any section that evaluated a primary care related measure excludes the sample of the non-primary care site. Minimum sample size was determined in accordance with *Center for Quality Improvement & Innovation* sample size calculator[2] based on the total eligible population that received case management services at each site.

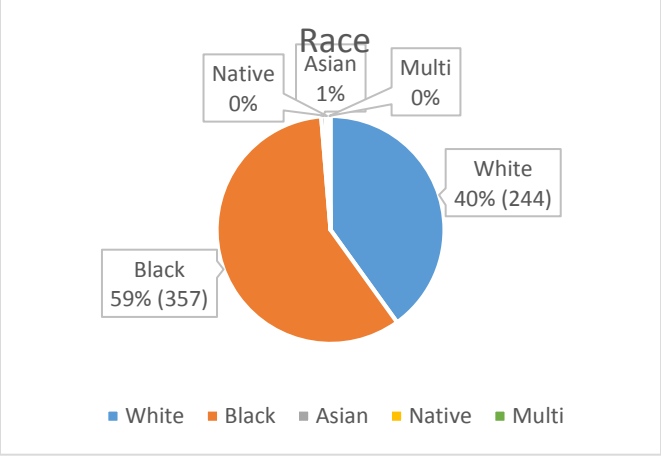
Agency	A	B	C	D	E	F	G
# of Charts Reviewed	67	105	97	70	105	105	60

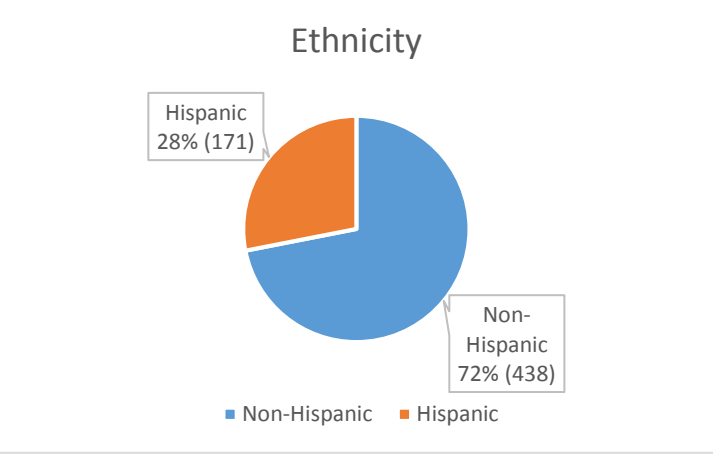
TOTAL 609 (549 excluding non-PCare site)

For each agency, a randomized sample of clients who received a billable Ryan White- A service under at least one (1) of eleven (11) case management subcategory codes during the March 1, 2018- February 28, 2019 grant year was queried from the Centralized Patient Care Data Management System data base. The total eligible population from which the sample was drawn was a pool of 11,159 case management clients. The number of clients selected at each site is proportional to the number of case management clients served there. Each sample was determined to be comparable to the racial, ethnic, age, and gender demographics of each site's overall case management patient population.









[2] New York Department of Health AIDS Institute. (2006). *HIVQUAL Workbook: Guide for quality improvement in HIV care*. NY: U.S. Department of Health and Human Services Health Resources and Services Administration HIV/AIDS Bureau.

Health insurance coverage type was also analyzed according to the client's registration. More than half of the sample (55%) was uninsured; 24% was enrolled in either Medicaid, Medicare, or some combination; 7% had a private or commercial plan; and an additional 14% had an unknown insurance coverage status.

Cumulative Data Summaries

APPOINTMENTS & ENCOUNTERS

The number of HIV-related primary care appointments and case management encounters in the given year were counted for each client.

HIV-RELATED PRIMARY CARE APPOINTMENTS

For this measure, the number of face-to-face encounters for an HIV-related primary care appointment with a medical provider was counted. Any number of appointments above three per year was simply coded as 3 appointments. Any Viral Load/CD4 count lab test that accompanied the appointment was also recorded, which is shared on page 9.

# of appointments	A	B	C	D	E	F	TOTAL
0 appts.	6 (9%)	14 (13%)	15 (15%)	1 (1%)	11 (10%)	7 (7%)	54 (10%)
1 appts.	12 (18%)	13 (12%)	20 (21%)	12 (17%)	26 (25%)	24 (23%)	107 (19%)
2 appt.	23 (34%)	17 (16%)	21 (22%)	37 (53%)	44 (42%)	34 (32%)	176 (32%)
3 + appts.	26 (39%)	61 (58%)	41 (42%)	20 (29%)	24 (23%)	40 (38%)	212 (39%)
TOTALS	*67 (100%)*	*105 (100%)*	*97 (100%)*	*70 (100%)*	*105 (100%)*	*105 (100%)*	*549 (100%)*

The overall sample trends towards a higher number of primary care appointment in the year, with the majority of the case management review clients having at least 3 appointments in the year (39%), followed by 32% of the clients having 2 appointments in the year, 19% having 1 appointment, and 10% of the sample having had 0 appointments.

CASE MANAGEMENT ENCOUNTERS

Frequency of case management encounters were also reviewed. The dates and types of the encounters (face-to-face vs. phone), as well as who provided the service (Clinical, Medical, Non-Medical Case Manager or Outreach Worker) and a general description of what was discussed during the encounter were also recorded.

The distribution of frequency of case management encounters could be described as an inverted bell curve, with most of the clients clustering either at the low end of one encounter (29%) within the year or more than 5 encounters (30%).

*"Overall, the average number of case management encounters for the entire sample was **five (5)**."*

# of CM encounters	A	B	C	D	E	F	G	TOTAL
1	1 (2%)	23 (21%)	20 (21%)	29 (41%)	53 (50%)	33 (31%)	15 (25%)	174 (29%)
2	2 (3%)	22 (21%)	10 (10%)	17 (24%)	22 (21%)	21 (20%)	3 (5%)	97 (16%)
3	3 (4%)	15 (14%)	13 (13%)	8 (11%)	8 (8%)	16 (15%)	4 (7%)	67 (11%)
4	3 (4%)	14 (13%)	13 (13%)	5 (7%)	5 (5%)	7 (7%)	1 (2%)	48 (8%)
5	3 (4%)	9 (9%)	9 (9%)	7 (10%)	7 (7%)	3 (3%)	4 (7%)	42 (7%)
Over 5	55 (82%)	22 (21%)	32 (33%)	4 (6%)	10 (10%)	25 (24%)	33 (55%)	181 (30%)
TOTALS	*67 (100%)*	*105 (100%)*	*97 (100%)*	*70 (100%)*	*105 (100%)*	*105 (100%)*	*60 (100%)*	*609 (100%)*
Range	1-51	1-15	1-17	1-6	1-24	1-25	1-82	1-82
Average	11.8	3.75	5	2.4	2.8	4	11	5

29% of the clients in the sample had just one case management encounter within the review year while another 30% had more than five, with the highest amount of encounters for one client being 82 within the grant year. Overall, the average number of encounters for the entire sample was five case management encounters. Neither race nor gender had a significant impact on the average number of encounters. The average number of encounters for clients who had contact with a Medical Case Manager was double that of those who did not have contact with a Medical Case Manager throughout the year, at six and three encounters, respectively. The agency with the highest average frequency of case management encounters averaged nearly one encounter per month, at 11.8.

*The average number of encounters for clients who had contact with a Medical Case Manager was **six**, while the average for those who did not work with an MCM was **three**.*

VIRAL SUPPRESSION

Any results of HIV Viral Load + CD4 count laboratory tests that accompanied HIV-related primary care appointments were recorded as part of the case management chart abstraction. Up to three laboratory tests could be recorded. Lab results with an HIV viral load result of less than 200 copies per milliliter were considered to be virally suppressed.

Upon coding, clients who were suppressed for all of their recorded labs (whether they had one, two, or three tests done within the year), were coded as "Suppressed." Clients who were unsuppressed (>200 copies/mL) for all of their labs were coded as "Unsuppressed." Clients who had more than one laboratory test done and were suppressed for at least one and unsuppressed for at least one were coded as "Mixed Status," and clients who had no laboratory tests done within the entire year were coded as "Unknown."

Therefore, it is important to note that the "VL Suppression Rate" is presented in two different ways in the chart below. The top rate, in blue, is the more conservative analysis of the percentage of clients who were coded as "Suppressed." In other words, it is the percentage of clients within the sample who were suppressed for *all* of their recorded labs during the year, which could be loosely interpreted as "durably suppressed." The second VL Suppression Rate offered in red is the more standardly used HRSA HAB Performance Measure[3] of having the *most recent* laboratory result on file under 200 copies/mL.

VL Status	A	B	C	D	E	F	TOTAL
VL Suppression Rate	69% 73%	55% 59%	55% 60%	66% 67%	59% 60%	64% 64%	60% 63%
Suppressed	46 (69%)	58 (55%)	53 (55%)	46 (66%)	62 (59%)	67 (64%)	332 (60%)
Mixed Status	8 (12%)	17 (16%)	12 (12%)	11 (16%)	9 (9%)	11 (10%)	68 (12%)
Unknown	5 (7%)	17 (16%)	19 (20%)	2 (3%)	15 (14%)	7 (7%)	65 (12%)
Unsuppressed	8 (12%)	13 (12%)	13 (13%)	11 (16%)	19 (18%)	20 (19%)	84 (15%)
NO INTERVENTION	6 (9%)	16 (15%)	10 (10%)	1 (1%)	11 (10%)	4 (4%)	48 (9%)
TOTALS	*67* *(100%)*	*105* *(100%)*	*97* *(100%)*	*70* *(100%)*	*105* *(100%)*	*105* *(100%)*	*549* *(100%)*

Across all primary care sites, the case management clients reviewed for these samples had a viral load suppression rate between 60-63%, depending on which estimate is used. In contrast, this result is much lower than what is typical for the Ryan White Part A Houston Primary Care Chart review, which has hovered around 85% for the past several years. This difference may be due to a number of factors, most likely of which is the difference in characteristics of the two reviews' samples. The Primary Care chart review sample is collected from a pool of clients who are considered *in care*, or have at least two medical appointments with a provider with prescribing privileges in the review year. Additionally, "fluctuating viral load" is one of the eligibility criteria for medical case management, so clients who have challenges maintaining a suppressed viral load are more likely to be seen by case management and be included in this sample.

Of particular interest in this review was the role of case management staff when a client received an unsuppressed laboratory result. For clients who were coded as "Unsuppressed," "Mixed Status," or "Unknown," the overall narrative of the client record was also reviewed to understand whether intervention from case management would have been appropriate and whether a CM staff did intervene to better coordinate care, encourage retention, or provide education on medication adherence. Overall, less than 10% of the sample (9%) was unsuppressed at some point during the review year *and* did not receive case management intervention when it would have been appropriate.

[3] Health Resources and Services Administration HIV/AIDS Bureau. (2019, December). Performance Measure Portfolio. Retrieved from https://hab.hrsa.gov/clinical-quality-management/performance-measure-portfolio

CARE STATUS

The chart abstractor also documented any circumstances in the record for which a client was new, lost, returning to care, or some combination of those care statuses. A client was considered "New to Care," if they were receiving services for the first time at that particular agency (so not necessarily new to HIV treatment or the Houston Ryan White system of care). "Lost to Care" was defined as not being seen for an HIV-related primary care appointment within the last six months and not having a future appointment scheduled, even beyond the review year. "Re-engaged in Care" was defined as any client who was previously lost to care, either during or before the review year, and later attended an HIV-related primary care appointment.

Care Status	A	B	C	D	E	F	TOTAL
New to Care	6 (9%)	23 (22%)	5 (5%)	13 (19%)	6 (6%)	3 (3%)	56 (10%)
Lost to Care	6 (9%)	11 (10.5%)	12 (12%)	3 (4%)	9 (9%)	9 (9%)	50 (9%)
Re-engaged in Care	3 (4.5%)	6 (6%)	12 (12%)	2 (3%)	15 (14%)	14 (13%)	52 (10%)
New + Later Lost	3 (4.5%)	4 (4%)	0 (0%)	1 (1%)	0 (0%)	0 (0%)	8 (1%)
Re-engaged + Lost	0 (0%)	9 (8.5%)	5 (5%)	1 (1%)	2 (2%)	1 (1%)	18 (3%)
Coordination of Care	*94% (17 of 18)*	*70% (37 of 53)*	*65% (22 of 34)*	*85% (17 of 20)*	*94% (30 of 32)*	*78% (21 of 27)*	*78% (144 of 184)*
N/A	49 (73%)	52 (49%)	63 (65%)	50 (71%)	73 (69%)	78 (74%)	365 (67%)
TOTALS	*67*	*105*	*97*	*70*	*105*	*105*	*549*

Overall, 10% of the sample was considered New to Care, 9% was Lost to Care, and 10% was Re-engaged in Care. An additional 1% initiated services and were later lost, and 3% returned to care and were then later lost to care again within the same year. Notably, two agencies had a higher than average percentage of New to Care clients within their sample, with 22% of Agency B clients and 19% Agency D clients being new.

When a client's attendance met one of the above care statuses, their medical record was reviewed to understand if case management or other staff was involved in coordinating their care. Activities that counted as "Coordination of Care" were any actions that welcomed the client into or back into care or attempted to retain them in care, such as: reminder phone calls, follow-up calls, attendance or introduction at the first appointment, or home visits. For agencies funded for Outreach Services, several progress notes appeared for clients who were lost or re-engaged in care. In the future, a more focused chart review sample of Outreach services may help to shed light on the benefits of this service category.

Every agency reviewed had policies and procedures in place for retention in care, as evidenced by both materials submitted as part of the Quality Management site visit and the percentage of New, Lost, and Re-engaged clients who received some type of retention in care service or service attempt. 78% of the clients within the sample who would have been subject to Coordination of Care services were contacted or assisted by staff in an effort to retain them in care. Some agencies had remarkably high Coordination of Care rates, at 94%.

COMORBIDITIES

In an effort to understand and document common comorbidities within the Houston Ryan White system of care, co-occurring conditions were recorded, including mental health and substance abuse issues, other medical conditions, and social conditions. This inventorying of co-morbidities may prove particularly helpful for selecting future training topics for case management staff.

MENTAL HEALTH & SUBSTANCE ABUSE (history or active)

Any diagnosis of a mental health disorder (MH) or substance abuse issue (SA) was recorded in the chart review tool, including a history of mental illness or substance abuse. All Electronic Medical Records include some variation of a "Problem List" template. This list was often a good source of information for MH and SA diagnoses, but providers sometimes also documented diagnoses or known histories of illness within progress notes without updating the Problem List. Clients sometimes also self-reported that they had been diagnosed with one of the below conditions by a previous medical provider. Any indication of the presence of mental illness or substance abuse, regardless of where the information was housed within the medical record, was recorded on the chart abstraction tool. Clients could also have or have had more than one of the MH or SA issues. Any conditions other than alcohol abuse, other substance abuse, depression, bipolar disorder, anxiety, or schizophrenia were recorded as "Other." The most common types of conditions that became coded as "Other" were Post-Traumatic Stress Disorder and Adjustment Disorder.

	A	B	C	D	E	F	G	TOTAL
% of sample w/ MH or SA issue	**51%**	**45%**	**49%**	**39%**	**53%**	**61%**	**80%**	53% (323 of 609)
Alcohol abuse/ dependence	9 (13%)	8 (8%)	7 (7%)	1 (1%)	4 (4%)	9 (9%)	6 (10%)	44 (7%)
Other Substance Abuse/ Dependence	7 (10%)	15 (14%)	19 (20%)	11 (16%)	38 (36%)	27 (26%)	13 (22%)	130 (21%)
Depression	15 (22%)	34 (32%)	24 (25%)	9 (13%)	22 (21%)	41 (39%)	12 (20%)	157 (26%)
Bipolar Disorder	6 (9%)	10 (10%)	7 (7%)	6 (9%)	6 (6%)	5 (5%)	9 (15%)	49 (8%)
Anxiety	13 (19%)	11 (10%)	17 (18%)	5 (7%)	5 (5%)	15 (14%)	6 (10%)	72 (12%)
Schizophrenia	3 (4%)	2 (2%)	1 (1%)	0 (0%)	7 (7%)	1 (1%)	2 (3%)	16 (3%)
Other	12 (18%)	16 (15%)	27 (28%)	6 (9%)	9 (9%)	16 (15%)	32 (53%)	118 (19%)
TOTALS	*67*	*105*	*97*	*70*	*105*	*105*	*60*	*609*

Overall, 53% of the sample had either an active diagnosis or history of a mental health or substance abuse issue documented somewhere within their medical record. This is inclusive of the Clinical Case Management site, for which diagnosis with or clinical indication of a MH or SA issue is an eligibility criteria.

MENTAL HEALTH & SUBSTANCE ABUSE REFERRALS

For clients with an *active* diagnosis of a mental health or substance abuse issue, the chart abstractor recorded if they were referred or already engaged in MH/SA services. This measure was *not* inclusive of clients who had a previous history of symptoms or whose recovery treatment was considered long complete. Because of this, the percentage in the top row of the previous chart and the percentage of clients considered "N/A" for a MH/SA referral do not equal 100%.

Received MH Referral?	A	B	C	D	E	F	G	TOTAL
N/A	39 (58%)	64 (61%)	54 (56%)	46 (66%)	68 (65%)	50 (48%)	7 (12%)	328 (54%)
Yes	25 (37%)	28 (27%)	38 (39%)	24 (34%)	35 (33%)	52 (50%)	53 (88%)	255 (42%)
No	3 (5%)	13 (12%)	5 (5%)	0 (0%)	2 (2%)	3 (3%)	0 (0%)	26 (4%)
TOTALS	*67 (100%)*	*105 (100%)*	*97 (100%)*	*70 (100%)*	*105 (100%)*	*105 (100%)*	*60 (100%)*	*609 (100%)*

Overall, 54% of the sample would not have been appropriate for a MH or SA referral based on the information available in their medical record. An additional 42% either did receive a referral or were already engaged in treatment and 4% did not receive a referral. This means that 91% of the sample (or 255 out of 281 individuals) who should have received a referral did receive one, according to their medical chart.

91% of the sample with active MH or SA symptoms was either referred for further counseling or treatment or already engaged in services.

MEDICAL CONDITIONS

Medical conditions other than HIV were also recorded in an effort to understand what co-occurring conditions may be considered commonly managed alongside HIV within the case management population. Sexually Transmitted Infections and Hypertension were common, at 31% and 23% prevalence within the sample, respectively. Insomnia was the most common co-occurring condition that was coded in the "Other" category.

	A	B	C	D	E	F	TOTAL
Opportunistic Infection	2 (3%)	2 (2%)	2 (2%)	1 (1%)	4 (4%)	3 (3%)	14 (3%)
STI	11 (16%)	38 (36%)	37 (38%)	28 (40%)	23 (22%)	32 (30%)	169 (31%)
Diabetes	11 (16%)	12 (11%)	4 (4%)	4 (6%)	20 (19%)	8 (8%)	59 (11%)
Cancer	0 (0%)	0 (0%)	0 (0%)	0 (0%)	4 (4%)	1 (1%)	5 (1%)
Hepatitis	4 (6%)	24 (23%)	6 (6%)	4 (6%)	17 (16%)	7 (7%)	62 (11%)
Hypertension	12 (18%)	18 (17%)	25 (26%)	13 (19%)	28 (27%)	29 (28%)	125 (23%)
Other	14 (21%)	15 (14%)	15 (15%)	18 (26%)	21 (20%)	6 (6%)	89 (16%)
TOTALS	*67*	*105*	*97*	*70*	*105*	*105*	*549*

SOCIAL CONDITIONS

Any indication within the medical record that a client had experienced homelessness/housing-related issues, pregnancy/pregnancy-related issues, a release from jail or prison, or intimate partner violence at any point within the review year was recorded in the chart abstraction tool. Homelessness and housing issues were the most commonly identified "Social Condition" within the sample. 4% of the sample reported experiencing some other type of social issue, the most common of which being a disclosed history of childhood sexual abuse.

	A	B	C	D	E	F	G	TOTAL
Homelessness or housing-related issues	4 (6%)	11 (10%)	9 (9%)	11 (16%)	8 (8%)	11 (10%)	6 (10%)	60 (10%)
Pregnancy or pregnancy-related issues	2 (3%)	0 (0%)	1 (1%)	0 (0%)	1 (1%)	0 (0%)	0 (0%)	4 (1%)
Recently released	0 (0%)	5 (5%)	2 (2%)	5 (7%)	5 (5%)	6 (6%)	5 (8%)	28 (5%)
Intimate Partner Violence	3 (4%)	2 (2%)	0 (0%)	2 (3%)	2 (2%)	3 (3%)	2 (3%)	14 (2%)
Other	3 (4%)	2 (2%)	3 (3%)	3 (4%)	5 (5%)	7 (7%)	2 (3%)	25 (4%)
TOTALS	*67*	*105*	*97*	*70*	*105*	*105*	*60*	*609*

CASE MANAGEMENT ROLE DELEGATION

One area of interest for the Ryan White Grant Administration Quality Management team is to quantify and better help address the workflow and role delegation of medical case management and non-medical case management staff within the Ryan White system of care. According to the service category definitions and funding structure, care should be taken to ensure that clients are assigned to work with case management staff according to their level of need.

Individuals who have higher, more intensive levels of need that interfere with their ability to stay successful in HIV treatment should be assigned to work with a licensed social worker for medical case management services. Individuals who have lower, more intermittent need that could be assisted through straight forward referral and follow-up (versus ongoing management) are more appropriate for non-medical case management services by Service Linkage Workers. Client needs and acuity levels should be assessed at intake and monitored throughout regular periods in the year to continuously evaluate what services and staff would be the best "fit" for a client's individual needs. In this way, resources can be appropriately allocated within the system of care and clients can be assigned to work with someone who can best meet their needs.

For these reasons, the chart abstractor documented what type of case manager each client worked with (a Medical Case Manager or Service Linkage Worker) and whether that client met the specified eligibility criteria for medical case management. It was also not uncommon for clients to work with both a Medical Case Manager *and* Service Linkage Worker within the same year, either because their level of need changed or to ensure that a client's issues were addressed in a timely manner, regardless of whether the most appropriate staff member was available in the clinic.

	A	B	C	D	E	F	TOTAL
Worked with MCM	51 (76%)	67 (64%)	70 (72%)	34 (49%)	16 (15%)	47 (45%)	285 (52%)
Met criteria for MCM	*37* (73%)	*34* (51%)	*68* (97%)	*30* (88%)	*16* (100%)	*44* (94%)	*229 (80%)*
Worked primarily with SLW	17 (25%)	48 (46%)	62 (64%)	40 (57%)	96 (91%)	59 (56%)	322 (59%)
Met criteria for MCM	*3* (18%)	*11* (23%)	*8* (13%)	*7* (18%)	*16* (18%)	*11* (19%)	*56 (17%)*
TOTALS	*67*	*105*	*97*	*70*	*105*	*105*	*549*

52% of the sample worked with a Medical Case Manager (licensed social worker) at any point within the review year and 80% of those clearly met the eligibility criteria for medical case management. An additional 7% of the sample was marked as "unknown" for whether they met the medical case management eligibility criteria, as a way for the chart abstractor to acknowledge that there may be more detail to the client's case than the information available in the medical record.

59% of the sample *primarily* worked with a Service Linkage Worker (SLW) within the review year, meaning that they either only worked with an SLW, or all of their interactions except for one were with an SLW. Of those, 17% had some information available in their medical record indicating that they technically met the criteria for medical case management and may have been considered more appropriate to work with a licensed social worker.

COMPREHENSIVE ASSESSMENTS

A cornerstone of service provision within case management is the opportunity for the client to be formally assessed at touchpoints throughout the year for their needs, treatment goals, and action steps for how they will work with the case manager or care team to achieve their treatment goals. Agencies need to use an approved assessment tool and service plan, which may either be the sample tools available through Ryan White Grant Administration or a pre-approved tool of the agency's choosing.

The Ryan White Part-A Standards for medical case management state that a comprehensive assessment should be completed with the client at intake and that they should be re-assessed at least every six months for as long as they are receiving medical case management services. A more formal, comprehensive assessment should be used at intake and annually, and a brief reassessment tool is sufficient at the 6-month mark. In other words, the ideal standard is that every client who receives case management services for an entire year should have at least two comprehensive assessments on file. A service plan should accompany each comprehensive assessment to outline the detailed plan of how the identified needs will be addressed with the client.

# of Comp. Assessments	A	B	C	D	E	F	G	TOTAL
0	18 (27%)	28 (27%)	23 (24%)	2 (3%)	10 (10%)	7 (7%)	13 (22%)	101 (17%)
1	27 (40%)	34 (32%)	14 (14%)	31 (44%)	3 (3%)	38 (36%)	15 (25%)	162 (27%)
2	6 (9%)	2 (2%)	0 (0%)	1 (1%)	1 (1%)	2 (2%)	4 (7%)	16 (3%)
N/A	16 (24%)	41 (39%)	60 (62%)	36 (51%)	91 (87%)	58 (55%)	28 (47%)	330 (54%)
Completion Rate	**97%**	**70%**	**46%**	**100%**	**93%**	**91%**	**91%**	94% (570 out of 609)
TOTALS	*67*	*105*	*97*	*70*	*105*	*105*	*60*	*609*

The date of each assessment was recorded in the chart abstraction tool. The client was considered "N/A" for a comprehensive assessment if they did not work with a medical case manager throughout the year. As outlined in the previous section, 48% of the sample did not work with a Medical Case Manager within the year. An additional 6% were served by a Medical Case Manager for a one-time, immediate need which was justified by staffing needs, most often an ADAP application or re-certification issue. 17% of the sample received zero comprehensive assessments, 27% received one, and 3% received two.

Completion Rate for this analysis was defined as the percentage of eligible medical case management clients who were assessed *at least once* throughout the year *or* had a documented reason for why they did not receive a comprehensive assessment (most often this was because the client declined or because they were no longer receiving medical case management services), *or*¸ they had evidence of an assessment just outside of the chart review dates. By this calculation, 94% of clients who should have received an assessment within the year did indeed receive one.

SERVICE PLANS

As mentioned, each comprehensive assessment should be accompanied by a service plan, otherwise known as a care plan, to outline what action will be taken to address the needs that are identified on the comprehensive assessment. A service plan can be thought of as an informal, working contract between client and social worker of who will be accountable for which actions in order for the client to meet their determined treatment goals. As with the comprehensive assessment, the date of each completed service plan was recorded in the chart abstraction tool, along with any documented justification for why a service plan was missing if it should have been completed.

# of Service Plans	A	B	C	D	E	F	G	TOTAL
0	25 (37%)	32 (30%)	32 (33%)	4 (6%)	10 (10%)	7 (7%)	20 (33%)	130 (22%)
1	22 (33%)	30 (29%)	5 (5%)	29 (41%)	3 (3%)	38 (36%)	11 (18%)	138 (23%)
2	4 (6%)	2 (2%)	0 (0%)	1 (1%)	1 (1%)	2 (2%)	1 (2%)	11 (2%)
N/A	16 (24%)	41 (39%)	60 (62%)	36 (61%)	91 (87%)	58 (55%)	28 (47%)	330 (54%)
Completion Rate	**73%**	**64%**	**22%**	**94%**	**93%**	**91%**	**72%**	**87%** (527 out of 609) **11%** (29 out of 279)
TOTALS	*67 (100%)*	*105 (100%)*	*97 (100%)*	*70 (100%)*	*105 (100%)*	*105 (100%)*	*60 (100%)*	*609 (100%)*

It is notable that less service plans are completed than comprehensive assessments, even though the two processes are intended to occur together, one right after the other. One common reason for this, as documented frequently in the client medical records, is that clients would often decline to continue on to complete the service plan, given the amount of time they had already spent in the clinic for the lengthy comprehensive assessment interview, in addition to whatever medical appointment they may have attended on that day.

Completion rates were calculated in two different ways. The first calculation, in blue, is the more liberal analysis that is consistent with the manner used to calculate the completion rate for comprehensive assessment. It is the percentage of eligible clients who received *at least one* service plan throughout the year *or* had a documented reason for why they did not complete the service plan *or* they had evidence of a completed service plan just outside of the review dates. By this calculation, 87% of clients who should have received a service plan within the year did indeed receive one.

The second, more conservative measurement in red is the more universally accepted standard for care planning in Ryan White Case Management Services, consistent with the HAB HRSA Performance Measure for Case Management[4]. This is the number of clients who were receiving case management services within the year and received at least two service plans within the year, excluding those had a documented reason for not completing a second care plan, such as only being enrolled in case management for only some of the year.

[4] Health Resources and Services Administration HIV/AIDS Bureau. (2019, December). Performance Measure Portfolio: MCM Measures. Retrieved from https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/mcmmeasures.pdf

BRIEF ASSESSMENTS

Like Medical Case Management, Non-Medical Case Management is guided by a continuous process of ongoing assessment, service provision, and evaluation. Clients should be assessed at intake using a Ryan White Grant Administration approved brief assessment form and should be reassessed at six month intervals if they are still being serviced by a Non-Medical Case Manager.

# of Brief Assessments	A	B	C	D	E	F	TOTAL
0	7 (10%)	6 (6%)	15 (15%)	2 (2%)	16 (15%)	14 (13%)	60 (11%)
1	10 (15%)	28 (27%)	37 (38%)	37 (53%)	49 (47%)	41 (39%)	202 (37%)
2	0 (0%)	1 (1%)	0 (0%)	1 (1%)	5 (5%)	4 (4%)	11 (2%)
N/A	50 (75%)	70 (67%)	45 (46%)	30 (43%)	35 (33%)	46 (44%)	276 (50%)
Completion rate	**94%**	**97%**	**77%**	**98%**	**86%**	**97%**	**91%** (248 out of 273)
TOTALS	*67 (100%)*	*105 (100%)*	*97 (100%)*	*70 (100%)*	*105 (100%)*	*105 (100%)*	*549 (100%)*

Dates of any brief assessments were recorded, along with any justification of why an assessment was not completed if one would have been expected. 50% of the sample would not been applicable for a brief assessment, as they did not receive services from a Non-Medical Case Manager. 11% of the sample received zero brief assessments, 37% received one, and 2% received two.

Completion rates represent the percentage of eligible clients who received *at least one* assessment within the review year *or* had a documented reason as to why one was not completed *or* had evidence of a completed assessment just outside of the review period.

ASSESSED NEEDS

All data from assessment tools was captured in the chart review tool. A total of 173 Comprehensive Assessments and 211 Brief Assessments were reviewed and recorded in order to quantify the frequency of needs. The count recorded is a raw count of how many times a need was recorded, encompassing both comprehensive and brief assessments and including clients who may have had the same need identified more than once at different points in time.

The top five most frequently assessed needs were: 1) Medical/Clinical, 2) Dental Care, 3) Vision Care, 4) Transportation, and 5) Mental Health. It should be noted, however, that there are no universal standards or instructions across case management systems on how to use these tools or how these needs are defined. For example, it was much more common for "Dental Care" to be identified as a need at agencies who had dental care co-located or easily available within their organization. Anecdotally, some case managers reported that they automatically checked "Medical/Clinical" as a need, regardless of whether or not the client needed assistance accessing medical care, because it was their understanding that this section *always* needed to be checked in order to justify billing for medical case management services. Therefore, this compilation of comprehensive and brief assessments should not be considered representative of *true need* within the HIV community in Houston, but rather, as representative of issues that case managers are discussing with clients.

Need identified on assessment	Count	Percentage %
Medical/Clinical	141	37%
Dental Care	123	32%
Vision Care	108	28%
Transportation	99	26%
Mental Health	95	25%
Insurance Benefits	85	22%
Medication Adherence	79	21%
Housing/Living Situation	66	17%
Substance/Alcohol Use	65	17%
HIV Education/Prevention	50	13%
Support System	34	9%
Employment/Income	34	9%
HIV-Related Legal	31	8%
Self-Efficacy	30	8%
Basic Necessities/Life Skills	29	8%
Nutrition/Food Pantry	22	6%
Family Planning/Safer Sex	15	4%
Financial Assistance	14	4%
Abuse History	12	3%
Cultural/Linguistic	9	2%
General Education/Vocation	9	2%
Vaccination	8	2%
Hearing Care	8	2%
Home Care Needs	5	1%
Client Strengths	4	1%
Child Care/Guardianship	2	1%
Other	2	1%
		Out of 384 assessments

Conclusion

The 2018-2019 Case Management chart review highlighted many trends about the case management client population, strengths in case management performance, and areas identified for future attention and improvement.

Overall, we continue to learn more about the needs of this patient population by expanding the sample size of the review and adding new elements to the chart abstraction tool. The top three most common co-occurring conditions were: Sexually Transmitted Infections (31%), Depression (26%), and Hypertension (23%). Diabetes was also relatively common (11%) and it has been suggested that providing overview information on nutrition counseling and diabetes management may be a useful topic for future frontline case management trainings. In addition, 53% of the overall sample had a history or active diagnosis of a mental health or substance abuse issue. 10% of the sample was homeless or unstably housed. The prevalence of these complex co-morbidities further emphasizes the unique benefit that case managers contribute to the HIV treatment setting.

There were also many areas of high performance displayed in this chart review. Most (39%) of the clients in the sample had at least three HIV-related primary care appointments within the review year. While the measurement for Viral Load Suppression changed from last year's chart review, there was a marked improvement in overall VL suppression from 43% to this year's 60%. Case Management staff demonstrated a high level of coordination of care in many areas. For example, 91% of those with active mental health or substance abuse symptoms either received a referral for further treatment or counseling or were already engaged in services. 78% of the clients who were New, Lost, or Returning to Care (or some combination) received coordination of care activities from case management in an effort to retain them in care. And finally, when a client was found to be virally unsuppressed through a laboratory test, case management staff were often involved to follow-up with clients and provide medication adherence counseling. Less than 10% of sample was found to be virally unsuppressed at some time throughout the year and did not receive attention and intervention from case management staff.

Case Management staff demonstrated high levels of coordination of care:

- 91% MH and SA referral rate

- 78% of New, Lost, or Returning to Care clients were assisted by CM

- <10% of sample was unsuppressed without intervention

The review also highlighted that there are still many opportunities for refinement in case management workflow and service provision. Termination planning and review for case closure were inconsistently practiced across agencies. The discrepancy between the completion rate for one assessment versus two assessments per year is striking. This indicates that, as a case management system, we are good at initiating services, but need to dedicate much more attention to following clients throughout their care. It is quite possible that the 11% performance rate of 2 care plans within a year for medical case management clients is artificially low if many of those clients could be considered "closed" for case management and excluded from the calculation. However, without proper case closure documentation in the medical chart and, worse, without communication to the client to follow-up with them or manage service expectations, those cases are considered "open" for all intents and purposes.

This lack of follow-through is further evidenced in the frequency of contact with a case manager. More than half (56%) of the sample had three or fewer interactions with the case manager. If the ideal standard is for a client to be formally assessed at least twice throughout the year to discuss their history, present concerns, barriers, and goals, with follow-through in between those formal sit-downs to work through the issues identified in the care plan, it leaves room to wonder how clients can be adequately served. Further training and capacity building in the areas of assessment and interview techniques, as well as continuing to refine case management role delegation, may help improve quality in these areas.

Appendix (Case Management Chart Review Tool)

CASE MANAGEMENT CHART REVIEW TOOL
Chart Review Date _____/_____/_____
Agency: ☐ AHF ☐ AH ☐ Ave360 ☐ HHS ☐ Legacy ☐ SHF

Review Period:
3/1/20__ - 2/28/20__

CLIENT INFORMATION

Pt. ID # _____ Race: _____

Client Case Status: ☐ Open/Active ☐ Closed ☐ Unk. Gender: _____

Last OAMC Appts:	Virally Suppressed?	← If No, linked to CM?
1.	☐ Y ☐ N ☐ Unk.	
2.	☐ Y ☐ N ☐ Unk.	
3.	☐ Y ☐ N ☐ Unk.	
☐ No appts. during review period		

Last CMngmt. Contact:	Type (F2F/PC/Consult.) + short description)	Signed/Dated/Clear?
1.		
2.		
3.		
4.		
5.		

During the review period, was the client: ☐ New to care ☐ Lost to care ☐ Re-engaged in care ☐ NA
If yes.... was there documentation of coordination of care or contact attempts? ☐ Y ☐ N ☐ NA

Does the client have an active diagnosis of the following diagnoses? (Check ALL that apply)
☐ Alcohol abuse/dependence
☐ Other substance abuse/dependence: _____
☐ Depression
☐ Bipolar disorders
☐ Anxiety disorders
☐ Schizophrenia
☐ Other: _____

Was the client referred or already engaged with MH/SA services?
☐ N/A ☐ Yes ☐ No

Does the client have any co-morbidity?
☐ Opportunistic Infection
☐ Sexually Transmitted Infections (STIs) : _____
☐ Diabetes
☐ Cancer
☐ Hepatitis
☐ Hypertension
☐ Other: _____

Was the client reported to have any of the following conditions?
☐ Homelessness
☐ Pregnancy (or other pregnancy-related conditions)
☐ Recently released
☐ IPV

INSURANCE, BENEFITS, AND INCOME INFORMATION

Health Insurance: ☐ Uninsured ☐ Medicaid _____ ☐ Medicare_____ ☐ Commercial _____
☐ VA ☐ Other? _____

Spouse/partner:	Children:	Other Dependents:	TOTAL HOUSEHOLD SIZE 1 2 3 4 5 6 7 8 9 10 Unk
Client Income $:	Spouse Income $:	Other Income $:	TOTAL HOUSEHOLD INCOME $:

Did the client lose insurance or coverage during the review period? ☐ Y N ☐ Unk. ☐
If so, were they provided with information/education or assistance? ☐ Y N ☐ NA ☐

CASE MANAGEMENT SERVICES

What types of services were provided by a **Medical Case Manager** (MCM?)	What types of services were provided by a **Service Linkage Worker** (SLW?)	Was the client referred for **Clinical Case Management** services in the review period?
☐ **NA (Client not assisted by MCM)** ☐ Comprehensive assessment ☐ Service Plan ☐ Medication adherence counseling ☐ Coordination of medical care ☐ Transportation ☐ ADAP/medication assistance ☐ Eligibility ☐ Community resource/benefits brokerage ☐ Other _____ Did client meet criteria for MCM? Y ☐ N ☐ Unk. ☐	☐ **NA (Client not assisted by SLW)** ☐ Brief assessment ☐ SLW referred client to OAMC ☐ OAMC visit scheduled by SLW ☐ SLW accompanied client to OAMC ☐ SLW called client to remind about OAMC visit ☐ Client did not keep OAMC appt. and SLW contacted them ☐ ADAP/medication assistance ☐ Transportation voucher ☐ Eligibility Were any of the above services provided by an Outreach Worker? Y ☐ N ☐ Unk. ☐	☐ **No- not applicable** ☐ No- applicable, but no referral documented ☐ Yes- and there is evidence of coordination of services ☐ Yes- and there is no evidence of coordination of services ☐ Yes- but client refused services or is already engaged in treatment

Was the case discharged/closed for CM during the review period?		Y ☐	N ☐	NA ☐	Unk. ☐
If yes.....	Client met agency criteria for closure?	Y ☐	N ☐	NA ☐	Unk. ☐
	Client completed treatment program (CCM)	Y ☐	N ☐	NA ☐	Unk. ☐
	Date and reason noted?	Y ☐	N ☐	NA ☐	Unk. ☐
	Summary of services received?	Y ☐	N ☐	NA ☐	Unk. ☐
	Referrals noted?	Y ☐	N ☐	NA ☐	Unk. ☐
	Instructions given to client at discharge?	Y ☐	N ☐	NA ☐	Unk. ☐

ASSESSMENTS & SERVICE PLANS

		If no assessment or plan:		
Brief Assess. Date 1:	Brief Assess. Date 2:	☐ evidence of one just outside of review period	☐ reason documented	☐ enough info to complete
Comp. Assess. Date 1:	Comp. Assess. Date 2:	☐ evidence of one just outside of review period	☐ reason documented	☐ enough info to complete
Service Plan Date 1:	Service Plan Date 2:	☐ evidence of one just outside of review period	☐ reason documented	☐ enough info to complete

COMPLETED ASSESSMENTS

	MOST RECENT ASSESSMENT TYPE (circle one) Comprehensive Brief					NEXT MOST RECENT ASSESSMENT TYPE (circle one) Comprehensive Brief				
Domain	Assessed?	Need Identified?	Accounted for in Service Plan?	Accounted for in progress notes?	Follow-up (referral, action, etc.)	Assessed?	Need Identified?	Accounted for in Service Plan?	Accounted for in progress notes?	Follow-up (referral, action, etc.)
Medical/Clinical										
Vaccination										
Nutrition/Food Pantry										
Dental Care										
Vision Care										
Hearing Care										
Home Care Needs										
Basic Necessities/Life Skills										
Mental Health										
Substance/Alcohol Use										
Abuse History										
Housing/Living Situation										
Support System										
Child Care/Guardianship										
Insurance Benefits										
Transportation										
HIV-Related Legal										
Cultural/Linguistic										
Self-Efficacy										
HIV Education/Prevention										
Family Planning/Safer Sex										
Employment/Income										
General Education/Vocation										
Financial Assistance										
Medication Adherence										
Client Strengths										
Other										

Umair A. Shah, M.D., M.P.H.
Executive Director

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Building a Healthy Community

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Oral Health Care-Rural Target Chart Review FY 2018

Ryan White Part A Quality Management Program–Houston EMA

October 2019

CONTACT:

Heather Keizman
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Harris County Public Health & Environmental Services
Ryan White Grant Administration
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HCPH is the local public health agency for the Harris County, Texas jurisdiction. It provides a wide variety of public health activities and services aimed at improving the health and well-being of the Harris County community.

Introduction

Part A funds of the Ryan White Care Act are administered in the Houston Eligible Metropolitan Area (EMA) by the Ryan White Grant Administration Section of Harris County Public Health. During FY 18, a comprehensive review of client dental records was conducted for services provided between 3/1/18 to 2/28/19. This review included one provider of Adult Oral Health Care that received Part A funding for rural-targeted Oral Health Care in the Houston EMA.

The primary purpose of this annual review process is to assess Part A oral health care provided to people living with HIV in the Houston EMA. Unlike primary care, there are no federal guidelines published by the U.S Health and Human Services Department for oral health care targeting people living with HIV. Therefore, Ryan White Grant Administration has adopted general guidelines from peer-reviewed literature that address oral health care for people living with HIV, as well as literature published by national dental organizations such as the American Dental Association and the Academy of General Dentistry, to measure the quality of Part A funded oral health care. The Ryan White Grant Administration Project Coordinator for Clinical Quality Improvement (PC/CQI) performed the chart review.

Scope of This Report

This report provides background on the project, supplemental information on the design of the data collection tool, and presents the pertinent findings of the FY 18 oral health care chart review. Any additional data analysis of items or information not included in this report can likely be provided after a request is submitted to Ryan White Grant Administration.

The Data Collection Tool

The data collection tool employed in the review was developed through a period of in-depth research and a series of working meetings between Ryan White Grant Administration. By studying the processes of previous dental record reviews and researching the most recent HIV-related and general oral health practice guidelines, a listing of potential data collection items was developed. Further research provided for the editing of this list to yield what is believed to represent the most pertinent data elements for oral health care in the Houston EMA. Topics covered by the data collection tool include, but are not limited to the following: basic client information, completeness of the health history, hard & soft tissue examinations, disease prevention, and periodontal examinations.

The Chart Review Process

All charts were reviewed by the PC/CQI, a Master's-level registered nurse experienced in identifying documentation issues and assessing adherence to published guidelines. The collected data for each site was recorded directly into a preformatted database. Once all data collection was completed, the database was queried for analysis. The data collected during this process is intended to be used for the purpose of service improvement.

The specific parameters established for the data collection process were developed from HIV-related and general oral health care guidelines available in peer-reviewed literature, and the professional experience of the reviewer on standard record documentation practices. Table 1 summarizes the various documentation criteria employed during the review.

Table 1. Data Collection Parameters

Review Area	Documentation Criteria
Health History	Completeness of Initial Health History: includes but not limited to past medical history, medications, allergies, substance use, HIV MD/primary care status, physician contact info, etc.; Completed updates to the initial health history
Hard/Soft Tissue Exam	Findings—abnormal or normal, diagnoses, treatment plan, treatment plan updates
Disease Prevention	Prophylaxis, oral hygiene instructions
Periodontal screening	Completeness

The Sample Selection Process

The sample population was selected from a pool of 326 unduplicated clients who accessed Part A oral health care between 3/1/18 and 2/28/19. The medical charts of 75 of these clients were used in the review, representing 23% of the pool of unduplicated clients.

In an effort to make the sample population as representative of the actual Part A oral health care population as possible, the EMA's Centralized Patient Care Data Management System (CPCDMS) was used to generate a list of client codes to be reviewed. The demographic make-up (race/ethnicity, gender, age) of clients accessing oral health services between 3/1/18 and 2/28/19 was determined by CPCDMS, which in turn allowed Ryan White Grant Administration to generate a sample of specified size that closely mirrors that same demographic make-up.

Characteristics of the Sample Population

The review sample population was generally comparable to the Part A population receiving rural-targeted oral health care in terms of race/ethnicity, gender, and age. It is important to note that the chart review findings in this report apply only to those who received rural-targeted oral health care from a Part A provider and cannot be generalized to all Ryan White clients or to the broader population of people living with HIV. Table 2 compares the review sample population with the Ryan White Part A rural-targeted oral health care population as a whole.

Table 2. Demographic Characteristics of FY 18 Houston EMA Ryan White Part A Oral Health Care Clients

	Sample		**Ryan White Part A EMA**	
Race/Ethnicity	Number	Percent	Number	Percent
African American	33	44%	143	43.9%
White	39	52%	176	54%
Asian	1	1.3%	3	.9%
Native Hawaiian/Pacific Islander	0	0%	0	0%
American Indian/Alaska Native	1	1.3%	2	.6%
Multi-Race	1	1.3%	2	.6%
	75		**326**	
Hispanic Status				
Hispanic	17	22.7%	81	25.5%
Non-Hispanic	58	77.3%	245	74.5%
	75		**326**	
Gender				
Male	52	69.3%	227	69.6%
Female	22	29.3%	97	29.8%
Transgender	1	1.3%	2	.6%
	75		**326**	
Age				
<=24	4	5.3%	15	4.6%
25 – 34	14	18.7%	63	19.3%
35 – 44	20	26.7%	96	29.5%
45 – 49	12	16%	52	16%
50 – 64	22	29.3%	86	26.4%
65+	3	4%	14	4.3%
	75		**326**	

Findings

Clinic Visits

Information gathered during the 2018 chart review included the number of visits during the study period. The average number of oral health visits per patient in the sample population was seven.

Health History

A complete and thorough assessment of a client's medical history is essential. Such information, such as current medications or any history of alcoholism for example, offers oral health care providers key information that may determine the appropriateness of prescriptions, oral health treatments and procedures.

Assessment of Medical History

	2016	2017	2018
Primary Care Provider	93%	100%	97%
Medical/Dental Health History*	87%	95%	100%
Medical History 6 month Update	100%	100%	96%

*HIV/AIDS Bureau (HAB) Performance Measures

Health Assessments

	2016	2017	2018
Vital Signs	95%	99%	100%
CBC documented	78%	97%	92%
Antibiotic Prophylaxis Given if Indicated			0% (0/1)

Prevention and Detection of Oral Disease

Maintaining good oral health is vital to the overall quality of life for people living with HIV because the condition of one's oral health often plays a major role in how well patients are able manage their HIV disease. Poor oral health due to a lack of dental care may lead to the onset and progression of oral manifestations of HIV disease, which makes maintaining proper diet and nutrition or adherence to antiretroviral therapy very difficult to achieve. Furthermore, poor oral health places additional burden on an already compromised immune system.

	2016	2017	2018
Oral Health Education*	88%	99%	99%
Hard Tissue Exam	88%	88%	96%
Soft Tissue Exam	86%	88%	96%
Periodontal screening*	84%	81%	97%
X-rays present	91%	92%	99%
Treatment plan*	94%	99%	99%

*HIV/AIDS Bureau (HAB) Performance Measures

Treatment Plan Status

	2018
Treatment plan complete	34%
Dental procedures done, additional procedures needed	45%
No dental procedures needed	10%
No dental procedures done	10%

Conclusions

Overall, oral health care services continues its trend of high quality care. The Houston EMA oral health care program has established a strong foundation for preventative care and we expect continued high levels of care for Houston EMA clients in future.

Appendix A – Resources

Dental Alliance for AIDS/HIV Care. (2000). *Principles of Oral Health Management for the HIV/AIDS Patient*. Retrieved from: http://aidsetc.org/sites/default/files/resources_files/Princ_Oral_Health_HIV.pdf.

HIV/AIDS Bureau. (2019). *HIV Performance Measures*. Retrieved from: http://hab.hrsa.gov/deliverhivaidscare/habperformmeasures.html.

Mountain Plains AIDS Education and Training Center. (2013). Oral Health Care for the HIV-infected Patient. Retrieved from: http://aidsetc.org/resource/oral-health-care-hiv-infected-patient.

New York State Department of Health AIDS Institute. (2004). *Promoting Oral Health Care for People with HIV Infection*. Retrieved from: http://www.hivdent.org/_dentaltreatment_/pdf/oralh-bp.pdf.

U.S. Department of Health and Human Services Health Resources and Services Administration. (2014). *Guide for HIV/AIDS Clinical Care.* Retrieved from: http://hab.hrsa.gov/deliverhivaidscare/2014guide.pdf.

U.S. Department of Health and Human Services Health Resources and Services Administration, HIV/AIDS Bureau Special Projects of National Significance Program. (2013). *Training Manual: Creating Innovative Oral Health Care Programs.* Retrieved from: http://hab.hrsa.gov/deliverhivaidscare/2014guide.pdf.

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Vision Care Chart Review Report FY 2018

Ryan White Part A Quality Management Program–Houston EMA

October 2019

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Follow HCPH on Twitter @hcphtx and like us on Facebook

Introduction

Part A funds of the Ryan White Care Act are administered in the Houston Eligible Metropolitan Area (EMA) by the Ryan White Grant Administration of Harris County Public Health. During FY 18, a comprehensive review of client vision records was conducted for services provided between 3/1/18 to 2/28/19.

The primary purpose of this annual review process is to assess Part A vision care provided to people living with HIV in the Houston EMA. Unlike primary care, there are no federal guidelines published by the U.S Department of Health and Human Services for general vision care targeting people living with HIV. Therefore, Ryan White Grant Administration has adopted general guidelines published by the American Optometric Association, as well as internal standards determined by the clinic, to measure the quality of Part A funded vision care. The Ryan White Grant Administration Project Coordinator for Clinical Quality Improvement (PC/CQI) performed the chart review.

Scope of This Report

This report provides background on the project, supplemental information on the design of the data collection tool, and presents the pertinent findings of the FY 18 vision care chart review. Also, any additional data analysis of items or information not included in this report can likely be provided after a request is submitted to Ryan White Grant Administration.

The Data Collection Tool

The data collection tool employed in the review was developed through a period of in-depth research conducted by the Ryan White Grant Administration. By researching the most recent vision practice guidelines, a listing of potential data collection items was developed. Further research provided for the editing of this list to yield what is believed to represent the most pertinent data elements for vision care in the Houston EMA. Topics covered by the data collection tool include, but are not limited to the following: completeness of the Client Intake Form (CIF), CD4 and VL measures, eye exams, and prescriptions for lenses. See Appendix A for a copy of the tool.

The Chart Review Process

All charts were reviewed by the PC/CQI, a Master's-level registered nurse experienced in identifying documentation issues and assessing adherence to published guidelines. The collected data for each site was recorded directly into a preformatted database. Once all data collection was completed, the database was queried for analysis. The data collected during this process is intended to be used for the purpose of service improvement.

The specific parameters established for the data collection process were developed from vision care guidelines and the professional experience of the reviewer on standard record documentation practices. Table 1 summarizes the various documentation criteria employed during the review.

Table 1. Data Collection Parameters	
Review Area	**Documentation Criteria**
Laboratory Tests	Current CD4 and Viral Load Measures
Client Intake Form (CIF)	Completeness of the CIF: includes but not limited to documentation of primary care provider, medication allergies, medical history, ocular history, and current medications
Complete Eye Exam (CEE)	Documentation of annual eye exam; completeness of eye exam form; comprehensiveness of eye exam (visual acuity, refraction test, binocular vision assessment, fundus/retina exam, and glaucoma test)
Ophthalmology Consult (DFE)	Performed/Not performed
Lens Prescriptions	Documentation of the Plan of Care (POC) and completeness of the dispensing form

The Sample Selection Process

The sample population was selected from a pool of 2,718 unduplicated clients who accessed Part A vision care between 3/1/18 and 2/28/19. The medical charts of 150 of these clients were used in the review, representing 5.5% of the pool of unduplicated clients.

In an effort to make the sample population as representative of the actual Part A vision care population as possible, the EMA's Centralized Patient Care Data Management System (CPCDMS) was used to generate the lists of client codes. The demographic make-up (race/ethnicity, gender, age) of clients accessing vision care services between 3/1/18 and 2/28/19 was determined by CPCDMS, which in turn allowed Ryan White Grant Administration to generate a sample of specified size that closely mirrors that same demographic make-up.

Characteristics of the Sample Population

The review sample population was generally comparable to the Part A population receiving vision care in terms of race/ethnicity, gender, and age. It is important to note that the chart review findings in this report apply only to those who receive vision care from a Part A provider and cannot be generalized to all Ryan White clients or to the broader population of people with HIV or AIDS. Table 2 compares the review sample population with the Ryan White Part A vision care population as a whole.

Table 2. Demographic Characteristics of FY 18 Houston EMA Ryan White Part A Vision Care Clients				
	Sample		**Ryan White Part A EMA**	
Race/Ethnicity	Number	Percent	Number	Percent
African American	72	48%	1,346	50%
White	73	49%	1,297	48%
Asian	3	2%	39	1%
Native Hawaiian/Pacific Islander	0	0%	6	<1%
American Indian/Alaska Native	0	0%	11	<1%
Multi-Race	1	<1%	19	<1%
TOTAL	**150**		**2,718**	
Hispanic Status				
Hispanic	53	35%	924	34%
Non-Hispanic	97	65%	1,718	63%
TOTAL	**150**		**2,718**	
Gender				
Male	113	75%	2,033	75%
Female	34	23%	685	25%
Transgender Male to Female	3	2%	37	1%
Transgender Female to Male	0	0%	0	0
TOTAL	**150**		**2,718**	
Age				
<= 24	3	2%	132	5%
25 – 34	35	23%	665	24%
35 – 44	31	21%	589	22%
45 – 49	15	10%	390	14%
50 – 64	61	41%	865	32%
65+	5	3%	77	3%
TOTAL	**150**		**2,718**	

Findings

Laboratory Tests

Having up-to-date lab measurements for CD4 and viral load (VL) levels enhances the ability of vision providers to ensure that the care provided is appropriate for each patient. CD4 and VL measures indicate stage of disease, so in cases where individuals are in the late stage of HIV disease, special considerations may be required.

Patient chart records should provide documentation of the most recent CD4 and VL information. Ideally this information should be updated in coordination with an annual complete eye exam.

	2016	2017	2018
CD4	91%	80%	83%
VL	91%	80%	83%

Client Intake Form (CIF)

A complete and thorough assessment of a patient's health history is essential when caring for individuals living with HIV or anyone who is medically compromised. The agency assesses this information by having patients complete the CIF. Information provided on the CIF, such as ocular history or medical history, guides clinic providers in determining the appropriateness of diagnostic procedures, prescriptions, and treatments. The CIF that is used by the agency to assess patient's health history captures a wide range of information; however, for the purposes of this review, this report will highlight findings for only some of the data collected on the form.

Below are highlights of the findings measuring completeness of the CIF.

	2016	2017	2018
Primary Care Provider	50%	81%	87%
Medication Allergies	100%	99%	100%
Medical History	100%	99%	100%
Current Medications	100%	99%	100%
Reason for Visit	100%	100%	100%
Ocular History	100%	99%	100%

Eye Examinations (Including CEE/DFE) and Exam Findings

Complete and thorough examination of the eye performed on a routine basis is essential for the prevention, detection, and treatment of eye and vision disorders. When providing care to people living with HIV, routine eye exams become even more important because there are a number of ocular manifestations of HIV disease, such as CMV retinitis.

CMV retinitis is usually diagnosed based on characteristic retinal changes observed through a DFE. Current standards of care recommend yearly DFE performed by an ophthalmologist for clients with CD4 counts <50 cells/mm3 (2). Five clients in this sample had CD4 counts <50 cells/mm3, and four had a DFE performed.

	2016	2017	2018
Complete Eye Exam	100%	100%	100%
Dilated Fundus Exam	98%	98%	94%
Internal Eye Exam	100%	100%	100%
Documentation of Diagnosis	100%	100%	100%
Documentation of Treatment Plan	100%	100%	100%
Visual Acuity	100%	100%	100%
Refraction Test	100%	100%	100%
Observation of External Structures	100%	100%	100%
Glaucoma Test	100%	100%	100%
Cytomegalovirus (CMV) screening	98%	98%	94%

Ocular Disease

Eleven clients (7.3%) demonstrated ocular disease, including visual field defects, lattice degeneration of the peripheral retina, corneal ulcer, cataracts, optic atrophy, pinguecula, conjunctivitis, and strabismic amblyopia. Four clients received treatment for ocular disease, four clients were referred to a specialty eye clinic, and three clients did not need treatment at the time of visit.

Prescriptions

Of records reviewed, 95% (99%-FY17) documented new prescriptions for lenses at the agency within the year.

Conclusions

Findings from the FY 18 Vision Care Chart Review indicate that the vision care providers perform comprehensive vision examinations for the prevention, detection, and treatment of eye and vision disorders. Performance rates are very high overall, and are consistent with quality vision care.

Appendix A—FY 18-Vision Chart Review Data Collection Tool

Mar 1, 18 to Feb 28, 19

Pt. ID # _____ Site Code:_____

CLIENT INTAKE FORM (CIF)

1. PRIMARY CARE PROVIDER documented: Y - Yes N - No
2. MEDICATION ALLERGIES documented: Y - Yes N - No
3. MEDICAL HISTORY documented: Y - Yes N - No
4. CURRENT MEDS are listed: Y - Yes N - No
5. REASON for TODAY's VISIT is documented: Y - Yes N - No
6. OCULAR HISTORY is documented: Y - Yes N - No

CD4 & VL

7. Most recently documented CD4 count is within past 12 months: Y - Yes N - No
8. CD4 count is < 50: Y - Yes N - No
9. Most recently documented VL count is within past 12 months: Y - Yes N – No

EYE CARE:

10. COMPLETE EYE EXAM (CEE) performed: Y - Yes N - No
11. Eye Exam included ASSESSMENT OF VISUAL ACUITY: Y - Yes N - No
12. Eye Exam included REFRACTION TEST: Y - Yes N - No
13. Eye Exam included OBSERVATION OF EXTERNAL STRUCTURES: Y - Yes N - No
14. Eye Exam included GLAUCOMA TEST (IOP): Y - Yes N - No
15. Internal Eye Exam findings are documented: Y - Yes N - No
16. Dilated Fundus Exam (DFE) done within year: Y - Yes N - No
17. Eye Exam included CYTOMEGALOVIRUS (CMV) SCREENING: Y - Yes N – No
18. New prescription lenses were prescribed: Y - Yes N - No
19. Eye Exam written diagnoses are documented: Y - Yes N - No
20. Eye Exam written treatment plan is documented: Y - Yes N - No
21. Ocular disease identified? Y - Yes N – No
22. Ocular disease treated appropriately? Y - Yes N - No
23. Total # of visits to eye clinic within year:_____

Appendix B – Resources

1. Casser, L., Carmiencke, K.., Goss, D.A., Knieb, B.A., Morrow, D., & Musick, J.E. (2005). Optometric Clinical Practice Guideline—Comprehensive Adult Eye and Vision Examination. *American Optometric Association*. Retrieved from http://www.aoa.org/Documents/CPG-1.pdf on April 15, 2012.

2. Heiden D., Ford N., Wilson D., Rodriguez W.R., Margolis T., et al. (2007). Cytomegalovirus Retinitis: The Neglected Disease of the AIDS Pandemic. *PLoS Med* 4(12): e334. Retrieved from: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2100142/ on April 15, 2012.

3. International Council of Ophthalmology. (2011). *ICO International Clinical Guideline, Ocular HIV/AIDS Related Diseases.* Retrieved from http://www.icoph.org/resources/88/ICO-International-Clinical-Guideline-Ocular-HIVAIDS-Related-Diseases-.html on December 15, 2012.

4. Panel on Opportunistic Infections in Adults and Adolescents with HIV. Guidelines for the prevention and treatment of opportunistic infections in adults and adolescents with HIV: recommendations from the Centers for Disease Control and Prevention, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. Available at http://aidsinfo.nih.gov/contentfiles/lvguidelines/adult_oi.pdf. Accessed February 1, 2019.

Houston Ryan White Health Insurance Assistance Service Utilization Report

Period Reported: 09/01/2019-1/31/20

Revised: 3/2/2020

	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	600	$52,811.73	370			*0*
Medical Deductible	131	$18,927.37	104			*0*
Medical Premium	2887	$1,070,615.40	726			*0*
Pharmacy Co-Payment	6378	$230,331.85	946			*0*
APTC Tax Liability	1	$500.00	1			*0*
Out of Network Out of Pocket	0	$0.00	0			*0*
ACA Premium Subsidy Repayment	8	$511.02	7	*NA*	*NA*	*NA*
Totals:	10005	$1,372,675.33	2154	0	$0.00	

Comments: This report represents services provided under all grants.

Quality Improvement Committee

2020 Criteria for Reviewing Proposed Ideas

(approved by the Quality Improvement Committee 03-17-20)

In order for the Quality Improvement Committee to review a request for an idea, the idea must:

1.) Fit within the HRSA Glossary of HIV-Related Service Categories.

2.) Not duplicate a service currently being provided by Ryan White Part A or B or State Services funding.

3.) Document the need using one or more Planning Council publications.

4.) *For an emerging need only*, attach documentation from an outside source. Acceptable sources may include:

- Letter on agency letterhead from three other agencies describing their experience related to this need.
- Or, documentation from HIV websites or newspaper articles including a copy of the original document or study sited in the article or website.

DRAFT

2020 Proposed Idea

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

THIS BOX TO BE COMPLETED BY RWPC SUPPORT STAFF ONLY

_____ Control Number Date Received_____

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

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

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

   This will provide _____ clients with _____ units of service.

2. ADDRESS THE FOLLOWING:
   A. DESCRIPTION OF SERVICE:

   B. TARGET POPULATION (Race or ethnic group and/or geographic area):

   C. SERVICES TO BE PROVIDED (including goals and objectives):

   D. ANTICIPATED HEALTH OUTCOMES (Related to Knowledge, Attitudes, Practices, Health Data, Quality of Life, and Cost Effectiveness):

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

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

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

REASON FOR RECOMMENDATION:

(Continue on Page 2 of this application form)

FY 2021 *HOW TO BEST MEET THE NEED* WORKGROUP SCHEDULE *(Revised 03/10/20)*

Houston Ryan White Planning Council, 2223 W. Loop South; Houston, TX 77027

TRAINING FOR ALL PARTICIPANTS:

1:30 p.m. ~ Thursday, April 9, 2020 ~ 2223 West Loop South, Room 532

SPECIAL WORKGROUP: 10 am, Monday, April 13, 2020

Special Workgroup Meeting to Discuss: *Ryan White Part A funded services to support Ending the HIV Epidemic activities, which may include Housing Services. Also, access to medication, especially through ADAP, availability of Legal Services and services for the homeless.*

Group Leaders:

2223 West Loop South, Room 416

All workgroup packets are available online at www.rwpcHouston.org on the calendar for each date below (packets are in pdf format and are posted as they become available).

Workgroup 1	***Workgroup 2***	***Workgroup 3***	***Workgroup 4***
10:30 a.m. **Tuesday, April 21, 2020** Room #416	**1:30 p.m.** **Tuesday, April 21, 2020** Room #416	**3:00 p.m.** **Wednesday, April 22, 2020** Room #416	**11:30 a.m.** **Tuesday, May 19, 2020** Room #240
Group Leaders:	**Group Leaders:**	**Group Leaders:**	**Group Leaders:**
SERVICE CATEGORIES: Ambulatory/Outpatient Medical Care (includes Emergency Financial Assistance, Local Pharmacy Assistance, Medical Case Management, Outreach and Service Linkage) – Adult and Rural Ambulatory/Outpatient Medical Care (includes Medical Case Management and Service Linkage) – Pediatric Case Management - Clinical Case Management - Non-Medical (Service Linkage at Test Sites) Referral for Health Care and Support Services‡ (ADAP workers) Vision Care	***SERVICE CATEGORIES:*** Health Insurance Premium & Co-pay Assistance Medical Nutritional Therapy and Supplements Mental Health Services‡ Oral Health – Rural & Untargeted‡ **Substance Abuse Treatment/ Counseling** Case Management - Non-Medical‡ (Targeting Substance Use Disorder)	***SERVICE CATEGORIES:*** Early Intervention Services‡ (for the incarcerated) Home & Community-based Health Services‡ (Adult Day Treatment) Hospice Linguistic Services‡ Transportation (Van-based -- untargeted & rural)	***SERVICE CATEGORIES:*** Blue Book

Part A categories in **BOLD** print are due to be RFP'd.

‡ Service Category for Part B/State Services (SS) only; Part B/SS categories are RFP'd every three to five years. **To confirm info for Part B/SS, call 713 526-1016.**

The Houston EMA Ryan White Planning Council Report
March 2020

Submitted 04-02-20

Chief Elected Official - Updates

- County Judge Lina Hidalgo appointed two new Council members: Rashel Richardson will be replacing Hoxi Jones as the Medicaid representative and Oscar Perez is the director of health promotions at Avenue 360.

Ryan White Office of Support - Updates

- Per the stay at home order from Judge Hidalgo and Mayor Turner, Office of Support staff have been working from home since March 16th.
- COVID-19 Activities include:
  - ✓ Distributing information about COVID-19 and HIV to Office of Support email lists that include consumers who have attended Road 2 Success, Project LEAP graduates, Council and Affiliate members and others.
  - ✓ Distributing access information about Ryan White funded and other service organizations to those described above. The information about Ryan White funded organizations is provided by Ryan White Grant Administration and The Resource Group.
  - ✓ Working with the Chair of the Council and Committee Co-Chairs to contact all Council and Affiliate members on a weekly basis to link Ryan White volunteers with services if needed.
  - ✓ Essential Council and Committee meetings will be help with the use of Zoom videoconferencing. All other meetings will be cancelled or postponed until after the coronavirus wanes.
  - ✓ The 2020 How to Best Meet the Need training and workgroup meetings will be held according to the original schedule using Zoom videoconferencing. Please notify Rod if you wish to participate in any of these meetings so that she can send you reminders and the link to the meeting. See the website for meeting packets. Or, call Rod and ask her to mail you a packet. Rod and Tori are in the office preparing mail outs and more approximately once a week.
  - ✓ Project LEAP 2020 has been postponed until at least the end of July 2020.
  - ✓ The monthly meetings with the youth group have been put on hold for the time being. We tried to secure speakers to meet with the youth via Zoom but speakers were uncomfortable with this, or they were being used for COVID-19 activities and our hosts, AIDS Foundation Houston staff, are working from home.
- Amber Harbolt, the Health Planner for the Office of Support, prepared the 2020 Houston Area HIV Needs Assessment for use in the FY 2021 How to Best Meet the Need, priority and allocations processes. There are a few portions of the report that will be finished as soon as possible.
- Diane Beck continues to familiarize herself with the County's new accounting software.

Ryan White Planning Council - Updates

- Using Zoom, the Quality Improvement Committee hosted a joint meeting of all committees to approve the criteria to be used to determine the FY 2021 service categories.
- The Comprehensive HIV Planning Committee met via Zoom to approve key sections of the 2020 Houston Area HIV Needs Assessment.
- Kudos to all committee Co-Chairs who have used Zoom and Robert's Rules of Order as they chair their meetings. Please see the instructions for chairing via Zoom.

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Houston EMA Ryan White Part A and MAI Administrative Agency Report

April 2, 2020

- **FY 2019 Award Update and Contract Status:** RWGA has reallocated funds per the Council's approved policy authorizing the Recipient to shift funds during the final quarter of the grant year in order to ensure the Houston EMA does not exceed 5% of its Formula award in total unspent funds. Allocations within contract totals may continue to change before being finalized in mid-May.

- **FY 2020 Part A/MAI Award Update and Contract Status:** Houston EMA services and administration continue under a partial Part A and MAI award. The Houston EMA Project Officer estimates full awards will be received by all recipients no later than mid-April.

- **RWGA COVID-19 Response Activities:** Information below details RWGA COVID-19 actions to date:
  - ✓ Updates on COVID-19 related information were distributed by RWGA multiple times during week to sub-recipients. This has transitioned to weekly.
  - ✓ In an effort to minimize patients need to visit sub-recipient clinics, RWGA has aligned with TDSHS' emergency eligibility extension. Ryan White Part A patients with birthdates in March or April have their current eligibility date extended to May 31, 2020.
  - ✓ RWGA cancelled the Annual Provider Meeting originally scheduled for Wednesday, March 18th. Future provider meetings, primarily Quality Management and related Case Management trainings will continue as scheduled. April trainings will be held virtually.
  - ✓ RWGA would like to support utilization of telehealth medical visits in response to COVID-19 as much as possible. RWGA was notified by Harris County Purchasing that telehealth primary care visits are NOT allowable under current Ryan White Primary Care contracts. However, there is an opportunity to establish purchase orders for telehealth primary care visits exclusively, in response to COVID-19. Fund availability will be short term, with a very limited allocation. Interested sub-recipients submitted the bulleted documentation below for consideration.
    - Protocol for determining patient appropriateness for telehealth visit

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HCPH is the local public health agency for the Harris County, Texas jurisdiction. It provides a wide variety of public health activities and services aimed at improving the health and well-being of the Harris County community.

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    - Patient consent for telehealth services
    - Description of telehealth platform.
  - ✓ RWGA has had two staff members activated in support of larger Harris County Public Health COVID-19 response activities. The HHS Reassignment Request form has been prepared by RWGA for submission by CJO.

- **Quarterly Texas/Louisiana RW Part A and TX Part B Recipient Meetings**: The seven Texas/Louisiana Part A programs were scheduled to meet in Austin, Friday, April 17th. Additionally, the 5 Texas Part A programs planned to meet with Texas Ryan White Part B leadership to discuss statewide HIV care services topics April 16th. Due to travel and meeting restrictions imposed by the COVID-19 response, both meetings have been cancelled. Depending on status of COVID-19 response, both meetings will take place during 3rd quarter 2020.

- **How to Best Meet the Need Training and Workgroups:** RWGA is preparing aggregated EMA and HSDA service utilization and allocation data for use during the How to Best Meet the Need process. The RWGA manager will present related Part A service category information, in addition to service utilization and allocation data.

Ryan White Part B, C, D HOPWA and State Services Grant Administrative Agency

RWPC Steering Committee & Council Report

April 2020

1. **Administrative Agency Update**
   - **a.** TRG attends weekly HRSA and DSHS meeting regarding COVID-19 updates. Updates are shared with subs weekly.
   - **b.** TRG staff is working remotely following the "Stay Home Work Safe" mandate
   - **c.** Contact us via email 8-5 M-Th; 8-2 F
2. **DSHS Funding Ryan White Part B & State Services Update**
   a. FY 2020-2021 Part B Start April 1st
   b. **Houston ADAP Enrollment Workers**:
   c. Training updates- THMP has release the 2020 training calendar
      - New Employee Training- May 13-14, 2020
      - Regional Update Meeting- Aug 18-19, 2020
      - Quarterly Regional Call- next call Apr 8, 2020
   d. TRG is in the process of hiring a Regional ADAP liaison, hopefully the position will be filled by April 1st; all Houston HSDA positions are currently filled.
   e. THMP has a new training site https://www.dshs.texas.gov/hivstd/training/meds.shtm
3. **HRSA Funding Ryan White Part D**
   - **a. The Positive VIBE Project (PVP) of Houston and Galveston Update (Ryan White Part D)**
     - No Updates.
4. **DSHS Funding HOPWA**
   - **a. HOPWA Bridge Re-Entry Initiative (BRI) Project with AIDS Foundation Houston**
     - No Updates.

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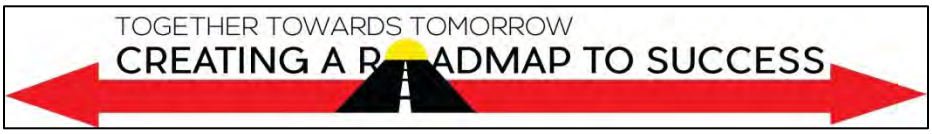
Ryan White Part B, C, D HOPWA and State Services Grant Administrative Agency



Community Initiatives

1. **Serving the Recently Released and Incarcerated**
   a. The February SIRR Meeting focused on presentations from the Crosswalk Center, Texas Advocates for Justice and Harris County Jail's Substance Abuse Services Department.
   b. The March SIRR Meeting will include a presentation about the 2019 Summit Evaluations and the start of planning for the 2020 Summit.
   c. The April *(4/22/2020)* SIRR Meeting will be focused on presenting the new service delivery model for the HCJ Service Delivery model.
   d. TRG is working with DSHS to provide training on Trauma Informed Care to the SIRR at a future meeting this year.
   e. To be added to the distribution list for meeting announcements, contact Felicia Booker fbooker@hivtrg.org
2. **Youth Transition Summit**
   a. The 2020 Youth Transitioning Summit will be held on August 5th from 9 a.m. to 3 p.m. The location is currently TBA. Planning for the Summit will start in April.
      i. 9 a.m. to 11 a.m. – Provider Sessions – How Agencies Can Support Transitioning
      ii. 12 p.m. to 3 p.m. – Youth Sessions
3. **Texas Black Women's Health Initiative (TxBWHI) Houston Team**
   a. Next monthly meeting will be 3/16/2020 at 6 pm @ 500 Via Zoom
   b. Contact Sha'Terra Johnson tbwihouston@gmail.com
4. **END HIV Houston**
   a. Contact Crystal Townsend ctownsend@hivtrg.org

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