Houston Area HIV Services Ryan White Planning Council

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

MEMORANDUM

To: Steering Committee Members:
Tana Pradia, Chair
Allen Murray, Vice Chair
Crystal Starr, Secretary
Veronica Ardoin, Co-Chair, Affected Community Committee
Rodney Mills, Co-Chair, Affected Community Committee
Daphne L. Jones, Co-Chair, Comprehensive HIV Planning Committee
Steven Vargas, Co-Chair, Comprehensive HIV Planning Committee
Ronnie Galley, Co-Chair, Operations Committee
Carol Suazo, Co-Chair, Operations Committee
Bobby Cruz, Co-Chair, Priority and Allocations Committee
Denis Kelly, Co-Chair, Quality Improvement Committee
Pete Rodriguez, Co-Chair, Quality Improvement Committee

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

From: Tori Williams

Date: Friday, June 26, 2020

Re: Meeting Announcement

Please note that there will be a:

Steering Committee Meeting
12 noon, Thursday, July 2, 2020
Zoom Conference Call – Please do not come to the office
Join Zoom Meeting by clicking onto: https://us02web.zoom.us/j/499715637
Meeting ID: 499 715 637
No password
Or, call 346 248-7799

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

Thank you!

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

AGENDA

12 noon, Thursday, July 2, 2020

Meeting Location: Online or via phone – Please do not come in person
Join Zoom Meeting by clicking on this link: https://us02web.zoom.us/j/499715637
Meeting ID: 499 715 637
To join via telephone call: (346) 248-7799

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

II. Public Comment and Announcements

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

III. Reports from Committees

A. Comprehensive HIV Planning Committee — Daphne L. Jones and Steven Vargas, Co-Chairs
   Item: 2020 Houston HIV Care Services Needs Assessment
   The document was mailed separately to provide more time for reading.
   Recommended Action: **Motion:** Approve the attached 2020 Houston HIV Care Services Needs Assessment.

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

B. Affected Community Committee — Veronica Ardoin and Rodney Mills, Co-Chairs
   Item: Training: COVI-19 and Lab Results
   Recommended Action: FYI: Philip Salerno, MT (ASCP), presented the attached PowerPoint presentation on COVID-19 and Lab Results.

Item: Public Hearing for the FY 2021 Priorities and Allocations
Recommended Action: FYI: On Thursday, June 18, 2020, the Affected Community Committee recorded the public hearing to announce the proposed FY 2021 Ryan White Service Priorities and Allocations. The video is available to watch on YouTube, see the link on the Ryan White website at www.rwpchouston.org. Public comments were accepted up until noon on June 30, 2020.

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

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

- FY19 Procurement Report – Part A & MAI, dated 06/07/20
- FY19 Service Utilization Report – Part A & MAI, dated 06/11/20
- FY19 Performance Measures Highlights

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

- FY 2019/20 Procurement Report Part B – dated 05/21/20
- FY 2019/20 Service Utilization 4th Qtr. Part B– dated 05/01/20
- FY 2019/20 Procurement Report DSHS SS – dated 05/21/20
- FY 2019/20 Health Insurance Program Report – dated 04/29/20

Item: FY 2021 How To Best Meet the Need Recommendations – **Emergency Financial Assistance - Other**
Recommended Action: **Possible Motion Regarding Housing** *The text will be provided at the Steering Committee meeting.*

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

Item: FY 2020 Ryan White Service Priorities
Recommended Action: **Motion:** Approve the attached FY 2021 Service Priorities for Ryan White Parts A and B, MAI** and State Services.

Item: FY 2021 Allocations: Level Funding Scenario – All Funding Streams
Recommended Action: **Motion 1**: Approve the attached FY 2021 Level Funding Scenario for Ryan White Parts A and B, MAI and State Services funds. See attached chart for details.

Item: FY 2021 Allocations: MAI** Increase/Decrease Funding Scenarios
Recommended Action: **Motion 2:** Approve the attached FY 2021 Increase & Decrease Funding Scenarios for Ryan White MAI* funds.

Item: FY 2021 Allocations: Part A Increase/Decrease Funding Scenarios
Recommended Action: **Motion 3**: Approve the attached FY 2021 Increase & Decrease Funding Scenarios for Ryan White Part A funds.

Item: FY 2021 Allocations: Part B & SS** Increase/Decrease Funding Scenarios
Recommended Action: **Motion 4**: Approve the attached FY 2021 Increase & Decrease Funding Scenarios for Ryan White Part B and State Services funding.

E. Operations Committee — Ronnie Galley and Carol Suazo, Co-Chairs
Item: Youth Group
Recommended Action: FYI: The Committee hosted a Zoom meeting with the Youth Group. The presenters were Diane Beck who hosted a COVID-19 JEOPARDY game, complete with prizes, and Sean Barrett, the Nutritionist at Legacy Community Health who provided practical information about nutrition for people living with HIV and other challenging illnesses. Rod Avila distributed face masks, prizes for the JEOPARDY game & box lunches to the youth.

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

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

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

VII. Announcements

VIII. Adjournment

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

MINUTES

12 noon, Thursday, June 4, 2020
Meeting Location: Zoom teleconference

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

Call to Order: Tana Pradia, Chair, called the meeting to order at 12:11 p.m.

During the opening remarks, Pradia said that the Council has done a wonderful job hosting robust meetings, making decisions thoughtfully and staying on top of deadlines so that our staff can soon begin to prepare the Ryan White Part A grant application. Although our work with the Youth Group had to be put on hold for two months, the housing staff at AIDS Foundation Houston is now back in the office and allowed us to host a Zoom meetings with their young housing clients. On another note, all of the Council related meetings in June will be held using Zoom. It is too early to say how we are going to handle the July meetings. Pradia thanked all of the How to Best Meet the Need workgroup co-chairs. They put a lot of time and effort into facilitating meetings in April and May. Many of the Co-chairs had never used Zoom before but they jumped in with both feet and did a great job. She also thanked Amber Harbolt who was the safety net for everyone. She was an amazing teacher, facilitator and cheerleader for those who were nervous. We could not have done the How To Best Meet the Need process without significant help from all of the staff, but Amber gets the award this year for being indispensable. Pradia 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 at today's meeting. Those selected to represent their committee were: Ardoin for Affected Community, Vargas for Comprehensive HIV Planning, Suazo for Operations, Murray for Priority and Allocations and Kelly for Quality Improvement.

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

Approval of the Minutes: ***Motion #2:*** *it was moved and seconded (Vargas, Kelly) to approve the April 2, 2020 minutes.* **Motion carried.** Abstentions: Ardoin, Suazo.

Public Comment and Announcements: None.

Reports from Committees
Comprehensive HIV Planning Committee: No report.

Affected Community Committee: Rodney Mills, Co-Chair, reported on the following:
Training: COVID-19 and Living with HIV: Pete Rodriguez, RN, presented the attached PowerPoint presentation on COVID-19 and Living with HIV.

Public Hearing for the 2021 How To Best Meet the Need Results: On Thursday, May 14, 2020, the Affected Community Committee recorded the public hearing to announce proposed changes to the FY 2021 Ryan White service definitions. The video is available to watch on YouTube, see the Council's website for the link. Public comments will be accepted until noon on June 2, 2020.

Quality Improvement Committee: Pete Rodriguez, Co-Chair, reported on the following:
Reports from Administrative Agent – Part A/MAI: See the attached reports from the Part A State Services Administrative Agent:

- FY19 Procurement Report – Part A & MAI, dated 04/30/20
- FY19 Service Utilization Report – Part A & MAI, dated 03/02/20

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

- FY 2019/20 Procurement Report 4th Qtr. Part B – dated 05/01/20
- FY 2019/20 Service Utilization 4th Qtr. Part B– dated 05/01/20
- FY 2019/20 Procurement Report DSHS SS – dated 05/01/20
- FY 2018/19 Health Insurance Program Report – dated 04/29/20

FY 2021 How To Best Meet the Need Recommendations
Emergency Financial Assistance - Other: **Motion #3:** *Approve the attached service definition for Emergency Financial Assistance – Other, which will be funded with Ryan White, MAI or State Services funding. The FY21 financial eligibility will be at 400% of poverty.* **Motion carried.** Abstentions: Kelly, Murray

Motion #4: *Approve the attached FY 2021 Service Definitions and Financial Eligibility for Ryan White Part A, Minority AIDS Initiative (MAI), Part B and State Services funded service categories, with the exception of Emergency Financial Assistance – Other, which was processed per the above motion.* **Motion carried.** Abstentions: Kelly

Targeting for FY 2021 Service Categories: **Motion #5:** *Approve the attached targeting chart.* **Motion carried.**

Assessment of the Ryan White Program Administrative Mechanism: **Motion #6:** *Approve the attached checklist for the 2020 Assessment of the Ryan White Program Administrative Mechanism.* **Motion carried.**

Priority and Allocations Committee: Bobby Cruz, Co-Chair, reported on the following:
FY 2021 Service Priorities: The Committee made recommendations regarding the FY 2021 service category Priorities which will be presented at the July Steering Committee and Council meetings.

FY 2020 Proposed Idea Form: **Motion #7:** *Approve page 2 of the FY 2020 Proposed Idea form. Page 1 was approved previously.* **Motion carried.**

Operations Committee: Ronnie Galley, Co-Chair, reported on the following:
Youth Group: The Committee hosted a Zoom meeting with the Youth Group. The presenter was Pete Rodriguez, RN, who spoke about COVID-19 and Living with HIV. In this presentation, Rodriguez included information about safe sex during COVID-19. Rod also distributed face masks and box lunches to the youth.

FY 2021 How To Best Meet the Need: The Committee will meet this week to make recommendations regarding the 2020-21 Blue Books and the FY 2021 Office of Support Budget. Please contact Tori if you wish to attend the meeting.

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

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

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

Announcements: None.

Adjournment: The meeting adjourned at 1:41 p.m.

Submitted by:

Tori Williams, Director Date

Approved by:

Committee Chair Date

2020 Steering Committee Voting Record for Meeting Date 06/04/20

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** HTBMN-EFA Other **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
Veronica Ardoin, Aff		X						X		X		
Steven Vargas, Comp		X				X				X		
Carol Suazo, Op		X						X		X		
Denis Kelly, QI		X				X						X
Non-voting members at the meeting:												
Rodney Mills, Aff												
Daphne L. Jones, Comp												
Ronnie Galley, Op												
Bobby Cruz, PA												
Pete Rodriguez, QI												
Absent members:												
Crystal Starr, Secretary												

MEMBERS	**Motion #4** FY21 HTBMN Recommendations **Carried**				**Motion #5** FY21 HIV Targeting Chart **Carried**				**Motion #6** Assessment of the AA Checklist **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		
Veronica Ardoin, Aff		X				X				X		
Steven Vargas, Comp		X				X				X		
Carol Suazo, Op		X				X				X		
Denis Kelly, QI		X				X				X		
Non-voting members at the meeting:												
Rodney Mills, Aff												
Daphne L. Jones, Comp												
Ronnie Galley, Op												
Bobby Cruz, PA												
Pete Rodriguez, QI												
Absent members:												
Crystal Starr, Secretary												

MEMBERS	Motion #7 FY 2020 Proposed Idea Form (pg 2) Carried			
	Absent	Yes	No	Abstain
Tana Pradia, Chair				C
Allen Murray, Vice Chair		X		
Veronica Ardoin, Aff		X		
Steven Vargas, Comp		X		
Carol Suazo, Op		X		
Denis Kelly, QI		X		
Non-voting members at the meeting:				
Rodney Mills, Aff				
Daphne L. Jones, Comp				
Ronnie Galley, Op				
Bobby Cruz, PA				
Pete Rodriguez, QI				
Absent members:				
Crystal Starr, Secretary				

NEW PUBLIC COMMENT

(as of June 2020)

PUBLIC COMMENT

Williams, Victoria (County Judge's Office)

From: FeedbackRWPC
Sent: Monday, June 22, 2020 10:08 AM
To: Williams, Victoria (County Judge's Office)
Subject: FW: Ryan White funding!

Public Comment from the website. ☺

Diane Beck
Council Coordinator

Sent: Sunday, June 21, 2020 8:57 PM
To: FeedbackRWPC <FeedbackRWPC@cjo.hctx.net>
Subject: Ryan White funding!

Ryan White is A Godsend for Me! In this pandemic of covid-19!!!! I would be very ill or dead if it loses any funding! I am so Very Grateful and Happy with the Service it provides! It's great the way it works! The only thing that's need improvement is more funding help for the seniors like me that use Ryan White Program!

Williams, Victoria (County Judge's Office)

From: Charlene Flash <cflash@avenue360.org>
Sent: Tuesday, June 16, 2020 9:37 AM
To: Williams, Victoria (County Judge's Office)
Cc: Eric James; Diane Arms; Oscar Perez; Greg Pate
Subject: Allocations commentary

Dear Tori,
Please see below comments from Avenue 360.

With the understanding that the planning council often uses historical spending under each service category to allocate future funds, I would urge them to consider a few key challenges unique to this funding cycle.

Dental: For dental, the reimbursement rate will be changing from a fee per unit to a fee per service cost. This will increase expenditures of the Ryan White dollars while also allowing possible expansion of services with a more reasonable cost reimbursement based on the true cost of providing dental services. We also have plans to expand to other locations in the City to expand access. While spending has been flat or low, an increase in capacity and providers should see a jump in numbers and would require more dental dollars be allocated. There has always been a need for more dental capacity. And looking ahead, when the RWPC looks back next year, remember that 2020 expenditures have been impacted greatly by COVID-19 precautions over a several month period. For two months, emergency only care caused a dramatic decrease in numbers while following social distancing and other CDC/TDA guidelines under routine care continues to hinder production.

Disparities: Allocation of funding should support the implementation of innovative models of service delivery that results in improvements in the HIV care continuum for minority populations. In order to effectively implement a treatment as prevention model in a clinical setting, additional support for designated staff is needed who can address the national HIV goals. Facilitating access to care and optimizing health outcomes for people living with HIV will contribute to the development of seamless systems that support retention in care to achieve viral suppress in order to maximize the benefits of early treatment and reduce transmission risk. Case management staff are often overwhelmed by the number of clients they have and are often not being able to adequately address all their needs. This support staff would provide clients more individualized, intensive services, while building a trusting relationship that would lead to improvement in health outcomes. Support for transportation is also needed. Bus vouchers often cause more of an inconvenience to patients as they have to take multiple bus routes, or don't have a bus stop near their home. Funding should be allocated to support transportation assistance through ride-hailing companies such as Uber and Lyft.

Housing: Housing remains a critically important service need for PLWH. Stable housing and respite support for those in need of that service is accentuated given the mass loss of employment in the context of the COVID-related economic downturn.

Thank you for your thoughtful advocacy for people living with HIV.

Warm regards,
Dr. Charlene Flash

Charlene A. Flash, MD MPH
President and CEO

Avenue 360 Health & Wellness
2150 W. 18th Street, Suite 300 | Houston, Texas 77008

Public Comment for June 11, 2020 Ryan White Planning Council meeting

I am providing this Public Comment in order to implore that

- someone from the Quality Improvement Committee second the motion to include housing in the definition for the Emergency Financial Assistance – Other category, that the Committee vote to approve the addition,
- that the Priorities and Allocations Committee consider this in the allocations as was stated at the Monday, June 8, 2020 meeting.
- And finally, that this Council vote to approve this addition when it is brought to them.
- HOPWA concerns: I fully understand and agree the most appropriate funding source for this service should be from HOPWA. However, The City of Houston does not include measures such as this in their priorities and have not funded such measures under HOPWA ever. About 15 years ago this Council did fund housing, and voted to no longer fund this service with the demand and assumption HOPWA would pick this up. In over a decade and a half this has not happened, and at this time there is no evidence this will change. So, as much as we want and hope HOPWA will fill this gap ***created by this Council 15 years ago***, it is not likely to happen. Until recently, with the arrival of COVID, I have not seen a desperate need to address this. But things are different now with COVID in our midst and at a time when we believe we can finally end the HIV epidemic.

The link below is for an article which explains States and local governments are running out, or have run out, of funds to continue helping people with housing issues. Couple this with the fact that our City did not put in provisions to keep people from being evicted once the moratorium is lifted sometime this July, it is this Council's responsibility to ensure the care People With HIV is maintained and facilitated by covering Housing under the EFA – Other category.

HOPWA has put money into its STRUMA and TBRA programs, but these do not fill the need for an emergency housing need should it arise for PWH in our area.

The City of Houston has Emergency Solutions Funding for homeless prevention, but this money will be available for everyone needing such a service, those with and those without HIV. What we have seen in these instances, is that PWH get lost in the shuffle and are not prioritized because they have HIV. We have the ability to do exactly that for anyone living with HIV, even if they are undocumented or have someone in their household that is undocumented.

We created this gap, and this is an opportunity for us to fill this gap. We need to take advantage of this at this time because of yet another even more contagious virus in our midst that can kill PWH. We are seeing a rise in COVID cases across the state and expect to see even more. COVID will be with us past the time the COVID Cares funds are supposed to be expended. The funds under this category will fill the gap created when they are expended.

Thank you, Steven Vargas

The Harris County Area Agency on Aging (HCAAA) is part of a nationwide network of agencies coordinating supportive services for adults 60 years or older, as well as their caregivers. HCAAA is committed to continuing to serve the needs of older adults in Harris County through the COVID-19 crisis.

Our home-delivered meal program has expanded to provide food through our traditional program or through our partnership with the Houston Food Bank to seniors that are choosing to stay healthy at home. We are providing masks upon request as long as supplies are available. In addition to our traditional transportation support for seniors, we are offering transportation services to City of Houston COVID testing sites.

Also, HCAAA will provide temporary utility and rental assistance to older adults economically impacted by COVID-19. Our call center remains fully staffed to provide information, referrals and assistance; and our benefits counselors remain ready to assist with any questions you may have regarding Medicare and other benefits. We also continue to provide assistance in getting prescription medication, nutritional supplements and incontinent supplies.

We are working to assist seniors with many other basic need services during this unprecedented time. We are available if seniors are feeling alone, lonely or isolated to talk and connect them with resources that can help them remain safe, well and healthy!

If you are 60 or older, live in Harris County and in need of food or other services that we offer, just call 832-393-4301.

Area Agency on Aging
HARRIS COUNTY

HOUSTON HEALTH DEPARTMENT

PUBLIC COMMENT

(From April and May 2020)

PUBLIC COMMENT – 04—24-20

Esteemed Ryan White Planning Councilmembers,

I am writing in support of using, under the Emergency Financial Assistance service category, funds to provide rapid response financial assistance to People With HIV (PWH) impacted by the COVID-19 pandemic and other disasters. Our current system is not built to act swiftly. Many PWH experience frustration when they need financial assistance and realize the monthly expenses owed tomorrow may not be available for two weeks to a month. And this is after the time taken to secure appointments, gather requested documentation, fill out paperwork, sign Consent forms, etc. "Rapid response" would need to be part of this service definition for processes to be developed which simplify or streamline eligibility and reduces the time between requesting and receiving help which resolves or alleviates the crisis. The community expects an emergency response when they reach out for emergency assistance, financial or otherwise. When our community hears "emergency" they anticipate a quick response as calls placed to the police, fire department or for an ambulance. Though such a response may not be feasible within our systems of care, it is a worthy goal and could yield better than a response which takes a couple of weeks to a month and does not meet the immediate need.

Some may consider such situations a result of poor planning, or an inability to maintain or cultivate a healthy support system. This may be the case for some. For many in our EMA, this situation may present itself as a result of COVID-19 ravaging their communities, disrupting their places of employment, schooling, even worship and interrupting their flow of funds to maintain housing, utilities and food needs; interrupting their plans for the future and career plans; and interrupt the very ability to be with others for comfort or solace as they scramble to help themselves and seek help from others..

We are rapidly approaching hurricane season and still do not know when we will be completely through the COVID-19 pandemic. These two could coincide and our area could experience what Polk County just did with dealing with COVID-19 and being hit by a destructive tornado. Some PWH in our area may not be eligible for federal relief funds at that point either for a variety of reasons, including but not limited to, being undocumented. Our current funded services may not cover some of their circumstances or needs. Imagine a PWH needing to relocate temporarily due to the presence of COVID-19 in their household. Or need supplies in order self-isolate due to exposure. What about PWH living out of motels due to the same situation? Moratoriums on evictions from homes or apartments do not cover motel stays. Our HOPWA funds do not prioritize emergency shelter vouchers so do not fund them. If we intend to prevent or minimize the impact of this pandemic or other disasters on People With HIV, being able to answer their calls for help and deliver that help with a rapid response could be the difference between a Person With HIV staying in or falling out of care. It could be the difference between being safe from acquiring another life-threatening virus or hospitalization with an uncertain outcome. It could be the difference between helping to flatten the curve and not, this one or a future one.

My hope, my request, and if necessary, my demand, is "support for increased demand for emergency housing for RWHAP clients"[1] via an Emergency Financial Assistance definition which allows a rapid response to emergency situations arising from events similar to what we are experiencing now with the COVID-19 pandemic. This service definition would need to be flexible enough to accommodate the unpredictable circumstances which may arise from the variety of events which affect our area and negatively impact our efforts to end the HIV epidemic. See the attached "PBS NewsHour" report for additional information.

– Steven Vargas, HIV Advocate and Long-Term Survivor, April 23, 2020

(continued on next page)

JBLIC COMMENT – 04–24-20

1. Quoted from the "HRSA Website Questions and Answers from 04-15-20 Conference Call, Coronavirus Disease 2019 (COVID-19) Frequently Asked Questions" under the CARES Act Funding on the last page, ninth bullet from the top.

Vargas submission for Public Comment. Excerpts from the report on "PBS NewsHour" (4/20/2020). For the full report, ease go to https://www.pbs.org/newshour/politics/millions-of-americans-are-receiving-relief-payments-this-week-t-who-is-being-left-out

t tens of thousands of the country's most vulnerable residents will not receive this form of financial assistance this eek — or, in some cases, at all. Undocumented immigrants and adult dependents don't qualify. Lower income dividuals and those with disabilities will, in some cases, face extra hurdles in seeking to claim the money. And consistent communication about the legislation from lawmakers and the U.S. Department of Treasury has raised estions over who exactly qualifies for the relief and why certain groups are left out.

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yond the potential challenges for those who are eligible in accessing the coronavirus aid, there are still others who ve been completely left out and aren't eligible. Adults claimed as dependents, including many students and people th disabilities, will not receive anything. Parents or guardians who claim adult children on their taxes also will not ceive the $500 credit provided to those with children under 17. On social media platforms, many are expressing their istration with the decision to omit them.

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zmin Franco, 2S, came to the U.S. from Mexico as a child, but is temporarily protected from deportation under the bama-era Deferred Action for Childhood Arrivals program. Some DACA recipients like Franco who have social security rds are eligible for payments; Franco's parents, however, are among the estimated 11 million undocumented migrants in the United States who aren't eligible for the payment. Franco's mother was recently laid off from a ocery store position, and her father also lost his job as a landscaper due to the pandemic. In addition to daily living penses, Franco's father has to pay for insulin to treat his diabetes without health insurance. "Having an underlying ndition like my dad does, it's such a horrible feeling to not be sure what would happen to him if he were to get sick th the coronavirus," Franco said.

e legislation excludes "any nonresident alien" foreigners from receiving money. The law also denies the money to gible taxpayers who either file a joint tax return with an undocumented person or claim an undocumented child, said ancine Lipman, a tax expert and professor with the University of Nevada, Las Vegas School of Law.

any noncitizens who work and pay taxes, including undocumented immigrants and those with legal work visas, have st jobs as a result of the pandemic. H-1, TN, and O-1 work visa holders are considered resident aliens and can receive l only if they've been in the U.S. long enough to meet the "substantial presence" test.

re is the link to an additional report from National Public Radio:

hat Happens If Undocumented Immigrants Get Infected With ronavirus? https://www.npr.org/2020/03/29/823438906/what-happens-if-undocumented-immigrants-get-infected-th-coronavirus?sc=18&f=

PUBLIC COMMENT – 04-23-20

Dear Ryan White Planning Council,

The ongoing COVID-19 pandemic has shed light on the struggle and disproportionate burden that vulnerable populations face daily. The requests for financial assistance from our patients – who mainly come from underrepresented communities – has rocketed since the "Stay Home, Work Safe" order was put in place. Many have lost their jobs and cannot afford rent or buying essential goods.

Moreover, the fact that many residents are not eligible for federal financial assistance only makes matter worse. Undocumented people are not eligible, even though they pay taxes. Additionally, people who file their taxes jointly with an undocumented person, or claim an undocumented child, are also ineligible. People with work visas can only receive their stimulus check if they can prove "substantial presence" in the country. The obstacles do not stop there.

The financial crisis that is emerging in the wake of the COVID-19 pandemic disproportionally affects those who have less access to healthcare, an impact that can be directly correlated with known social determinants of health. People are afraid to use public transportation and cannot afford ride share apps; affordable housing is becoming more and more problematic; and fear of exorbitant medical expenses continues to drive people away from care. On top of this, we are still researching the impact of this crisis on mental health – we foresee that mental health services, though costly, will emerge as a pivotal service.

There is a vulnerable population that is suffering in silence and fear. In extraordinary times like these, we need to lead with extraordinary example. Please, consider the use of emergency financial assistance funds as a rapid response aid for those ineligible for assistance.

Jonatan Gioia, MD
Research Associate
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Williams, Victoria (County Judge's Office)

From:	Richard Gamez <rcgamez@aol.com>
Sent:	Thursday, April 23, 2020 3:57 PM
To:	Williams, Victoria (County Judge's Office)
Cc:	Richard Gamez
Subject:	Emergency Financial Assistance for those ineligible

Good afternoon, Ms. Williams,

Please include this report as support for the Emergency Financial Assistance funding as a rapid response aid for those ineligible for other more immediate assistance.

https://www.washingtonpost.com/business/2020/04/05/undocumented-immigrants-coronavirus/

Thank you.
Richard Gamez
Member of the Latino HIV Task Force

The Washington Post

Business

Undocumented workers among those hit first — and worst — by the coronavirus shutdown

By Tracy Jan
April 4

Evilin Cano was dismantling a rooftop skating rink in Manhattan's Seaport district when her construction crew was notified that the venue would be closing, along with much of New York — and that she would be out of a job.

The next night, the 33-year-old undocumented day laborer from Guatemala fell ill with a fever. Her head pounded. Her throat hurt. She could not stop coughing or vomiting. And she was short of breath. She does not know whether she has covid-19 because three hospitals told her not to bother coming in for testing unless she's gasping for air.

"They told me to stay at home, don't go out, and when I can no longer breathe, call 9-1-1 for them to pick me up," Cano said.

The collapse of the U.S. economy brought about by the coronavirus pandemic has exposed the extreme vulnerabilities of millions of undocumented workers like Cano, who are disproportionately employed in industries undergoing mass layoffs as well as high-risk jobs that keep society running while many Americans self-isolate at home.

Many of the undocumented, working in construction, restaurants and other service sectors, have already lost their jobs. Others, in industries like agriculture and health care that have been declared essential, work in jobs that typically require close quarters or interacting with the public, putting them at higher risk of getting sick.

Unlike many American workers, undocumented immigrants can't count on the social safety net if they lose their jobs or get sick. Most do not have health insurance or access to paid sick leave — putting them and the people they encounter at risk. Most aren't eligible for unemployment insurance or the cash payments included in the $2 trillion relief package Congress passed last month — even if they pay taxes or their children are U.S. citizens.

"The government has announced it was going to support people affected by the coronavirus but that's for Americans — not for people like us who are undocumented," said Cano, who applied for asylum in November. "My fear is if I seek help, this country will see me as just trying to take advantage of the system."

Cano said she had been a police officer living a middle-class life in Guatemala when a gang tried to kidnap her teenage daughter, and she fled with her two eldest to New York.

She was just five days into a three-month job at the Seaport transforming what had been a temporary winterscape into a summer oasis when the contractor pulled her crew aside on March 20 and told them not to return.

Soon after Cano got sick, her daughter developed a fever, too. So did her boyfriend. Unable to seek care, Cano spent five days in bed and remains quarantined in her Brooklyn home.

Construction had been a step up for Cano. When she first came to the U.S. more than a year ago, she patched together a living at a Salvadoran restaurant, earning $50 for 13 hours of overnight work cleaning and preparing pupusas for delivery. When the till came up short, she said, the cashier would dock the difference from Cano's earnings. One night, she made so little that she had to borrow the $2.75 bus fare home.

Last June, she became a day laborer in construction — doing demolition work, painting and the finishing touches. She made $150 per nine-hour shift — enough to support her 17- and 16-year-old and still send money back to the 11- and 7-year-old she left behind with her mother.

Now, she is broke — with no savings and no income. She felt heartsick during a recent phone call home, telling her mother that no money would be coming this month.

The Brooklyn community job center where Cano and other day laborers used to gather each morning is deserted, like similar centers around the country. New contracts, now fielded over the phone, have dropped from about 20 a week before the coronavirus crisis to around five, said Ligia Guallpa, executive director of the Worker's Justice Project, which runs the center.

"I'm trying to figure out how to find another job, but I'm not healthy — and there are no jobs," Cano said. "At this point, I'm looking for anything just to support my kids."

Once she recovers, Cano plans to sell homemade tamales for $3 each — the way she supported her family over the winter when construction work was slow. She hopes it will be enough to cover their groceries.

"I cannot go back to Guatemala," Cano said. "I'd be sentencing my kids to death."

The 7 million immigrants without authorization to work in the United States make up just over 4 percent of the country's labor force, but account for at least 12 percent of workers in construction, 10 percent in hotels, and 8 percent in restaurant and food service — among the hardest hit sectors in the pandemic, according to an analysis of 2018 Census data by New American Economy. The analysis shows that undocumented immigrants also make up 14 percent of agricultural workers and 7 percent of home health aides, two industries considered critical to the health of the U.S. economy and its citizens during the coronavirus crisis.

Researchers and industry groups say undocumented laborers are significantly undercounted and comprise more than half of the workforce in some occupations, such as farmworkers.

"A lot of undocumented immigrants will be hit first — and worst — by this recession," said Orson Aguilar, director of economic policy at UnidosUS.

In the absence of a federal safety net, advocates from California to New York are pushing cities and states to provide economic relief to workers regardless of immigration status. Some have begun cobbling together funds to help undocumented workers pay rent and buy food.

Even workers who thought they had stability are discovering that no job is secure in the coronavirus-induced recession.

Juan, a 36-year-old head cook at a diner in Berkeley, Calif., saw his hours cut in half — to just five hours a day, for takeout and delivery only — once the governor ordered the state to shelter in place.

He donned a mask and gloves when he left for work and sanitized all equipment at the restaurant before touching it, fearful that he'd carry the virus home to his 9-year-old daughter, who has asthma.

Then last Friday, he learned that the restaurant was shutting its doors, even for takeout.

"I'm in shock," said Juan, who asked that only his first name be used because of his immigration status. "I was kind of afraid to go to work, but now I don't know what to do."

Others say their undocumented status prevents them from demanding protective equipment as they continue to go about their jobs.

An undocumented farmworker in northern Ohio, who spoke on the condition of anonymity for fear of losing her $10 an hour job, said she has been planting tomatoes, onions and other produce — without the protection of gloves and masks and without access to soap and running water.

The 36-year-old farmworker, who came to the U.S. from Monterrey, Mexico, when she was 15, brings her own liquid soap from home and uses drinking water to wash her hands during breaks.

She works alongside migrant workers who live in crowded quarters at a labor camp and who she fears wear the same dirty clothes all week because they don't have laundry facilities on site.

The county health department has instructed the farmworkers to work six feet apart — an edict she says is impossible to follow when they unload plants from the trailers to bring into the nurseries. For one week, her employer took workers' temperatures. But no longer.

The mother of four follows a strict routine when she returns from work — removing her shoes outside, washing her clothes daily, and not allowing her children to hug her until she's taken a shower "because I'm not sure if I have the virus or not."

The backdrop for many of the undocumented is the fear of deportation — despite a recent commitment from Immigration and Customs Enforcement to halt most enforcement during the coronavirus outbreak, especially near health-care facilities.

"That provides little comfort," said Anu Joshi, vice president of policy at the New York Immigration Coalition. "ICE field offices have a lot of leeway in moments of crisis to implement their own prioritization rules."

Others worry about jeopardizing their chances to gain permanent status in the U.S. The administration implemented a rule in February that would make it more difficult for low-income immigrants, including those who entered the country legally, to become permanent residents if they have received public benefits, including health coverage for the poor such as Medicaid. But it recently made an exception for those seeking medical attention for the coronavirus.

The most terrifying part of Lydia Nakiberu's day has become her two-hour commute — on two trains and a bus — to her job as a home health aide outside Boston.

She shoves her hands in her pockets so as not to touch anything, wears a mask, scrubs her hands every chance she gets — but worries about spreading the virus to the 86-year-old man she cares for. Or to her family.

"They tell us, 'When you get sick, you have to go to the hospital,' but all the undocumented domestic workers I know are so scared that ICE might get their information and come for them," said Lydia, 41, who does not have health insurance.

Both Lydia and her husband, Jerry, are undocumented immigrants from Uganda who have raised their children — ages 13, 12 and 8 — in the United States. Jerry spent three months in an immigration detention center in 2012 after losing an asylum case and missed the birth of his youngest son.

At the nursing home where Jerry works as a nurse, masks are rationed, with caregivers allotted just one for the entire day. They have gloves, but no protective gowns. He thinks the government should be doing more to help workers on health care's front line — even if they are not authorized to work.

"They need us more than ever before," said Jerry, 54.

Perhaps when this is all over, he said, the American public will recognize how undocumented immigrants risked their lives to help during a time of crisis. In another burst of optimism, he said he hopes that the government would grant legal status to parents of U.S. citizens and other immigrants who have long paid taxes.

But until then, Lydia said: "We are scared about the virus. We are scared about ICE. We are scared about almost everything right now."

Tracy Jan
Tracy Jan covers the intersection of race and the economy for The Washington Post, a beat she launched in December 2016. She previously was a national political reporter at the I

Williams, Victoria (County Judge's Office)

From: James Williams <jastaswillias@gmail.com>
Sent: Thursday, April 23, 2020 3:58 PM
To: Williams, Victoria (County Judge's Office)
Subject: Support for Emergency Financial Assistance funds proposal

I am writing in support of the use of Emergency Financial Assistance funds for a rapid response to help those ineligible for other more immediate assistance. I was offended to hear that families with at least one person without a Social Security number would also not be eligible for COVID-19 Relief funds from our Republican government. Anything we can do to offset this misguided and unfair situation should be done. If any person is being cut-off for having at least one person without a SSN in their household is being deemed guilty by association. This is inherently wrong. I am grateful that the Ryan White Program is there to make things better for at least some suffering from this injustice.

-- James Thomas Williams

April 23, 2020

To: Ryan White Office of Support

From: Latino HIV Task Force

Latino HIV Task Force (LHTF) would like to express its concerns about how the Covid-19 has impacted the Latino community.

Harris County as a whole has 43% Hispanic, 29% White, 20% African American, and 7% Asian in population composition.

The Covid-19 breakdown as of April 21, 2020 is 25% Hispanic, 23% African American, 18% White, 4% Asian and 1% other.

As the Covid-19 continues to spread across Harris County and the City of Houston, the Latino communities are among those who will continue to be disproportionally affected by the virus. Barricading access to governmental programs; services; and benefits through means of discrimination on the basis of immigration status, socio-economic status, race, color, age, gender identification and sexual orientation will further exacerbate health and economic inequities.

Latino Children are affected by the following supportive services received by school districts. Many children will be impacted by lack of nutritional supplements provided by the school. They will suffer due to unavailable free lunch programs. Many children and youth access school facilitated health care, for vaccinations and mental health services. Children ages 5 – 17 years old will miss the WHO recommendation of 60 minutes a day of moderate-to-vigorous physical activities. This will increase their risk of establishing bad habits like increased TV or Video Games or other electronics' use. But also, snacking that can damage future cardiovascular and musculoskeletal health. In addition, the current situation impacts the health of our children and youth who suffer from living with HIV. Many of these children did not have the tools needed to complete their school-work because of the lack of internet access and most importantly their lack of laptops, computers or tablets.

Adolescents are impacted because of school closures and social distancing is challenging. Adolescents at this age are growing independent and begin to prioritize connections with peers over parents. They may grieve their rites of passage they were due to experience, like proms and graduations. Anxiety could increase in adolescents as they try to understand the Covid-19 pandemic.

In general, Latino seniors tend to seek less medical and counseling help than African-American and Anglo seniors do. Fearful of government policies with regard to the Latino communities, especially immigrants, they avoid dealing with governmental agencies and CBOs that might report them to immigration authorities. This reluctance to seek help is especially true for the undocumented, or those with undocumented family members. Many Latino seniors serve as the backbone of their families, caring for grandchildren and other children in their community while schools are closed; and these children may have been infected, which puts them at a higher risk of infection themselves. If these seniors become infected and do not get the help they need, the entire family structure will be disrupted, with huge social and financial repercussions to the greater society. This is why getting this financial aid is so very urgent.

Many in the Latino communities are ineligible for unemployment insurance or the $1,200 stimulus check that the government just released. Our undocumented are unable to rely on the government's relief aid, some despite having paid taxes and living in the U.S. for more than two decades. If they are stricken with the Covid-19, they will question whether to seek medical attention because of facing deportation, or being separated from family. If they are not faced with being undocumented, many work as cooks, cleaners, janitors, industries which have been hit the hardest by the pandemic. The majority of this group do not have health insurance or are under insured. If living with HIV, many can access Ryan White Services. These will not cover loss of wages, or some high medical bills associated with treatment due to this Pandemic.

Many of our agencies have reached their limits in assisting clients with rental and utilities assistance. Transportation, while always a barrier, continues to be as such with the added dangers of acquiring COVID-19 from the need to use public transportation. Metro reports an increase of COVID-19 diagnoses for bus drivers, Quality Assurance staff, bus cleaners, etc. Access to Food Pantry has been challenging to more families than usual.

The Emergency Financial Assistance service category provided by Ryan White with COVID-19 Relief Funds, while a great help if no restrictions are put in place, will not assist the Latino community if they continue to uphold restrictions that discriminate and will be a tremendous negative impact on our communities if they do. But, if this category is created to provide a more equitable situation for those ineligible for other financial assistance, and maintains the flexibility and agility to respond quickly, then we will have finally created a financial relief category which truly serves ALL people with HIV in our area, including immigrants of undocumented status and the families which include them.

Gloria Sierra, Chair

Steven Vargas, Co-Chair

Richard Gamez, Secretary

PUBLIC COMMENT – as of 04-15-20

From: Steven Vargas <sivargas68@yahoo.com>
Sent: Wednesday, April 15, 2020 12:28 PM
To: Williams, Victoria (County Judge's Office); Martin, Carin (PHS); Tana Brown; Barr, Melody - HCD
Subject: Fwd: Coronavirus eviction rules don't always help people in motels

This is something I was thinking an emergency response fund could address and help alleviate.

I hope to be proven wrong, but I don't think HOPWA's STRUMA or TBRA programs would be able to assist in such cases.

Back in in 2006-2008, the Ryan White Program did fund temporary stays in motels for those returning to society from incarceration. This made it easier to assist with accessing medical care and more stable housing. At the time, PC members thought HOPWA would be able to do something similar and supplant those funds and recreate something similar.

I see similar functions for such funds for:

1. PWH returning from incarceration.

2. PWH needing temporary stay away from home due to something like COVID, whether the PWH needs isolating or need to be somewhere away from home where someone in their home has COVID or something similar

3. PWH needing a temporary stay if home is unlivable due to a fire or other disaster (hurricane, tornado, flood, infestation)

I have worked at two Houston ASOs and both have had to fund such stays for PWH during my tenure with them. Sometimes the agency had to use general funds to do so to address the need in a timely and useful fashion.

---------- Forwarded message ---------
From: **Stateline Daily** <outreach@pewtrusts.org>
Date: Wed, Apr 15, 2020, 11:31 AM
Subject: Coronavirus eviction rules don't always help people in motels
To: <sivargas68@yahoo.com>

View in web browser

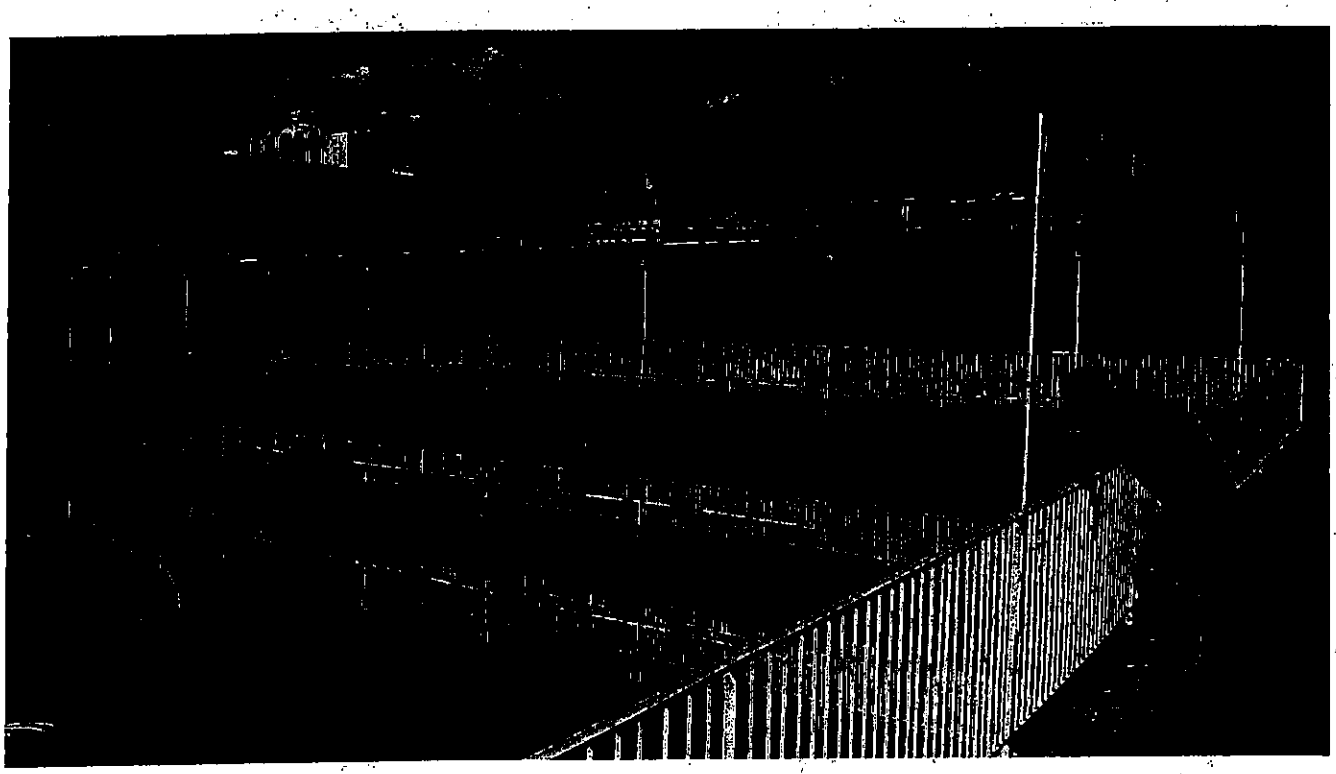
PEW

Stateline Daily

Stateline

Coronavirus Eviction Rules Don't Always Help People in Motels

STATELINE ARTICLE April 15, 2020 By: Teresa Wiltz Topics: Business of Government & Health Read time: 5 min



A man stands outside of his Reno, Nevada, motel room before the pandemic. Many families and individuals living in extended-stay motels are facing eviction during the pandemic.

John Locher/The Associated Press

Read *Stateline* coverage of the latest state action on coronavirus.

For the past few months, Stefanie Craft, her five kids and two pets, a cat and a dog, have been camped out in the Economy Inn and Suites in North Charleston, South Carolina. It wasn't her first choice: Black mold crawling up the walls of their rental house forced her hand.

Still, it's home, for now, so they're riding out the pandemic in one room with a "sink-sized kitchen."

Now Craft, 44, who says she has always paid her $325 weekly motel rent on time, is facing eviction. She lost her job supervising a local car wash when the coronavirus shuttered her city. A local church paid her rent this week, she said, but she's terrified about what will happen next. The motel's manager could not be reached for comment about Craft's case.

"I have no clue what I'm going to do," Craft told *Stateline* in a telephone interview. "We have nowhere to go. That's why we're here."

States have reached different conclusions.

This month, North Carolina Attorney General Josh Stein, a Democrat, ordered local motels and hotels to stop threatening to evict tenants during the pandemic.

Hotels have been devastated by the pandemic, said Lynn Minges, president and CEO of the North Carolina Restaurant and Lodging Association. Eight out of 10 hotels in the state either were forced to close or are operating at less than 20% capacity, she said, adding that many are sheltering homeless families and individuals.

"We're clear that it is unlawful for a hotel to evict a guest if that is how they are finding shelter," Minges said. "They are still responsible for the payment of those rooms," but those are matters that can be resolved later, she said.

In neighboring South Carolina, however, the state's April no-eviction order does not apply to people living in motels.

And sometimes states and localities don't agree. In Michigan, for example, tenant protection laws do not cover motel residents.

But after Kent County, Michigan, motels evicted more than a dozen families and threatened to evict roughly 75 more last month, local officials got involved, said Casey Gordon, who works with homeless students and families for the Kent County Intermediate School District.

County officials, Grand Rapids city administrators and the county public health department told motel owners that they were essential businesses and evicting residents would violate the local eviction moratorium, Gordon said.

But many motels shut down anyway and kicked families out, according to Gordon, and some families ended up in shelters. Others are living in "doubled-up situations," couch-surfing with friends. Some ended up in other motels.

"It's getting really difficult," Gordon said. "Hotels are saying, 'We can't continue to provide staffing. People aren't coming into work.'"

In some places, evictions are happening at the same time that cities, in an effort to protect people who experience chronic homelessness, are commandeering empty motels to house them.

Many federal agencies, such as the U.S. Department of Education, consider people to be homeless if they're living in hotels or motels. But there are no clear statistics tracking this population.

Motel residents are a difficult population to pin down because they live in a motel when they can afford it and when they can't they often move to their cars or a friend's couch. Nor

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U.S. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT
WASHINGTON, DC 20410-7000

OFFICE OF COMMUNITY PLANNING
AND DEVELOPMENT

May 22, 2020

MEMORADUM FOR: All Community Planning and Development Field Office Directors, Deputy Directors and Program Managers

FROM: John Gibbs, Assistant Secretary, Acting, D

SUBJECT: Availability of Additional Waivers for Community Planning and Development (CPD) Grant Programs to Prevent the Spread of COVID-19 and Mitigate Economic Impacts Caused by COVID-19

PURPOSE

This memorandum explains the availability of waivers of certain regulatory requirements and one NOFA requirement associated with several CPD grant programs to prevent the spread of COVID-19 and to facilitate assistance to eligible communities and households economically impacted by COVID-19. This memorandum covers program-specific waivers for the following CPD programs:

- Housing Opportunities for Persons with AIDS (HOPWA);
- Continuum of Care (CoC);
- Youth Homelessness Demonstration Program (YHDP); and
- Emergency Solutions Grants Program

This memorandum also announces a simplified notification process for recipients of these programs to use this waiver flexibility to expedite the delivery of assistance. CPD Field Office Directors, Deputy Directors, and Program Managers are instructed to inform CPD recipients operating within their jurisdictions of the content of this memorandum.

NOTIFICATION PROCESS

Recipients may use the waivers described in this memorandum to assist affected CPD program beneficiaries and CPD program eligible households to prevent the spread of COVID-19 and to mitigate against the economic impact caused by COVID-19 for eligible households. To use the waiver flexibility provided in this memorandum, the recipient must provide notification in writing, either through mail or e-mail, to the CPD Director of the HUD Field Office serving its jurisdiction no less than two days before the recipient anticipates using the waiver flexibility. Further directions on notifying HUD can be found in Attachment #1.

WAIVER AUTHORITY

In December 2019, a new coronavirus known as SARS-CoV-2 was first detected in Wuhan, Hubei Province, People's Republic of China, causing outbreaks of the coronavirus disease COVID-19 that has now spread globally. The first case was reported in the United States in January 2020. In March 2020, the World Health Organization declared the coronavirus outbreak a pandemic and President Trump declared the outbreak a national emergency. During this time, the majority of states have declared states of emergency with most shutting down large gathering places and limiting the movement of their residents. As a consequence, many CPD recipients are facing challenges in ensuring appropriate shelter options are available for program participants who need to be separated from others because they are exhibiting symptoms, training staff on how to safely work with program participants and prevent spreading the virus, obtaining supplies to prevent the spread of the virus, and maintaining necessary staffing levels during the outbreak. Further, many program participants are suffering economic consequences from the mass shutdown of businesses and lack of availability of traditional mainstream benefits. A number of recipients have inquired about the availability of waivers of various CPD program requirements to facilitate assistance to program participants and prevent the spread of the virus.

In accordance with 24 CFR 5.110, HUD may, upon a determination of good cause and subject to statutory limitations, waive regulatory provisions. Additional regulatory waiver authority is provided in 24 CFR 91.600. On March 31, 2020, CPD issued its first waivers of regulatory authority to help recipients prevent and mitigate the spread of COVID-19. This memorandum includes additional waivers for the ESG, CoC, YHDP, and HOPWA Programs.

WAIVER AVAILABILITY

To provide additional flexibility to communities to prevent the spread of COVID-19 and better assist individuals and families, including those experiencing homelessness infected with the virus or economically impacted by the virus, I hereby find good cause to provide the regulatory waivers below. To use each waiver, each recipient must follow the notification process described above and update its program records to include written documentation of the specific conditions that justify the recipient's use of the waiver, consistent with the justifications and applicability provisions below. Provisions that are not specifically waived remain in full effect.

EMERGENCY SOLUTIONS GRANT PROGRAM

To the extent that funding provided under the CARES Act for the ESG program is subject to the same requirements in 24 CFR part 576 that apply to ESG funding provided through annual appropriations, the waivers made available on March 31, 2020 for ESG are made available with respect to the CARES Act funding for the same justifications and subject to the same conditions.

Additionally, the following housing stability case management waiver is made available with respect to all ESG grants, whether funded under the CARES Act or annual ESG appropriations.

1. Housing Stability Case Management

Requirement: Program participants receiving homelessness prevention or rapid re-housing assistance must meet with a case manager not less than once per month, unless certain statutory prohibitions apply.

Citation: 24 CFR 576.401(e)

Explanation: Under 24 CFR 576.401(e), the recipients or subrecipients must require program participants to meet with a case manager not less than once per month to assist them in ensuring long-term housing stability, unless the Violence Against Women Act of 1994 or Family Violence Prevention and Services Act prohibits the recipient or subrecipient from making its shelter or housing conditional on the participant's acceptance of services. As provided by the CARES Act, people experiencing homelessness cannot be required to receive treatment or perform any other prerequisite activities as a condition for receiving shelter, housing, or other services funded with ESG grants provided under the CARES Act. Accordingly, 24 CFR 576.401(e) does not apply to the extent the assistance is provided with CARES Act funding to people who qualified as homeless at the start of that assistance.

Justification: HUD originally waived this requirement for 2-months on March 31, 2020. Recipients are continuing to report limited staff capacity as staff members are home for a variety of reasons related to COVID-19 (e.g., quarantining, children home from school, working elsewhere in the community to manage the COVID-19 response). In addition, not all program participants have capacity to meet via phone or internet. Waiving the monthly case management requirement as specified below will allow recipients to provide case management on an as needed basis and reduce the possible spread and harm of COVID-19.

Applicability: This waiver is in effect for an additional three months beginning on the date of this memorandum.

CONTINUUM OF CARE PROGRAM and YOUTH HOMELESSNESS DEMONSTRATION PROGRAM

To the extent YHDP grants are subject to the same requirements in 24 CFR part 578 that apply to grants provided under the CoC Program, the same waivers made available on March 31, 2020 for grants provided under the CoC Program are made available to YHDP grants for the same justifications and subject to the same conditions. Additionally, the following waivers are available to CoC Program and YHDP recipients.

2. Permanent Housing Rapid Re-housing Limit to 24 Months of Rental Assistance

Requirement: CoC Program funds may be used to provide short-term (up to 3 months) and/or medium-term (for 3 to 24 months) tenant-based rental assistance.

Citation: 24 CFR 578.37(a)(1)(ii), 24 CFR 578.37(a)(1)(ii)(C), and 24 CFR 578.51(a)(1)(i)

Explanation: The CoC Program regulation at 24 CFR 578.37(a)(1)(ii) and 24 CFR 578.51(a)(1)(i) defines medium-term rental assistance as 3 to 24 months and 578.37(a)(1)(ii) and 24 CFR 578.37(a)(1)(ii)(C) limits rental assistance in rapid re-housing projects to medium-term rental assistance, or no more than 24 months.

Justification: Waiving the limit on using rental assistance in rapid re-housing projects to pay more than 24 months will ensure that individuals and families currently receiving rapid re-housing assistance do not lose their assistance, and consequently their housing, during the COVID-19 public health crisis and the subsequent economic downturn. This will reduce the spread and harm of COVID-19 by enabling affected program participants to continue to socially isolate in their housing.

Applicability: The 24-month rental assistance restriction is waived for program participants in a permanent housing rapid re-housing project who will have reached 24 months of rental assistance beginning on the date of this memorandum until a state or local public health official has determined special measures are no longer necessary to prevent the spread of COVID-19. Program participants who have reached 24 months of rental assistance during this time and who will not be able to afford their rent without additional rental assistance will be eligible to receive rental assistance until 3 months after a state or local public health official has determined that special measures are no longer necessary to prevent the spread of COVID-19.

3. Limit to be Eligible for DedicatedPLUS Project When Coming from Transitional Housing Being Eliminated

Requirement: To be eligible for a DedicatedPLUS project an individual or family must meet the criteria of DedicatedPLUS in the Notice of Funding Availability under which the grant was awarded. One of the possible criteria is residing in transitional housing *that will be eliminated* and meeting the definition of chronically homeless in effect at the time in which the individual or family entered the transitional housing project.

Citation: Section III.C.3.f.(2) of the FY 2018 CoC Program Competition NOFA and Section III.C.2.g.(2) of the FY 2019 CoC Program Competition NOFA.

Explanation: Section III.C.3.f.(2) of the FY 2018 CoC Program Competition NOFA and Section III.C.2.g.(2) of the FY 2019 CoC Program Competition NOFA

define a DedicatedPLUS project as a PSH project where 100 percent of the beds are dedicated to serve individuals and families residing in one of six places at intake, including residing in a transitional housing project that will be eliminated.

Justification: Waiving the requirement within the definition of DedicatedPLUS project that the transitional housing project is being eliminated will expand permanent housing options available for people moving out of transitional housing and will make more transitional housing beds available to others who need it. Expanding permanent housing options for persons in transitional housing will assist in preventing the spread of COVID-19 by allowing more people to move off the streets and into transitional housing.

Applicability: The definition of DedicatedPLUS project is waived for DedicatedPLUS projects funded in the FY 2018 and FY 2019 CoC Program Competitions to allow these projects to serve individuals and families residing in transitional housing, whether it is being eliminated or not, as long as the individual or family met the definition of chronically homeless upon entry to the TH.

4. Assistance Available at Time of Renewal

Requirement: With respect to renewing CoC Program awards, 24 CFR 578.33(c) requires that assistance for a renewal period will be up to 100 percent of the amount available for supportive services and HMIS costs in the final year of the prior funding period, up to 100 percent of the amount for leasing and operating in the final year of the prior funding period adjusted in proportion to changes in FMR for the geographic area, and for rental assistance up to 100 percent of the result of multiplying the number and unit size(s) in the grant agreement by the number of months in the grant agreement and the applicable FMR.

Citation: 24 CFR 578.33(c)

Explanation: 24 CFR 578.33(c) requires that budget line item amounts a recipient is awarded for renewal in the CoC Program Competition will be based on the amounts in the final year of the prior funding period for the project.

Justification: Waiving the requirement that the renewal grant amount is based on the budget line items in the final year of the grant being renewed will allow recipients to amend their budgets temporarily to address the needs of its program participants in responding to COVID-19 (e.g., providing different supportive services necessitated by the pandemic or serving fewer people because of the layout of the housing does not meet local social distancing recommendations) without changing the original design of the project when it is not operating in a public health crisis and can resume normal operations.

Applicability: The requirement that the renewal grant amount be based on the budget line items in the final year of the grant being renewed is waived for all projects that amend their grant agreement between March 31, 2020 and October 1, 2020 to move funds between budget line items in a project in response to the COVID-19 pandemic. Recipients may then apply in the next FY CoC Program Competition based on the budget line items in the grants before they were amended.

Notification: Recipients utilizing this waiver flexibility do not need to follow the notification process outlined in Attachment #1. Instead, HUD will consider any grant agreement amendment executed between March 31, 2020 and October 1, 2020 to move funds between budget line items in response to the COVID-19 pandemic as notification to HUD.

5. Permanent Housing-Rapid Re-housing Monthly Case Management

Requirement: Recipients must require program participants of permanent housing – rapid re-housing projects to meet with a case manager at least monthly.

Citation: 24 CFR 578.37(a)(1)(ii)(F)

Explanation: The CoC Program interim rule at 24 CFR 578.37(a)(1)(ii)(F) requires program participants to meet with a case manager not less than once per month to assist them in ensuring long-term housing stability. The project is exempt from this requirement already if the Violence Against Women Act of 1994 (42 U.S.C. 13925 *et seq.*) or the Family Violence Prevention and Services Act (42 U.S.C. 10401 *et seq.*) prohibits the recipient carrying out the project from making its housing conditional on the participant's acceptance of services.

Justification: HUD originally waived this requirement for 2-months beginning March 31, 2020. Recipients are continuing to report limited staff capacity as staff members are home for a variety of reasons related to COVID-19 (e.g., quarantining, children home from school, working elsewhere in the community to manage the COVID-19 response). In addition, not all program participants have capacity to meet via phone or internet. Waiving the monthly case management requirement as specified below will allow recipients to provide case management on an as-needed basis and reduce the possible spread and harm of COVID-19.

Applicability: This requirement in 24 CFR 578.37(a)(1)(ii)(F) that projects require program participants to meet with case mangers not less than once per month is waived for all permanent housing- rapid re-housing projects for an additional three months beginning on the date of this memorandum.

HOUSING OPPORTUNITIES FOR PERSONS WITH AIDS (HOPWA)

6. HOPWA – Time Limits for Short-Term Housing Facilities and Short-Term Rent,

Mortgage, and Utility Payments

Requirement: Time Limits for Short-Term Supported Housing

Citation: 24 CFR 574.330(a)(1), Time Limits

Explanation: A short-term supported housing facility may not provide residence to any individual for more than 60 days during any six-month period. Short-Term Rent, Mortgage, and Utility (STRMU) payments to prevent the homelessness of the tenant or mortgagor of a dwelling may not be provided for costs accruing over a period of more than 21 weeks in any 52-week period.

Justification: This waiver is required to prevent homelessness or discharge to unstable housing situations for households residing in short-term housing facilities or units assisted with STRMU if permanent housing cannot be achieved within the time limits specified in the regulation.

Applicability: On an individual household basis, grantees or project sponsors may assist eligible households for a period that exceeds the time limits specified in the regulations. A short-term supported housing facility may provide residence to any individual for a period of up to 120 days in a six-month period. STRMU payments to prevent the homelessness of the tenant or mortgagor of a dwelling may be provided for costs accruing up to 52 weeks in a 52-week period.

This waiver is in effect for one year beginning on the date of this memorandum for grantees and project sponsors that are able to meet the following criteria:

a. The grantee or project sponsor documents that a good faith effort has been made on an individual household basis to assist the household to achieve permanent housing within the time limits specified in the regulations but that financial needs and/or health and safety concerns have prevented the household from doing so; and
b. The grantee or project sponsor has written policies and procedures outlining efforts to regularly reassess the needs of assisted households as well as processes for granting extensions based on documented financial needs and/or health and safety concerns.

7. HOPWA – Property Standards

Requirement: Property Standards for HOPWA

Citation: 24 CFR 574.310(b), Housing Quality Standards

Explanation: This section of the HOPWA regulations provides that all housing assisted

with acquisition, rehabilitation, conversion, lease, or repair; new construction of single room occupancy dwellings and community residences; project or tenant-based rental assistance; or operating costs must meet the applicable housing quality standards outlined in the regulations.

Justification: This waiver is required to enable grantees and project sponsors to expeditiously meet the critical housing needs of the many eligible families that have been affected by COVID-19 while also minimizing the spread of coronavirus.

Applicability: This waiver is in effect for one year beginning on the date of this memorandum for grantees and project sponsors that are able to meet the following criteria:

a. The grantee or project sponsor is able to visually inspect the unit using technology, such as video streaming, to ensure the unit meets HQS before any assistance is provided; and
b. The grantee or project sponsor has written policies to physically reinspect the unit after the health officials determine special measures to prevent the spread of COVID-19 are no longer necessary.

8. HOPWA – FMR Rent Standard

Requirement: Rent Standard for HOPWA Rental Assistance

Citation: 24 CFR 574.320(a)(2), Rent Standard

Explanation: Grantees must establish rent standards for their rental assistance programs based on FMR (Fair Market Rent) or the HUD-approved community-wide exception rent for unit size. Generally, the rental assistance payment may not exceed the difference between the rent standard and 30 percent of the family's adjusted income.

Justification: This waiver of the FMR rent standard limit permits HOPWA grantees to establish rent standards, by unit size, that are reasonable, and based upon rents being charged for comparable unassisted units in the area, taking into account the location, size, type, quality, amenities, facilities, management and maintenance of each unit. Grantees, however, are required to ensure the reasonableness of rent charged for a unit in accordance with §574.320(a)(3).

This waiver is required to expedite efforts to identify suitable housing units for rent to HOPWA beneficiaries and HOPWA-eligible families that have been affected by COVID-19, and to provide assistance to families that must rent units at rates that exceed the HOPWA grantee's normal rent standard as calculated in accordance with §574.320(a)(2).

Applicability: Such rent standards may be used for up to one year beginning on the date of this memorandum.

Attachment #1 to Memorandum:

Procedure for Using Available Waivers of Program and Consolidated Plan Requirements to Prevent the Spread of COVID-19 and Mitigate Economic Impacts Caused by COVID-19

This attachment provides further information on the process that grantees must follow to use the waiver flexibility provided in the memorandum.

Grantees must email notification to the Community Planning and Development Director of the HUD Field Office serving the grantee.

The email notification must be sent two days before the grantee anticipates using waiver flexibility, and include the following details:

- Requestor's name, title, and contact information;
- Date on which the grantee anticipates first use of the waiver flexibility; and
- A list of the waiver flexibilities the grantee will use:
    1. ESG Program – Housing Stability Case Management
    2. CoC Program and YHDP - Permanent Housing Rapid Re-housing Limit to 24 Months of Rental Assistance
    3. CoC Program NOFA Requirement– Limit to be Eligible for DedicatedPLUS Project When Coming from Transitional Housing (TH) that TH Must be Being Eliminated
    5. CoC – Permanent Housing – Rapid Re-housing Monthly Case Management
    6. HOPWA – Time Limits for Short-Term Housing Facilities and Short-Term Rent, Mortgage, and Utility Payments
    7. HOPWA – Property Standards
    8. HOPWA – FMR Rent Standard

PUBLIC COMMENT REGARDING HEALTH INSURANCE PREMIUM AND COPAY ASSISTANCE

Received by the Office of Support on 04-20-20

Tori,

I wanted to let you know that I have received several questions concerning Insurance premium and copay assistance. Maybe we can add this to the public comment. The individuals did not want to be identified.

Apparently we only have one provider/agency participating in this category.

I have received a lot of questions concerning this category in the past, but today I received a question/concern about copayments.

Their concern was about the lack of acknowledgement that their request was received, when it was paid, if it would be paid, etc.
So my understanding was that there was no feedback once their request was sent in. This person said it would be helpful because they were getting past due notices and did not know what to say to the providers when they called.
I mentioned that they should tell them know that a third party was making the payment. That if they paid, they would not be reimbursed.
That they needed to wait a little longer for payment

I think in this scenario, it would be helpful for the agency to let the customer/client know that the copayment would be accepted or paid and give them some kind of timeline, or in best practice, send them an email back when a payment was made.

Thanks and have a great day,

Take care,

Bobby

Comprehensive HIV Planning Committee Report

THIS DOCUMENT WAS MAILED SEPARATELY AND ONE WEEK EARLIER THAN THE MEETING PACKET SO THAT MEMBERS WOULD HAVE MORE TIME TO READ THE DOCUMENT. - TORI

DRAFT

06/12/20

2020 Houston HIV Care Services Needs Assessment

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

2020 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, in collaboration toward the development of one local ending the HIV epidemic plan. Approved Needs Assessment report; the rest is ongoing

2. *Determine the size and demographics of the estimated population of individuals who are unaware of their HIV status. Epi report is complete and posted on RW website. done

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.

   Done.

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

   In progress

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

   Done.

S Wagner
Committee Chairperson

6/11/2020
Date

Affected Community Committee Report

COVID-19 and Lab Results

COVID-19

- The name of this disease is coronavirus disease 2019, abbreviated as COVID-19. In COVID-19, the 'CO' stands for 'corona,' 'VI' for 'virus,' and 'D' for disease.
- The virus spreads mainly from person to person, mainly through respiratory droplets produced when an infected person coughs, sneezes, or talks, hence the six foot social distancing rule.
- As of today the Harris County Judge has re-instated the requirement to wear masks in public gatherings until June 30, 2020.

COVID-19

- Symptoms may appear 2-14 days after exposure to the virus. People with these symptoms may have COVID-19:
  - Fever or chills
  - Cough or shortness of breath or difficulty breathing
  - Fatigue
  - Muscle or body aches
  - Headache
  - New loss of taste or smell
  - Sore throat or congestion or runny nose
  - Nausea or vomiting
  - Diarrhea

COVID-19

- Those at high-risk for severe illness from COVID-19 are:
  - People aged 65 years and older
  - People who live in a nursing home or long-term care facility
  - People of all ages with underlying medical conditions, particularly if not well controlled, including:
    - ✓ People with chronic lung disease or moderate to severe asthma
    - ✓ People who have serious heart conditions
    - ✓ People who are immunocompromised including poorly controlled HIV or AIDS
    - ✓ People with severe obesity (body mass index [BMI] ≥40)
    - ✓ People with diabetes or chronic kidney disease undergoing dialysis or liver disease

COVID-19

- Also practice good hygiene around your pets. To date no pets have been found to transmit the virus to humans but we can pass on the virus to them.
- Free testing for the presence of the virus is available at publichealth.harriscountytx.gov where you will find additional information including a dashboard with various metrics.
- Testing for the COVID-19 antibody is not free and must be ordered by your physician.

Laboratory Testing

- There are multiple abbreviations used in the clinical laboratory that can be confusing to the average patient who is HIV positive.
- So we will quickly discuss the commonly ordered laboratory tests so that you have a better understanding of the testing and your results.

Major Categories of Tests

- Hematology
- Chemistry
- Immunology or Serology

Hematology

- Common tests ordered include CBC, WBC Differential, and T Cell counts
- CBC = Complete Blood Count
- Common components of the CBC include:

Component	Purpose	Reference Range*
WBC = White Blood Cell	White blood cells protect the body against infection	3.8-10.8 (Thousand/uL [microliter])
RBC = Red Blood Cells	Respiration, carry O_2 to the cells and remove CO_2	4.20-5.8 (Million/uL)

*Reference Ranges will vary from test procedure and performing laboratory.

Hematology (cont.)

Component	Purpose	Reference Range*
HGB = Hemoglobin	Fills up the RBC that carries O_2/CO_2 & gives the blood cell its red color.	13.2-17.1 (g/dL [grams/ deciliter]), Sex dependent
HCT or PCV = Hematocrit or Packed Cell Volume	Measures the volume of RBCs in the blood as a percentage of RBCs in the blood.	38.5-50.0 (%)

Hematology (cont.)

Component	Purpose	Reference Range*
Red blood cell indices: MCV (mean corpuscular volume), MCH (mean corpuscular hemoglobin), MCHC (mean corpuscular hemoglobin concentration), and RDW (Red cell distribution width)	Calculated values derived from other measurements in the CBC. The MCV value indicates the size of the RBCs. The MCH value is the amount of hemoglobin in an average RBC. The MCHC measures the concentration of hemoglobin in an average RBC. The RDW indicates if the RBCs are all the same or different sizes or shapes.	MCV: 80.0-100.0 (fL [femtoliter]) MCH: 27.0-33.0 (pg [picogram]) MCHC: 32.0-36.0 (g/dL) RDW: 11.0-15.0 (%)

Hematology (cont.)

Component	Purpose	Reference Range*
PCT = Platelet (thrombocyte) Count	Platelets are the smallest type of blood cell and are important in blood clotting.	140-400 (Thousand/uL)
MPV = Mean Platelet Volume	Mean platelet volume measures the average amount of platelets in the blood.	7.5-11.5 (fL)
Calculated WBC Differential includes: Absolute Neutrophils, Absolute Lymphocytes, Absolute Monocytes, Absolute Eosinophils, & Absolute Basophils	Different WBCs are present to fight infections. The WBCs are stained and counted in the analyzer.	Neutrophiles = 1500-7800 (cells/uL), Lymphocytes = 850-3900, Monocytes = 200-950, Eosinophiles = 15-500, & Basophiles = 0-200

Hematology (cont.)

Component	Purpose	Reference Range*
WBC Differential includes: Neutrophils, Lymphocytes, Monocytes, Eosinophils, & Basophils	(Segmented) Neutrophils are increased due to bacterial infections, Lymphocytes & Monocytes are increased due to viral infections, Eosinophils are increased due to allergies or parasitic infections, & Basophils are increased due to inflammatory reactions during immune response.	Neutrophiles = 1500-7800 (cells/uL), Lymphocytes = 850-3900, Monocytes = 200-950, Eosinophiles = 15-500, & Basophiles = 0-200

Hematology (cont.)

- T Cell counts components include:

Component	Purpose	Reference Range*
Absolute & %CD4 (Helper Cells)	Type of Lymphocyte, and these are the cells that the HIV virus kills	Absolute CD4: 490-1740 (cells/uL) %CD4: 30-61 (%)
Absolute & %CD8 (Suppressor Cells)	Another type of Lymphocyte that seek out and destroy cells infected with viruses, including HIV-infected cells	Absolute CD8: 180-1170 (cells/uL) %CD8: 12-42 (%)
Helper/Suppressor Ratio	Ratio of CD4 to CD8 cells	0.86-5.00
Absolute Lymphocytes	See previous discussion	850-3900 (cells/uL)

Hematology (cont.)

- HIV 1 RNA (ribonucleic acid) Quantitative (QN) PCR (Polymerase chain reaction):

Component	Purpose	Reference Range*
HIV 1 RNA, QN PCR	Viral load	<20 (copies/mL [milliliter])
HIV 1 RNA, QN PCR	Viral Load	<1.30 (Log copies/mL [logarithmic]), Log value is a measurement used to expresses the viral load values as a power of ten (written log10 and is used because large changes can only be captured on graphs or diagrams by using a log scale.

Chemistry

- Usually called a Chemistry Profile or Comprehensive Metabolic Profile
- Test are grouped by the body parts or chemical constituents; e.g., liver function tests (LFTs), kidney, etc.
- The commonly ordered tests have reference ranges based upon a fasting specimen meaning that you have not eaten since the previous evening meal.

Chemistry

Component	Reference Range*
Glucose - diabetes and prediabetes	65-99 (mg/dL [milligrams/deciliter])
BUN (Blood Urea Nitrogen) – Kidney function	7-25 (mg/dL)
Creatinine – Kidney function	0.70-1.25 (mg/dL), age and sex variations
Ca = Calcium (most plentiful mineral in your body)	8.6-10.3 (mg/dL)
Phosphorus – Kidney function	2.5 to 4.5 (mg/dL)
Bilirubin – Liver Function	0.2-1.2 (mg/dL)
Alk Phos = Alkaline Phosphatase - Liver	40-115 (U/L [units/liter])
AST = Aspartate Aminotransferase - Liver	10-35 (U/L)
ALT = Alanine Aminotransferase - Liver	9-46 (U/L)

Quality Improvement Committee Report

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FY 2019 PERFORMANCE MEASURES HIGHLIGHTS

RYAN WHITE GRANT ADMINISTRATION

HARRIS COUNTY PUBLIC HEALTH (HCPH)

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.

Follow HCPH on Twitter @hcphtx and like us on Facebook

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Highlights from FY 2019 Performance Measures

Measures in this report are based on the 2019/2020 Houston Ryan White Quality Management Plan, Appendix B. HIV Performance Measures.

Clinical Case Management

- During FY 2019, from 3/1/2019 through 2/29/2020, 1,299 clients utilized Part A clinical case management. According to CPCDMS, 732 (56%) of these clients accessed primary care two or more times at least three months apart during this time period after utilizing clinical case management.
- Among these clients, 32% accessed mental health services at least once during this time period after utilizing clinical case management.
- For clients who have lab data in CPCDMS, 80% were virally suppressed.

Medical Case Management

- During FY 2019, 5,304 clients utilized Part A medical case management. According to CPCDMS, 2,644 (50%) of these clients accessed primary care two or more times at least three months apart during this time period after utilizing medical case management.
- Among these clients, 13% of clients accessed mental health services at least once during this time period after utilizing medical case management.
- For clients who have lab data in CPCDMS, 73% were virally suppressed.

Outreach

- During FY 2019, 215 (34%) clients accessed primary care within three months of their first outreach visit.
- 66% of FY 2018 clients moved from an unsuppressed to suppressed viral load status within six to twelve months after their first outreach visit.

Primary Medical Care

- During FY 2019, 8,620 clients utilized Part A primary medical care. According to CPCDMS, 5,040 (75%) of these clients accessed primary care two or more times at least three months apart during this time period.
- Among clients whose initial primary care medical visit occurred during this time period, 18% had a CD4 < 200 within the first 90 days of initial enrollment in primary medical care.
- Among these clients, 86% had a viral load test performed at least every six months during this time period. Among clients with viral load tests, 78% were virally suppressed during this time period.
- 69% of new clients were engaged in care during this time period.
- During FY 2019, the average wait time for an initial appointment availability to enroll in primary medical care was 10 days, while the average wait time for an appointment availability to receive primary medical care was 8 days.

Service Linkage (Non-Medical Case Management)

- During FY 2019, 8,717 clients utilized Part A non-medical case management / service linkage. According to CPCDMS, 4,174 (48%) of these clients accessed primary care two or more times at least three months apart during this time period after utilizing non-medical case management.
- Among these clients, 50% of clients utilized primary medical care for the first time after accessing service linkage for the first time.
- The median number of days between the first service linkage visit and the first primary medical care visit was 14 days during this time period.

Substance Abuse Treatment

- During FY 2019, 17 (71%) clients utilized primary medical care after accessing Part A substance abuse treatment services.
- Among clients with viral load tests, 83% were virally suppressed during this time period.

Transportation

- Van-Based Transportation:
  - During FY 2019, 550 (69%) clients accessed primary care after utilizing van transportation services.
  - Among van-based transportation clients, 57% clients accessed LPAP services at least once during this time period after utilizing van transportation services.

- Bus Pass Transportation:
  - During FY 2019, 908 (37%) clients accessed primary care after utilizing bus pass services.
  - Among bus pass clients, 22% of clients accessed LPAP services at least once during this time period after utilizing bus pass services.
  - Among bus pass clients, 78% clients accessed any RW or State service after accessing bus pass services.

Vision Care

- During FY 2019, 871 clients were diagnosed with HIV/AIDS related and general ocular disorders. Among 130 clients with follow-up appointments, 6% of clients had disorders that were either resolved or improved, while 90% of clients had disorders that remained the same.

Ryan White Part A
HIV Performance Measures
FY 2019 Report

Clinical Case Management
All Providers

For FY 2019 (3/1/2019 to 2/29/2020), 1,299 clients utilized Part A clinical case management.

HIV Performance Measures	FY 2018	FY 2019	Change
A minimum of 75% of clients will utilize Part A/B/C/D primary care two or more times at least three months apart after accessing clinical case management	542 (49.5%)	732 (56.4%)	**6.9%**
35% of clinical case management clients will utilize mental health services	328 (30.0%)	413 (31.8%)	**1.8%**
75% of clients for whom there is lab data in the CPCDMS will be virally suppressed (<200)	453 (78.6%)	548 (80.2%)	**1.6%**
Less than 15% of clients will be homeless or unstably housed	164 (15.0%)	142 (10.9%)	**-4.1%**

According to CPCDMS, 24 (1.9%) clients utilized primary care for the first time and 97 (7.5%) clients utilized mental health services for the first time after accessing clinical case management.

Clinical Chart Review Measures	FY 2018
85% of clinical case management clients will have a case management care plan developed and/or updated two or more times in the measurement year	3%
Percentage of clients identified with an active substance abuse condition referred to substance abuse treatment	*100%

Of the 14 clinical case management clients with active substance use disorder, all 14 (100%) received a referral for further treatment.

Ryan White Part A
HIV Performance Measures
FY 2019 Report

Health Insurance Assistance
All Providers

HIV Performance Measures	FY 2018	FY 2019	Change
75% of clients for whom there is lab data in the CPCDMS will be virally suppressed (<200)	1,421 (81.0%)	1,511 (80.6%)	**-0.4%**

Ryan White Part A
HIV Performance Measures
FY 2019 Report

Local Pharmacy Assistance
All Providers

HIV Performance Measures	FY 2018	FY 2019	Change
75% of clients for whom there is lab data in the CPCDMS will be virally suppressed (<200)	3,118 (77.9%)	3,537 (79.1%)	1.2%

Ryan White Part A
HIV Performance Measures
FY 2019 Report

Medical Case Management
All Providers

For FY 2019 (3/1/2019 to 2/29/2020), 5,304 clients utilized Part A medical case management.

HIV Performance Measures	**FY 2018**	**FY 2019**	**Change**
A minimum of 85% of clients will utilize Part A/B/C/D primary care two or more times at least three months apart after accessing medical case management	3,177 (52.2%)	2,644 (49.9%)	**-2.3%**
15% of medical case management clients will utilize mental health services	799 (13.1%)	680 (12.8%)	**-0.3%**
45% of clients who have third-party payer coverage (e.g. Medicare, Medicaid, private insurance) after accessing medical case management	*N/A	1,580 (29.8%)	**N/A**
75% of clients for whom there is lab data in the CPCDMS will be virally suppressed (<200)	2,489 (74.0%)	1,996 (72.7%)	**-1.3%**
50% of clients will have at least one medical visit in each six-month period of the 24-month measurement period with a minimum of 60 days between medical visits	1,118 (38.2%)		
Less than 20% of clients will have more than a six month gap in medical care in the measurement year	753 (24.3%)	605 (23.4%)	**-0.9%**
Less than 15% of clients will be homeless or unstably housed	1,022 (16.8%)	760 (14.3%)	**-2.5%**

According to CPCDMS, 125 (2.4%) clients utilized primary care for the first time and 184 (3.5%) clients utilized mental health services for the first time after accessing medical case management.

*Note that the methodology of how this data is analyzed is being refined. Due to the way insurance data is collected, FY18 data cannot be re-evaluated.

Clinical Chart Review Measures	**FY 2018**
60% of medical case management clients will have a case management care plan developed and/or updated two or more times in the measurement year	11%

Ryan White Part A
HIV Performance Measures
FY 2019 Report

Medical Nutritional Supplements
All Providers

HIV Performance Measures	FY 2018	FY 2019	Change
75% of clients for whom there is lab data in the CPCDMS will be virally suppressed (<200)	388 (84.3%)	376 (81.7%)	**-2.6%**
90% of clients diagnosed with wasting syndrome or suboptimal body mass will improve or maintain body mass index (BMI) in the measurement year	8 (66.7%)	3 (50.0%)	**-16.7%**

Ryan White Part A
HIV Performance Measures
FY 2019 Report

Oral Health Care
All Providers

Clinical Chart Review Measures*	**FY 2017**	**FY 2018**
100% of oral health clients will have a dental and medical health history (initial or updated) at least once in the measurement year	95%	100%
90% of oral health clients will have a dental treatment plan developed and/or updated at least once in the measurement year	99%	99%
85% of oral health clients will receive oral health education at least once in the measurement year	99%	99%
90% of oral health clients will have a periodontal screen or examination at least once in the measurement year	81%	97%
50% oral health clients will have a Phase 1 treatment plan that is completed within 12 months	27%	34%

* To review the full FY 2018 chart review reports, please visit:
https://publichealth.harriscountytx.gov/Services-Programs/Programs/RyanWhite/Quality

Ryan White Part A
HIV Performance Measures
FY 2019 Report

Outreach Services
All Providers

HIV Performance Measures	FY 2018	FY 2019	Change
Percentage of clients who attended a primary care visit within three months of the first Outreach visit	311 (39.1%)	215 (34.4%)	**-4.7%**
Percentage of clients who attended a primary are visit within three months of the first Outreach visit and a subsequent visit 6 to 12 months thereafter	206 (66.2%)	*N/A	**N/A**
Percentage of clients who went from an unsuppressed VL (>=200 copies/ml) to a suppressed viral load (<200 copies/ml) within 12 months of the first Outreach visit	268 (54.9%)	*N/A	**N/A**

*Please note that due to the time parameters for this measure, data can only be produced for the previous fiscal year.

Ryan White Part A
HIV Performance Measures
FY 2019 Report

Primary Medical Care
All Providers

For FY 2019 (3/1/2019 to 2/29/2020), 8,620 clients utilized Part A primary medical care.

HIV Performance Measures	**FY 2018**	**FY 2019**	**Change**
90% of clients will have two or more medical visits, at least 90 days apart, in an HIV care setting in the measurement year	4,624 (74.5%)	5,040 (75.3%)	**0.8%**
Less than 20% of clients will have a CD4 < 200 within the first 90 days of initial enrollment in primary medical care	304 (19.8%)	273 (17.7%)	**-2.1%**
95% of clients will have Hepatitis C (HCV) screening performed at least once since HIV diagnosis	5,967 (74.0%)	6,050 (70.2%)	**-3.8%**
30% of clients will receive an oral exam by a dentist at least once during the measurement year	2,034 (25.2%)	2,179 (25.3%)	**0.1%**
85% of clients will have a test for syphilis performed within the measurement year	6,648 (82.5%)	7,127 (82.7%)	**0.2%**
95% of clients will be screened for Hepatitis B virus infection status at least once since HIV diagnosis	6,726 (83.5%)	7,337 (85.1%)	**1.6%**
90% of clients will have a viral load test performed at least every six months during the measurement year	4,063 (82.1%)	4,647 (86.3%)	**4.2%**
90% of clients for whom there is lab data in the CPCDMS will be virally suppressed (<200)	6,139 (76.2%)	6,742 (78.2%)	**2.0%**
35% of clients will have at least one medical visit in each six-month period of the 24-month measurement period with a minimum of 60 days between medical visits	2,677 (25.0%)		
Less than 20% of clients will have more than a six month gap in medical care in the measurement year	1,719 (27.7%)	1,855 (27.7%)	**0.0%**
60% of new clients will be engaged in care	420 (70.5%)	383 (68.5%)	**-2.0%**
100% of Ryan White Part A program-funded outpatient/ambulatory care organizations in the system/network will have a wait time of 15 or fewer business days for a Ryan White Part A program-eligible patient to receive an initial appointment to enroll in outpatient/ambulatory medical care	**Data below**		
100% of Ryan White Part A program-funded outpatient/ambulatory care organizations in the system/network will have a wait time of 15 or fewer business days for a Ryan White Part A program-eligible patient to receive an appointment for outpatient/ambulatory medical care	**Data below**		

For FY 2019, 83% of Ryan White Part A outpatient/ambulatory care organizations provided a waiting time of 15 or fewer business days for a program-eligible patient to receive an initial appointment to enroll in medical care.

Average wait time for initial appointment availability to enroll in outpatient/ambulatory medical care: EMA = 10 Days

Agency 1:	9
Agency 2:	5
Agency 3:	17
Agency 4:	12
Agency 5:	9
Agency 6:	10

For FY 2019, 100% of Ryan White Part A outpatient/ambulatory care organizations provided a waiting time of 15 or fewer business days for a program-eligible patient to receive an appointment for medical care.

Average wait time for appointment availability to receive outpatient/ambulatory medical care: EMA = 8 Days

Agency 1:	11
Agency 2:	4
Agency 3:	14
Agency 4:	5
Agency 5:	5
Agency 6:	8

Clinical Chart Review Measures*	FY 2017	FY 2018
100% of eligible clients will be prescribed Pneumocystis jiroveci pneumonia (PCP) prophylaxis	93.0%	93.9%
100% of pregnant women living with HIV will be prescribed antiretroviral therapy	100%	100%
75% of female clients will have received cervical cancer screening in the past three years	82.5%	81.6%
55% of clients will complete the vaccination series for Hepatitis B	51.4%	49.3%
85% of clients will receive HIV risk counseling within the measurement year	90.7%	83.9%
95% of clients will be screened for substance abuse (alcohol and drugs) in the measurement year	99.1%	99.4%
90% of clients who were prescribed antiretroviral therapy will have a fasting lipid panel during the measurement year	88.8%	89.9%
65% of clients at risk for sexually transmitted infections will have a test for gonorrhea and chlamydia within the measurement year	77.6%	78.9%
75% of clients will have documentation that a TB screening test was performed and results interpreted (for tuberculin skin tests) at least once since HIV diagnosis	67.2%	71.0%
65% of clients seen for a visit between October 1 and March 31 will receive an influenza immunization OR will report previous receipt of an influenza immunization	53.5%	62.9%
95% of clients will be screened for clinical depression using a standardized tool with follow-up plan documented	96.4%	98.1%
90% of clients will have ever received pneumococcal vaccine	83.4%	83.1%
100% of clients will be screened for tobacco use at least one during the two-year measurement period	100%	98.7%
Percentage of clients who received cessation counseling intervention if identified as a tobacco user	55.7%	67.8%
95% of clients will be prescribed antiretroviral therapy during the measurement year	98.7%	99.4%
85% of clients will have an HIV drug resistance test performed before initiation of HIV antiretroviral therapy if therapy started during the measurement year	71.4%	75.0%
75% of eligible reproductive-age women will receive reproductive health care (fertility desires assessed and client counseled on conception or contraception)	34.9%	53.7%
90% of clients will be screened for Intimate Partner Violence	78.6%	93.2%
100% of clients on ART will be screened for adherence	100.0%	100%

* To view the full FY 2018 chart review reports, please visit:
http://publichealth.harriscountytx.gov/Services-Programs/Programs/RyanWhite/Quality

Ryan White Part A
HIV Performance Measures
FY 2019 Report

Service Linkage / Non-Medical Case Management
All Providers

For FY 2019 (3/1/2019 to 2/29/2020), 8,717 clients utilized Part A non-medical case management.

HIV Performance Measures	**FY 2018**	**FY 2019**	**Change**
A minimum of 70% of clients will utilize Part A/B/C/D primary care two or more times at least three months apart after accessing non-medical case management (service linkage)	3,548 (46.4%)	4,174 (47.9%)	**1.5%**
60% of clients will access RW primary medical care for the first time after accessing service linkage for the first time	459 (48.9%)	501 (49.6%)	**0.7%**
Mean of less than 30 days between first ever service linkage visit and first ever primary medical care visit:			
Mean	32	28	**-12.5%**
Median	15	14	**-6.7%**
Mode	1	1	**0.0%**
60% of newly enrolled clients will have a medical visit in each of the four-month periods of the measurement year	133 (47.7%)	128 (45.2%)	**-2.5%**

Ryan White Part A
HIV Performance Measures
FY 2019 Report

Substance Abuse Treatment
All Providers

HIV Performance Measures	FY 2018	FY 2019	Change
A minimum of 70% of clients will utilize Parts A/B/C/D primary medical care after accessing Part A-funded substance abuse treatment services*	16 (57.1%)	17 (70.8%)	**13.7%**
75% of clients for whom there is lab data in the CPCDMS will be virally suppressed (<200)	18 (69.2%)	19 (82.6%)	**13.4%**
90% of clients will complete substance abuse treatment program	See data below		

***Overall, the number of clients who received primary care in FY 2019 was 17 (70.8%), with 13 receiving the services through Ryan White and 4 receiving the services through other insurauce such as Medicare.**

Number of clients engaged in substance abuse treatment program during FY 2019: **24**

Number of clients completing substance abuse treatment program during FY 2019 (March 2019 to February 2020): **14**

Number of clients completing substance abuse treatment during FY 2019 who entered treatment in FY 2018: **3**

Number of FY19 substance abuse treatment clients who are receiving primary care through other insurance, such as Medicare: **4**

Number of FY19 clients engaged in substance abuse treatment who completed treatment after FY19: **3**

Ryan White Part A
HIV Performance Measures
FY 2019 Report

Transportation
All Providers

Van-Based Transportation	**FY 2018**	**FY 2019**	**Change**
A minimum of 70% of clients will utilize Parts A/B/C/D primary care services after accessing Van Transportation services	491 (63.7%)	550 (68.6%)	**4.9%**
55% of clients will utilize Parts A/B LPAP services after accessing Van Transportation services	417 (54.1%)	455 (56.7%)	**2.6%**

Bus Pass Transportation	**FY 2018**	**FY 2019**	**Change**
A minimum of 50% of clients will utilize Parts A/B/C/D primary care services after accessing Bus Pass services	926 (34.8%)	908 (36.6%)	**1.8%**
A minimum of 20% of clients will utilize Parts A/B LPAP services after accessing Bus Pass services	591 (22.2%)	534 (21.5%)	**-0.7%**
A minimum of 85% of clients will utilize any RW Part A/B/C/D or State Services service after accessing Bus Pass services	2,013 (75.6%)	1,941 (78.2%)	**2.6%**

Ryan White Part A
HIV Performance Measures
FY 2019 Report

Vision Care
All Providers

HIV Performance Measures	**FY 2019**
75% of clients with diagnosed HIV/AIDS related and general ocular disorders will resolve, improve or stay the same over time	See ocular disorder table

Clinical Chart Review Measures*	**FY 2017**	**FY 2018**
100% of vision clients will have a medical health history (initial or updated) at least once in the measurement year	99%	100%
100% of vision clients will have a vision history (initial or updated) at least once in the measurement year	99%	100%
100% of vision clients will have a comprehensive eye exam at least once in the measurement year	100%	100%

* To review the full FY 2018 chart review reports, please visit:
http://publichealth.harriscountytx.gov/Services-Programs/Programs/RyanWhite/Quality

Ocular Disorder	Number of Diagnoses	Number with Follow-up	*Improved		*Resolved		*Same		*Worsened	
			#	%	#	%	#	%	#	%
Accommodation Spasm										
Acute Retinal Necrosis										
Anisocoria	1	0								
Bacterial Retinitis										
Cataract	130	19	1	5.3%			17	89.5%	1	5.3%
Chalazion	5	0								
Chorioretinal Scar	8	0								
Chorioretinitis										
CMV Retinitis - Active										
CMV Retinitis - Inactive										
Conjunctivitis	25	4	1	25.0%	2	50.0%	1	25.0%		
Covergence Excess										
Convergence Insufficiency										
Corneal Edema	1	0								
Corneal Erosion										
Corneal Foreign Body										
Corneal Opacity	35	5					5	100%		
Corneal Ulcer	2	1			1	100%				
Cotton Wool Spots										
Diabetic Retinopathy	5	1	1	100%						
Dry Eye Syndrome	326	55					55	100%		
Ecchymosis										
Esotropia	2	2					2	100%		
Exotropia	6	4					4	100%		
Glaucoma	5	1					1	100%		
Glaucoma Suspect	53	9					7	77.8%	2	22.2%
Iritis	1	0								
Kaposi Sarcoma	1	0								
Keratitis	12	2			2	100%				
Keratoconjuctivitis	1	0								
Keratoconus	3	0								
Lagophthalmos										
Macular Hole										
Meibomianitis	1	0								
Molluscum Contagiosum										
Optic Atrophy	4	1							1	100%
Papilledema										

Ocular Disorder	Number of Diagnoses	Number with Follow-up	*Improved		*Resolved		*Same		*Worsened	
			#	%	#	%	#	%	#	%
Paresis of Accommodation										
Pseudophakia	10	1					1	100%		
Refractive Change/Transient										
Retinal Detachment	1	0								
Retinal Hemorrhage										
Retinal Hole/Tear	2	0								
Retinopathy HTN	3	0								
Suspicious Optic Nervehead(s)	1	0								
Toxoplasma Retinochoriochitis										
Thyroid Eye Disease										
Visual Field Defect	9	3					3	100%		
Vitreous Degeneration	6	1					1	100%		
Other	212	21					20	95.2%	1	4.8%
Total	**871**	**130**	**3**	**2.3%**	**5**	**3.8%**	**117**	**90.0%**	**5**	**3.8%**

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

Reflects spending through March 2020 Final

Spending Target: 100.0

Priority	Service Category	Original Allocation per RWPC	% of Grant Award	Amendment*	Contractual Amount	Amendment	Revised Contractual Amount	Date of Original Procurement	Expended YTD	5/21/20 Percent YTD
4	Oral Health Care	$2,186,905	65%	$31,973	$2,218,878	-$184,119	$2,034,759	4/1/2019	$1,913,401	94%
5	Health Insurance Premiums and Cost Sharing	$1,040,351	31%	$0	$1,040,351	$24,474	$1,064,825	4/1/2019	$1,064,825	100%
8	Home and Community Based Health Services	$113,315	3%	$0	$113,315	$25,645	$138,960	4/1/2019	$138,960	100%
	Increased RWB Award added to OHS per Increase Scenario*	$0	0%	-$31,973	$0					
	Total Houston HSDA	3,340,571	100%	0	3,372,544	-$134,000	$3,238,544		3,117,186	96%

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

* Result of Increased Scenario for RWB award

** TRG reallocated funds in final quarter to meet its required spending threshold of 95% and to avoid returning funds to DSHS. Thus, HCBHS was increased by $ 25,645, HIP was increased by $ 24,474 and $134,000 was reallocated to another HSDA

2019-2020 Ryan White Part B Service Utilization Report
4/1/2019- 03/31/2020 Houston HSDA (4816)
4th Quarter

Revised 5/1/2020

Funded Service	UDC		Gender			Race			Age Group						
	Goal	YTD	M	Female	[illegible]	MTF	[illegible]	White	[illegible]	Other	[illegible]	13-19	[illegible]	25-34	[illegible]	45-49	[illegible]	65+
Health Insurance Premiums	2,500	1,362	[illegible]	18.35%	[illegible]	0.58%	[illegible]	26.28%	[illegible]	2.93%	[illegible]	0.14%	[illegible]	15.63%	[illegible]	30.02%	[illegible]	8.05%
Home and Communiy Based Health Services	6	24	[illegible]	25.00%	[illegible]	0.00%	[illegible]	16.67%	[illegible]	0.00%	[illegible]	0.00%	[illegible]	0.00%	[illegible]	45.83%	[illegible]	12.51%
Oral Health Care	4,150	3,513	[illegible]	27.55%	[illegible]	1.28%	[illegible]	13.66%	[illegible]	2.00%	[illegible]	0.22%	[illegible]	17.87%	[illegible]	25.96%	[illegible]	7.57%
Unduplicated Clients Served By State Services Funds:	2,100	1,839	[illegible]	21.66%	[illegible]	0.93%	[illegible]	18.87%	[illegible]	1.64%	[illegible]	0.12%	[illegible]	11.17%	[illegible]	33.94%	[illegible]	9.49%

The Houston Regional HIV/AIDS Resource Group, Inc.

FY 1920 DSHS State Services

Procurement Report

September 1, 2019- August 31, 2020

Chart reflects spending through March 2020

Spending Target: 58.33

Revised 5/21/2020

Priority	Service Category	Original Allocation per RWPC	% of Grant Award	Amendments per RWPC	Contractual Amount	Amendment	Contractual Amount	Date of Original Procurement	Expended YTD	Percent YTD
5	Health Insurance Premiums and Cost Sharing (1)	$864,506	43%	$0	$864,506	$0	$864,506	9/1/2019	$0	0%
6	Mental Health Services (2)	$300,000	15%	$0	$300,000	$0	$300,000	9/1/2019	$88,408	29%
7	EIS - Incarcerated	$175,000	9%	$0	$175,000	$0	$175,000	9/1/2019	$95,747	55%
11	Hospice	$259,832	13%	$0	$259,832	$0	$259,832	9/1/2019	$132,880	51%
	Non Medical Case Management (3)	$350,000	17%	$0	$350,000	$0	$350,000	9/1/2019	$128,013	37%
15	Linguistic Services (4)	$68,000	3%	$0	$68,000	$0	$68,000	9/1/2019	$28,050	41%
	Increased award amount -Approved by RWPC for Health Insurance (a)	$0	0%	-$142,285						
	Total Houston HSDA	2,017,338	100%	-$142,285	$2,017,338	$0	$1,667,338		473,098	28%

Note

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

(2) Mental Health reporting services utilization is down and additional back billing has not been submitted.

(3) N-Medical Case Management a new agency is behind 2 months of reporting spending.

(4) Linguistic is behind with 1 month of reporting spending.

Houston Ryan White Health Insurance Assistance Service Utilization Report

Period Reported: 09/01/2019-3/31/20

Revised: 4/29/2020

Request by Type	Assisted			NOT Assisted		
	Number of Requests (UOS)	*Dollar Amount of Requests*	Number of Clients (UDC)	*Number of Requests (UOS)*	*Dollar Amount of Requests*	*Number of Clients (UDC)*
Medical Co-Payment	1180	$102,206.12	578			*0*
Medical Deductible	139	$20,904.36	111			*0*
Medical Premium	4044	$1,481,440.99	757			*0*
Pharmacy Co-Payment	11210	$395,329.57	1225			*0*
APTC Tax Liability	1	$500.00	1			*0*
Out of Network Out of Pocket	0	$0.00	0			*0*
ACA Premium Subsidy Repayment	17	$1,614.02	9	*NA*	*NA*	*NA*
Totals:	16591	$1,998,767.02	2681	0	$0.00	

Comments: This report represents services provided under all grants.

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

FY 2019 Ryan White Part A and MAI
Procurement Report

Priority	Service Category	Original Allocation *RWPC Approved Level Funding Scenario*	Award Reconcilation (b)	July Adjustments (carryover)	October Adjustments	Final Quarter Adjustments	Total Allocation	Percent of Grant Award	Amount Procured (a)	Procure-ment Balance	Original Date Procured	Expended YTD	Percent YTD	Percent Expected YTD
1	**Outpatient/Ambulatory Primary Care**	**9,783,470**	**0**	**100,096**	**55,000**	**1,003,609**	**10,942,175**	**48.76%**	**10,942,175**	**0**		**10,946,926**	**100%**	**100%**
1.a	Primary Care - Public Clinic (a)	3,591,064	0	0	30,000	253,939	3,875,003	17.27%	3,875,003	0	3/1/2019	$3,602,340	93%	100%
1.b	Primary Care - CBO Targeted to AA (a) (e) (f)	940,447	0	25,032	25,000	827,488	1,817,967	8.10%	1,817,967	0	3/1/2019	$1,556,441	86%	100%
1.c	Primary Care - CBO Targeted to Hispanic (a) (e)	786,424	0	25,032	0		811,456	3.62%	811,456	0	3/1/2019	$1,474,133	182%	100%
1.d	Primary Care - CBO Targeted to White/MSM (a) (e)	1,023,797	0	25,032	0		1,048,829	4.67%	1,048,829	0	3/1/2019	$757,590	72%	100%
1.e	Primary Care - CBO Targeted to Rural (a) (e)	1,149,761	0	0	0	-77,818	1,071,943	4.78%	1,071,943	0	3/1/2019	$1,045,332	98%	100%
1.f	Primary Care - Women at Public Clinic (a)	1,874,540	0	0			1,874,540	8.35%	1,874,540	0	3/1/2019	$2,087,591	111%	100%
1.g	Primary Care - Pediatric (a.1)	15,437	0				15,437	0.07%	15,437	0	3/1/2019	$9,000	58%	100%
1.h	Vision	402,000	0	25,000	0		427,000	1.90%	427,000	0	3/1/2019	$414,500	97%	100%
2	**Medical Case Management**	**2,535,802**	**0**	**50,000**	**-120,000**	**-583,281**	**1,882,521**	**8.39%**	**1,882,521**	**0**		**1,608,774**	**85%**	**100%**
2.a	Clinical Case Management	488,656	0	0	0		488,656	2.18%	488,656	0	3/1/2019	$488,627	100%	100%
2.b	Med CM - Public Clinic (a)	482,722	0	0	0	-380,921	101,801	0.45%	101,801	0	3/1/2019	$193,192	190%	100%
2.c	Med CM - Targeted to AA (a) (e)	321,070	0	16,666	0	-207,935	129,801	0.58%	129,801	0	3/1/2019	$265,920	205%	100%
2.d	Med CM - Targeted to H/L (a) (e)	321,072	0	16,666	0		337,738	1.51%	337,738	0	3/1/2019	$111,665	33%	100%
2.e	Med CM - Targeted to W/MSM (a) (e)	107,247	0	16,668	0		123,915	0.55%	123,915	0	3/1/2019	$99,192	80%	100%
2.f	Med CM - Targeted to Rural (a)	348,760	0	0	-60,000	37,575	326,335	1.45%	326,335	0	3/1/2019	$226,844	70%	100%
2.g	Med CM - Women at Public Clinic (a)	180,311	0	0			180,311	0.80%	180,311	0	3/1/2019	$97,999	54%	100%
2.h	Med CM - Targeted to Pedi (a.1)	160,051	0	0	-60,000	-32,000	68,051	0.30%	68,051	0	3/1/2019	$20,562	30%	100%
2.i	Med CM - Targeted to Veterans	80,025	0	0	0		80,025	0.36%	80,025	0	3/1/2019	$67,977	85%	100%
2.j	Med CM - Targeted to Youth	45,888	0	0			45,888	0.20%	45,888	0	3/1/2019	$36,798	80%	100%
3	**Local Pharmacy Assistance Program (a) (e)**	**2,657,166**	**500,000**	**125,126**	**0**	**-1,443,535**	**1,838,757**	**8.19%**	**1,838,757**	**0**	3/1/2019	**$1,736,234**	**94%**	**100%**
4	**Oral Health**	**166,404**	**0**	**0**	**0**	**0**	**166,404**	**0.74%**	**166,404**	**0**	3/1/2019	**166,400**	**100%**	**100%**
4.a	Oral Health - Untargeted (c)	0					0	0.00%	0	0	N/A	$0	0%	**0%**
4.b	Oral Health - Targeted to Rural	166,404	0	0			166,404	0.74%	166,404	0	3/1/2019	$166,400	100%	100%
5	**Mental Health Services (c)**	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**	**NA**	**$0**	**0%**	**0%**
6	**Health Insurance (c)**	**1,173,070**	**166,000**	**0**	**100,000**	**0**	**1,439,070**	**6.41%**	**1,439,239**	**-169**	3/1/2019	**$1,439,239**	**100%**	**100%**
7	**Home and Community-Based Services (c)**	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**	**NA**	**$0**	**0%**	**0%**
8	**Substance Abuse Services - Outpatient**	**45,677**	**0**	**0**	**-10,000**	**0**	**35,677**	**0.16%**	**35,677**	**0**	3/1/2019	**$35,344**	**99%**	**100%**
9	**Early Intervention Services (c)**	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**	**NA**	**$0**	**0%**	**0%**
10	**Medical Nutritional Therapy (supplements)**	**341,395**	**0**	**0**	**0**	**0**	**341,395**	**1.52%**	**341,395**	**0**	3/1/2019	**$307,128**	**90%**	**100%**
11	**Hospice Services**	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**	**NA**	**$0**	**0%**	**0%**
12	**Outreach Services**	**420,000**	**0**			**-131,351**	**288,649**	**1.29%**	**288,649**	**0**	**3/1/2019**	**$288,185**	**100%**	**100%**
13	**Emergency Financial Assistance**	**450,000**	**0**	**0**	**0**	**858,980**	**1,308,980**	**5.83%**	**1,308,980**	**0**	**3/1/2019**	**$1,305,439**	**100%**	**100%**
14	**Referral for Health Care and Support Services (c)**	**0**	**0**	**0**			**0**	**0.00%**	**0**	**0**	NA	$0	**0%**	**0%**
15	**Non-Medical Case Management**	**1,231,002**	**0**	**100,000**	**-25,000**	**295,578**	**1,601,580**	**7.14%**	**1,601,580**	**0**		**1,544,450**	**96%**	**100%**
15.a	Service Linkage targeted to Youth	110,793	0	0	-10,000		100,793	0.45%	100,793	0	3/1/2019	$117,714	117%	100%
15.b	Service Linkage targeted to Newly-Diagnosed/Not-in-Care	100,000	0		-15,000		85,000	0.38%	85,000	0	3/1/2019	$97,796	115%	100%
15.c	Service Linkage at Public Clinic (a)	427,000	0	0	0	125,664	552,664	2.46%	552,664	0	3/1/2019	$522,850	95%	100%
15.d	Service Linkage embedded in CBO Pcare (a) (e)	593,209	0	100,000	0	169,914	863,123	3.85%	863,123	0	3/1/2019	$806,091	93%	100%
16	**Medical Transportation**	**424,911**	**0**	**0**	**0**	**0**	**424,911**	**1.89%**	**424,911**	**0**		**424,910**	**100%**	**100%**
16.a	Medical Transportation services targeted to Urban	252,680	0	0	0		252,680	1.13%	252,680	0	3/1/2019	$281,980	112%	100%
16.b	Medical Transportation services targeted to Rural	97,185	0	0	0		97,185	0.43%	97,185	0	3/1/2019	$67,884	70%	100%
16.c	Transportation vouchering (bus passes & gas cards)	75,046	0	0	0		75,046	0.33%	75,046	0	3/1/2019	$75,046	100%	0%
17	**Linguistic Services (c)**	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**	**NA**	$0	**0%**	**0%**
BES27516	**Total Service Dollars**	**19,228,897**	**666,000**	**375,222**	**0**	**0**	**20,270,119**	**89.04%**	**20,270,288**	**-169**		**19,803,028**	**98%**	**100%**
	Grant Administration	**1,675,047**	**119,600**	**0**	**0**	**0**	**1,794,647**	**8.00%**	**1,794,647**	0	**N/A**	**627,328**	**35%**	**100%**
BES27517	HCPHES/RWGA Section	1,183,084	119,600	0		0	1,302,684	5.81%	1,302,684	0	N/A	$462,731	36%	100%
PC	RWPC Support*	491,963			0	0	491,963	2.19%	491,963	0	N/A	164,598	33%	100%

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

FY 2019 Ryan White Part A and MAI Procurement Report

Priority	Service Category	Original Allocation *RWPC Approved Level Funding Scenario*	Award Reconcilation (b)	July Adjustments (carryover)	October Adjustments	Final Quarter Adjustments	Total Allocation	Percent of Grant Award	Amount Procured (a)	Procure-ment Balance	Original Date Procured	Expended YTD	Percent YTD	Percent Expected YTD
[redacted]	**Quality Management**	**495,000**	**-119,600**	**0**	**0**	**0**	**375,400**	**1.67%**	**375,400**	**0**	**N/A**	**$84,702**	**23%**	**100%**
		21,398,944	**666,000**	**375,222**	**0**	**0**	**22,440,166**	**98.71%**	**22,440,335**	**-169**	[redacted]	**20,515,058**	**91%**	**100%**
									Unallocated	Unobligated				
	Part A Grant Award:	**22,439,871**	***Carry Over:***	**465**		***Total Part A:***	**22,440,336**	**170**	**-169**					[redacted]
	[redacted]	**Original Allocation**	**Award Reconcilation (b)**	**July Adjusments (carryover)**	**October Adjustments**	**Final Quarter Adjustments**	**Total Allocation**	**Percent**	**Total Expended on Services**	**Percent**				
	Core (must not be less than 75% of total service dollars)	**16,702,984**	**666,000**	**275,222**	**25,000**	**-1,023,207**	**17,669,206**	**87.17%**	**16,240,044**	**82.01%**				
	Non-Core (may not exceed 25% of total service dollars)	**2,525,913**	**0**	**100,000**	**-25,000**	**1,154,558**	**2,600,913**	**12.83%**	**3,562,984**	**17.99%**				
	Total Service Dollars (does not include Admin and QM)	**19,228,897**	**666,000**	**375,222**	**0**	**0**	**20,270,119**	[redacted]	**19,803,028**	[redacted]				
	[redacted]													
	Total Admin (must be ≤ 10% of total Part A + MAI)	**1,675,047**	**119,600**	**0**	**0**	**0**	**1,794,647**	**8.00%**						
	Total QM (must be ≤ 5% of total Part A + MAI)	**495,000**	**-119,600**	**0**	**0**	**0**	**375,400**	**1.67%**						

MAI Procurement Report

Priority	Service Category	Original Allocation *RWPC Approved Level Funding Scenario*	Award Reconcilation (b)	July Adjustments (carryover)	October Adjustments	Final Quarter Adjustments	Total Allocation	Percent of Grant Award	Amount Procured (a)	Procure-ment Balance	Date of Procure-ment	Expended YTD	Percent YTD	Percent Expected YTD
1	**Outpatient/Ambulatory Primary Care**	**1,846,845**	**40,438**	**18,861**	**0**	**0**	**1,906,144**	**85.62%**	**1,906,144**	**0**	[redacted]	**1,898,600**	**100%**	**100%**
1.b (MAI)	Primary Care - CBO Targeted to African American	934,693	20,219	9,430	0	0	964,342	43.32%	964,342	0	3/1/2019	$1,109,900	115%	100%
1.c (MAI)	Primary Care - CBO Targeted to Hispanic	912,152	20,219	9,431	0	0	941,802	42.30%	941,802	0	3/1/2019	$788,700	84%	100%
2	**Medical Case Management**	**320,100**	**0**	**0**	**0**	**0**	**320,100**	**14.38%**	**320,100**	**0**	[redacted]	**$210,675**	**66%**	100%
2.c (MAI)	MCM - Targeted to African American	160,050					160,050	7.19%	160,050	0	3/1/2019	$142,705	89%	100%
2.d (MAI)	MCM - Targeted to Hispanic	160,050					160,050	7.19%	160,050	0	3/1/2019	$67,970	42%	100%
[redacted]	**Total MAI Service Funds**	**2,166,945**	**40,438**	**18,861**	**0**	**0**	**2,226,244**	**100.00%**	**2,226,244**	**0**	[redacted]	**2,109,275**	**95%**	**100%**
	Grant Administration	0	0	0	0	0	0	0.00%	0	0		0	0%	0%
	Quality Management	0	0	0	0	0	0	0.00%	0	0		0	0%	0%
	Total MAI Non-service Funds	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**		**0**	**0%**	**0%**
[redacted]	**Total MAI Funds**	**2,166,945**	**40,438**	**18,861**	**0**	**0**	**2,226,244**	**100.00%**	**2,226,244**	**0**		**2,109,275**	**95%**	**100%**
	MAI Grant Award	**2,226,244**	***Carry Over:***	**0**		***Total MAI:***	**2,226,244**							[redacted]
	Combined Part A and MAI Orginial Allocation Total	**23,565,889**												

Footnotes:

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

Prepared by: Ryan White Grant Administration

FY 2019 Ryan White Part A and MAI Service Utilization Report

RW PART A SUR: 4th Quarter (3/1-2/29)																	
Priority	Service Category	Goal	Unduplicated Clients Served YTD	Male	Female	Trans gender	AA (non-Hispanic)	White (non-Hispanic)	Other (non-Hispanic)	Hispanic	0-12	13-19	20-24	25-34	35-44	45-49	50-64	65 plus
1	**Outpatient/Ambulatory Primary Care (excluding Vision)**	**6,467**	**8,742**	**73%**	**25%**	**2%**	**47%**	**13%**	**2%**	**37%**	**0%**	**1%**	**5%**	**27%**	**27%**	**12%**	**26%**	**2%**
1.a	Primary Care - Public Clinic (a)	2,350	3,606	68%	31%	1%	51%	9%	2%	38%	0%	0%	2%	17%	26%	15%	36%	4%
1.b	Primary Care - CBO Targeted to AA (a)	1,060	2,115	68%	29%	3%	99%	0%	1%	0%	0%	1%	7%	40%	26%	10%	16%	1%
1.c	Primary Care - CBO Targeted to Hispanic (a)	960	1,760	83%	14%	3%	0%	0%	0%	100%	0%	1%	8%	31%	31%	12%	17%	1%
1.d	Primary Care - CBO Targeted to White and/or MSM (a)	690	819	88%	11%	1%	0%	88%	12%	0%	0%	0%	4%	30%	24%	12%	28%	2%
1.e	Primary Care - CBO Targeted to Rural (a)	400	693	70%	29%	1%	44%	24%	2%	30%	0%	0%	6%	32%	27%	11%	22%	2%
1.f	Primary Care - Women at Public Clinic (a)	1,000	1,113	0%	100%	0%	59%	8%	2%	31%	0%	0%	1%	11%	30%	17%	35%	5%
1.g	Primary Care - Pediatric (a)	7	8	100%	0%	0%	38%	13%	0%	50%	25%	38%	38%	0%	0%	0%	0%	0%
1.h	Vision	1,600	2,777	74%	25%	1%	47%	14%	3%	37%	0%	0%	4%	23%	24%	13%	31%	4%
2	**Medical Case Management (f)**	**3,075**	**6,013**															
2.a	Clinical Case Management	600	1,299	77%	21%	2%	54%	13%	2%	31%	0%	0%	4%	29%	26%	9%	28%	4%
2.b	Med CM - Targeted to Public Clinic (a)	280	631	92%	7%	1%	62%	11%	1%	25%	0%	0%	2%	29%	22%	11%	33%	3%
2.c	Med CM - Targeted to AA (a)	550	1,570	65%	32%	3%	99%	0%	1%	0%	0%	0%	6%	36%	26%	12%	18%	2%
2.d	Med CM - Targeted to H/L(a)	550	723	80%	16%	4%	0%	0%	0%	100%	0%	1%	7%	29%	33%	10%	17%	2%
2.e	Med CM - Targeted to White and/or MSM (a)	260	518	86%	14%	1%	0%	88%	12%	0%	0%	0%	2%	24%	21%	15%	33%	5%
2.f	Med CM - Targeted to Rural (a)	150	716	68%	32%	1%	49%	27%	3%	22%	0%	0%	6%	23%	24%	12%	31%	4%
2.g	Med CM - Targeted to Women at Public Clinic (a)	240	282	0%	100%	0%	72%	8%	2%	18%	0%	0%	1%	12%	30%	14%	37%	5%
2.h	Med CM - Targeted to Pedi (a)	125	72	58%	42%	0%	68%	8%	1%	22%	60%	31%	10%	0%	0%	0%	0%	0%
2.i	Med CM - Targeted to Veterans	200	190	96%	4%	0%	67%	23%	1%	9%	0%	0%	0%	1%	6%	3%	59%	31%
2.j	Med CM - Targeted to Youth	120	12	83%	17%	0%	42%	8%	0%	50%	0%	8%	92%	0%	0%	0%	0%	0%
3	**Local Drug Reimbursement Program (a)**	**2,845**	**5,080**	**74%**	**24%**	**3%**	**48%**	**14%**	**2%**	**36%**	**0%**	**0%**	**5%**	**30%**	**28%**	**13%**	**23%**	**2%**
4	**Oral Health**	**200**	**326**	**67%**	**32%**	**1%**	**43%**	**31%**	**2%**	**24%**	**0%**	**0%**	**5%**	**22%**	**27%**	**10%**	**31%**	**4%**
4.a	Oral Health - Untargeted (d)	NA	NA															
4.b	Oral Health - Rural Target	200	326	67%	32%	1%	43%	31%	2%	24%	0%	0%	5%	22%	27%	10%	31%	4%
5	**Mental Health Services (d)**	**NA**	**NA**															
6	**Health Insurance**	**1,700**	**2,153**	**80%**	**19%**	**1%**	**46%**	**24%**	**3%**	**26%**	**0%**	**0%**	**2%**	**17%**	**19%**	**13%**	**39%**	**9%**
7	**Home and Community Based Services (d)**	**NA**	**NA**															
8	**Substance Abuse Treatment - Outpatient**	**40**	**24**	**96%**	**4%**	**0%**	**25%**	**42%**	**4%**	**29%**	**0%**	**0%**	**4%**	**33%**	**21%**	**25%**	**17%**	**0%**
9	**Early Medical Intervention Services (d)**	**NA**	**NA**															
10	**Medical Nutritional Therapy/Nutritional Supplements**	**650**	**479**	**78%**	**22%**	**0%**	**41%**	**22%**	**3%**	**34%**	**0%**	**0%**	**1%**	**12%**	**17%**	**15%**	**44%**	**12%**
11	**Hospice Services (d)**	**NA**	**NA**															
12	**Outreach**	**700**	**723**	**77%**	**22%**	**1%**	**59%**	**13%**	**1%**	**28%**	**0%**	**1%**	**8%**	**32%**	**24%**	**10%**	**23%**	**2%**
13	**Non-Medical Case Management**	**7,045**	**9,239**															
13.a	Service Linkage Targeted to Youth	320	190	78%	20%	2%	57%	5%	3%	35%	0%	15%	85%	0%	0%	0%	0%	0%
13.b	Service Linkage at Testing Sites	260	150	74%	24%	2%	57%	10%	3%	30%	0%	0%	0%	47%	28%	7%	14%	3%
13.c	Service Linkage at Public Clinic Primary Care Program (a)	3,700	4,033	67%	32%	1%	59%	9%	1%	30%	0%	0%	0%	17%	24%	13%	40%	6%
13.d	Service Linkage at CBO Primary Care Programs (a)	2,765	4,866	73%	24%	3%	54%	14%	2%	30%	1%	1%	6%	29%	25%	10%	24%	3%
14	**Transportation**	**2,850**	**3,020**															
14.a	Transportation Services - Urban	170	617	66%	32%	2%	62%	10%	3%	26%	0%	0%	5%	29%	25%	12%	25%	3%
14.b	Transportation Services - Rural	130	131	68%	31%	1%	31%	41%	2%	25%	0%	0%	2%	18%	27%	10%	40%	3%
14.c	Transportation vouchering	2,550	2,272															
15	**Linguistic Services (d)**	**NA**	**NA**															
16	**Emergency Financial Assistance (e)**	**NA**	**1,605**	**76%**	**22%**	**2%**	**48%**	**11%**	**3%**	**38%**	**0%**	**0%**	**6%**	**30%**	**28%**	**13%**	**22%**	**1%**
17	**Referral for Health Care - Non Core Service (d)**	**NA**	**NA**															
Net unduplicated clients served - all categories*		**12,941**	**14,676**	**73%**	**25%**	**2%**	**52%**	**15%**	**2%**	**31%**	**0%**	**1%**	**4%**	**24%**	**24%**	**12%**	**30%**	**5%**
Living AIDS cases + estimated Living HIV non-AIDS (from FY 19 App) (b)		NA																

Available Data As Of: 6/11/2020

DRAFT - 05/28/20

Houston EMA/HSDA Ryan White Part A Service Definition **Emergency Financial Assistance – Other** (Revised April 2020)	
HRSA Service Category Title:	**Emergency Financial Assistance**
Local Service Category Title:	**Emergency Financial Assistance - Other**
Service Category Code **(RWGA use only):**	
Amount Available **(RWGA use only):**	
Budget Type **(RWGA use only):**	**Hybrid**
Budget Requirements or Restrictions:	Direct cash payments to clients are not permitted. It is expected that all other sources of funding in the community for emergency financial assistance will be effectively used and that any allocation of RWHAP funds for these purposes will be as the payer of last resort, and for limited amounts, uses, and periods of time. Continuous provision of an allowable service to a client must not be funded through EFA. The agency must set priorities, delineate and monitor what part of the overall allocation for emergency assistance is obligated for each subcategory. Careful monitoring of expenditures within a subcategory of "emergency assistance" is necessary to assure that planned amounts for specific services are being implemented, and to determine when reallocations may be necessary. At least **75%** of the total amount of the budget must be solely allocated to the actual cost of disbursements. Maximum allowable unit cost for provision of food vouchers or and/or utility assistance to an eligible client = $xx.00/unit
HRSA Service Category Definition **(do <u>not</u> change or alter):**	**Emergency Financial Assistance** - Provides limited one-time or short-term payments to assist the RWHAP client with an emergent need for paying for essential utilities, housing, food (including groceries, and food vouchers), transportation, and medication. Emergency financial assistance can occur as a direct payment to an agency or through a voucher program.
Local Service Category Definition:	**Emergency Financial Assistance** is provided with limited frequency and for a limited period of time, with specified frequency and duration of assistance. Emergent need must be documented each time funds are used. Emergency essential living needs include food, telephone, and utilities (i.e. electricity, water, gas and all required fees) for eligible PLWH.
Target Population (age, gender, geographic, race, ethnicity, etc.):	PLWH living within the Houston Eligible Metropolitan Area (EMA).

housing, limited to people who are displaced from their home due to acute housing needs,

Services to be Provided:	**Emergency Financial Assistance** provides funding through: • Short-term payments to agencies • Establishment of voucher programs Service to be provided include: • Food Vouchers • Utilities (gas, water, basic telephone service and electricity) The agency must adhere to the following guidelines in providing these services: • Assistance must be in the form of vouchers made payable to vendors, merchants, etc. No payments may be made directly to individual clients or family members. • Limitations on the provision of emergency assistance to eligible individuals/households should be delineated and consistently applied to all clients. • Allowable support services with an $800/year/client cap.
Service Unit Definition(s): **(HIV Services use only)**	A unit of service is defined as provision of food vouchers or and/or utility assistance to an eligible client.
Financial Eligibility:	Refer to the RWPC's approved *Financial Eligibility for Houston EMA Services*.
Client Eligibility:	PLWHA residing in the Houston EMA (prior approval required for non-EMA clients).
Agency Requirements:	Agency must be dually awarded as HOWPA sub-recipient work closely with other service providers to minimize duplication of services and ensure that assistance is given only when no reasonable alternatives are available. It is expected that all other sources of funding in the community for emergency assistance will be effectively used and that any allocation of EFA funding for these purposes will be the payer of last resort, and for limited amounts, limited use, and limited periods of time. Additionally, agency must document ability to refer clients for food, transportation, and other needs from other service providers when client need is justified.
Staff Requirements:	None.
Special Requirements:	Agency must: Comply with the Houston EMA/HSDA Standards of Care and Emergency Financial Assistance service category program policies.

DRAFT - 05/28/20

Houston EMA/HSDA Ryan White Part A Service Definition **Emergency Financial Assistance – Other** (Revised April 2020)	
HRSA Service Category Title:	**Emergency Financial Assistance**
Local Service Category Title:	**Emergency Financial Assistance - Other**
Service Category Code **(RWGA use only):**	
Amount Available **(RWGA use only):**	
Budget Type **(RWGA use only):**	**Hybrid**
Budget Requirements or Restrictions:	Direct cash payments to clients are not permitted. It is expected that all other sources of funding in the community for emergency financial assistance will be effectively used and that any allocation of RWHAP funds for these purposes will be as the payer of last resort, and for limited amounts, uses, and periods of time. Continuous provision of an allowable service to a client must not be funded through EFA. The agency must set priorities, delineate and monitor what part of the overall allocation for emergency assistance is obligated for each subcategory. Careful monitoring of expenditures within a subcategory of "emergency assistance" is necessary to assure that planned amounts for specific services are being implemented, and to determine when reallocations may be necessary. At least **75%** of the total amount of the budget must be solely allocated to the actual cost of disbursements. Maximum allowable unit cost for provision of food vouchers or and/or utility assistance to an eligible client = $xx.00/unit
HRSA Service Category Definition **(do <u>not</u> change or alter):**	**Emergency Financial Assistance** - Provides limited one-time or short-term payments to assist the RWHAP client with an emergent need for paying for essential utilities, housing, food (including groceries, and food vouchers), transportation, and medication. Emergency financial assistance can occur as a direct payment to an agency or through a voucher program.
Local Service Category Definition:	**Emergency Financial Assistance** is provided with limited frequency and for a limited period of time, with specified frequency and duration of assistance. Emergent need must be documented each time funds are used. Emergency essential living needs include food, telephone, and utilities (i.e. electricity, water, gas and all required fees) for eligible PLWH.
Target Population (age, gender, geographic, race, ethnicity, etc.):	PLWH living within the Houston Eligible Metropolitan Area (EMA).

housing, limited to people who are displaced from their home due to acute housing needs.

Services to be Provided:	**Emergency Financial Assistance** provides funding through: • Short-term payments to agencies • Establishment of voucher programs Service to be provided include: • Food Vouchers • Utilities (gas, water, basic telephone service and electricity) The agency must adhere to the following guidelines in providing these services: • Assistance must be in the form of vouchers made payable to vendors, merchants, etc. No payments may be made directly to individual clients or family members. • Limitations on the provision of emergency assistance to eligible individuals/households should be delineated and consistently applied to all clients. • Allowable support services with an $800/year/client cap.
Service Unit Definition(s): **(HIV Services use only)**	A unit of service is defined as provision of food vouchers or and/or utility assistance to an eligible client.
Financial Eligibility:	Refer to the RWPC's approved *Financial Eligibility for Houston EMA Services*.
Client Eligibility:	PLWHA residing in the Houston EMA (prior approval required for non-EMA clients).
Agency Requirements:	Agency must be dually awarded as HOWPA sub-recipient work closely with other service providers to minimize duplication of services and ensure that assistance is given only when no reasonable alternatives are available. It is expected that all other sources of funding in the community for emergency assistance will be effectively used and that any allocation of EFA funding for these purposes will be the payer of last resort, and for limited amounts, limited use, and limited periods of time. Additionally, agency must document ability to refer clients for food, transportation, and other needs from other service providers when client need is justified.
Staff Requirements:	None.
Special Requirements:	Agency must: Comply with the Houston EMA/HSDA Standards of Care and Emergency Financial Assistance service category program policies.

2020 HHS Federal Poverty Guidelines

Effective Date: 01/15/2020

Poverty Level	Size of Family Unit							
	1	2	3	4	5	6	7	8
100%	12,760	17,240	21,720	26,200	30,680	35,160	39,640	44,120
133%	16,971	22,929	28,888	34,846	40,804	46,763	52,721	58,680
150%	19,140	25,860	32,580	39,300	46,020	52,740	59,460	66,180
200%	25,520	34,480	43,440	52,400	61,360	70,320	79,280	88,240
250%	31,900	43,100	54,300	65,500	76,700	87,900	99,100	110,300
300%	38,280	51,720	65,160	78,600	92,040	105,480	118,920	132,360
350%	44,660	60,340	76,020	91,700	107,380	123,060	138,740	154,420
400%	51,040	68,960	86,880	104,800	122,720	140,640	158,560	176,480
450%	57,420	77,580	97,740	117,900	138,060	158,220	178,380	198,540
500%	63,800	86,200	108,600	131,000	153,400	175,800	198,200	220,600

For family units with more than 8 members, add $4,480 for each additional member. (The same increment applies to smaller family sizes also, as can be seen in the figures above.)

Priority and Allocations Committee Report

DRAFT

Worksheet for Determining FY 2021 Service Priorities

Core Services	HL Scores	HL Rank	Approved FY 2020 Priorities	Proposed FY 2021 Priorities	Justification
Ambulatory/Outpatient Medical Care	HHH	2	1	1	
Medical Case Management	HHH	2	2	2	
Local Pharmacy Assistance Program	HHH	2	3	3	
Oral Health Services	HLL	3	4	4	
Health Insurance	HLL	3	5	5	
Mental Health Services	HLH	4	6	6	
Early Intervention Services (jail)	LLL	8	7	7	TRG and SIRR have prioritized improving coordination system in Early Intervention Services.
Medical Nutritional Therapy	LLH	7	10	8	Higher utilization for Medical Nutrition Therapy compared to Adult Day Treatment and Substance Abuse Treatment
Day Treatment	LLH	7	8	9	
Substance Abuse Treatment	LLH	7	9	10	
Hospice*	-	-	11	11	

Support Services	HL Scores	HL Rank	Approved FY 2020 Priorities	Proposed FY 2021 Priorities	Justification
Referral for Health Care & Support Services	HHH	2	14	12	The ADAP Eligibility Workers funded through Referral for Health Care & Support Services support access to life-sustaining HIV medications.
Non-medical case management	HHH	2	15	13	
Medical Transportation	HLL	3	16	14	
Emergency Financial Assistance	HLH	4	13	15	
Linguistics Services	LLL	8	17	16	
Outreach	LLL	8	12	17	

*Hospice does not have HL Score or HL Rank.

HOUSTON EMA/HSDA
Needs Assessment Rankings

Chart for Determining FY2021 Service Priorities

Core Service	Need	Use	Access/ Ease	Need	Use	Access/ Ease	HL Scores	HL Rank	Tie Breaker	Changes
Primary Care	89	9,384	90	H	H	H	HHH	2		
Medical/Clinical Case Management	73	6,712	92	H	H	H	HHH	2		
Local Medication Assistance	79	5,119	94	H	H	H	HHH	2		
Oral Health Services	72	3,830	80	H	L	L	HLL	3		
Health Insurance	57	2,374	84	H	L	L	HLL	3		
Mental Health Services	51	2,03	80	H	L	H	HLH	4		
Early Intervention Services (jail)	9	677	78	L	L	L	LLL	8		
Hospice		28			L					
Proposed MIDPOINTS	48	4,706	86							

Ranking	
HHL	1
HHH	2
HLL	3
HLH	4
LHL	5
LHH	6
	7
LLL	8

Support Services	Need	Use	Access/ Ease	Need	Use	Access/ Ease	HL Scores	HL Rank	Tie Breaker	Changes
Non-medical Case Management	73	6,132	92	H	H	H	HHH	2		
Referral for Health Care & Support Services	68	6,266	87	H	H	H	HHH	2		
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Transportation Services	5	84	84	L	L	L	LLL	8		
Outreach Services	5	778	89	L	L	L	LLL	8		
Proposed MIDPOINTS	[illegible]	[illegible]	[illegible]							

Midpoint=Highest Use+Lowest Use/2
High (H)=Use above the midpoint
Low (L)=Use below the midpoint

Needs Assessment Data for FY 2021 Priorities

04-27-20

Need

Service Category	Proportion
Medical	
Case management	73
Day treatment	32
Early intervention (jail only)	9
Health insurance assistance	57
Local medication assistance	79
Medical nutrition therapy	36
Mental health services	51
Oral health care	72
Primary care	89
Substance abuse services	24
Mean	52
Non-Medical	
Emergency Financial Assistance	79
Linguistic Services	5
Non-Medical Case Management	73
Outreach Services	5
Referral for Health Care & Support Services	68
Transportation	48
Mean	46

Acccessibility

Service Category	Proportion
Medical	
Case management	92
Day treatment	90
Early intervention (jail only)	78
Health insurance assistance	84
Local medication assistance	94
Medical nutrition therapy	86
Mental health services	90
Oral health care	80
Primary care	90
Substance abuse services	86
Mean	87
Non-Medical	
Emergency Finanical Assistance	94
Linguistic Services	89
Non-Medical Case Management	92
Outreach Services	89
Referral for Health Care & Support Services	97
Transportation	86
Mean	91

Houston Ryan White Planning Council

Priority Setting Process

May 23, 2019

Principles and Criteria

Principles

Sound priority setting must be based on clearly stated and consistently applied principles for decision-making.

- **These principles are the basic ideals for action**

Criteria

Criteria are the standards on which judgment will be based.

Priority Setting

Needs Assessment Data — The percentages are taken from the needs assessment and then broken down and used to determine the priorities.

Midpoint — When a service percentage is above the set median point it will rank as a high for that column, if below the midpoint then it will be a low rank. This will be done for each column.

High Low Score — E.g. Score: LLHL

Attached is a listing of each possible high low scenario.

Priority Setting

The group will then place each service into one of two groups: Core or Non Core

CORE	NON-CORE
Outpatient/Ambulatory Medical Care (Primary Care)	Case Management (Non-Medical)
Local Pharmaceutical Assistance Program (LPAP)	Health Education Risk Reduction
Oral Health Care	Medical Transportation
Early Intervention Services	Outreach Services
Health Insurance Premium and Cost-Sharing Assistance	Psychosocial Support Services
Home Health Care	Referral for healthcare/supportive services
Home	Treatment Adherence Counseling
Hospice	
Home and community based health services	
Medical Nutrition Therapy	
Mental Health	
Outpatient Substance Abuse	
Medical Case Management (including treatment adherence services)	

Prioritization

Lets Try It!

Happy HSDA

Service	*Need*	*Use*	*Availability*
Oral Health Care	68	45	15
Primary Care	82	82	3
Case Management	81	76	10
Medical Case Management	68	68	7
Van Transportation	51	49	15
Health Insurance	77	42	30
Vision Care	74	31	38

Let's set our midpoints!

**Hint, Remember the midpoint is the average of the highest and lowest NA percentage.*

Need: 67% Use: 57 % Availability: 21%

Prioritization

Happy HSDA

Service	*Need*	*Use*	*Availability*	*Need*	*Use*	*Avail*
Oral Health Care	68	45	15	H	L	L
Primary Care	82	82	3	H	H	L
Case Management	81	76	10	H	H	L
Medical Case Management	68	68	7	H	H	L
Van Transportation	51	49	15	L	L	L
Health Insurance	77	42	30	H	L	H

Midpoints: Need: 67% Use: 57 % Availability: 21%

Service	High-Low Scores:	C/N	Rank
Primary Care:	HHL	C	1
Medical Case Management:	HHL	C	2
Health Insurance:	HLH	C	3
Oral Health:	HLL	C	4
Case Management:	HHL	N	5
Van Transportation:	LLL	N	6

Prioritization

Tie Breaking and finalizing

Once this is done the committee will use any additional relevant information and public comment to break any ties until there is an established priority list.

Prioritization

What happens when there is NO new Needs Assessment data?

During years where there is no new needs assessment data (or "off years") the group will use data from the most recent needs assessment activities, special studies, HBTMN, etc.

The group does not complete another High-Low process during these years, the work is already done !, instead....

The group will be given the listing of the previous years priorities and make changes in the priorities as appropriate.

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Houston Ryan White Planning Council
Priority and Allocations Committee

Proposed Ryan White Part A, MAI, Part B and State Services Funding FY 2021 Allocations

(Priority and Allocations Committee approved 06-16-20)

MOTION 1: All Funding Streams – Level Funding Scenario

Level Funding Scenario for Ryan White Part A, MAI, Part B and State Services Funding.
Approve the attached Ryan White Part A, MAI, Part B, and State Services Funding FY 2021 Level Funding Scenario.

MOTION 2: MAI Increase / Decrease Scenarios

Decrease Funding Scenario for Ryan White Minority AIDS Initiative (MAI).
Primary care subcategories will be decreased by the same percent. This applies to the total amount of service dollars available.

Increase Funding Scenario for Ryan White Minority AIDS Initiative (MAI).
Primary care subcategories will be increased by the same percent. This applies to the total amount of service dollars available.

MOTION 3: Part A Increase / Decrease Scenarios

Decrease Funding Scenario for Ryan White Part A Funding.
All service categories except subcategories 1.g, 2.h, 2.i, 2.j, and 10 will be decreased by the same percent. This applies to the total amount of service dollars available.

Increase Funding Scenario for Ryan White Part A Funding.
Step 1: Allocate first $200,000 to Medical Case Management (category 2). Subcategory to be determined by the Administrative Agent, with consideration to MAI allocations under MCM and final quarter adjustments.

Step 2: Allocate the next $100,000 to Health Insurance Assistance Program (category 5).

Step 3: Allocate the next $100,000 to Local Pharmacy Assistance Program - Untargeted (category 3.b).

Step 4: Any remaining increase in funds following application of Steps 1, 2, and 3 will be allocated by the Ryan White Planning Council, with prioritization given to new programs.

MOTION 4: Part B and State Services Increase/Decrease Scenario

Decrease Funding Scenario for Ryan White Part B and State Services Funding.
A decrease in funds of any amount will be allocated by the Ryan White Planning Council after the notice of grant award is received.

Increase Funding Scenario for Ryan White Part B and State Services Funding.
Step 1: Allocate the first $200,000 to be divided evenly between Oral Health – General Oral Health (category 4.a.) and Oral Health – Prosthodontics (category 4.b.).

Step 2: Allocate the next $200,000 to Health Insurance Assistance Program (category 5).

Step 3: Any remaining increase in funds following application of Steps 1 and 2 will be allocated by the Ryan White Planning Council after the notice of grant award is received.

Priorities and Allocations Committee approved on 06/16/20

FY2021 - Level Funding Scenario - Draft 5 - 06-17-20

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		Part A	MAI	Part B	State Services	State Rebate	Total	FY 2021 Allocations & Justification
	Remaining Funds to Allocate	$0	$0	$0	$0	$0	$0	
		Part A	MAI	Part B	State Services	State Rebate	Total	FY 2021 Allocations & Justification
1	**Ambulatory/Outpatient Primary Care**	**$10,965,788**	**$2,002,859**	**$0**	**$0**	**$0**	**$12,968,647**	**FY21 Part A: Increase Part A by $879,962. Breakdown and justification across subcategories is shown below.**
1.a	PC-Public Clinic	$3,927,300					$3,927,300	**FY21 Part A: Increase Part A $336,236 to accommodate projected increase due to COVID-19 related unemployment.**
1.b	PC-AA	$1,064,576	$1,012,700				$2,077,276	**Added $57,788 per FY20 Part A Increase Scenario FY21 Part A: Increase Part A $112,078 to accommodate projected increase due to COVID-19 related unemployment.**
1.c	PC-Hisp - see 1.b above	$910,551	$990,160				$1,900,711	**Added $57,788 per FY20 Part A Increase Scenario FY21 Part A: Increase Part A $112,078 to accommodate projected increase due to COVID-19 related unemployment.**
1.d	PC-White - see 1.b above	$1,147,924					$1,147,924	**FY21 Part A: Increase Part A $112,078 to accommodate projected increase due to COVID-19 related unemployment.**
1.e	PC-Rural	$1,100,000					$1,100,000	**FY21 Part A: Decrease $49,761 due to underspending.**
1.f	PC-Women	$2,100,000					$2,100,000	**FY21 Part A: Increase $225,460 due to FY19 expenditures.**
1.g	PC-Pedi	$15,437					$15,437	
1.h	Vision Care	$500,000					$500,000	**FY21 Part A: Increase $48,000 due to repeated requests for increase.**
1.j	PC-Pay for Performance Pilot Project	$200,000					$200,000	**Established at $200,000 per FY20 Part A Increase Scenario**
2	**Medical Case Management**	**$1,730,000**	**$320,100**	**$0**	**$0**	**$0**	**$2,050,100**	**FY21 Part A: Decrease Part A by $385,802 due to underspending in FY19. Subcategory to be determined by the AA, with consideration to MAI allocations under MCM and final quarter adjustments.**
2.a	CCM-Mental/Substance	$488,656					$488,656	
2.b	MCM-Public Clinic	$427,722					$427,722	
2.c	MCM-AA	$266,070	$160,050				$426,120	
2.d	MCM-Hisp	$266,072	$160,050				$426,122	
2.e	MCM-White	$52,247					$52,247	
2.f	MCM-Rural	$273,760					$273,760	
2.g	MCM-Women	$125,311					$125,311	
2.h	MCM-Pedi	$90,051					$90,051	**FY21 Part A: Decrease Part A by $70,000 (1 FTE) which Part D will fund.**
2.i	MCM-Veterans	$80,025					$80,025	

Priorities and Allocations Committee approved on 06/16/20

FY2021 - Level Funding Scenario - Draft 5 - 06-17-20

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		Part A	MAI	Part B	State Services	State Rebate	Total	FY 2021 Allocations & Justification
	Remaining Funds to Allocate	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	
2.j	MCM-Youth	$45,888					$45,888	
3	**Local Pharmacy Assistance Program**	**$1,810,360**	**$0**	**$0**	**$0**	**$0**	**$1,810,360**	
3.a	LPAP-Public Clinic	$310,360					$310,360	**FY21 Part A: Decrease Part A by $300,000 due to underspending in FY19**
3.b	LPAP-Untargeted	$1,500,000					$1,500,000	**FY21 Part A: Decrease Part A by $1,046,806 due to underspending in FY19**
4	**Oral Health**	**$166,404**	**$0**	**$2,218,878**	**$0**		**$2,385,282**	
4.a	General Oral Health			$1,658,878				**FY21 Part B: Divided Oral Health Untargeted subcategory into General Oral Health (4.a) and Prosthodontics (4.b); decreased $100,000 in General Oral Health to provide increase in Prosthodonics.**
4.b	Prosthodontics			$560,000				**FY21 Part B: Divided Oral Health Untargeted subcategory into General Oral Health (4.a) and Prosthodontics (4.b); increased $100,000 for Prosthodonics.**
4.c	Rural Dental	$166,404					$166,404	
5	**Health Insurance Co-Pays & Co-Ins**	**$1,383,137**	**$0**	**$1,028,433**	**$853,137**	**$136,918**	**$3,401,625**	**Added $43,898 per FY20 Part A Increase Scenario Note from TRG: Increased State Rebate by $11,918 and decreased Part B by $11,918 due to decrease in Part B FY20 award amount. FY21 SS: Decrease $11,369 in SS due to decrease in SS FY20 award amount.**
6	**Mental Health Services**	**$0**	**$0**	**$0**	**$300,000**	**$0**	**$300,000**	
7	**Early Intervention Services**	**$0**	**$0**	**$0**	**$175,000**	**$0**	**$175,000**	
8	**Medical Nutritional Therapy**	**$341,395**	**$0**	**$0**	**$0**	**$0**	**$341,395**	
9	**Home & Community Based Health Services**	**$0**	**$0**	**$113,315**	**$0**	**$0**	**$113,315**	
9.a	In-Home (skilled nursing & health aide)						$0	
9.b	Facility-based (adult day care)			$113,315			$113,315	
10	**Substance Abuse Treatment - Outpatient**	**$45,677**	**$0**	**$0**	**$0**	**$0**	**$45,677**	
11	**Hospice**	**$0**	**$0**	**$0**	**$259,832**	**$0**	**$259,832**	
12	**Referral for Health Care & Support Services**	**$0**	**$0**	**$0**	**$0**	**$450,000**	**$450,000**	**Note from TRG: Increased State Rebate by $75,000 to support an AEW at each clinic (1 additional FTE).**
13	**Non-Medical Case Management**	**$1,267,002**	**$0**	**$0**	**$350,000**	**$0**	**$1,617,002**	
13.a	SLW-Youth	$110,793					$110,793	
13.b	SLW-Testing	$100,000					$100,000	
13.c	SLW-Public	$370,000					$370,000	**FY21 Part A: Decrease Part A by $57,000 (1 FTE) due to budget shortfalls.**

Priorities and Allocations Committee approved on 06/16/20

FY2021 - Level Funding Scenario - Draft 5 - 06-17-20

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		Part A	MAI	Part B	State Services	State Rebate	Total	FY 2021 Allocations & Justification
	Remaining Funds to Allocate	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	
13.d	SLW-CBO, includes some Rural	$686,209					$686,209	**FY21 Part A: Decrease Part A by $57,000 (1 FTE) due to budget shortfalls.**
13.e	SLW-Substance Use	$0			$350,000		$350,000	
14	**Transportation**	**$424,911**	**$0**	**$0**	**$0**	**$0**	**$424,911**	
14.a	Van Based - Urban	$252,680					$252,680	
14.b	Van Based - Rural	$97,185		$0			$97,185	
14.c	Bus Passes & Gas Vouchers	$75,046					$75,046	
15	**Emergency Financial Assistance**	**$1,545,439**	**$0**	**$0**	**$0**	**$0**	**$1,545,439**	
15.a	EFA - Pharmacy Assistance	$1,305,439					$1,305,439	**FY21 Part A: Increase Part A by $780,439 to fund at the amount expended in FY19, and in light of unemployment resulting from the COVID-19 pandemic.**
15.b	EFA - Other	$240,000					$240,000	**FY21 Part A: Fund at $240,000 (new subcategory in FY21)**
16	**Linguistic Services**	**$0**	**$0**	**$0**	**$68,000**	**$0**	**$68,000**	
17	**Outreach Services**	**$420,000**	**$0**	**$0**	**$0**	**$0**	**$420,000**	
	Total Service Allocation	**$20,100,113**	**$2,322,959**	**$3,360,626**	**$2,005,969**	**$586,918**	**$28,376,585**	
NA	Quality Management	$412,940					$412,940	
NA	Administration	$1,795,958					$1,795,958	
NA	Compassionate Care Program					$388,082	$388,082	**Note from TRG: Decrease State Rebate by $11,918**
	Total Non-Service Allocation	**$2,208,898**	**$0**	**$0**	**$0**	**$388,082**	**$2,596,980**	
	Total Grant Funds	**$22,309,011**	**$2,322,959**	**$3,360,626**	**$2,005,969**	**$975,000**	**$30,973,565**	

Remaining Funds to Allocate (exact same as the yellow row on top)	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**

Tips:

* Do not make changes to any cells that are underlined. These cells represent running totals. If you make a change to these cells, then the formulas throughout the sheet will become "broken" and the totals will be incorrect.
* It is useful to keep a running track of the changes made to any service allocation. For example, if you want to change an allocation from $42,000 to $40,000, don't just delete the cell contents and type in a new number. Instead, type in "=42000-2000". This shows that you

Core medical **$16,442,761** **82%**

[For Staff Only]

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	Part A	MAI	Part B	State Services	State Rebate	Total	FY 2021 Allocations & Justification
Remaining Funds to Allocate	$0	$0	$0	$0	$0	$0	

If needed, use this space to enter base amounts to be used for calculations

	RW/A Amount Actual	MAI Amount Actual	Part B actual	State Service est.	State Rebate est.	
Total Grant Funds	$22,309,011	$2,322,959	$3,360,626	$2,005,969	$975,000	$30,973,565