Houston Area HIV Services Ryan White Planning Council

Office of Support
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MEMORANDUM

To: Steering Committee Members:
Crystal R. Starr, Chair
Skeet Boyle, Vice Chair
Kevin Aloysius, Secretary
Holly Renee McLean, Co-Chair, Affected Community Committee
Tony Crawford, Co-Chair, Affected Community Committee
Josh Mica, Co-Chair, Comprehensive HIV Planning Committee
Steven Vargas, Co-Chair, Comprehensive HIV Planning Committee
Ronnie Galley, Co-Chair, Operations Committee
Matilda Padilla, Co-Chair, Operations Committee
Bobby Cruz, Co-Chair, Priority and Allocations Committee
Peta-gay Ledbetter, Co-Chair, Priority and Allocations Committee
Denis Kelly, Co-Chair, Quality Improvement Committee
Daphne L. Jones, Co-Chair, Quality Improvement Committee

Copy: Carin Martin
Heather Keizman
Mauricia Chatman
Yvette Garvin
Sha'Terra Johnson-Fairley
Mackenzie A. Hudson
Diane Beck
Ann Robison
David Williams (email only)

From: Tori Williams

Date: Thursday, May 26, 2022

Re: Meeting Announcement

We look forward to seeing you at the:

Ryan White Steering Committee Meeting
12 noon, Thursday, June 2, 2022

Join the Zoom Meeting by clicking on:
https://us02web.zoom.us/j/85782189192?pwd=YmtrcktWcHY5SlV2RE50ZzYraEErQT09
Meeting ID: 857 8218 9192
Passcode: 885832
Or, use your phone to dial in by calling 346 248-7799

Please contact Rod to RSVP, even if you cannot attend. She 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
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STEERING COMMITTEE

AGENDA
12 noon, Thursday, June 2, 2022

Join Zoom Meeting by clicking onto:
https://us02web.zoom.us/j/85782189192?pwd=YmtrcktWcHY5SlV2RE50ZzYraEErQT09
Meeting ID: 857 8218 9192
Passcode: 885832
Or, dial in by calling 346 248-7799

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

II. Public Comment and Announcements

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

III. Reports from Committees

A. Comprehensive HIV Planning Committee — Steven Vargas and Josh Mica, Co-Chairs

Item: 2022 Integrated HIV Prevention and Care Services Plan

Recommended Action: FYI: Staff has accomplished the following in their efforts to gather data for the 2022 Integrated Plan:

- Developed a work plan. See attached.
- Developed a crosswalk of comprehensive plans for HIV and other fields from the national, state and local levels – Complete
- Developed a resource inventory – Complete
- Identified and summarized all local, HIV needs assessments – Partially complete. Waiting for recent prevention needs assessments from both the City and County Health Departments.
- Conducted at least 11 focus groups with approximately 95 people from priority populations such as: individuals who are transgender, gay, bisexual and MSM; and/or individuals who have injected drugs, exchanged sex for money, food or housing, were born outside of the US, are young and others. See the attached list.
- In the process of interviewing 36 stakeholders. See the attached list.

Item: 2022 Integrated HIV Prevention and Care Services Plan
Recommended Action: FYI: The Planning Council, CPG and the Houston Health Department have hosted four Quality of Life Workgroup meetings in an effort to create a 5th Pillar. See the attached for the recommended vision statement, definition and themes. The workgroup is now in the process of turning the themes into action items for the Integrated Plan. Contact Diane to receive announcements about upcoming meetings.

Item: Final Decision-Making Process for the 2022 Integrated HIV Prevention and Care Services Plan
Recommended Action: **Motion:** Under the leadership of three process co-chairs representing Ryan White Parts A, Part B and CPG, recommendations made at the community integrated planning meetings will move forward to the CPG and Ryan White Planning Council for final approval. (CPG has approved this motion.)

Item: 2022 Quarterly Committee Report
Recommended Action: FYI: See the attached quarterly report.

B. Joint Meeting of the Affected Community and Project LEAP Committees — Holly Renee McLean and Tony Crawford, Co-Chairs

Item: 2021 Project LEAP Evaluation Report
Recommended Action: FYI: See the attached Summary of the 2021 Project LEAP Evaluation Report

Item: 2022 Project LEAP
Recommended Action: **Motion:** Use the same service definition and student selection guidelines in 2022 that were used in 2021.

Item: 2022 Project LEAP
Recommended Action: FYI: If the last two items are approved, Project LEAP 2022 will begin on July 27, 2022, with the students graduating shortly before Thanksgiving. It will be taught using a hybrid format. All Ryan White volunteers are encouraged to help recruit student applicants. See the attached flyers and application forms which will be distributed at Ryan White funded clinic sites, displayed at universities, local bars and more. See the attached list of distribution sites. Please spread the word in person, virtually and more.

Item: 2022 Proyecto VIDA
Recommended Action: FYI: Verbal updates on Proyecto VIDA. This program is scheduled to start on June 8, 2022. — Steven Vargas, Co-Facilitator Proyecto VIDA

C. Quality Improvement Committee — Denis Kelly and Daphne Jones, Co-Chairs
Item: ADAP Updates as of May 3, 2022
Recommended Action: FYI: See attached updates.

Item: Reports from AA – Part A/MAI*
Recommended Action: FYI: No reports were received in May 2022 due to the unusual meeting date.

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

- FY 20/21 Procurement Report – Part B, dated 03/17/22
- FY 21/22 Procurement Report – State Services, dated 03/17/22
- FY 21/22 Service Utilization Report – State Services, dated 03/29/22
- FY21/22 Health Insurance Program Report, dated 03/21/22

Item: Public Comment Regarding Mental Health, dated 05/03/33
Recommended Action: FYI: In response to the attached public comment, the Mental Health service definition will not be voted on today. Because Mental Health is funded with State Services dollars, there is time to review and make recommendations regarding this service at the next Quality Improvement Committee meeting.

Item: FY 2023 Service Definitions and Financial Eligibility
Recommended Action: **Motion:** Approve the attached FY 2023 Service Definitions and Financial Eligibility recommendations for Ryan White Part A/MAI, Part B and State Services funded services. See the attached Summary of How To Best Meet the Need recommendations (neon green paper) and financial eligibility (on the Table of Contents).

Item: FY 2023 Targeting for FY 2023 Service Categories
Recommended Action: **Motion:** Approve the attached FY 2023 Targeting for Ryan White Part A/MAI, Part B and State Services funded service categories (neon pink paper).

Item: Coordination of Substance Use Disorder Prevention & Care Services
Recommended Action: FYI: Per the instructions for the 2022 Integrated HIV Prevention and Care Services Plan, the Houston EMA is to create a plan for the coordination of substance use disorder prevention and care services. Soon, a workgroup meeting will be called to discuss the topic. All are encouraged to attend.

D. Priority and Allocations Committee — Peta-gay Ledbetter and Bobby Cruz, Co-Chairs
Item: FY 2023 Service Priorities
Recommended Action: FYI: The Committee made recommendations regarding the FY 2023 service priorities, which will be presented to the Steering Committee and Planning Council after the public hearing in late June 2022.

** MAI = Minority AIDS Initiative Funding*

Item: Ryan White FY 2023 Allocations
Recommended Action: FYI: The process for allocating FY 2023 Ryan White Part A/MAI, Part B and State Services funding will begin in early June 2023. See Diane if you wish to receive reminders.

E. Operations Committee — Ronnie Galley and Matilda Padilla, Co-Chairs
Item: FY 2023 Council Support Budget
Recommended Action: FYI: Because the Operations Committee was unable to meet in May, the attached FY 2023 Council Support Budget will be discussed at the June 14, 2022 Committee meeting and presented to the Steering Committee and Council in July 2022. Please see the attached, proposed budget as an FYI. All are welcome to send public comment, or observe the June 14th Committee meeting.

V. Report from the Office of Support — Tori Williams, Director

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

VII. Report from The Resource Group — Sha'Terra Johnson, Health Planner

IX. Announcements

X. Adjournment

HOUSTON AREA HIV SERVICES RYAN WHITE PLANNING COUNCIL
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STEERING COMMITTEE

MINUTES

12 noon, Thursday, April 7, 2022
Meeting Location: Zoom teleconference

MEMBERS PRESENT	MEMBERS ABSENT	STAFF PRESENT
Skeet Boyle, Vice Chair	Crystal Starr, excused	*Ryan White Grant Administration*
Kevin Aloysius, Secretary	Holly McLean, Excused	Carin Martin
Tony Crawford		Mauricia Chatman
Josh Mica		
Steven Vargas		*The Resource Group*
Ronnie Galley		Sha'Terra Johnson
Matilda Padilla		Liege Quednau, Intern
Bobby Cruz		
Peta-gay Ledbetter		*Office of Support*
Daphne L. Jones		Tori Williams
Denis Kelly		Mackenzie Hudson
		Diane Beck

Call to Order: Ardry Skeet Boyle, Vice Chair, called the meeting to order at 12:03 p.m.

During the opening remarks, Boyle thanked everyone who has been participating in the Quality of Life Workgroups. At least 60 people have joined the discussions about adding a 5th pillar to the structure that CDC and HRSA developed to End the HIV Epidemic. This 5th pillar looks at quality of life and why we need more than biomedical solutions to end the epidemic. Send Diane an email if you wish to receive meeting invitations. Meetings are hybrid so participants can join via Zoom or come to the church in person. To get the meeting address or the Zoom link, you must register. The next meeting will be on May 5, 2022 at 4 pm. Boyle then called for a Moment of Reflection.

Boyle invited committee co-chairs to select the co-chair who would be voting on behalf of their committee. Those selected to vote for their committee at today's meeting are: Crawford for Affected Community, Vargas for Comprehensive HIV Planning, Padilla for Operations, Ledbetter for Priority and Allocations and Jones 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 March 3, 2022 minutes.* **Motion carried.** Abstentions: Aloysius, Padilla.

Public Comment and Announcements: None.

Reports from Committees

Comprehensive HIV Planning Committee: Steven Vargas, Co-Chair, reported on the following:
2022 Integrated HIV Prevention and Care Services Plan: The timeline to produce the 2022 Integrated Plan is as follows (see attached, detailed timeline):

- Write select portions of the plan using consultants - done
- Gather data – January thru June
- Educate the community on the data gathered – April thru June
- Community meetings to finalize the EHE Plan – July
- Community meetings to create strategies & more for the Integrated Plan – Aug.
- Write remaining portions of the Plan – Sept thru Nov
- Polish and submit the Plan – late November (Due Dec. 9, 2022)

2022 Integrated HIV Prevention and Care Services Plan: The Quality of Life Workgroup meetings and the Focus Group meetings have been going well.

2022 Integrated HIV Prevention and Care Services Plan: Should Houston share our crosswalk of national, state and local comprehensive plans with others in Texas as a show of collaboration and cooperation among all Texas planning bodies? And, should those who our crosswalk as a template be asked to credit the Houston Planning Council? ***Motion #3****: it was moved and seconded (Kelly, Galley) to share our crosswalk with other Texas planning bodies and ask to be credited for the baseline document.* **Motion Carried.**

Affected Community Committee: Tony Crawford, Co-Chair, reported on the following:
The Committee did not meet in March so that members could attend the Joint Meeting of all committees to review and approve the criteria used to justify the FY 2023 service definitions.

Quality Improvement Committee: Daphne Jones, Co-Chair, reported on the following:
Criteria for FY 2023 Service Categories: ***Motion #4:*** *Approve the attached criteria to be used to justify the FY 2023 Service Categories.* **Motion Carried.**

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

- FY21 Procurement Report – Part A/MAI, dated 03/08/22
- FY21 Service Utilization Report, 3rd Qtr. – Part A/MAI, dated 03/08/22
- FY20 Chart Reviews:
  - Primary Care
  - Case Management
  - Oral Health – Rural
  - Vision Care

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

- FY21 Health Insurance Program Report, dated 03/09/22

Operations Committee: Matilda Padilla, Co-Chair, reported on the following:
In-Person vs. Virtual Meetings: ***Motion #5:*** *Due to the loss of the large meeting rooms at the current office location, and the impending move to another location:*

- *Planning Council meetings will be held off-site as hybrid meetings.*
- *Ryan White standing committee and many workgroup meetings will continue to be held virtually.* *(continued on next page)*

If a member of a committee or the public wish to attend a standing committee or workgroup meeting in person, up to four individuals can participate in the meeting at the Office of Support, with preference given to the public and the committee/workgroup meeting co-chairs. **Motion Carried.**

Committee Vice Chair: Skeet Boyle was elected to serve as the Committee Vice Chair.

2022 Council Training Schedule: The Operations Committee is going collaborate with the Comprehensive HIV Planning Committee to Coordinate 2022 Council trainings with trainings needed for the Integrated Plan.

Priority and Allocations Committee: Bobby Cruz, Co-Chair, reported on the following:
The Committee did not meet in March so that members could attend the Joint Meeting of all committees to review and approve the criteria used to justify the FY 2023 service definitions.

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, Health Planner, summarized the attached report.

Announcements: Boyle said that the HIV and Aging Coalition is having a meet and greet tomorrow at Montrose Center. He also said that St. John's is still doing drive up food distribution events and now includes a walk up option for those who do not drive. Mica put in the Zoom Chat: Bunnies on the Bayou is back this Easter Sunday, which provides funding for a lot of good beneficiaries. If you are interested in volunteering, please reach out to him or purchase tickets at https://bunniesonthebayou.org/.

Adjournment: ***Motion:*** *it was moved and seconded (Boyle, Mica) to adjourn the meeting at 1:14 p.m.* **Motion Carried.**

Submitted by: Approved by:

_____ _____

Tori Williams, Director Date Committee Chair Date

2022 Steering Committee Voting Record for Meeting Date 04/07/22

C = Chaired the meeting, ja = Just arrived, lm = Left the meeting
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** Share our crosswalk **Carried**				**Motion #4** Criteria to justify the FY23 Service Categories **Carried**				**Motion #5** Hybrid/Virtual Meetings **Carried**			
	Absent	**Yes**	**No**	**Abstain**	**Absent**	**Yes**	**No**	**Abstain**	**Absent**	**Yes**	**No**	**Abstain**	**Absent**	**Yes**	**No**	**Abstain**	**Absent**	**Yes**	**No**	**Abstain**
Skeet Boyle, Vice Chair				**C**				**C**				**C**				**C**				**C**
Kevin Aloysius, Secretary		**X**				**X**				**X**				**X**				**X**		
Tony Crawford, Aff	**X**				**X**					**X**				**X**				**X**		
Steven Vargas, Comp		**X**				**X**				**X**				**X**				**X**		
Matilda Padilla, Op		**X**				**X**				**X**				**X**				**X**		
Peta-gay Ledbetter, PA		**X**				**X**				**X**				**X**				**X**		
Daphne L. Jones, QI		**X**				**X**				**X**				**X**				**X**		
Non-voting members at the meeting:																				
Josh Mica, Comp																				
Ronnie Galley, Op																				
Bobby Cruz, PA																				
Denis Kelly, QI																				
Absent members:																				
Crystal Starr, Chair																				
Holly McLean, Aff																				

Comprehensive HIV Planning Committee Report

WORKPLAN

2022 Integrated HIV Prevention and Care Plan
Due to CDC and HRSA on December 9, 2022

April 2021 – July 2022:	**Gather information** from racial justice trainings, reviewing services attached to EHE pillars, focus group meetings with priority populations and subject matter-expert stakeholders.
June 2022	**Community Education Meetings** Host community meetings to present all data gathered from the focus groups, stakeholder interviews, needs assessments, resource inventory, crosswalk of comprehensive plans and more.
July 2022	**Complete the Houston EHE Plan**
Early August 2022	Host a 1-2 final **Community Education Meetings**
Mid August 2022	Host 1 -5 community meetings to **create the strategies, objectives and activities.** Use breakrooms if some of the work can be divided into sections, such as early intervention, coordination of effort, etc. These meetings could be facilitated by 3 process co-chairs who represent Ryan White Part A (the Planning Council), Ryan White Part B (rural areas) and CPG.
Sept – Oct 2022	**Write the Plan** ***Who provides "final" approval of the plan?***
November 2022	**Get Letters of Concurrence from Planning Bodies**

Focus Groups with Priority Populations identified by CPG or PC:

To date, approximately 95 people from priority populations have been interviewed within focus groups. Three focus groups with TSU students have also been held. Their demographic data to be provided at a later data. It is not included in the data below and will be kept separate throughout the project.

- Transgender individuals, esp. those who are LatinX/Black and/or under the age of 25 – **Need more** – we have set up 3 more focus groups for June.
- Gay, bisexual MSM, esp. those who are LatinX/Black – **Need more** – Two more focus groups have been scheduled at FLAS.
- People who exchange sex for money, etc. – **Complete**
- People who inject drugs or use methamphetamine or crack – **Complete**
- Heterosexual cisgender women of color, esp. those living in high HIV or STI prevalence neighborhoods – **Complete**
- People who were born outside the US – **Complete**
- Youth – **Complete**

Also scheduled in May and June: 2 – 4 more focus groups with individuals who are recently released.

Stakeholder Interviewees for the 2022 Integrated Plan

ADOLESCENTS

- Robert Woods, The Center for Success & Independence
- Gloria Sierra, Transitions adolescents into adult care
- Legacy representative in charge of their school-based
- Dr. Charlene Flash, Cougar SMART Program with Avenue 360
- Christine Markham, Chair of UT Health Promotion program
- Nettie Johnson, retired RN, Baylor Teen Clinic

AGING

- Kyle Leisher, SPRY Program, Montrose Center
- Tony Fernandez, LBTQ and Aging Coalition
- Jeremy Scott, HIV and Aging Coalition

CARE

- Dawn Jenkins, Director of HIV Services, Thomas St. Health Center
- An HIV case manager at the VA hospital

- Shannon Schrader, MD, Private physician who worked in private practice and for Legacy for a while
- Paul Simmons, HIV nurse, Legacy
- Carin Martin, Manager, Ryan White Grant Administration for Part A
- A representative from The Resource Group
- Katy Caldwell, Retired Executive Director, Legacy Community Health

HOMELESS

- Ana Rausch, Coalition for the Homeless
- Person coordinating the Bread of Life Housing for sex offenders and arsonists

MENTAL HEALTH

- Ann Robison, Executive Director, Montrose Center
- Andrea Usanga, Executive Director, Network of Behavioral Health Providers,
- Angelina Hudson, National Alliance on Mental Illness
- Wayne Young, The Harris Center

OTHER

- Kathy Griffin, works with sex workers
- Nike Blue, Houston Area Women's Center (HAWC)
- 1-2 Case Managers who have transitioned individuals who have lost their jobs & private insurance

PREVENTION

- Franaldo Curl, Coordinator, HCPH HIV Prevention Programs
- Marlene McNeese, National Co-Chair, President's Advisory Council on HIV/AIDS (PACHA); Bureau Chief, Houston Health Dept.
- Ann Robbins, Senior Public Health Advisor, TB, HIV/STD and Viral Hepatitis Section, DSHS.

RECENTLY RELEASED

- _____, Ed Emmett Diversion Center
- SIRR – Serving the Incarcerated and Recently Released

SUBSTANCE USE DISORDER AND RECOVERY

- _____, Lambda Center Coordinator
- Mary Beck, Council on Recovery
- DeLisa Duncan Russell, CEO, Right Step, Addiction Rehab Center
- Leonard Kincaid, Houston Recovery Center
- Dr. Thanh Thuy Truong (Dr. Truong), local representative, National Opioid Response Network

FAITH COMMUNITY LEADERS

- Pastor Rudy, St. John's Church Downtown

Quality of Life VISION for PLHIV

All people living with HIV will have unfettered and 'hassle-free,' access to a full range of life-extending high quality culturally sensitive, gender affirming care and social support free from all stigma and discrimination that prioritizes our mental, emotional, and spiritual health as well as our financial wellbeing. People living with HIV are "people first" and our quality of life is not defined by our race, gender identity, sexual orientation, HIV status or measured solely by viral suppression.

Quality of Life THEMES

1. Intersectional stigma, discrimination, racial and social justice, human rights and dignity
2. Overall wellbeing, mental, emotional and spiritual health
3. Aging, comorbidities and life span (can include functionality, cognitive ability, geriatrics)
4. Healthcare services access, care and support
5. Economic justice, employment, stable and safe housing, food security
6. Policy and research

Quality of Life DEFINITION

We demand a quality of life that achieves the following:

1. Ensures that all people living with HIV thrive and live long healthy dignified lives.
2. Recognizes that HIV is a racial and social justice issue and works to dismantle the structural barriers that marginalize and diminish our quality of life.
3. Uplifts our humanity and dignity as human beings; we are people living with HIV and not a public health threat.
4. Values our emotional labor and personal stories as worthy of compensation and meaningfully involves people living with HIV as subject matter experts in all decisions that impact our lives as paid staff and consultants and not just as volunteers.
5. Recognizes that because we have a large number of people aging with HIV that include those born with HIV, long term survivors and people over the age of 50, we need for accessible services, support and care to ensure that we age with dignity
6. Understands that safe and stable housing, healthcare and financial security are basic human rights. We should not have to live in poverty to be eligible for services.
7. Recognizes that we are human beings entitled to live full rich pleasurable sexually active lives without fear of prosecution and understands the importance of social support networks to our overall well being.
8. Embraces our rich diversity in race, age, gender identity or expression, language, sexual orientation, income, ethnicity, country of origin or where we live and tells the full story of our resilience and not just our diagnosis.

THEME #1: Intersectional stigma, discrimination, racial and social justice, human rights and dignity

Strategy	Actions/Activities	Responsible Party	Year 1, 2, 3, 4 or 5
Reduce the impact of intersectional stigma for PLHIV and communities vulnerable to HIV	Implement new research tool developed by the Global Network of PLHIV called stigma index		
Ensure that all funding, policies, programs and decisions use an intersectional racial/social justice lens approach	Develop & apply racial/social justice lens to all decision making		
Implement/Operationalize MIPA throughout all service delivery	Integrate MIPA into RW planning councils		

THEME #2: Overall well-being, mental, emotional and spiritual health

Strategy	Actions/Activities	Responsible Party	Year 1, 2, 3, 4 or 5
Focus on “people first” rather than just treating HIV	Re-evaluate rapid start and other programs to ensure that services are person centered		
Eliminate use of stigmatizing language by organizations, services and throughout the workforce	Include people first language training requirement in all contracts and pay PLHIV to deliver trainings		
Increase the availability of social support services	Require all Part A providers to provide support groups led by PLHIV Develop at least 3 support groups by December 2023 for high priority populations Develop list of peer/PLHIV willing to lead support groups and be compensated		

THEME #3: Aging, comorbidities and life span (can include functionality, cognitive ability, geriatrics)

Strategy	Actions/Activities	Responsible Party	Year 1, 2, 3, 4 or 5
Reduce mortality rates for PLHIV	Develop data that more adequately reflects mortality and comorbidities of PLHIV		
Address aging needs of PLHIV	Develop aging related services for PLHIV at all health care providers Ensure that all demographics are represented in research Create a research CAB focused on aging issues Develop needs assessment to gather data to address the special needs of verticals		

PROPOSED

Final Decision-Making Process for the 2022 Integrated HIV Prevention and Care Services Plan

Philosophy: The planning bodies are responsible for submitting one integrated prevention and care services plan that includes the Ending the HIV Epidemic Plan as a component within the Integrated Plan. The planning bodies are also responsible for working with our community partners to carry out the activities listed within the plan.

Note regarding this particular plan: HRSA and CDC are very clear that, throughout the Integrated Plan, they want the voices of new people who have come to the planning table through new outreach efforts.

3 Co-Chairs – Representatives from Part A, Part B & CPG

Workgroups – instead, use the information gathered from:

Focus groups with special populations

Stakeholder interviews

August Community Meetings

PROPOSED MOTION: Under the leadership of 3 Process Co-Chairs representing Ryan White Parts A, Part B, and CPG, recommendations made at the community integrated planning meetings will move forward to CPG and the Ryan White Planning Council for final approval.

2022 QUARTERLY REPORT
COMPREHENSIVE HIV PLANNING COMMITTEE

(May 2022)

Vision for the Comprehensive HIV Planning Committee

"Houston will become a place where new cases of HIV are rare and when they do occur, every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity or socio-economic circumstance, will have unfettered access to high quality, life-extending care, free from stigma and discrimination"

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

1. Assess, evaluate, and make ongoing recommendations for the Integrated HIV Prevention and Care Services Plan and corresponding areas of the Ending the HIV Epidemic Initiative, in collaboration toward the development of an ending the HIV epidemic plan.

   Ongoing

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

   Completed

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.

   To be done soon

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

   Currently working on

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

   Done

Steven Vargas and Josh Mica, Co-Chairs — May 12, 2022

Committee Chairperson — **Date**

Affected Community Committee Report

Houston Area HIV Services Ryan White Planning Council
Office of Support

Project L.E.A.P. 2021 Course Overview

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

Week	Date	Topics
1	July 28 Zoom	• Overview of Project LEAP • Housekeeping, Logistics, Ground Rules and Expectations • Student Introductions and Expectations • HIV, Hepatitis and COVID-19 • Robert's Rules of Order • Ending the HIV Epidemic Initiative
2	August 4 Zoom	• Epidemiology Overview • Panel: Barriers to Reaching, Linking & Retention in Care, focusing on African Americans, Hispanics, MSM and Youth • Needs Assessment and Introduction to the Class Project • Class Project – Survey skills training
3	August 11 Zoom	• HIV Prevention Programs: CDC to CPG • PrEP and PEP • Overview of HIV Care Funds • From HRSA to Council: Overview of the Ryan White Program • Designing HIV Care Services *"How to Best Meet the Need"*
4	August 18 Zoom	• The HIV Continuum of Care • Comprehensive HIV Planning • LEAP Class Project • Barriers to Care for the Transgender Community
5	August 25 Zoom	• LEAP Class Project • Government 101 • The Criminalization of HIV
6	September 1 Zoom	• Epi Report and EIIHA Strategy • Intimate Partner Violence/Coercive Control & HIV • Advocacy 101 and Positive Women's Network
7	September 8 Zoom	• Ending the HIV Epidemic Brainstorming Session • Housing Opportunities for Persons with AIDS (HOPWA) • Blue Book Jeopardy
8	September 15	No class – students attend one of several Ending the HIV Epidemic workgroup meetings in August

Houston Area HIV Services Ryan White Planning Council
Office of Support

Project L.E.A.P. 2021 Course Overview

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

Week	Date	Topics
9	September 22 Zoom	• Standards of Care & Perform Measures • Conflict of Interest • RFP (Request for Proposal) Process • Homelessness and HIV • People First Language
10	September 29 Zoom	• Plan for LEAP Graduation • Priority and Allocations Exercise
11	October 6 Zoom	• Leadership and Presentation Skills Training
12	October 13	No class – students attend an HIV related community meeting of their choice before the end of October
13	October 20	• History of HIV in the Houston Area • Plan for LEAP Graduation • Community Meeting Report-Backs • Council and CPG Application Forms
14	October 27	• Empowerment • LEAP Class Project
15	November 3	• Practice Class Project Presentation • Prepare for the RWPC Meeting • From Project LEAP to Planning Body: Panel of Planning Body and C.A.B. Members • Council and CPG Application Forms
16	**Thursday,** November 11	• Practice Class Project Presentation • Council and CPG Application Forms • Attend the RWPC Meeting and Present the Class Project • Course Wrap-Up, Feedback and Evaluation
17	**November 30** **United Way**	• Graduation Dinner and Ceremony

SUMMARY

Evaluation of Project LEAP 2021

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

The Evaluation Report summarizes results from the 2021 Project LEAP cohort, including the ways in which the 2021 syllabus met the objectives outlined in the RWPC-approved Service Definition, the extent of the program's achievement in increasing the knowledge and skills of PLWH and affected individuals, and lessons learned for future program implementation.

In 2020 and 2021, local health departments issued stay-at-home guidance due to the COVID-19 pandemic. As a result, the start times for both programs was postponed from early April to early August. Also, many health department employees were deployed to COVID-related tasks and were unavailable as HIV subject experts at a couple of Project LEAP classes. In spite of this, the 2020 and 2021 Project LEAP classes met the goals and had high student retention rates throughout the 17-week program.

SERVICE DEFINITION OBJECTIVE 1: In 2021, class was held once a week from July 28 – November 11, 2021. There were at least 44 contact hours of classroom training, most of which were held virtually. There were also 6 hours of participation in planning body activities, although these were Ryan White activities since the Houston HIV Prevention Community Planning Group hosted few, if any, meetings during that timeframe. Instead, students attended Ending the HIV Epidemic workgroup meetings as well as an HIV-related community meeting of their choice. Project LEAP 2021 met all curriculum requirements, in spite of limited access to subject experts.

SERVICE DEFINITION OBJECTIVE 2: Only one student applicant wanted to attend the evening class and he was able to change his work schedule to allow him to participate in the morning class. Hence, the 2021 program only offered a morning class, which started with 18 students. The one student who was under the age of 24 never attended a class. The remaining 17 students graduated. Of the students enrolled in the program, 67% were male, 22% were female and 11% were transgender females. Race/ethnicity included 72% black, 11% Latinx and 17% white. Of those who graduated, 3 applied for and were appointed to the 2022 Ryan White Planning Council. Another graduate became an Affiliate Committee member and five are participating in the Integrated Planning workgroup meetings. It is unknown how many applied to be CPG members.

THE LIFE-CHANGING IMPACT OF PROJECT LEAP: Perhaps because the classes were virtual, it was exceptionally difficult to collect weekly evaluations from the students. But, the following quotes indicate that the students benefited from the class:

- Project L.E.A.P. has taught me to become a better leader and advocate for the community. They do such a great job in showing you all of the available Ryan White resources. They help you find your voice!
- Project L.E.A.P. has given me Tons of New Information that is Available to those that are living HIV+ as well as Re-Enforced and updated the information I already knew. I had an Amazing group of Classmates and Instructors. I look forward to passing on this information to those I can and one

day we will "Ring the Bells" to see the end of the HIV/AIDS Epidemic.

- Project L.E.A.P. has introduced me to some of the most passionate, knowledgeable, and friendliest people I have ever known. From the LEAP cohort, to the presenters, to the LEAP leaders, I have felt welcomed into this safe space and have been encouraged to learn and grow while encouraging others in my cohort to do the same. It has been an honor to meet everyone and I hope to take the friendships, connections, and knowledge I have gained throughout these past months and make a real difference in the world. Thank you, Project L.E.A.P.!
- Project LEAP is a magnificent program where a well deserved group of people come together and share their strength, experiences, and hope. It's a safe space for those living with HIV and their allies to bring together ways to end the HIV epidemic.
- Project Leap has made me an even stronger Man. You never know what the next person is going through. I'm here to do the work and not to just collect a check
- Project LEAP has been an opportunity for me to get a glimpse into my new reality. I can no longer disassociate my experience as a member of this community. While I have much more to learn I know that I will experience growth if I keep heading in the right direction as a person seeking to positively impact PLWH because "nothing about us without us is for us.

BUDGET INFORMATION:

Original Cost of the Program:	$ 52,000
2021 Cost of the Program:	- 5,169
Total Savings in 2021	**$ 46,831**

2021 Expenses:

Supplies	$ 550
Facilities Rental	
St. Philips Church (3 classes)	210
United Way (graduation)	413
Speaker Fees	300
Student Reimbursement	0
Meals (graduation)	2,119
Staff Mileage	0
Miscellaneous	
Graduation shirts	855
Masks	494
Hand sanitizer	228
TOTAL	**$ 5,169**

2021 CURRICULUM: See next two pages

Service Category Title: Grant Administration – 2021 Project LEAP

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

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

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

Except under unusual circumstances, such as severe weather or a public health emergency (for example an outbreak of the flu), each class provided during the term of this agreement will include graduation and at least:

A. 44 contact hours of classroom training;

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

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

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

Agency will provide reimbursement of eligible expenses to participants during the period of enrollment to reimburse these participants for out of pocket costs related to their in-person classroom participation, limited to transportation, childcare, and meals.

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

Agency will provide Harris County with a written report summarizing the activities accomplished during the term of the contract within thirty calendar days after the completion of the project. If completed with a noncontract agreement, written report must be submitted at the end, or before the end, of the project calendar year.

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

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

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

1. Establishing realistic training schedule(s) which accommodate varying health situations of those selected participants;
2. Conducting a pre-training evaluation of participants to determine their knowledge and beliefs concerning HIV disease and understanding of HIV-related funding processes in the Houston area. Agency must incorporate responses from this pre-training evaluation in the final design of the course curriculum to ensure that, to the extent reasonably possible, the specific training needs of the selected participants are addressed in the curriculum;
3. Conducting a post-training evaluation to measure the change in participants knowledge and beliefs concerning HIV disease and understanding of HIV-related funding processes in the Houston area;
4. Providing reimbursement of allowable expenses to help defray costs of the individual's in-person participation, limited to transportation, child care, and meals; and

5. Providing both lecture and hands-on experiential class activities to enable participants to maximize opportunities for learning, except under unusual circumstances, such as severe weather or a public health emergency when hands-on activities are not feasible.

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

1. Involving HCPH/RWGA, The Houston Regional HIV/AIDS Resource Group (TRG) and other administrative agencies for public HIV care and prevention funds in curriculum development and training activities;
2. Ensuring representatives from the RWPC, the Houston Community Planning Group (CPG) and Project LEAP alumni are members of the Project LEAP External Advisory Panel. The responsibility of the Project LEAP External Advisory Panel is to:
   - Assist in curriculum development;
   - Provide input into criteria for selecting Project LEAP participants;
   - Assist with the development of a recruitment strategy;
   - If the agency finds it difficult to find individuals that meet the criteria for participation in the Project, assist with student recruitment; and
   - Review the final report for the Project in order to highlight the successes and brainstorm/problem solve around issues identified in the report. The results of the review will be sent to the Ryan White Operations Committee and the next Advisory Panel.
3. Collaborating with the Project LEAP External Advisory Panel during the initial 60 days of the Contract term. The criteria developed and utilized will, to the maximum extent possible, ensure participants selected represent the groups most affected by HIV disease, consistent with current HIV epidemiological data in the Houston EMA/HSDA, including youth (ages 18-24) and transgender persons living with HIV.

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

EXAMPLES

Recommended Project LEAP Class of 2021

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

	EMA HIV/AIDS prevalence as of 12/31/25*		PC Members as of 09/01/25		Non-Aligned Consumers on PC	
Race/Ethnicity	**No.**	**%**	**No.**	**%**	**No.**	**%**
White, not Hispanic	5,605	26.85%	7	19.44%	4	25.00%
Black, not Hispanic	10,225	48.98%	19	52.78%	8	50.00%
Hispanic	4,712	22.57%	10	27.78%	4	25.00%
Other	333	01.60%	0	00.00%	0	0.00%
Total*	**20,875**	**100%**	**36**	**100%**	**16**	**100%**
Gender	**Number**	**Percentage**	**No.**	**%**	**No.**	**%**
Male	15,413	73.83%	21	58.33%	11	68.75%
Female	5,462	26.17%	15	41.67%	5	31.25%
Total*	**20,875**	**100%**	**36**	**100%**	**16**	**100%**

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

DRAFT

2021 Project LEAP Student Selection Guidelines

The following guidelines will be used by the Office of Support to select students for the 2021 Project LEAP cohort. They are presented in order of priority:

1. As outlined in the 2021 Service Definition for Project LEAP:

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

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

2. If the applicant is a prior LEAP graduate, they may be selected for the 2021 cohort if they have not been appointed to the Planning Council following LEAP participation and if space in the class is available.

3. Be available for the 2021 Project LEAP class schedule.

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

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

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

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

Last Updated 5/23/2022

2022 Project LEAP Recruitment

Status	Date	Location/Event	Recruiter
AGENCIES			
		AIDS Healthcare Foundation/Out of the Closet	Tori → Matilda
		Avenue 360	Tori → Denis
		Harris Health/TSHC	Tana
		Legacy (California)	Tana
		Montrose Center	Crystal (maybe), Tana
		St. Hope Foundation	Tana (Greenspoint) Crystal (Bellaire, will email to Herman for distribution) Skeet (Sugar Land)
		Bee Busy	Skeet
		AAMA	Steven
		Accesshealth/Ft. Bend	Diane
		AFH & Housing Complexes	Johnny
		Baylor Teen Clinics	Diane/Paul R.
		Bering support group, church, dental clinic, day treatment	Allen
		Blast Fax	Diane
		Brentwood Project WAITT	Ronnie
		A Caring Safe Place/Lydia's Place	Skeet
		Catholic Charities	Tori → Carol
		Central Care	
		Change Happens!	Skeet
		HATCH (Montrose Center)	Tana
		HAWC	Tori → Nike
		Law Harrington Apartments	Skeet
		Living Without Limits	Cecilia (NOT CURRENTLY MEETING)
		Lord of the Streets	Crystal (Partial services)
		RMCC	Robert
		San Jacinto Apartments	Skeet/Johnny/Crystal
		Santa Maria Hostel	Diane
		St. John's Downtown/Bread of Life	Skeet
		SEARCH	Crystal will check if open
		Tony's Place	Skeet/Johnny/Crystal
		The Women's Home	Tana
GROUPS			
		2005 – 2021 LEAP Graduates	Diane
		AA State of Emergency Task Force	Tori → Sha'Terra
		Adolescent Trial Network	Tori → Moreniké
		FIMR	Diane
		Ft. Bend Coalition	Tori → Sha'Terra
		HCV Task Force	Tori → Steven
		Heterosexual Peer Group	Tori → Cecilia
		HIV & Aging Coalition	Skeet

Status	Date	Location/Event	Recruiter
GROUPS	***continued***		
		HIV Prevention Contractors	Tori → HHD
		HOPWA All-Providers	Tori → Melody
		Houston Medical Monitoring Project	Tori → Osaro
		IMPAACT CAB	Tori → Moreniké
		Impulse Group Houston	Crystal
		Latino HIV Task Force	Tori → Gloria
		Mahogany Project	Crystal
		MPACT	Tori → Antonio
		National HIV Behavioral Surveillance	Tori → Imran
		Part A CM Supervisors/CM	Diane
		Part D Partners	Tori → Sha'Terra
		Positive Women's Network	Tana
		Project PATHH	Skeet
		Rural Part B/SS Providers	Tori → Sha'Terra
		Save Our Sisters	Crystal
		Serenity Sisters Support Group	
		SIRR	Diane
		Youth Task Force	Tori → Gloria
		United Way Interagency Meeting	NOT CURRENTLY MEETING
		VA Hospital	Tori → Chris E. OR Cecilia
MEDIA/ONLINE			
		Ads in Outsmart, Houston Defender, and community newspapers in rural areas; RMCC bulletin/email list	Diane
		DSHS Insider	Tori
		Idealist	Tori
		Posse (largest HIV+ meetup grp in Houston)	Allen → Denis
		Project LEAP Alumni FB Page	Diane
		Texas HIV Coalition FB Page	Diane
SPECIAL EVENTS			
		AIDS Walk	NOT APPLICABLE
		Organizing for Power	Tana
		Planning Council	Diane
		Volunteer Round Up (date TBD)	NOT APPLICABLE
OTHER			
		Multi Service Centers • Acres Home • Emancipation • Hiram Clarke • Kashmere • Leonel Castillo • Sunnyside • Third Ward • West Gray	All
		Social Media sites	All
		Bars/Clubs/testing events	All
		Grocery Stores	All
		Post Offices	All
		Houston Community College	Crystal
		Joseph Gathe, MD office	Skeet
		Grace Place	Crystal

Status	Date	Location/Event	Recruiter
OTHER	***continued***		
		Green Grove MBC	
		Greater New Hope Baptist Church	
		~~Houston Public Library~~	They told Tracy NO, Ms. Dee also told NO
		Lone Star College	
		Kindred & Plymouth Church	Tori → Amber re church list
		Radio PSA	NOT APPLICABLE
		Rice University	Tori → Bobby
		St. Joseph downtown	Tori
		St. Thomas	Tori → Bobby
		San Jacinto College	Allen
		SHAPE Community Center	Crystal
		Shrine of the Black Madonna	Crystal
		U of H downtown and central	Tori
		TSU	Crystal, Tana
		Urgent Care Clinics	All
		Walgreens	Tori → Tom Lindstrom
		Wheeler Ave Church	NOT CURRENTLY MEETING
		Dr. Crofoot	Tori → Maggie
		Dr. Schrader	Tori
		U.T. Physicians – Fannin	
		U.T. Physicians – Bellaire	Tori → Bobby
		Dr. Gary Brewton	Tori
		Baylor Clinic	Allen
		Dr. Arya Mouisha	Tori → Dr. Patel

Project LEAP 2022

Project LEAP has allowed me the chance to stop standing on the sideline of the HIV/AIDS field, now I can start being an actual player.

~ Project LEAP Graduate

Project L.E.A.P….Learning, Empowerment, Advocacy, and Participation

~

What is Project LEAP?

A free 17-week training course for individuals living with or affected by HIV to gain the knowledge and skills they need to help plan HIV prevention and care services in the Houston Area. Topics covered include HIV 101, a history of HIV in the Houston area, local HIV trends, services for people living with HIV and much, much more!

When Does it Meet?

Wednesdays from July - November (on Zoom)
Students may join ONE of two classes:

Option 1: Day class: 10:00 am – 2:00 pm

Option 2: Evening class: 5:30 – 9:30 pm

How To Apply?

A brief written application and interview are required. To receive an application, please contact the Ryan White Planning Council Office of Support: 832 927-7926

Or, you can apply online at
www.surveymonkey.com/r/P-LEAP2022

Deadline to Apply:

Applications must be received by 5pm on Friday, July 8, 2022. If you wish to apply after July 8th, please call the Office of Support: 832 927-7926.

If you have questions about Project LEAP or the application process, please contact:

Diane Beck, Office of Support at 832 927-7926, Diane.Beck@cjo.hctx.net or **www.rwpchouston.org**

Internal use only:
Date received: _____
Date of interview: _____
Selected: ☐ Yes ☐ No

Houston Area HIV Services Ryan White Planning Council
Office of Support

2223 West Loop South, Suite 240; Houston, Texas 77027
Phone 832-927-7926 ◆ Fax 713-572-3740 ◆ www.rwpchouston.org

APPLICATION FOR PROJECT LEAP CLASS OF 2022

APPLICANT INFORMATION:

DATE: _____

FIRST NAME: _____ NICKNAME: _____ LASTNAME: _____

ADDRESS: _____ APT/UNIT #: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ CELL: _____ EMAIL: _____

If applicable: EMPLOYER: _____

POSITION/TITLE: _____

PHONE: _____ *EMAIL:* _____ Can we contact you at work? ☐ No ☐ Yes

PREFERRED COMMUNICATION: ☐ Home phone ☐ Cell phone ☐ Home email ☐ Work phone ☐ Work email

- **Have you ever been in Project LEAP?** ☐ No ☐ Yes, but did not graduate ☐ Yes, graduated. Year: _____*
  **If you graduated, were you appointed to the Ryan White Planning Council?* ☐ *No* ☐ *Yes* ☐ *I don't know*

EMERGENCY CONTACT:

NAME: _____ RELATIONSHIP TO YOU: _____

PHONE: _____ EMAIL: _____

DEMOGRAPHIC INFORMATION:

THE PROJECT LEAP SERVICE DEFINITION REQUIRES THE COLLECTION OF CERTAIN DEMOGRAPHIC INFORMATION ABOUT ALL APPLICANTS. THIS INFORMATION WILL NOT BE USED FOR ANY OTHER PURPOSE THAN FOR THE SELECTION OF PROJECT LEAP PARTICIPANTS.

Please check <u>one box</u> for each item below:

Gender: ☐ Male ☐ Female ☐ Transgender/Gender Non-Conforming

Race/Ethnicity: ☐ White/non-Hispanic ☐ Black/non-Hispanic ☐ Hispanic/Latino
☐ Asian American ☐ Pacific Islander ☐ American Indian/Alaskan Native ☐ Other

Age: ☐ Under 18 ☐ 18 – 24 ☐ 25 – 34 ☐ 35 – 44 ☐ 45 – 49 ☐ 50+

THE PROJECT LEAP SERVICE DEFINITION REQUIRES THE HIV STATUS OF APPLICANTS BE DOCUMENTED BY THE OFFICE OF SUPPORT. YOU WILL BE ASKED YOUR HIV STATUS DURING THE APPLICATION INTERVIEW. THIS INFORMATION WILL NOT BE USED FOR ANY OTHER PURPOSE THAN FOR THE SELECTION OF PROJECT LEAP PARTICIPANTS. YOU MAY DECLINE TO PROVIDE THIS INFORMATION.

HOW DID YOU HEAR ABOUT PROJECT LEAP? *Please check all that apply:*

☐ **Name of person who referred you (optional):** _____

☐ Case manager/social worker ☐ Educator/outreach worker ☐ Email distribution list ☐ Facebook/other social media
☐ Friend/family member ☐ Flyer ☐ Former LEAP student ☐ Health fair/event ☐ Media (e.g., magazine, newspaper)
☐ Planning Council or CPG *member* ☐ Planning Council or CPG *staff* ☐ Other: _____
☐ At an agency, please specify: _____

APPLICATION QUESTIONS:

PLEASE KNOW THAT PROJECT LEAP APPLICATIONS ARE CONSIDERED PUBLIC DOCUMENTS. THEREFORE, ANY INFORMATION YOU PROVIDE BELOW INCLUDING HIV STATUS OR OTHER HEALTH OR PERSONAL INFORMATION COULD BE VIEWED BY MEMBERS OF THE PUBLIC UPON REQUEST.

1. **Please tell us about yourself including any experience you have working or volunteering in the HIV community in Houston or other areas.**

2. **Why do you want to be in Project LEAP?**

3. **Project LEAP meets weekly for 17 weeks for 4 hours each week from July through November 2022. Are you able to attend the Project LEAP class schedule?** ☐ Yes ☐ No

Please return your completed application form to:
Ryan White Planning Council Office of Support
2223 West Loop South, Suite 240; Houston, TX 77027
Fax: 713-572-3740 Email: Diane.Beck@cjo.hctx.net

Or apply online: **www.surveymonkey.com/r/P-LEAP2022**

Applications are due by 5:00 pm on Friday, July 8, 2022. If you wish to apply after July 8th, please call the Office of Support: 832 927-7926.

An in-person (virtual) interview with Office of Support staff is required. Interviews will be scheduled as applications are received. Applicants will be notified if they have been accepted into the class or not by Friday, July 15, 2022.

Quality Improvement Committee Report

FY 2023 How to Best Meet the Need Training – Updated May 3, 2022

ADAP updates

HRSA PCN 21-02

There is no news on eliminating the current six-month self-attestation requirement for ADAP. THMP estimates it could cost as much as **$17m** per year to move to annual recertifications consistent with the new eligibility guidance.

(NEW) Part B Care Services may seek approval from Department leadership to eliminate the six-month self-attestation for care services only to align with Part A programs that have done so. If so, this would be separate from what ADAP may do.

Health Insurance

There will be **no expansion** of Health Insurance purchasing (per Imelda, "downtown" doesn't want to even hear insurance expansion discussed).

Spenddown

The existing Spenddown policy continues at least through 10/31/22. The Standard Deduction – the spenddown replacement – is on track. By the end of August, DSHS will publish the standard deduction dollar amount with a 60-day comment period.

90-day Refills

Currently not on the table.

CABENUVA Injectable

No movement on adding Cabenuva – THMP cites concerns over long term costs.

Budget

Shortfalls are possible in State fiscal year 2024 and 2025.

Take Charge Texas (TCT)

For THMP, DSHS states they are "hoping for improvements by late May."

Local concern

The Council may anticipate continued need for Emergency Financial Assistance (EFA) funding to cover medications while clients await processing of new applications, six-month attestations and annual recertifications. THMP said they are adding contract staff to help address this issue.

Part A Reflects "Decrease" Funding Scenario
MAI Reflects "Decrease" Funding Scenario

FY 2021 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**	**10,965,788**	**-75,776**	**1,415,641**	**60,600**	**0**	**12,366,253**	**51.76%**	**12,366,253**	**0**		**7,220,250**	**58%**	**92%**
1.a	Primary Care - Public Clinic (a)	3,927,300	-27,177				3,900,123	16.33%	3,900,123	0	3/1/2021	$1,624,811	42%	92%
1.b	Primary Care - CBO Targeted to AA (a) (e) (f)	1,064,576	-7,367	441,880	244,386		1,743,475	7.30%	1,743,475	0	3/1/2021	$1,383,479	79%	92%
1.c	Primary Care - CBO Targeted to Hispanic (a) (e)	910,551	-6,301	441,880	75,000		1,421,130	5.95%	1,421,130	0	3/1/2021	$1,182,227	83%	92%
1.d	Primary Care - CBO Targeted to White/MSM (a) (e)	1,147,924	-7,944	441,880			1,581,861	6.62%	1,581,861	0	3/1/2021	$611,515	39%	92%
1.e	Primary Care - CBO Targeted to Rural (a) (e)	1,100,000	-7,612		-75,000		1,017,388	4.26%	1,017,388	0	3/1/2021	$889,773	87%	92%
1.f	Primary Care - Women at Public Clinic (a)	2,100,000	-14,532				2,085,468	8.73%	2,085,468	0	3/1/2021	$1,156,539	55%	92%
1.g	Primary Care - Pediatric (a.1)	15,437					15,437	0.06%	15,437	0	3/1/2021	$3,600	23%	92%
1.h	Vision	500,000	-3,460	90,000	-85,000		501,540	2.10%	501,540	0	3/1/2021	$368,305	73%	92%
1.x	Primary Care Health Outcome Pilot	200,000	-1,384		-98,786		99,830	0.42%	99,830	0		$0	0%	92%
2	**Medical Case Management**	**1,730,000**	**-100,528**	**30,000**	**0**	**0**	**1,659,472**	**6.95%**	**1,659,472**	**0**		**1,303,825**	**79%**	**92%**
2.a	Clinical Case Management	488,656	-3,381	30,000			515,275	2.16%	515,275	0	3/1/2021	$321,267	62%	92%
2.b	Med CM - Public Clinic (a)	277,103	-1,918				275,185	1.15%	275,185	0	3/1/2021	$217,703	79%	92%
2.c	Med CM - Targeted to AA (a) (e)	169,009	-1,170				167,839	0.70%	167,839	0	3/1/2021	$223,684	133%	92%
2.d	Med CM - Targeted to H/L (a) (e)	169,011	-1,170				167,841	0.70%	167,841	0	3/1/2021	$118,776	71%	92%
2.e	Med CM - Targeted to W/MSM (a) (e)	61,186	-423				60,763	0.25%	60,763	0	3/1/2021	$75,679	125%	92%
2.f	Med CM - Targeted to Rural (a)	273,760	-1,894				271,866	1.14%	271,866	0	3/1/2021	$116,646	43%	92%
2.g	Med CM - Women at Public Clinic (a)	75,311	-521				74,790	0.31%	74,790	0	3/1/2021	$130,594	175%	92%
2.h	Med CM - Targeted to Pedi (a.1)	90,051	-90,051				0	0.00%	0	0	3/1/2021	$0	#DIV/0!	92%
2.i	Med CM - Targeted to Veterans	80,025	0				80,025	0.33%	80,025	0	3/1/2021	$58,009	72%	92%
2.j	Med CM - Targeted to Youth	45,888	0				45,888	0.19%	45,888	0	3/1/2021	$41,467	90%	92%
3	**Local Pharmacy Assistance Program**	**1,810,360**	**-12,528**	**22,920**	**0**	**0**	**1,820,752**	**7.62%**	**1,820,752**	**0**	3/1/2021	**$937,799**	**52%**	**92%**
3.a	Local Pharmacy Assistance Program-Public Clinic (a) (e)	310,360	-2,148				308,212	1.29%	308,212	0	3/1/2021	$260,442	85%	92%
3.b	Local Pharmacy Assistance Program-Untargeted (a) (e)	1,500,000	-10,380	22,920			1,512,540	6.33%	1,512,540	0	3/1/2021	$677,357	45%	92%
4	**Oral Health**	**166,404**	**-1,152**	**0**	**0**	**0**	**165,252**	**0.69%**	**165,252**	**0**	3/1/2021	**149,300**	**90%**	**92%**
4.a	Oral Health - Untargeted (c)	0					0	0.00%	0	0	N/A	$0	0%	0%
4.b	Oral Health - Targeted to Rural	166,404	-1,152		0		165,252	0.69%	165,252	0	3/1/2021	$149,300	90%	92%
5	**Health Insurance (c)**	**1,383,137**	**-9,571**	**300,000**	**0**	**0**	**1,673,566**	**7.01%**	**1,673,566**	**0**	3/1/2021	**$1,305,834**	**78%**	**92%**
6	**Mental Health Services (c)**	**0**					**0**	**0.00%**	**0**	**0**	**NA**	**$0**	**0%**	**0%**
7	**Early Intervention Services (c)**	**0**					**0**	**0.00%**	**0**	**0**	**NA**	**$0**	**0%**	**0%**
8	**Medical Nutritional Therapy (supplements)**	**341,395**	**-2,362**		**55,000**		**394,033**	**1.65%**	**394,033**	**0**	**3/1/2021**	**$315,468**	**80%**	**92%**
9	**Home and Community-Based Services (c)**	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**	**NA**	**$0**	**0%**	**0%**
9.a	In-Home	0									N/A	$0	0%	0%
9.b	Facility Based	0									N/A	$0	0%	0%
10	**Substance Abuse Services - Outpatient**	**45,677**	**0**	**0**	**0**	**0**	**45,677**	**0.19%**	**45,677**	**0**	3/1/2021	**$25,150**	**55%**	**92%**
11	**Hospice Services**	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**	**NA**	**$0**	**0%**	**0%**
12	**Referral for Health Care and Support Services (c)**	**0**	**0**				**0**	**0.00%**	**0**	**0**	**NA**	**$0**	**0%**	**0%**
13	**Non-Medical Case Management**	**1,267,002**	**-8,768**	**40,000**	**-70,600**	**0**	**1,227,634**	**5.14%**	**1,227,634**	**0**	**3/1/2021**	**$958,125**	**78%**	**92%**
13.a	Service Linkage targeted to Youth	110,793	-767		-20,600		89,426	**0.37%**	89,426	0	3/1/2021	$79,723	89%	92%
13.b	Service Linkage targeted to Newly-Diagnosed/Not-in-Care	100,000	-692		-50,000		49,308	**0.21%**	49,308	0	3/1/2021	$56,791	115%	92%
13.c	Service Linkage at Public Clinic (a)	370,000	-2,560				367,440	**1.54%**	367,440	0	3/1/2021	$373,442	102%	92%
13.d	Service Linkage embedded in CBO Pcare (a) (e)	686,209	-4,749	40,000			721,460	**3.02%**	721,460	0	3/1/2021	$448,168	62%	92%
13.e	SLW-Substance Use	0	0				0	**0.00%**	0	0	NA	$0	0%	0%
14	**Medical Transportation**	**424,911**	**-2,940**	**0**	**0**	**0**	**421,971**	**1.77%**	**421,971**	**0**		**316,768**	**75%**	**92%**
14.a	Medical Transportation services targeted to Urban	252,680	-1,749				250,931	1.05%	250,931	0	3/1/2021	$235,244	94%	92%
14.b	Medical Transportation services targeted to Rural	97,185	-673				96,512	0.40%	96,512	0	3/1/2021	$81,524	84%	92%
14.c	Transportation vouchering (bus passes & gas cards)	75,046	-519				74,527	0.31%	74,527	0	3/1/2021	$0	0%	92%
15	**Emergency Financial Assistance**	**1,545,439**	**-10,694**	**0**	**-45,000**	**0**	**1,489,745**	**6.24%**	**1,489,745**	**0**		**986,085**	**66%**	**92%**
16.a	EFA - Pharmacy Assistance	1,305,439	-9,034		75,000		1,371,405	5.74%	1,371,405	0	3/1/2021	$913,437	67%	92%

Part A Reflects "Decrease" Funding Scenario
MAI Reflects "Decrease" Funding Scenario

FY 2021 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
16.b	EFA - Other	240,000	-1,661		-120,000		118,339	0.50%	118,339	0	3/1/2021	$72,648	61%	92%
16	**Linguistic Services (c)**	0	0				0	0.00%	0	0	NA	$0	0%	0%
17	**Outreach**	420,000	-2,906				417,094	1.75%	417,094	0	3/1/2021	$259,504	0%	92%
BEU27516	**Total Service Dollars**	20,100,113	-227,226	1,808,561	0	0	21,681,448	90.75%	21,681,448	-1		13,778,108	64%	92%
	Grant Administration	1,795,958	0	0	0	0	1,795,958	7.52%	1,795,958	0	N/A	1,263,365	70%	92%
BEU27517	HCPH/RWGA Section	1,271,050		0		0	1,271,050	5.32%	1,271,050	0	N/A	$896,759	71%	92%
PC	RWPC Support*	524,908			0	0	524,908	2.20%	524,908	0	N/A	366,606	70%	92%
BEU27521	**Quality Management**	412,940		0	0	0	412,940	1.73%	412,940	0	N/A	$279,210	68%	92%
		22,309,011	-227,226	1,808,561	0	0	23,890,346	100.00%	23,890,346	-1		15,320,683	64%	92%
								Unallocated	Unobligated					
	Part A Grant Award:	22,171,816	*Carry Over:*	1,718,511		*Total Part A:*	23,890,327	-19	-1					

		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)	16,442,761	-201,918	1,768,561	115,600	0	18,125,004	83.60%		
	Non-Core (may not exceed 25% of total service dollars)	3,657,352	-25,309	40,000	-115,600	0	3,556,443	16.40%		
	Total Service Dollars (does not include Admin and QM)	20,100,113	-227,226	1,808,561	0	0	21,681,448			
	Total Admin (must be ≤ 10% of total Part A + MAI)	1,795,958	0	0	0	0	1,795,958	6.42%		
	Total QM (must be ≤ 5% of total Part A + MAI)	412,940	0	0	0	0	412,940	1.48%		

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**	2,002,860	-52,609	100,100	0	0	2,050,351	86.50%	2,050,351	0		1,627,450	79%	92%
1.b (MAI)	Primary Care - CBO Targeted to African American	1,012,700	-26,601	50,050			1,036,149	43.71%	1,036,149	0	3/1/2021	$866,250	84%	92%
1.c (MAI)	Primary Care - CBO Targeted to Hispanic	990,160	-26,009	50,050			1,014,201	42.79%	1,014,201	0	3/1/2021	$761,200	75%	92%
2	**Medical Case Management**	320,100	0	0	0	0	320,100	13.50%	320,100	0		$214,146	67%	92%
2.c (MAI)	MCM - Targeted to African American	160,050					160,050	6.75%	160,050	0	3/1/2021	$119,733	75%	92%
2.d (MAI)	MCM - Targeted to Hispanic	160,050					160,050	6.75%	160,050	0	3/1/2021	$94,412	59%	92%
	Total MAI Service Funds	2,322,960	-52,609	100,100	0	0	2,370,451	100.00%	2,370,451	0		1,841,596	78%	92%
	Grant Administration	0	0	0	0	0	0	0.00%	0	0		0	0%	0%
	Quality Management	0	0	0	0	0	0	0.00%	0	0		0	0%	0%
	Total MAI Non-service Funds	0	0	0	0	0	0	0.00%	0	0		0	0%	0%
BEO 27516	**Total MAI Funds**	2,322,960	-52,609	100,100	0	0	2,370,451	100.00%	2,370,451	0		1,841,596	78%	92%
	MAI Grant Award	3,175,710	*Carry Over:*	905,361		*Total MAI:*	4,081,071							
	Combined Part A and MAI Orginial Allocation Total	24,631,971												

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.

Part A Reflects "Decrease" Funding Scenario
MAI Reflects "Decrease" Funding Scenario

FY 2021 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
(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 2021 Ryan White Part A and MAI Service Utilization Report

RW PART A SUR- 3rd Quarter (3/1-11/30)

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**	**7,274**	**75%**	**23%**	**2%**	**46%**	**13%**	**3%**	**39%**	**0%**	**0%**	**4%**	**28%**	**27%**	**12%**	**26%**	**2%**
1.a	Primary Care - Public Clinic (a)	2,350	2,455	72%	27%	1%	44%	9%	2%	45%	0%	0%	3%	16%	26%	14%	37%	4%
1.b	Primary Care - CBO Targeted to AA (a)	1,060	2,042	69%	28%	3%	99%	0%	1%	0%	0%	0%	6%	38%	28%	10%	16%	1%
1.c	Primary Care - CBO Targeted to Hispanic (a)	960	1,607	81%	15%	4%	0%	0%	0%	100%	0%	0%	6%	31%	30%	12%	20%	1%
1.d	Primary Care - CBO Targeted to White and/or MSM (a)	690	703	88%	11%	1%	0%	85%	15%	0%	0%	0%	3%	24%	26%	11%	33%	2%
1.e	Primary Care - CBO Targeted to Rural (a)	400	654	69%	30%	1%	48%	22%	2%	29%	0%	0%	3%	31%	28%	11%	25%	2%
1.f	Primary Care - Women at Public Clinic (a)	1,000	661	0%	99%	1%	53%	5%	2%	40%	0%	0%	1%	11%	26%	18%	39%	5%
1.g	Primary Care - Pediatric (a)	7	6	83%	17%	0%	50%	0%	0%	50%	17%	67%	17%	0%	0%	0%	0%	0%
1.h	Vision	1,600	2,240	73%	25%	2%	48%	12%	3%	37%	0%	0%	4%	25%	24%	13%	29%	5%
2	**Medical Case Management (f)**	**3,075**	**4,462**															
2.a	Clinical Case Management	600	747	73%	24%	3%	57%	12%	1%	30%	0%	0%	4%	23%	27%	12%	29%	5%
2.b	Med CM - Targeted to Public Clinic (a)	280	495	91%	6%	2%	54%	12%	2%	33%	0%	1%	2%	26%	23%	10%	33%	5%
2.c	Med CM - Targeted to AA (a)	550	1,321	68%	29%	3%	98%	0%	2%	0%	0%	1%	6%	31%	26%	11%	23%	3%
2.d	Med CM - Targeted to H/L(a)	550	706	79%	16%	5%	0%	0%	0%	100%	0%	0%	6%	27%	30%	12%	22%	2%
2.e	Med CM - Targeted to White and/or MSM (a)	260	372	84%	14%	2%	0%	88%	12%	0%	0%	0%	3%	23%	22%	7%	37%	7%
2.f	Med CM - Targeted to Rural (a)	150	397	66%	33%	1%	47%	30%	2%	21%	0%	0%	2%	25%	25%	10%	31%	7%
2.g	Med CM - Targeted to Women at Public Clinic (a)	240	234	0%	100%	0%	73%	7%	2%	18%	0%	0%	2%	21%	33%	12%	29%	5%
2.h	Med CM - Targeted to Pedi (a)	125	0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
2.i	Med CM - Targeted to Veterans	200	176	95%	5%	0%	71%	20%	1%	8%	0%	0%	0%	0%	4%	3%	51%	42%
2.j	Med CM - Targeted to Youth	120	14	86%	7%	7%	71%	0%	0%	29%	0%	21%	79%	0%	0%	0%	0%	0%
3	**Local Drug Reimbursement Program (a)**	**2,845**	**4,490**	**73%**	**23%**	**4%**	**47%**	**13%**	**2%**	**38%**	**0%**	**0%**	**4%**	**28%**	**28%**	**13%**	**26%**	**2%**
4	**Oral Health**	**200**	**331**	**69%**	**30%**	**1%**	**48%**	**25%**	**1%**	**27%**	**0%**	**0%**	**2%**	**24%**	**24%**	**14%**	**31%**	**5%**
4.a	Oral Health - Untargeted (d)	NA	NA															
4.b	Oral Health - Rural Target	200	331	69%	30%	1%	48%	25%	1%	27%	0%	0%	2%	24%	24%	14%	31%	5%
5	**Mental Health Services (d)**	**NA**	**NA**															
6	**Health Insurance**	**1,700**	**1,380**	**80%**	**18%**	**1%**	**43%**	**27%**	**2%**	**28%**	**0%**	**0%**	**1%**	**14%**	**17%**	**11%**	**43%**	**14%**
7	**Home and Community Based Services (d)**	**NA**	**NA**															
8	**Substance Abuse Treatment - Outpatient**	**40**	**21**	**86%**	**5%**	**10%**	**33%**	**43%**	**0%**	**24%**	**0%**	**0%**	**0%**	**29%**	**38%**	**14%**	**19%**	**0%**
9	**Early Medical Intervention Services (d)**	**NA**	**NA**															
10	**Medical Nutritional Therapy/Nutritional Supplements**	**650**	**505**	**75%**	**24%**	**1%**	**40%**	**19%**	**4%**	**37%**	**0%**	**0%**	**1%**	**11%**	**17%**	**10%**	**48%**	**13%**
11	**Hospice Services (d)**	**NA**	**NA**															
12	**Outreach**	**700**	**880**	**74%**	**22%**	**4%**	**56%**	**13%**	**1%**	**30%**	**0%**	**1%**	**5%**	**34%**	**26%**	**11%**	**22%**	**2%**
13	**Non-Medical Case Management**	**7,045**	**6,155**															
13.a	Service Linkage Targeted to Youth	320	149	79%	19%	1%	55%	6%	1%	38%	0%	19%	81%	0%	0%	0%	0%	0%
13.b	Service Linkage at Testing Sites	260	79	76%	22%	3%	52%	4%	1%	43%	0%	0%	0%	61%	22%	3%	14%	1%
13.c	Service Linkage at Public Clinic Primary Care Program (a)	3,700	2,849	68%	31%	1%	54%	10%	2%	35%	0%	0%	0%	18%	24%	12%	39%	7%
13.d	Service Linkage at CBO Primary Care Programs (a)	2,765	3,078	74%	23%	3%	53%	13%	2%	32%	1%	1%	5%	28%	24%	10%	27%	3%
14	**Transportation**	**2,850**	**1,900**															
14.a	Transportation Services - Urban	170	606	70%	29%	1%	57%	9%	1%	33%	0%	0%	3%	27%	26%	11%	27%	5%
14.b	Transportation Services - Rural	130	216	67%	32%	1%	31%	34%	1%	33%	0%	0%	4%	17%	25%	15%	32%	7%
14.c	Transportation vouchering	2,550	1,078															
15	**Linguistic Services (d)**	**NA**	**NA**															
16	**Emergency Financial Assistance (e)**	**NA**	**763**	**71%**	**26%**	**3%**	**56%**	**9%**	**1%**	**34%**	**0%**	**0%**	**3%**	**26%**	**25%**	**12%**	**30%**	**3%**
17	**Referral for Health Care - Non Core Service (d)**	**NA**	**NA**															
*Net unduplicated clients served - all categories**		12,941	12,739	73%	24%	2%	50%	14%	2%	34%	0%	1%	4%	24%	24%	11%	30%	5%
Living AIDS cases + estimated Living HIV non-AIDS (from FY19 App) (b)		NA	28,225	60%	21%		39%	18%	3%	20%	0%	5%		15%	22%	26%	15%	

Available Data As Of: 3/8/2022

Prepared by: Ryan White Grant Administration

FY 2021 Ryan White Part A and MAI Service Utilization Report

RW MAI Service Utilization Report - 3rd Quarter (03/01 -11/30)

Priority	Service Category MAI unduplicated served includes clients also served under Part A	Goal	Unduplicated MAI Clients Served YTD	Male	Female	Trans gender	AA (non-Hispanic)	White (non-Hispanic)	Other (non-Hispanic)	Hispanic	0-12	13-19	20-24	25-34	35-44	45-49	50-64	65 plus
	Outpatient/Ambulatory Primary Care (excluding Vision)																	
1.b	Primary Care - MAI CBO Targeted to AA (g)	1,060	1,496	70%	27%	3%	99%	0%	1%	0%	0%	0%	7%	36%	27%	11%	18%	1%
1.c	Primary Care - MAI CBO Targeted to Hispanic (g)	960	1,308	82%	14%	4%	0%	0%	0%	100%	0%	0%	6%	30%	31%	13%	19%	1%
2	**Medical Case Management (f)**																	
2.c	Med CM - Targeted to AA (a)	1,060	742	76%	20%	4%	53%	10%	1%	35%	0%	1%	9%	39%	26%	9%	15%	1%
2.d	Med CM - Targeted to H/L(a)	960	555	73%	24%	3%	72%	10%	3%	15%	0%	1%	4%	38%	27%	14%	14%	1%

RW Part A New Client Service Utilization Report - 3rd Quarter (03/01-11/30)
Report reflects the number & demographics of clients served during the report period who did not receive services during previous 12 months (3/1/20 - 2/28/21)

Priority	Service Category	Goal	Unduplicated New Clients Served YTD	Male	Female	Trans gender	AA (non-Hispanic)	White (non-Hispanic)	Other (non-Hispanic)	Hispanic	0-12	13-19	20-24	25-34	35-44	45-49	50-64	65 plus
1	**Primary Medical Care**	2,100	1,373	80%	18%	3%	51%	11%	2%	35%	0%	1%	9%	40%	24%	8%	1%	16%
2	**LPAP**	1,200	536	76%	20%	4%	53%	10%	1%	35%	0%	1%	9%	39%	26%	9%	1%	15%
3.a	Clinical Case Management	400	78	73%	24%	3%	72%	10%	3%	15%	0%	1%	4%	38%	27%	14%	1%	14%
3.b-3.h	Medical Case Management	1,600	798	77%	20%	4%	54%	14%	2%	30%	0%	2%	8%	37%	25%	8%	3%	19%
3.i	Medical Case Manangement - Targeted to Veterans	60	33	94%	6%	0%	85%	12%	0%	3%	0%	0%	0%	0%	6%	9%	39%	45%
4	**Oral Health**	40	43	74%	26%	0%	49%	30%	0%	21%	0%	0%	2%	35%	23%	14%	5%	21%
12.a. 12.c. 12.d.	**Non-Medical Case Management (Service Linkage)**	3,700	1,393	74%	24%	2%	56%	13%	2%	29%	1%	2%	6%	31%	23%	9%	23%	5%
12.b	**Service Linkage at Testing Sites**	260	69	78%	17%	4%	54%	1%	3%	42%	0%	6%	16%	51%	12%	1%	13%	1%

Footnotes:

(a)	Bundled Category
(b)	Age groups 13-19 and 20-24 combined together; Age groups 55-64 and 65+ combined together.
(d)	Funded by Part B and/or State Services
(e)	Total MCM served does not include Clinical Case Management
(f)	CBO Pcare targeted to AA (1.b) and HL (1.c) goals represent combined Part A and MAI clients served

Available Data As Of: 3/8/2022

The Houston Regional HIV/AIDS Resource Group, Inc.
FY 2021 Ryan White Part B
Procurement Report
April 1, 2021 - March 31, 2022

Reflects spending through January 2022

Spending Target: 83%

Revised 3/17/22

Priority	Service Category	Original Allocation per RWPC	% of Grant Award	Amendment*	Contractual Amount	Amendment	Contractual Amount	Date of Original Procurement	Expended YTD	Percent YTD
4	Oral Health Care (1)	$1,674,036	50%	$0	$1,674,036	$0	$1,674,036	4/1/2021	$1,213,929	73%
4	Oral Health Care -Prosthodontics (1)	$544,842	16%	$0	$544,842	$0	$544,842	4/1/2021	$389,141	71%
5	Health Insurance Premiums and Cost Sharing (2)	$1,028,433	31%	$0	$1,028,433	$0	$1,028,433	4/1/2021	$426,148	41%
9	Home and Community Based Health Services (3)	$113,315	3%	$0	$113,315	$0	$113,315	4/1/2021	$24,560	22%
	Increased RWB Award added to OHS per Increase Scenario*	$0	0%	$0	$0					
	Total Houston HSDA	3,360,626	100%	0	3,360,626	$0	$3,360,626		2,053,778	61%

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

(1) Working with agency on spending and looking into possible reallocation

(2) 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

(3) Demand is still down because of COVID & Category is two months behind in reporting

The Houston Regional HIV/AIDS Resource Group, Inc.

FY 2122 DSHS State Services

Procurement Report

September 1, 2021 - August 31, 2022

Chart reflects spending through January 2022

Spending Target: 42%

Revised 3/17/2022

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)**	$853,137	43%	**$0**	$853,137	$0	$853,137	9/1/2020	$0	0%
6	**Mental Health Services (2)**	$300,000	15%	**$0**	$300,000	$0	$300,000	9/1/2020	$39,400	13%
7	**EIS - Incarcerated**	$175,000	9%	**$0**	$175,000	$0	$175,000	9/1/2020	$64,159	37%
11	**Hospice**	$259,832	13%	**$0**	$259,832	$0	$259,832	9/1/2020	$84,920	33%
13	**Non Medical Case Management (2)**	$350,000	17%	**$0**	$350,000	$0	$350,000	9/1/2020	$79,416	23%
16	**Linguistic Services**	$68,000	3%	**$0**	$68,000	$0	$68,000	9/1/2020	$30,075	44%
	Total Houston HSDA	**2,005,969**	**100%**	**$0**	$2,005,969	$0	$2,005,969		297,970	15%

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) Subcontractors behind in reporting

2021 - 2022 DSHS State Services Service Utilization Report

9/1/2021 thru 03/29/2022 Houston HSDA

2nd Quarter

Revised 3/29/2022

	UDC		Gender				Race				Age Group							
Funded Service	***Goal***	**YTD**	**Male**	**Female**	**FTM**	**MTF**	**AA**	**White**	**Hisp**	**Other**	**0-12**	**13-19**	**20-24**	**25-34**	**35-44**	**45-49**	**50-64**	**65+**
Early Intervention Services	***700***	337	85.79%	11.88%	0.00%	2.33%	62.62%	16.02%	19.58%	1.78%	0.00%	0.60%	5.35%	33.82%	24.33%	19.88%	14.54%	1.48%
Health Insurance Premiums	***2,300***	883	79.22%	19.44%	0.00%	1.34%	39.00%	29.60%	28.80%	2.60%	0.00%	0.00%	0.70%	9.51%	14.38%	23.78%	32.61%	19.02%
Hospice	***35***	16	81.25%	18.75%	0.00%	0.00%	68.75%	12.50%	18.75%	0.00%	0.00%	0.00%	0.00%	25.00%	18.75%	12.50%	31.25%	12.50%
Linguistic Services	***50***	47	51.02%	44.90%	0.00%	4.08%	46.80%	6.38%	10.65%	36.17%	0.00%	0.00%	0.00%	12.76%	23.40%	36.17%	21.27%	6.40%
Mental Health Services	***250***	63	95.40%	1.55%	0.00%	3.05%	28.58%	44.44%	26.98%	0.00%	0.00%	0.00%	3.16%	14.30%	12.70%	28.56%	31.75%	9.53%
Unduplicated Clients Served By State Services Funds:	*NA*	1,346	78.54%	19.30%	0.00%	2.16%	49.15%	21.79%	20.95%	8.11%	0.00%	0.12%	1.84%	19.08%	18.71%	24.18%	26.28%	9.79%

Houston Ryan White Health Insurance Assistance Service Utilization Report

Period Reported: 09/01/2021-02/28/2022

Revised: 3/21/2022

	Assisted			NOT Assisted		
Request by Type	Number of Requests (UOS)	*Dollar Amount of Requests*	Number of Clients (UDC)	*Number of Requests (UOS)*	*Dollar Amount of Requests*	*Number of Clients (UDC)*
Medical Co-Payment	669	$71,835.00	320			*0*
Medical Deductible	27	$14,101.44	20			*0*
Medical Premium	3835	$1,006,289.91	856			*0*
Pharmacy Co-Payment	13526	$762,663.13	1336			*0*
APTC Tax Liability	0	$0.00	0			*0*
Out of Network Out of Pocket	0	$0.00	0			*0*
ACA Premium Subsidy Repayment	13	$4,424.01	8	*NA*	*NA*	*NA*
Totals:	18070	$1,850,465.47	2540	0	$0.00	

Comments: This report represents services provided under all grants.

Public Comment

Re: Mental Health Service Category Definition
May 3, 2022

In regard to How to Best Meet the Need recommendations for the Mental Health Service category definition to be reviewed by the Quality Improvement Committee meeting on May 3, 2022, Ann Robison submitted the following comment to the Office of Support via email:

> "We are requesting that the Council consider adding psychiatric encounters to the mental health service category under State Services. It is in the state's definition. We are using residents to provide the care. We do not take anyone who already has a psychiatrist somewhere else. We only take people in crisis who do not already have a psychiatrist. The residents at this time are paid for by a Baylor grant from HRSA but we have to pay for the supervision. We think the same rate used for therapy would be fine at this point but we do see people living with HIV who have been unable to access psychiatry services at the clinics because of wait lists and staff shortages. Thanks."

Houston Area HIV Services Ryan White Planning Council

FY 2023 How to Best Meet the Need Quality Improvement Committee Service Category Recommendation Summary (as of 05/04/22)

Those services for which no change is recommended include:

Ambulatory Outpatient Medical Care (including Emergency Financial Assistance - Pharmacy Assistance, and Outreach)

Emergency Financial Assistance – Other

Health Insurance Premium and Cost Sharing Assistance

Home and Community Based Health Services (Adult Day Treatment)

Hospice Services

Linguistic Services

Medical Nutritional Therapy/Supplements

Oral Health (Untargeted and Targeting the Northern Rural Area)

Substance Abuse Treatment

Transportation

Vision Care

Services <u>with</u> recommended changes include the following:

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

- Recommend to the Priority and Allocations Committee to increase funding for all Case Management services specifically to increase salaries to reduce staff turnover.

Local Pharmacy Assistance Program (LPAP)

- Increase the FPL* for non-HIV medication to 500%.

Early Intervention Services (EIS) **/ Referral for Health Care and Support Services** (RHCSS)

- Transition EIS to RHCSS to better align with the scope of services provided.

Mental Health Services

- Table approval of this service category to allow the committee more time to discuss the public comment received on May 3, 2022.

**FPL = Federal Poverty Level.*

Table of Contents

FY 2023 Houston EMA/HSDA Service Categories Definitions
Ryan White Part A, Part B and State Services

FY 2020 Houston EMA Ryan White Part A/MAI Service Definition **Comprehensive Outpatient Primary Medical Care including Medical Case Management, Service Linkage, Outreach, Emergency Financial Assistance - Pharmacy Assistance and Local Pharmacy Assistance Program (LPAP) Services**	
HRSA Service Category Title: **RWGA Only**	1. Outpatient/Ambulatory Medical Care 2. Medical Case Management 3. AIDS Pharmaceutical Assistance (local) 4. Case Management (non-Medical) 5. Emergency Financial Assistance – Pharmacy Assistance 6. Outreach
Local Service Category Title:	Adult Comprehensive Primary Medical Care - CBO i. Community-based Targeted to African American ii. Community-based Targeted to Hispanic iii. Community-based Targeted to White/MSM
Amount Available: **RWGA Only**	Total estimated available funding: $0.00 (to be determined) Note: The Houston Ryan White Planning Council (RWPC) determines overall annual Part A and MAI service category allocations & reallocations. RWGA has sole authority over contract award amounts.
Target Population:	**Comprehensive Primary Medical Care – Community Based:** i. Targeted to African American: African American ages 13 or older ii. Targeted to Hispanic: Hispanic ages 13 or older iii. Targeted to White: White (non-Hispanic) ages 13 or older **Outreach:** Services will be available to eligible HIV-infected clients residing in the Houston EMA/HSDA with priority given to clients most in need. Services are restricted to those clients who meet the contractor's RWGA approved Outreach Inclusion Criteria. The Outreach Inclusion Criteria components must include, at minimum 2 consecutive missed primary care provider and/or HIV lab appointments. Outreach Inclusion Criteria may also include VL suppression, substance abuse, and ART treatment failure components.
Client Eligibility: Age, Gender, Race, Ethnicity, Residence, etc.	PLWHA residing in the Houston EMA (prior approval required for non-EMA clients). Contractor must adhere to Targeting requirements and Budget limitations as applicable.
Financial Eligibility:	*See Current Approved Financial Eligibility for Houston EMA/HSDA*

Budget Type: **RWGA Only**	Hybrid Fee for Service
Budget Requirement or Restrictions: **RWGA Only**	**Primary Medical Care:** No less than 75% of clients served in a Targeted subcategory must be members of the targeted population with the following exceptions: 100% of clients served with MAI funds must be members of the targeted population. 10% of funds designated to primary medical care must be reserved for invoicing diagnostic procedures at actual cost. Contractors may not exceed the allocation for each individual service component (Primary Medical Care, Medical Case Management, Local Pharmacy Assistance Program and Service Linkage) without prior approval from RWGA. **Local Pharmacy Assistance Program (LPAP):** Houston RWPC guidelines for Local Pharmacy Assistance Program (LPAP) services: Contractor shall offer HIV medications from an approved formulary for a total not to exceed $18,000 per contract year per client. Contractor shall offer HIV-related medications for a total not to exceed $3,000 per contract year per client. These guidelines are determined by the RWPC. The RWPC determines the subcategories that shall include Ryan White LPAP funding. Medications must be provided in accordance with Houston EMA guidelines, HRSA/HAB rules and regulations and applicable Office of Pharmacy Affairs 340B guidelines. At least 75% of the total amount of the budget for LPAP services must be solely allocated to the actual cost of medications and may not include any storage, administrative, processing or other costs associated with managing the medication inventory or distribution. **Emergency Financial Assistance – Pharmacy Assistance** Direct cash payments to clients are not permitted. It is expected that all other sources of funding in the community for emergency financial assistance will be effectively used and that any allocation of RWHAP funds for these purposes will be as the payer of last resort, and for limited amounts, uses, and periods of time. Continuous provision of an allowable service to a client should not be funded through emergency financial assistance. **Outreach**

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

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

	to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication. • **Case Management (non-Medical)** includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does. • **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. • **Outreach Services** include the provision of the following three activities: Identification of people who do not know their HIV status and linkage into Outpatient/Ambulatory Health Services, Provision of additional information and education on health care coverage options, Reengagement of people who know their status into Outpatient/Ambulatory Health Services
Standards of Care:	Contractors must adhere to the most current published Part A/B Standards of Care for the Houston EMA/HSDA. **Services must meet or exceed applicable United States Department of Health and Human Services (DHHS) guidelines for the Treatment of HIV/AIDS.**
Local Service Category Definition/Services to be Provided:	**Outpatient/Ambulatory Primary Medical Care:** Services include on-site physician, physician extender, nursing, phlebotomy, radiographic, laboratory, pharmacy, intravenous therapy, home health care referral, licensed dietician, patient medication education, and patient care coordination. The Contractor must provide continuity of care with inpatient services and subspecialty services (either on-site or through specific referral to appropriate medical provider upon primary care Physician's order). Services provided to women shall further include OB/GYN physician & physician extender services on-site or by referral, OB/GYN services, colposcopy, nursing, phlebotomy, radiographic, laboratory, pharmacy, intravenous therapy, home health care referral, licensed dietician, patient medication/women's health

	education, patient care coordination, and social services. The Contractor must provide continuity of care with inpatient services and subspecialty services (either on-site or through specific referral protocols to appropriate agencies upon primary care Physician's order). **Outpatient/Ambulatory Primary Medical Care must provide:** • Continuity of care for all stages of adult HIV infection; • Laboratory and pharmacy services including intravenous medications (either on-site or through established referral systems); • Outpatient psychiatric care, including lab work necessary for the prescribing of psychiatric medications when appropriate (either on-site or through established referral systems); • Access to the Texas ADAP program (either on-site or through established referral systems); • Access to compassionate use HIV medication programs (either directly or through established referral systems); • Access to HIV related research protocols (either directly or through established referral systems); • Must at a minimum, comply with Houston EMA/HSDA Part A/B Standards for HIV Primary Medical Care. The Contractor must demonstrate on an ongoing basis the ability to provide state-of-the-art HIV-related primary care medicine in accordance with the most recent DHHS HIV treatment guidelines. Rapid advances in HIV treatment protocols require that the Contractor provide services that to the greatest extent possible maximize a patient's opportunity for long-term survival and maintenance of the highest quality of life possible. • On-site Outpatient Psychiatry services. • On-site Medical Case Management services. • On-site Medication Education. • Physical therapy services (either on-site or via referral). • Specialty Clinic Referrals (either on-site or via referral). • On-site pelvic exams as needed for female patients with appropriate follow-up treatment and referral. • On site Nutritional Counseling by a Licensed Dietitian. **Services for women must also provide:** • Well woman care, including but not limited to: PAP, pelvic exam, HPV screening, breast examination, mammography, hormone replacement and education, pregnancy testing, contraceptive services excluding birth control medications. • Obstetric Care: ante-partum through post-partum services, child birth/delivery services. Perinatal preventative education and treatment.

	• On-site or by referral Colposcopy exams as needed, performed by an OB/GYN physician, or physician extender with a colposcopy provider qualification. • Social services, including but not limited to, providing women access to child care, transportation vouchers, food vouchers and support groups at the clinic site. **Nutritional Assessment:** Services include provision of information about therapeutic nutritional/supplemental foods that are beneficial to the wellness and increased health conditions of clients by a Licensed Dietitian. Services may be provided either through educational or counseling sessions. Clients who receive these services may utilize the Ryan White Part A-funded nutritional supplement provider to obtain recommended nutritional supplements in accordance with program rules. Clients are limited to one (1) nutritional assessment per calendar year without prior approval of RWGA. Patient Medication Education Services must adhere to the following requirements: • Medication Educators must be State Licensed Medical Doctor (MD), Nurse Practitioner (NP), Physician Assistant PA), Nurse (RN, LVN) or Pharmacist. Prior approval must be obtained prior to utilizing any other health care professional not listed above to provide medication education. • Clients who will be prescribed ongoing medical regimens (i.e. ART) must be assessed for adherence to treatment at every clinical encounter using the EMA's approved adherence assessment tool. Clients with adherence issues related to lack of understanding must receive more education regarding their medical regimen. Clients with adherence issues that are behavioral or involve mental health issues must be provided counseling by the Medical Case Manager, Physician or Physician Extender and/or licensed nursing staff and, if clinically indicated, assessment and treatment by a qualified Psychiatrist or Psychiatric Nurse Practitioner. **Outpatient Psychiatric Services:** The program must provide: • Diagnostic Assessments: comprehensive evaluation for identification of psychiatric disorders, mental status evaluation, differential diagnosis which may involve use of other clinical and laboratory tests, case formulation, and treatment plans or disposition. • Emergency Psychiatric Services: rapid evaluation, differential diagnosis, acute treatment, crisis intervention, and referral. Must be available on a 24 hour basis including emergency room referral.

	• Brief Psychotherapy: individual, supportive, group, couple, family, hypnosis, biofeedback, and other psychophysiological treatments and behavior modification. • Psychopharmacotherapy: evaluation and medication treatment of psychiatric disorders, including, but not limited to, anxiety disorders, major depression, pain syndromes, habit control problems, psychosis and organic mental disorders. • Rehabilitation Services: Physical, psychosocial, behavioral, and/or cognitive training. Screening for Eye Disorders: Contractor must ensure that patients receive appropriate screening and treatment for CMV, glaucoma, cataracts, and other related problems. **Local Medication Assistance Program (LPAP):** LPAP provides pharmaceuticals to patients otherwise ineligible for medications through private insurance, Medicaid/Medicare, State ADAP, SPAP or other sources. Allowable medications are only those on the Houston EMA Ryan White Part A Formulary. Eligible clients may be provided Fuzeon™ on a case-by-case basis with prior approval of Ryan White Grant Administration (RWGA). The cost of Fuzeon™ does not count against a client's annual maximum. HIV-related medication services are the provision of physician or physician-extender prescribed HIV-related medications to prevent serious deterioration of health. Does not include drugs available to the patient from other programs or payers or free of charge (such as birth control and TB medications) or medications available over the counter (OTC) without prescription. Contractor must offer all medications on the Texas ADAP formulary, for a total not to exceed $18,000.00 per contract year per client. Contractor must provide allowable HIV-related medications (i.e. non-HIV medications) for a total not to exceed $3,000 per contract year per client. Contractor may be reimbursed ADAP dispensing fees (e.g. $5/Rx) in accordance with RWGA business rules for those ADAP clients who are unable to pay the ADAP dispensing fee. **Medical Case Management Services:** Services include screening all primary medical care patients to determine each patient's level of need for Medical Case Management services, performing a comprehensive assessment, including an assessment of the patient's health literary, and developing a medical service plan for each client that demonstrates a documented need for such services, monitoring medical service plan to ensure its implementation, and educating client regarding wellness, medication and health care appointment adherence. The Medical Case Manager serves as an advocate for the client and as a liaison with medical providers on behalf of the client. The Medical Case Manager ensures linkage to

	mental health, substance abuse and other client services as indicated by the medical service plan. **Service Linkage:** The purpose of Service Linkage is to assist clients with the procurement of needed services so that the problems associated with living with HIV are mitigated. Service Linkage is a working agreement between a client and a Service Linkage Worker for an indeterminate period, based on client need, during which information, referrals and service linkage are provided on an as-needed basis. Service Linkage assists clients who do not require the intensity of Medical Case Management per RWGA Quality Management guidelines. Service Linkage is both office-based and field based. Service Linkage Workers are expected to coordinate activities with referral sources where newly-diagnosed or not-in-care PLWHA may be identified, including 1:1 case conferences with testing site personnel to ensure the successful transition of referrals into Primary Care Services. Such incoming referral coordination includes meeting prospective clients at the referring Provider location in order to develop rapport with individuals prior to the individual's initial Primary Care appointment and ensuring such new intakes to Primary Care services have sufficient support to make the often difficult transition into ongoing primary medical care. Service Linkage also includes follow-up to re-engage lost-to-care patients. Lost-to-care patients are those patients who have not returned for scheduled appointments with Provider nor have provided Provider with updated information about their current Primary Medical Care provider (in the situation where patient may have obtained alternate service from another medical provider). Contractor must document efforts to re-engage lost-to-care patients prior to closing patients in the CPCDMS. Service Linkage extends the capability of existing programs by providing "hands-on" outreach and linkage to care services to those PLWHA who are not currently accessing primary medical care services. Service Linkage includes the issuance of bus pass vouchers and gas cards per published RWGA guidelines. Service Linkage complements and extends the service delivery capability of Medical Case Management services. **Outreach**: Providing allowable Ryan White Program outreach and service linkage activities to PLWHA who know their status but are not actively engaged in outpatient primary medical care with information, referrals and assistance with medical appointment setting, mental health, substance abuse and psychosocial services as needed; advocating on behalf of clients to decrease service gaps and remove barriers to services helping clients develop and utilize independent living skills and strategies. Assist clients in obtaining needed resources, including bus pass vouchers and gas cards per published HCPH/RWGA policies. Outreach services must be conducted at times and in places where there is a high probability

	that individuals with HIV infection will be contacted, designed to provide quantified program reporting of activities and outcomes to accommodate local evaluation of effectiveness, planned and delivered in coordination with local and state HIV prevention outreach programs to avoid duplication of effort, targeted to populations known, through review of clinic medical records, to be at disproportionate risk of disengagement with primary medical care services. **Emergency Financial Assistance – Pharmacy Assistance** provides limited one-time and/or short-term 30-day supply of pharmaceuticals to patients otherwise ineligible for medications through private insurance, Medicaid/Medicare, State ADAP, SPAP or other sources. One refill for up to 30-day supply available with RWGA prior approval. Allowable medications are only those on the Houston EMA Ryan White Part A Formulary. HIV-related medication services are the provision of physician or physician-extender prescribed medications to prevent serious deterioration of health. Does not include drugs available to the patient from other programs or payers or free of charge or medications available over the counter (OTC) without prescription. Contractor must offer all medications on the Texas ADAP formulary.
Agency Requirements:	**Providers and system must be Medicaid/Medicare certified.** **Eligibility and Benefits Coordination:** Contractor must implement consumer-friendly, culturally and linguistically appropriate new and ongoing patient eligibility verification and benefit coordination processes that ensure accountability with Ryan White Payer of Last Resort requirements while achieving maximum utilization of eligible benefits. Eligibility processes should provide clients with a meaningful understanding of their benefits, expected out-of-pocket expenses and other information needed to ensure full and continued participation in care. **LPAP and EFA – Pharmacy Assistance Services:** Contractor must: Provide pharmacy services on-site or through an established contractual relationship that meets all requirements. Alternate (off-site) approaches must be approved prior to implementation by RWGA. Either directly, or via subcontract with an eligible 340B Pharmacy program entity, must: Ensure a comprehensive financial intake application to determine client eligibility for this program to insure that these funds are used as a last resort for purchase of medications.

	Ensure the documented capability of interfacing with the Texas HIV Medication Program operated by the Texas Department of State Health Services. This capability must be fully documented and is subject to independent verification by RWGA. Ensure medication assistance provided to clients does not duplicate services already being provided in the Houston area. The process for accomplishing this must be fully documented and is subject to independent verification by RWGA. Ensure, either directly or via a 340B Pharmacy Program Provider, at least 2 years of continuous documented experience in providing HIV/AIDS medication programs utilizing Ryan White Program or similar public sector funding. This experience must be documented and is subject to independent verification by RWGA. Ensure all medications are purchased via a qualified participant in the federal 340B Drug Pricing Program and Prime Vendor Program, administered by the HRSA Office of Pharmacy Affairs. Note: failure to maintain 340B or Prime Vendor drug pricing may result in a negative audit finding, cost disallowance or termination of contract awarded. Contractor must maintain 340B Program participation throughout the contract term. All eligible medications must be purchased in accordance with Program 340B guidelines and program requirements. Ensure Houston area HIV/AIDS service providers are informed of this program and how the client referral and enrollment processes functions. Contractor must maintain documentation of such marketing efforts. Implement a consistent process to enroll eligible patients in available pharmaceutical company Patient Assistance Programs prior to using Ryan White Part A funded LPAP resources. Ensure information regarding the program is provided to PLWHA, including historically under-served and unserved populations (e.g., African American, Hispanic/Latino, Asian, Native American, Pacific Islander) and women not currently obtaining prescribed HIV and HIV-related medications. Offer, at no charge to the client, delivery options for medication refills, including but not limited to courier, USPS or other package delivery service. **Case Management Operations and Supervision:** The Service Linkage Workers (SLW) and Medical Case Managers (MCM) must function within the clinical infrastructure of Contractor and receive ongoing supervision that meets or exceeds published Standards of Care. An MCM may supervise SLWs.

Staff Requirements:	Contractor is responsible for ensuring that services are provided by State licensed internal medicine and OB/GYN physicians, specialty care physicians, psychiatrists, registered nurses, nurse practitioners, vocational nurses, pharmacists, physician assistants, clinical nurse specialists, physician extenders with a colposcopy provider qualification, x-ray technologists, State licensed dieticians, licensed social worker and ancillary health care providers in accordance with appropriate State licensing and/or certification requirements and with knowledge and experience of HIV disease. In addition, Contractor must ensure the following staff requirements are met: **Outpatient Psychiatric Services:** Director of the Program must be a Board Certified Psychiatrist. Licensed and/or Certified allied health professionals (Licensed Psychologists, Physicians, Psychiatric Nurse Practitioners, Licensed Master Social Workers, Licensed Professional Counselors, Licensed Marriage and Family Therapists, Certified Alcohol and Drug Abuse Counselors, etc.) must be used in all treatment modalities. Documentation of the Director's credentials, licensures and certifications must be included in the proposal. Documentation of the Allied Health professional licensures and certifications must be included in the proposal appendices. **Medication and Adherence Education:** The program must utilize an RN, LVN, PA, NP, pharmacist or MD licensed by the State of Texas, who has at least two (2) years paid experience in the preceding five (5) years in HIV/AIDS care, to provide the educational services. Licensed social workers who have at least two (2) years paid experience in the preceding five (5) years in HIV/AIDS care may also provide adherence education and counseling. **Nutritional Assessment (primary care):** Services must be provided by a licensed registered dietician. Dieticians must have a minimum of two (2) years of experience providing nutritional assessment and counseling to PLWHA. **Medical Case Management:** The program must utilize a state licensed Social Worker to provide Medical Case Management Services. The Contractor must maintain the assigned number of Medical Case Management FTEs throughout the contract term. **Contractor must provide to RWGA the names of each Medical Case Manager and the individual assigned to supervise those Medical Case Managers within 30 days of start of grant year, and thereafter within 15 days after hire.** **Service Linkage:** The program must utilize Service Linkage Workers who have at a minimum a Bachelor's degree from an accredited college or university with a major in social or behavioral sciences. Documented paid work experience in providing client

	services to PLWHA may be substituted for the Bachelor's degree requirement on a 1:1 basis (1 year of documented paid experience may be substituted for 1 year of college). All Service Linkage Workers must have a minimum of one (1) year paid work experience with PLWHA. Contractor must maintain the assigned number of Service Linkage FTEs throughout the contract term. **Contractor must provide to RWGA the names of each Service Linkage Worker and the individual assigned to supervise those Service Linkage Workers within 30 days of start of grant year, and thereafter within 15 days after hire.** **Supervision of Case Managers:** The Service Linkage Workers and Medical Case Managers must function within the clinical infrastructure of Contractor and receive ongoing supervision that meets or exceeds Houston EMA/HSDA Part A/B Standards of Care for Service Linkage and Medical Case Management as applicable. An MCM may supervise SLWs.
Special Requirements:	**All primary medical care services must meet or exceed current United States DHHS Treatment Guidelines for the treatment and management of HIV disease.** Contractor must provide all required program components - Primary Medical Care, Medical Case Management, Service Linkage (non-medical Case Management) and Local Pharmacy Assistance Program (LPAP) services. **Primary Medical Care Services:** Services funded under this grant cannot be used to supplant insurance or Medicare/Medicaid reimbursements for such services. Clients eligible for such reimbursement may not be billed to this contract. Medicare and private insurance co-payments may be eligible for reimbursement under Ryan White Health Insurance Assistance (HINS) program guidelines. Patients needing such assistance should be referred to the local Ryan White-funded HINS provider for assistance. Under no circumstances may the Contractor bill the County for the difference between the reimbursement from Medicaid, Medicare or Third Party insurance and the fee schedule under the contract. Furthermore, potential clients who are Medicaid/Medicare eligible or have other Third Party payers may not be denied services or referred elsewhere by the Contractor based on their reimbursement status (i.e. Medicaid/Medicare eligible clients may not be referred elsewhere in order that non-Medicaid/Medicare eligible clients may be added to the contract). Failure to serve Medicaid/Medicare eligible clients based on their reimbursement status will be grounds for the immediate termination of contract.

	For primary medical care services targeted to the Latino community at least 50% of the clinical care team must be fluent in Spanish. **Diagnostic Procedures:** A single Diagnostic Procedure limited to procedures on the approved list of diagnostic procedures (see below) without prior County approval. Approved diagnostic procedures will be reimbursed at invoice cost. Part A and Part A/MAI-funded programs must refer to the RWGA website for the most current list of approved diagnostic procedures and corresponding codes: www.hcphes.org/rwga. **Diagnostic procedures not listed on the website must have prior approval by RWGA.** **Outpatient Psychiatric Services:** Client must not be eligible for services from other programs/providers or any other reimbursement source (i.e. Medicaid, Medicare, private insurance) unless the client is in crisis and cannot be provided immediate services from the other programs/providers. In this case, clients may be provided services, as long as the client applies for the other programs/providers, until the other programs/providers can take over services. Program must be supervised by a Psychiatrist and include diagnostic assessments, emergency evaluations and psycho-pharmacotherapy. **Maintaining Referral Relationships** (Point of Entry Agreements): Contractor must maintain appropriate relationships with entities that constitute key points of access to the health care system for individuals with HIV disease, including but not limited to, Harris Health System and other Houston EMA-located emergency rooms, Harris County Jail, Texas Department of Criminal Justice incarceration facilities, Immigration detention centers, substance abuse treatment and detoxification programs, adult and juvenile detention facilities, Sexually Transmitted Disease clinics, federally qualified health centers (FQHC), HIV disease counseling and testing sites, mental health programs and homeless shelters. These referral relationships must be documented with written collaborative agreements, contracts or memoranda of understanding between Contractor and appropriate point of entry entities and are subject to audit by RWGA. Contractor and POE entity staff must regularly (e.g. weekly, bi-weekly depending on volume of referrals) meet 1:1 to discuss new referrals to primary medical care services. Such case conferences must be documented in the client record and properly entered into the CPCDMS. Use of CPCDMS Data System: Contractor must comply with CPCDMS business rules and procedures. Contractor must enter into the CPCDMS all required clinical data, including but not limited to, HAART treatment including all changes in medication

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

FY 2023 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/09/2022**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/02/2022**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Improvement Committee**		Date: **05/03/2022**
Recommendations:	Approved: Y:_ ___ No: _____ Approved With Changes: _____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMTN Workgroup #1**	Date: **04/19/2022**
Recommendations:	Financial Eligibility: PriCare=300%, EFA=500%, MCM/SLW/ Outreach=none, LPAP (HIV meds) 500%
1. Update the justification chart, keep the service definition and the financial eligibility the same for Primary Care, Emergency Financial Assistance-Pharmacy, Medical Case Management, Service Linkage, Outreach and Local Pharmacy Assistance Program for HIV meds.	
2. Increase the financial eligibility for LPAP non-HIV meds to 500%.	
3. Recommend that the Priority & Allocations Committee increase funding for all Case Management services specifically to increase salaries to reduce staff turnover.	

FY 2020 Houston EMA Ryan White Part A/MAI Service Definition **Comprehensive Outpatient Primary Medical Care including Medical Case Management, Service Linkage and Local Pharmacy Assistance Program (LPAP) Services**	
HRSA Service Category Title: **RWGA Only**	1. Outpatient/Ambulatory Medical Care 2. Medical Case Management 3. AIDS Pharmaceutical Assistance (local) 4. Case Management (non-Medical) 5. Emergency Financial Assistance – Pharmacy Assistance 6. Outreach
Local Service Category Title:	Adult Comprehensive Primary Medical Care i. Targeted to Public Clinic ii. Targeted to Women at Public Clinic
Amount Available: **RWGA Only**	Total estimated available funding: $0.00 (to be determined) 1. Primary Medical Care: $0.00 (including MAI) i. Targeted to Public Clinic: $0.00 ii. Targeted to Women at Public Clinic: $0.00 2. LPAP $0.00 3. Medical Case Management: $0.00 i. Targeted to Public Clinic: $0.00 ii. Targeted to Women at Public Clinic: $0.00 4. Service Linkage: $0.00 Note: The Houston Ryan White Planning Council (RWPC) determines annual Part A and MAI service category allocations & reallocations. RWGA has sole authority over contract award amounts.
Target Population:	Comprehensive Primary Medical Care – Community Based i. Targeted to Public Clinic ii. Targeted to Women at Public Clinic **Outreach:** Services will be available to eligible HIV-infected clients residing in the Houston EMA/HSDA with priority given to clients most in need. Services are restricted to those clients who meet the contractor's RWGA approved Outreach Inclusion Criteria. The Outreach Inclusion Criteria components must include, at minimum 2 consecutive missed primary care provider and/or HIV lab appointments. Outreach Inclusion Criteria may also include VL suppression, substance abuse, and ART treatment failure components.

Client Eligibility: Age, Gender, Race, Ethnicity, Residence, etc.	PLWHA residing in the Houston EMA (prior approval required for non-EMA clients). Contractor must adhere to Targeting requirements and Budget limitations as applicable.
Financial Eligibility:	*See Current Year Approved Financial Eligibility for Houston EMA/HSDA*
Budget Type: **RWGA Only**	Hybrid Fee for Service
Budget Requirement or Restrictions: **RWGA Only**	**Primary Medical Care:** 100% of clients served under the *Targeted to Women at Public Clinic* subcategory must be female 10% of funds designated to primary medical care must be reserved for invoicing diagnostic procedures at actual cost. Contractors may not exceed the allocation for each individual service component (Primary Medical Care, Medical Case Management, Local Pharmacy Assistance Program and Service Linkage) without prior approval from RWGA. **Local Pharmacy Assistance Program (LPAP):** Houston RWPC guidelines for Local Pharmacy Assistance Program (LPAP) services: Contractor shall offer HIV medications from an approved formulary for a total not to exceed $18,000 per contract year per client. Contractor shall offer HIV-related medications for a total not to exceed $3,000 per contract year per client. These guidelines are determined by the RWPC. The RWPC determines the subcategories that shall include Ryan White LPAP funding. Medications must be provided in accordance with Houston EMA guidelines, HRSA/HAB rules and regulations and applicable Office of Pharmacy Affairs 340B guidelines. At least 75% of the total amount of the budget for LPAP services must be solely allocated to the actual cost of medications and may not include any storage, administrative, processing or other costs associated with managing the medication inventory or distribution. **Emergency Financial Assistance – Pharmacy Assistance** Direct cash payments to clients are not permitted. It is expected that all other sources of funding in the community for emergency financial assistance will be effectively used and that any allocation of RWHAP funds for these purposes will be as the payer of last

	resort, and for limited amounts, uses, and periods of time. Continuous provision of an allowable service to a client should not be funded through emergency financial assistance. **Outreach** Outreach services are restricted to those patients who have not returned for scheduled appointments with Provider as outlined in the RWGA approved Outreach Inclusion Criteria, and are included on the Outreach list.
Service Unit Definition/s: **RWGA Only**	• Outpatient/Ambulatory Medical Care: One (1) unit of service = One (1) primary care office/clinic visit which includes the following: • Primary care physician/nurse practitioner, physician's assistant or clinical nurse specialist examination of the patient, and • Medication/treatment education • Medication access/linkage • OB/GYN specialty procedures (as clinically indicated) • Nutritional assessment (as clinically indicated) • Laboratory (as clinically indicated, not including specialized tests) • Radiology (as clinically indicated, not including CAT scan or MRI) • Eligibility verification/screening (as necessary) • Follow-up visits wherein the patient is not seen by the MD/NP/PA are considered to be a component of the original primary care visit. • Outpatient Psychiatric Services: 1 unit of service = A single (1) office/clinic visit wherein the patient is seen by a State licensed and board-eligible Psychiatrist or qualified Psychiatric Nurse Practitioner. This visit may or may not occur on the same date as a primary care office visit. • Medication Education: 1 unit of service = A single pharmacy visit wherein a Ryan White eligible client is provided medication education services by a qualified pharmacist. This visit may or may not occur on the same date as a primary care office visit. Maximum reimbursement allowable for a medication education visit may not exceed $50.00 per visit. The visit must include at least one prescription medication being provided to clients. A maximum of one (1) Medication Education Visit may be provided to an individual client per day, regardless of the number of prescription medications provided. • Nutritional Assessment and Plan: 1 unit of service = A single comprehensive nutritional assessment and treatment plan performed by a Licensed, Registered Dietician initiated upon a physician's order. Does not include the provision of Supplements or other products (clients may be referred to the

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

	B Grantees to provide HIV/AIDS medications to clients. This assistance can be funded with Part A grant funds and/or Part B base award funds. Local pharmacy assistance programs are not funded with ADAP earmark funding. • **Medical Case Management** services (including treatment adherence) are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication. • **Case Management (non-Medical)** includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does. • **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. • **Outreach Services** include the provision of the following three activities: Identification of people who do not know their HIV status and linkage into Outpatient/Ambulatory Health Services, Provision of additional information and education on health care coverage options, Reengagement of people who know their status into Outpatient/Ambulatory Health Services
Standards of Care:	Contractors must adhere to the most current published Part A/B Standards of Care for the Houston EMA/HSDA. **Services must meet or exceed applicable United States Department of Health and Human Services (DHHS) guidelines for the Treatment of HIV/AIDS.**

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

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

clinically indicated, assessment and treatment by a qualified Psychiatrist or Psychiatric Nurse Practitioner.

Outpatient Psychiatric Services:

The program must provide:

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

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

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

Contractor must offer all medications on the Texas ADAP formulary, for a total not to exceed $18,000.00 per contract year per client. Contractor must provide allowable HIV-related medications (i.e. non-HIV medications) for a total not to exceed $3,000 per contract year per client. Contractor may be reimbursed ADAP

	dispensing fees (e.g. $5/Rx) in accordance with RWGA business rules for those ADAP clients who are unable to pay the ADAP dispensing fee. **Medical Case Management Services:** Services include screening all primary medical care patients to determine each patient's level of need for Medical Case Management services, performing a comprehensive assessment, including an assessment of the patient's health literary, and developing a medical service plan for each client that demonstrates a documented need for such services, monitoring medical service plan to ensure its implementation, and educating client regarding wellness, medication and health care appointment adherence. The Medical Case Manager serves as an advocate for the client and as a liaison with medical providers on behalf of the client. The Medical Case Manager ensures linkage to mental health, substance abuse and other client services as indicated by the medical service plan. **Service Linkage:** The purpose of Service Linkage is to assist clients with the procurement of needed services so that the problems associated with living with HIV are mitigated. Service Linkage is a working agreement between a client and a Service Linkage Worker for an indeterminate period, based on client need, during which information, referrals and service linkage are provided on an as-needed basis. Service Linkage assists clients who do not require the intensity of Medical Case Management per RWGA Quality Management guidelines. Service Linkage is both office-based and field based. Service Linkage Workers are expected to coordinate activities with referral sources where newly-diagnosed or not-in-care PLWHA may be identified, including 1:1 case conferences with testing site personnel to ensure the successful transition of referrals into Primary Care Services. Such incoming referral coordination includes meeting prospective clients at the referring Provider location in order to develop rapport with individuals prior to the individual's initial Primary Care appointment and ensuring such new intakes to Primary Care services have sufficient support to make the often difficult transition into ongoing primary medical care. Service Linkage also includes follow-up to re-engage lost-to-care patients. Lost-to-care patients are those patients who have not returned for scheduled appointments with Provider nor have provided Provider with updated information about their current Primary Medical Care provider (in the situation where patient may have obtained alternate service from another medical provider). Contractor must document efforts to re-engage lost-to-care patients prior to closing patients in the CPCDMS. Service Linkage extends the capability of existing programs by providing "hands-on" outreach and linkage to care services to those PLWHA who are not currently accessing primary medical care services. Service Linkage includes the issuance of

	bus pass vouchers and gas cards per published RWGA guidelines. Service Linkage complements and extends the service delivery capability of Medical Case Management services. **Outreach**: Providing allowable Ryan White Program outreach and service linkage activities to PLWHA who know their status but are not actively engaged in outpatient primary medical care with information, referrals and assistance with medical appointment setting, mental health, substance abuse and psychosocial services as needed; advocating on behalf of clients to decrease service gaps and remove barriers to services helping clients develop and utilize independent living skills and strategies. Assist clients in obtaining needed resources, including bus pass vouchers and gas cards per published HCPH/RWGA policies. Outreach services must be conducted at times and in places where there is a high probability that individuals with HIV infection will be contacted, designed to provide quantified program reporting of activities and outcomes to accommodate local evaluation of effectiveness, planned and delivered in coordination with local and state HIV prevention outreach programs to avoid duplication of effort, targeted to populations known, through review of clinic medical records, to be at disproportionate risk of disengagement with primary medical care services. **Emergency Financial Assistance – Pharmacy Assistance** provides limited one-time and/or short-term 30-day supply of pharmaceuticals to patients otherwise ineligible for medications through private insurance, Medicaid/Medicare, State ADAP, SPAP or other sources. One refill for up to 30-day supply available with RWGA prior approval. Allowable medications are only those on the Houston EMA Ryan White Part A Formulary. HIV-related medication services are the provision of physician or physician-extender prescribed medications to prevent serious deterioration of health. Does not include drugs available to the patient from other programs or payers or free of charge or medications available over the counter (OTC) without prescription. Contractor must offer all medications on the Texas ADAP formulary.
Agency Requirements:	**Providers and system must be Medicaid/Medicare certified.** **Eligibility and Benefits Coordination:** Contractor must implement consumer-friendly, culturally and linguistically appropriate new and ongoing patient eligibility verification and benefit coordination processes that ensure accountability with Ryan White Payer of Last Resort requirements while achieving maximum utilization of eligible benefits. Eligibility processes should provide clients with a meaningful understanding of their benefits, expected out-of-pocket expenses and other information needed to ensure full and continued participation in care.

	LPAP and EFA – Pharmacy Assistance Services: Contractor must: Provide pharmacy services on-site or through an established contractual relationship that meets all requirements. Alternate (off-site) approaches must be approved prior to implementation by RWGA. Either directly, or via subcontract with an eligible 340B Pharmacy program entity, must: Ensure a comprehensive financial intake application to determine client eligibility for this program to insure that these funds are used as a last resort for purchase of medications. Ensure the documented capability of interfacing with the Texas HIV Medication Program operated by the Texas Department of State Health Services. This capability must be fully documented and is subject to independent verification by RWGA. Ensure medication assistance provided to clients does not duplicate services already being provided in the Houston area. The process for accomplishing this must be fully documented and is subject to independent verification by RWGA. Ensure, either directly or via a 340B Pharmacy Program Provider, at least 2 years of continuous documented experience in providing HIV/AIDS medication programs utilizing Ryan White Program or similar public sector funding. This experience must be documented and is subject to independent verification by RWGA. Ensure all medications are purchased via a qualified participant in the federal 340B Drug Pricing Program and Prime Vendor Program, administered by the HRSA Office of Pharmacy Affairs. Note: failure to maintain 340B or Prime Vendor drug pricing may result in a negative audit finding, cost disallowance or termination of contract awarded. Contractor must maintain 340B Program participation throughout the contract term. All eligible medications must be purchased in accordance with Program 340B guidelines and program requirements. Ensure Houston area HIV/AIDS service providers are informed of this program and how the client referral and enrollment processes functions. Contractor must maintain documentation of such marketing efforts. Implement a consistent process to enroll eligible patients in available pharmaceutical company Patient Assistance Programs prior to using Ryan White Part A funded LPAP resources.

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

	minimum of two (2) years of experience providing nutritional assessment and counseling to PLWHA. **Medical Case Management:** The program must utilize a state licensed Social Worker to provide Medical Case Management Services. The Contractor must maintain the assigned number of Medical Case Management FTEs throughout the contract term. **Contractor must provide to RWGA the names of each Medical Case Manager and the individual assigned to supervise those Medical Case Managers by 03/30/15, and thereafter within 15 days after hire.** **Service Linkage:** The program must utilize Service Linkage Workers who have at a minimum a Bachelor's degree from an accredited college or university with a major in social or behavioral sciences. Documented paid work experience in providing client services to PLWHA may be substituted for the Bachelor's degree requirement on a 1:1 basis (1 year of documented paid experience may be substituted for 1 year of college). All Service Linkage Workers must have a minimum of one (1) year paid work experience with PLWHA. Contractor must maintain the assigned number of Service Linkage FTEs throughout the contract term. **Contractor must provide to RWGA the names of each Service Linkage Worker and the individual assigned to supervise those Service Linkage Workers by 03/30/15, and thereafter within 15 days after hire.** **Supervision of Case Managers:** The Service Linkage Workers and Medical Case Managers must function within the clinical infrastructure of Contractor and receive ongoing supervision that meets or exceeds Houston EMA/HSDA Part A/B Standards of Care for Service Linkage and Medical Case Management as applicable. An MCM may supervise SLWs.

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

include diagnostic assessments, emergency evaluations and psycho-pharmacotherapy.

Maintaining Referral Relationships (Point of Entry Agreements): Contractor must maintain appropriate relationships with entities that constitute key points of access to the health care system for individuals with HIV disease, including but not limited to, Harris Health System and other Houston EMA-located emergency rooms, Harris County Jail, Texas Department of Criminal Justice incarceration facilities, Immigration detention centers, substance abuse treatment and detoxification programs, adult and juvenile detention facilities, Sexually Transmitted Disease clinics, federally qualified health centers (FQHC), HIV disease counseling and testing sites, mental health programs and homeless shelters. These referral relationships must be documented with written collaborative agreements, contracts or memoranda of understanding between Contractor and appropriate point of entry entities and are subject to audit by RWGA. Contractor and POE entity staff must regularly (e.g. weekly, bi-weekly depending on volume of referrals) meet 1:1 to discuss new referrals to primary medical care services. Such case conferences must be documented in the client record and properly entered into the CPCDMS.

Use of CPCDMS Data System: Contractor must comply with CPCDMS business rules and procedures. Contractor must enter into the CPCDMS all required clinical data, including but not limited to, HAART treatment including all changes in medication regimens, Opportunistic Infections, screening and treatment for STDs and Hepatitis A, B, C and other clinical screening and treatment data required by HRSA, TDSHS and the County. Contractor must perform Registration updates in accordance with RWGA CPCDMS business rules for all clients wherein Contractor is client's CPCDMS record-owning agency. Contractor must utilize an electronic verification system to verify insurance/3rd party payer status monthly or per visit (whichever is less frequent).

Bus Pass Distribution: The County will provide Contractor with METRO bus pass vouchers. Bus Pass vouchers must be distributed in accordance with RWGA policies and procedures, standards of care and financial eligibility guidelines. Contractor may only issue METRO bus pass vouchers to clients wherein the Contractor is the CPCDMS record owning Contractor. METRO bus pass vouchers shall be distributed as follows:

Expiration of Current Bus Pass: In those situation wherein the bus pass expiration date does not coincide with the CPCDMS registration update the Contractor must distribute METRO bus pass vouchers to eligible clients upon the expiration of the current bus pass or when a Value-based bus card has been expended on eligible

	transportation needs. Contractor may issue METRO bus passes to eligible clients living outside the METRO service area in those situations where the Contractor has documented in the client record that the client will utilize the METRO system to access needed HIV-related health care services located in the METRO service area. **Gas Cards:** Primary Medical Care Contractors must distribute gasoline vouchers to eligible clients residing in the rural service area in accordance with RWGA policies and procedures, standards of care and financial eligibility guidelines. Gas Cards are only available to Rural primary medical care Contractors without prior approval by RWGA.

FY 2023 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/09/2022**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/02/2022**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Improvement Committee**		Date: **05/03/2022**
Recommendations:	Approved: Y:_ ___ No: _____ Approved With Changes: _____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMTN Workgroup #1**		Date: **04/19/2022**
Recommendations:	Financial Eligibility: PriCare=300%, EFA=500%, MCM/SLW/ Outreach=none, LPAP (HIV meds) 500%	
1. Update the justification chart, keep the service definition and the financial eligibility the same for Primary Care, Emergency Financial Assistance-Pharmacy, Medical Case Management, Service Linkage, Outreach and Local Pharmacy Assistance Program for HIV meds.		
2. Increase the financial eligibility for LPAP non-HIV meds to 500%.		
3. Recommend that the Priority & Allocations Committee increase funding for all Case Management services specifically to increase salaries to reduce staff turnover.		

FY 2020 Houston EMA Ryan White Part A/MAI Service Definition **Comprehensive Outpatient Primary Medical Care including Medical Case Management, Service Linkage and Local Pharmacy Assistance Program (LPAP) Services - Rural**	
HRSA Service Category Title: **RWGA Only**	1. Outpatient/Ambulatory Medical Care 2. Medical Case Management 3. AIDS Pharmaceutical Assistance (local) 4. Emergency Financial Assistance – Pharmacy Assistance 5. Case Management (non-Medical)
Local Service Category Title:	Adult Comprehensive Primary Medical Care - Targeted to Rural
Amount Available: **RWGA Only**	Total estimated available funding: $0.00 (to be determined) 1. Primary Medical Care: $0.00 2. LPAP $0.00 3. Medical Case Management: $0.00 4. Service Linkage: $0.00 Note: The Houston Ryan White Planning Council (RWPC) determines overall annual Part A and MAI service category allocations & reallocations. RWGA has sole authority over contract award amounts.
Target Population:	Comprehensive Primary Medical Care – Targeted to Rural
Client Eligibility: Age, Gender, Race, Ethnicity, Residence, etc.	PLWHA residing in the Houston EMA/HSDA counties **other than Harris County** (prior approval required for non-EMA clients). Contractor must adhere to Targeting requirements and Budget limitations as applicable.
Financial Eligibility:	*See Current Year Approved Financial Eligibility for Houston EMA/HSDA*
Budget Type: **RWGA Only**	Hybrid Fee for Service
Budget Requirement or Restrictions: **RWGA Only**	**Primary Medical Care:** No less than 75% of clients served in a Targeted subcategory must be members of the targeted population with the following exceptions: 10% of funds designated to primary medical care must be reserved for invoicing diagnostic procedures at actual cost. Contractors may not exceed the allocation for each individual service component (Primary Medical Care, Medical Case Management, Local Pharmacy Assistance Program and Service Linkage) without prior approval from RWGA.

	Local Pharmacy Assistance Program (LPAP): Houston RWPC guidelines for Local Pharmacy Assistance Program (LPAP) services: Contractor shall offer HIV medications from an approved formulary for a total not to exceed $18,000 per contract year per client. Contractor shall offer HIV-related medications for a total not to exceed $3,000 per contract year per client. These guidelines are determined by the RWPC. The RWPC determines the subcategories that shall include Ryan White LPAP funding. Medications must be provided in accordance with Houston EMA guidelines, HRSA/HAB rules and regulations and applicable Office of Pharmacy Affairs 340B guidelines. At least 75% of the total amount of the budget for LPAP services must be solely allocated to the actual cost of medications and may not include any storage, administrative, processing or other costs associated with managing the medication inventory or distribution. **Emergency Financial Assistance – Pharmacy Assistance** Direct cash payments to clients are not permitted. It is expected that all other sources of funding in the community for emergency financial assistance will be effectively used and that any allocation of RWHAP funds for these purposes will be as the payer of last resort, and for limited amounts, uses, and periods of time. Continuous provision of an allowable service to a client should not be funded through emergency financial assistance.
Service Unit Definition/s:	• Outpatient/Ambulatory Medical Care: One (1) unit of service = One (1) primary care office/clinic visit which includes the following: • Primary care physician/nurse practitioner, physician's assistant or clinical nurse specialist examination of the patient, and • Medication/treatment education • Medication access/linkage • OB/GYN specialty procedures (as clinically indicated) • Nutritional assessment (as clinically indicated) • Laboratory (as clinically indicated, not including specialized tests) • Radiology (as clinically indicated, not including CAT scan or MRI) • Eligibility verification/screening (as necessary)

	• Follow-up visits wherein the patient is not seen by the MD/NP/PA are considered to be a component of the original primary care visit. • Outpatient Psychiatric Services: 1 unit of service = A single (1) office/clinic visit wherein the patient is seen by a State licensed and board-eligible Psychiatrist or qualified Psychiatric Nurse Practitioner. This visit may or may not occur on the same date as a primary care office visit. • Nutritional Assessment and Plan: 1 unit of service = A single comprehensive nutritional assessment and treatment plan performed by a Licensed, Registered Dietician initiated upon a physician's order. Does not include the provision of Supplements or other products (clients may be referred to the Ryan White funded Medical Nutritional Therapy provider for provision of medically necessary supplements). The nutritional assessment visit may or may not occur on the same date as a medical office visit. • AIDS Pharmaceutical Assistance (local): A unit of service = a transaction involving the filling of a prescription or any other allowable medication need ordered by a qualified medical practitioner. The transaction will involve at least one item being provided for the client, but can be any multiple. The cost of medications provided to the client must be invoiced at actual cost. • Medical Case Management: 1 unit of service = 15 minutes of direct medical case management services to an eligible PLWHA performed by a qualified medical case manager. • Service Linkage (non-Medical Case Management): 1 unit of service = 15 minutes of direct service linkage services to an eligible PLWHA performed by a qualified service linkage worker. • Emergency Financial Assistance – Pharmacy Assistance: A unit of service = a transaction involving the filling of a prescription or any other allowable HIV treatment medication need ordered by a qualified medical practitioner. The transaction will involve at least one item being provided for the client, but can be any multiple. The cost of medications provided to the client must be invoiced at actual cost.
HRSA Service Category Definition:	• **Outpatient/Ambulatory medical care** is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or

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

	management including face-to-face, phone contact, and any other forms of communication. • **Case Management (non-Medical)** includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does. • **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.
Standards of Care:	Contractors must adhere to the most current published Part A/B Standards of Care for the Houston EMA/HSDA. **Services must meet or exceed applicable United States Department of Health and Human Services (DHHS) guidelines for the Treatment of HIV/AIDS.**
Local Service Category Definition/Services to be Provided:	**Outpatient/Ambulatory Primary Medical Care:** Services include on-site physician, physician extender, nursing, phlebotomy, radiographic, laboratory, pharmacy, intravenous therapy, home health care referral, licensed dietician, patient medication education, and patient care coordination. The Contractor must provide continuity of care with inpatient services and subspecialty services (either on-site or through specific referral to appropriate medical provider upon primary care Physician's order). Services provided to women shall further include OB/GYN physician & physician extender services on-site or by referral, OB/GYN services, colposcopy, nursing, phlebotomy, radiographic, laboratory, pharmacy, intravenous therapy, home health care referral, licensed dietician, patient medication/women's health education, patient care coordination, and social services. The Contractor must provide continuity of care with inpatient services and subspecialty services (either on-site or through specific referral protocols to appropriate agencies upon primary care Physician's order). **Outpatient/Ambulatory Primary Medical Care must provide:** • Continuity of care for all stages of adult HIV infection;

	• Laboratory and pharmacy services including intravenous medications (either on-site or through established referral systems); • Outpatient psychiatric care, including lab work necessary for the prescribing of psychiatric medications when appropriate (either on-site or through established referral systems); • Access to the Texas ADAP program (either on-site or through established referral systems); • Access to compassionate use HIV medication programs (either directly or through established referral systems); • Access to HIV related research protocols (either directly or through established referral systems); • Must at a minimum, comply with Houston EMA/HSDA Part A/B Standards for HIV Primary Medical Care. The Contractor must demonstrate on an ongoing basis the ability to provide state-of-the-art HIV-related primary care medicine in accordance with the most recent DHHS HIV treatment guidelines. Rapid advances in HIV treatment protocols require that the Contractor provide services that to the greatest extent possible maximize a patient's opportunity for long-term survival and maintenance of the highest quality of life possible. • On-site Outpatient Psychiatry services. • On-site Medical Case Management services. • On-site Medication Education. • Physical therapy services (either on-site or via referral). • Specialty Clinic Referrals (either on-site or via referral). • On-site pelvic exams as needed for female patients with appropriate follow-up treatment and referral. • On site Nutritional Counseling by a Licensed Dietitian. **Services for women must also provide:** • Well woman care, including but not limited to: PAP, pelvic exam, HPV screening, breast examination, mammography, hormone replacement and education, pregnancy testing, contraceptive services excluding birth control medications. • Obstetric Care: ante-partum through post-partum services, child birth/delivery services. Perinatal preventative education and treatment. • On-site or by referral Colposcopy exams as needed, performed by an OB/GYN physician, or physician extender with a colposcopy provider qualification.

	• Social services, including but not limited to, providing women access to child care, transportation vouchers, food vouchers and support groups at the clinic site; **Nutritional Assessment:** Services include provision of information about therapeutic nutritional/supplemental foods that are beneficial to the wellness and increased health conditions of clients by a Licensed Dietitian. Services may be provided either through educational or counseling sessions. Clients who receive these services may utilize the Ryan White Part A-funded nutritional supplement provider to obtain recommended nutritional supplements in accordance with program rules. Clients are limited to one (1) nutritional assessment per calendar year without prior approval of RWGA. Patient Medication Education Services must adhere to the following requirements: • Medication Educators must be State Licensed Medical Doctor (MD), Nurse Practitioner (NP), Physician Assistant PA), Nurse (RN, LVN) or Pharmacist. Prior approval must be obtained prior to utilizing any other health care professional not listed above to provide medication education. • Clients who will be prescribed ongoing medical regimens (i.e. ART) must be assessed for adherence to treatment at every clinical encounter using the EMA's approved adherence assessment tool. Clients with adherence issues related to lack of understanding must receive more education regarding their medical regimen. Clients with adherence issues that are behavioral or involve mental health issues must be provided counseling by the Medical Case Manager, Physician or Physician Extender and/or licensed nursing staff and, if clinically indicated, assessment and treatment by a qualified Psychiatrist or Psychiatric Nurse Practitioner. **Outpatient Psychiatric Services:** The program must provide: • Diagnostic Assessments: comprehensive evaluation for identification of psychiatric disorders, mental status evaluation, differential diagnosis which may involve use of other clinical and laboratory tests, case formulation, and treatment plans or disposition.

	• Emergency Psychiatric Services: rapid evaluation, differential diagnosis, acute treatment, crisis intervention, and referral. Must be available on a 24 hour basis including emergency room referral. • Brief Psychotherapy: individual, supportive, group, couple, family, hypnosis, biofeedback, and other psychophysiological treatments and behavior modification. • Psychopharmacotherapy: evaluation and medication treatment of psychiatric disorders, including, but not limited to, anxiety disorders, major depression, pain syndromes, habit control problems, psychosis and organic mental disorders. • Rehabilitation Services: Physical, psychosocial, behavioral, and/or cognitive training. Screening for Eye Disorders: Contractor must ensure that patients receive appropriate screening and treatment for CMV, glaucoma, cataracts, and other related problems. **Local Medication Assistance Program (LPAP):** LPAP provides pharmaceuticals to patients otherwise ineligible for medications through private insurance, Medicaid/Medicare, State ADAP, SPAP or other sources. Allowable medications are only those on the Houston EMA Ryan White Part A Formulary. Eligible clients may be provided Fuzeon™ on a case-by-case basis with prior approval of Ryan White Grant Administration (RWGA). The cost of Fuzeon™ does not count against a client's annual maximum. HIV-related medication services are the provision of physician or physician-extender prescribed HIV-related medications to prevent serious deterioration of health. Does not include drugs available to the patient from other programs or payers or free of charge (such as birth control and TB medications) or medications available over the counter (OTC) without prescription. Contractor must offer all medications on the Texas ADAP formulary, for a total not to exceed $18,000.00 per contract year per client. Contractor must provide allowable HIV-related medications (i.e. non-HIV medications) for a total not to exceed $3,000 per contract year per client. Contractor may be reimbursed ADAP dispensing fees (e.g. $5/Rx) in accordance with RWGA business rules for those ADAP clients who are unable to pay the ADAP dispensing fee. **Medical Case Management Services:** Services include screening all primary medical care patients to determine each patient's level of need for Medical Case Management services, performing a comprehensive assessment, including an assessment of the patient's health literary, and developing a medical service plan for each client that demonstrates a documented need for such services, monitoring medical service plan to ensure its implementation, and

	educating client regarding wellness, medication and health care appointment adherence. The Medical Case Manager serves as an advocate for the client and as a liaison with medical providers on behalf of the client. The Medical Case Manager ensures linkage to mental health, substance abuse and other client services as indicated by the medical service plan. **Service Linkage:** The purpose of Service Linkage is to assist clients with the procurement of needed services so that the problems associated with living with HIV are mitigated. Service Linkage is a working agreement between a client and a Service Linkage Worker for an indeterminate period, based on client need, during which information, referrals and service linkage are provided on an as-needed basis. Service Linkage assists clients who do not require the intensity of Medical Case Management per RWGA Quality Management guidelines. Service Linkage is both office-based and field based. Service Linkage Workers are expected to coordinate activities with referral sources where newly-diagnosed or not-in-care PLWHA may be identified, including 1:1 case conferences with testing site personnel to ensure the successful transition of referrals into Primary Care Services. Such incoming referral coordination includes meeting prospective clients at the referring Provider location in order to develop rapport with individuals prior to the individual's initial Primary Care appointment and ensuring such new intakes to Primary Care services have sufficient support to make the often difficult transition into ongoing primary medical care. Service Linkage also includes follow-up to re-engage lost-to-care patients. Lost-to-care patients are those patients who have not returned for scheduled appointments with Provider nor have provided Provider with updated information about their current Primary Medical Care provider (in the situation where patient may have obtained alternate service from another medical provider). Contractor must document efforts to re-engage lost-to-care patients prior to closing patients in the CPCDMS. Service Linkage extends the capability of existing programs by providing "hands-on" outreach and linkage to care services to those PLWHA who are not currently accessing primary medical care services. Service Linkage includes the issuance of bus pass vouchers and gas cards per published RWGA guidelines. Service Linkage complements and extends the service delivery capability of Medical Case Management services. **Emergency Financial Assistance – Pharmacy Assistance** provides limited one-time and/or short-term 30-day supply of pharmaceuticals to patients otherwise ineligible for medications through private insurance, Medicaid/Medicare, State ADAP, SPAP or other sources. One refill for up to 30-day supply available with RWGA prior approval. Allowable medications are only those on the Houston EMA Ryan White Part A Formulary. HIV-related

	medication services are the provision of physician or physician-extender prescribed medications to prevent serious deterioration of health. Does not include drugs available to the patient from other programs or payers or free of charge or medications available over the counter (OTC) without prescription. Contractor must offer all medications on the Texas ADAP formulary.
Agency Requirements:	**Providers and system must be Medicaid/Medicare certified.** **Eligibility and Benefits Coordination:** Contractor must implement consumer-friendly, culturally and linguistically appropriate new and ongoing patient eligibility verification and benefit coordination processes that ensure accountability with Ryan White Payer of Last Resort requirements while achieving maximum utilization of eligible benefits. Eligibility processes should provide clients with a meaningful understanding of their benefits, expected out-of-pocket expenses and other information needed to ensure full and continued participation in care. **LPAP and EFA – Pharmacy Assistance Services:** Contractor must: Provide pharmacy services on-site or through an established contractual relationship that meets all requirements. Alternate (off-site) approaches must be approved prior to implementation by RWGA. Either directly, or via subcontract with an eligible 340B Pharmacy program entity, must: Ensure a comprehensive financial intake application to determine client eligibility for this program to insure that these funds are used as a last resort for purchase of medications. Ensure the documented capability of interfacing with the Texas HIV Medication Program operated by the Texas Department of State Health Services. This capability must be fully documented and is subject to independent verification by RWGA. Ensure medication assistance provided to clients does not duplicate services already being provided in the Houston area. The process for accomplishing this must be fully documented and is subject to independent verification by RWGA. Ensure, either directly or via a 340B Pharmacy Program Provider, at least 2 years of continuous documented experience in providing HIV/AIDS medication programs utilizing Ryan White Program or similar public sector funding. This experience must be documented and is subject to independent verification by RWGA.

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

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

	for Service Linkage and Medical Case Management as applicable. An MCM may supervise SLWs.
Special Requirements: **RWGA Only**	**All primary medical care services must meet or exceed current United States DHHS Treatment Guidelines for the treatment and management of HIV disease.** Contractor must provide all required program components - Primary Medical Care, Medical Case Management, Service Linkage (non-medical Case Management) and Local Pharmacy Assistance Program (LPAP) services. **Primary Medical Care Services:** Services funded under this grant cannot be used to supplant insurance or Medicare/Medicaid reimbursements for such services. Clients eligible for such reimbursement may not be billed to this contract. Medicare and private insurance co-payments may be eligible for reimbursement under Ryan White Health Insurance Assistance (HINS) program guidelines. Patients needing such assistance should be referred to the local Ryan White-funded HINS provider for assistance. Under no circumstances may the Contractor bill the County for the difference between the reimbursement from Medicaid, Medicare or Third Party insurance and the fee schedule under the contract. Furthermore, potential clients who are Medicaid/Medicare eligible or have other Third Party payers may not be denied services or referred elsewhere by the Contractor based on their reimbursement status (i.e. Medicaid/Medicare eligible clients may not be referred elsewhere in order that non-Medicaid/Medicare eligible clients may be added to the contract). Failure to serve Medicaid/Medicare eligible clients based on their reimbursement status will be grounds for the immediate termination of contract. **For primary medical care services targeted to the Latino community at least 50% of the clinical care team must be fluent in Spanish.** **Diagnostic Procedures:** A single Diagnostic Procedure limited to procedures on the approved list of diagnostic procedures (see below) without prior County approval. Approved diagnostic procedures will be reimbursed at invoice cost. Part A and Part A/MAI-funded programs must refer to the RWGA website for the most current list of approved diagnostic procedures and corresponding codes: www.hcphes.org/rwga. **Diagnostic procedures not listed on the website must have prior approval by RWGA.** **Outpatient Psychiatric Services:** Client must not be eligible for services from other programs/providers or any other reimbursement source (i.e. Medicaid, Medicare, private insurance) unless the client

	is in crisis and cannot be provided immediate services from the other programs/providers. In this case, clients may be provided services, as long as the client applies for the other programs/providers, until the other programs/providers can take over services. Program must be supervised by a Psychiatrist and include diagnostic assessments, emergency evaluations and psycho-pharmacotherapy. **Maintaining Referral Relationships** (Point of Entry Agreements): Contractor must maintain appropriate relationships with entities that constitute key points of access to the health care system for individuals with HIV disease, including but not limited to, Harris Health System and other Houston EMA-located emergency rooms, Harris County Jail, Texas Department of Criminal Justice incarceration facilities, Immigration detention centers, substance abuse treatment and detoxification programs, adult and juvenile detention facilities, Sexually Transmitted Disease clinics, federally qualified health centers (FQHC), HIV disease counseling and testing sites, mental health programs and homeless shelters. These referral relationships must be documented with written collaborative agreements, contracts or memoranda of understanding between Contractor and appropriate point of entry entities and are subject to audit by RWGA. Contractor and POE entity staff must regularly (e.g. weekly, bi-weekly depending on volume of referrals) meet 1:1 to discuss new referrals to primary medical care services. Such case conferences must be documented in the client record and properly entered into the CPCDMS. Use of CPCDMS Data System: Contractor must comply with CPCDMS business rules and procedures. Contractor must enter into the CPCDMS all required clinical data, including but not limited to, HAART treatment including all changes in medication regimens, Opportunistic Infections, screening and treatment for STDs and Hepatitis A, B, C and other clinical screening and treatment data required by HRSA, TDSHS and the County. Contractor must perform Registration updates in accordance with RWGA CPCDMS business rules for all clients wherein Contractor is client's CPCDMS record-owning agency. Contractor must utilize an electronic verification system to verify insurance/3rd party payer status monthly or per visit (whichever is less frequent). **Bus Pass Distribution:** The County will provide Contractor with METRO bus pass vouchers. Bus Pass vouchers must be distributed in accordance with RWGA policies and procedures, standards of care and financial eligibility guidelines. Contractor may only issue METRO bus pass vouchers to clients wherein the Contractor is the CPCDMS record owning Contractor. METRO bus pass vouchers shall be distributed as follows:

	Expiration of Current Bus Pass: In those situation wherein the bus pass expiration date does not coincide with the CPCDMS registration update the Contractor must distribute METRO bus pass vouchers to eligible clients upon the expiration of the current bus pass or when a Value-based bus card has been expended on eligible transportation needs. Contractor may issue METRO bus passes to eligible clients living outside the METRO service area in those situations where the Contractor has documented in the client record that the client will utilize the METRO system to access needed HIV-related health care services located in the METRO service area. **Gas Cards:** Primary Medical Care Contractors must distribute gasoline vouchers to eligible clients residing in the rural service area in accordance with RWGA policies and procedures, standards of care and financial eligibility guidelines. Gas Cards are only available to Rural primary medical care Contractors without prior approval by RWGA.

FY 2023 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/09/2022**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/02/2022**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Improvement Committee**		Date: **05/03/2022**
Recommendations:	Approved: Y:_ ___ No: _____ Approved With Changes: _____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMTN Workgroup #1**	Date: **04/19/2022**
Recommendations:	Financial Eligibility: PriCare=300%, EFA=500%, MCM/SLW/ Outreach=none, LPAP (HIV meds) 500%
1. Update the justification chart, keep the service definition and the financial eligibility the same for Primary Care, Emergency Financial Assistance-Pharmacy, Medical Case Management, Service Linkage, Outreach and Local Pharmacy Assistance Program for HIV meds.	
2. Increase the financial eligibility for LPAP non-HIV meds to 500%.	
3. Recommend that the Priority & Allocations Committee increase funding for all Case Management services specifically to increase salaries to reduce staff turnover.	

FY 2020 Houston EMA Ryan White Part A/MAI Service Definition **Comprehensive Outpatient Primary Medical Care including Medical Case Management and Service Linkage Services - Pediatric**	
HRSA Service Category Title: **RWGA Only**	1. Outpatient/Ambulatory Medical Care 2. Medical Case Management 3. Case Management (non-Medical)
Local Service Category Title:	Comprehensive Primary Medical Care Targeted to Pediatric
Target Population:	HIV-infected resident of the Houston EMA 0 – 18 years of age. Provider may continue services to previously enrolled clients until the client's 22nd birthday.
Financial Eligibility:	*See Current Fiscal Year Approved Financial Eligibility for Houston EMA/HSDA*
Budget Type: **RWGA Only**	Hybrid Fee for Service
Budget Requirement or Restrictions: **RWGA Only**	**Primary Medical Care:** 10% of funds designated to primary medical care must be reserved for invoicing diagnostic procedures at actual cost. Contractors may not exceed the allocation for each individual service component (Primary Medical Care, Medical Case Management and Service Linkage) without prior approval from RWGA.
Service Unit Definition/s: **RWGA Only**	• Outpatient/Ambulatory Medical Care: One (1) unit of service = One (1) primary care office/clinic visit which includes the following: • Primary care physician/nurse practitioner, physician's assistant or clinical nurse specialist examination of the patient, and • Medication/treatment education • Medication access/linkage • OB/GYN specialty procedures (as clinically indicated) • Nutritional assessment (as clinically indicated) • Laboratory (as clinically indicated, not including specialized tests) • Radiology (as clinically indicated, not including CAT scan or MRI) • Eligibility verification/screening (as necessary) • Follow-up visits wherein the patient is not seen by the MD/NP/PA are considered to be a component of the original primary care visit. • Outpatient Psychiatric Services: 1 unit of service = A single (1) office/clinic visit wherein the patient is seen by a State licensed and board-eligible Psychiatrist or qualified Psychiatric Nurse Practitioner. This visit may or may not occur on the same date as a primary care office visit. • Medical Case Management: 1 unit of service = 15 minutes of direct medical case management services to an eligible PLWHA performed by a qualified medical case manager. • Service Linkage (non-Medical Case Management): 1 unit of service = 15 minutes of direct service linkage services to an eligible

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

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

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

Services for females of child bearing age must also provide:

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

Patient Medication Education Services must adhere to the following requirements:

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

Outpatient Psychiatric Services:

The program must provide:

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

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

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

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

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

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

FY 2023 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/09/2022**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Steering Committee**		Date: **06/02/2022**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Improvement Committee**		Date: **05/03/2022**
Recommendations:	Approved: Y:_ ___ No: _____ Approved With Changes: _____	If approved with changes list changes below:
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Step in Process: **HTBMTN Workgroup #1**	Date: **04/19/2022**
Recommendations:	Financial Eligibility: PriCare=300%, MCM/SLW=none
1. Update the justification chart, keep the service definition and the financial eligibility the same.	
2. Recommend that the Priority & Allocations Committee increase funding for all Case Management services specifically to increase salaries to reduce staff turnover.	
3.	

FY 2020 Houston EMA Ryan White Part A/MAI Service Definition Clinical Case Management	
HRSA Service Category Title: **RWGA Only**	**Medical Case Management**
Local Service Category Title:	**Clinical Case Management (CCM)**
Budget Type: **RWGA Only**	**Unit Cost**
Budget Requirements or Restrictions: **RWGA Only**	Not applicable.
HRSA Service Category Definition: **RWGA Only**	***Medical Case Management services (including treatment adherence)*** are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication.
Local Service Category Definition:	**Clinical Case Management**: Identifying and screening clients who are accessing HIV-related services from a clinical delivery system that provides Mental Health treatment/counseling and/or Substance Abuse treatment services; assessing each client's medical and psychosocial history and current service needs; developing and regularly updating a clinical service plan based upon the client's needs and choices; implementing the plan in a timely manner; providing information, referrals and assistance with linkage to medical and psychosocial services as needed; monitoring the efficacy and quality of services through periodic reevaluation; advocating on behalf of clients to decrease service gaps and remove barriers to services helping clients develop and utilize independent living skills and strategies. Assist clients in obtaining needed resources, including bus pass vouchers and gas cards per published HCPHS/RWGA policies.
Target Population (age,	Services will be available to eligible HIV-infected clients residing in

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

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

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

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

FY 2023 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/09/2022**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Steering Committee**		Date: **06/02/2022**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Improvement Committee**		Date: **05/03/2022**
Recommendations:	Approved: Y:_ ___ No: _____ Approved With Changes: _____	If approved with changes list changes below:
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Step in Process: **HTBMTN Workgroup #1**	Date: **04/19/2022**
Recommendations:	Financial Eligibility: None
1. Recommend that the Priority & Allocations Committee increase funding for all Case Management services specifically to increase salaries to reduce staff turnover.	
2. Update the justification chart, keep the service definition and the financial eligibility the same.	
3.	

FY 2020 Houston EMA Ryan White Part A/MAI Service Definition **Service Linkage at Testing Sites**	
HRSA Service Category Title: **RWGA Only**	**Non-medical Case Management**
Local Service Category Title:	**A. Service Linkage targeted to Not-In-Care and Newly-Diagnosed PLWHA in the Houston EMA/HDSA** **Not-In-Care PLWHA** are individuals who know their HIV status but have not been actively engaged in outpatient primary medical care services for more than six (6) months. **Newly-Diagnosed** PLWHA are individuals who have learned their HIV status within the previous six months and are not currently receiving outpatient primary medical care or case management services as documented in the CPCDMS data system. **B.** ***Youth targeted Service Linkage, Care and Prevention:*** Service Linkage Services targeted to Youth (13 – 24 years of age), including a focus on not-in-care and newly-diagnosed Youth in the Houston EMA. *Not-In-Care PLWHA are Youth who know their HIV status but have not been actively engaged in outpatient primary medical care services in the previous six (6) months. *Newly-Diagnosed Youth are Youth who have learned their HIV status within the previous six months and are not currently receiving outpatient primary medical care or case management services as documented in the CPCDMS data system.
Budget Type: **RWGA Only**	Fee-for-Service
Budget Requirements or Restrictions: **RWGA Only**	Early intervention services, including HIV testing and Comprehensive Risk Counseling Services (CRCS) must be supported via alternative funding (e.g. TDSHS, CDC) and may not be charged to this contract.
HRSA Service Category Definition: **RWGA Only**	***Case Management (non-Medical)*** includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does. ***Early intervention services (EIS)*** include counseling individuals with respect to HIV/AIDS; testing (including tests to confirm the presence of the disease, tests to diagnose to extent of immune deficiency, tests to provide information on appropriate therapeutic measures); referrals; other clinical and diagnostic services regarding HIV/AIDS; periodic medical evaluations for individuals with HIV/AIDS; and providing therapeutic measures.
Local Service Category Definition:	**A.** ***Service Linkage:*** Providing allowable Ryan White Program outreach and service linkage activities to newly-diagnosed and/or ***Not-In-Care*** PLWHA who know their status but are not currently enrolled

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

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

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

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

FY 2023 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/09/2022**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Steering Committee**		Date: **06/02/2022**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Improvement Committee**		Date: **05/03/2022**
Recommendations:	Approved: Y:_ ___ No: _____ Approved With Changes: _____	If approved with changes list changes below:
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Step in Process: **HTBMTN Workgroup #1**	Date: **04/19/2022**
Recommendations:	Financial Eligibility: None
1. Recommend that the Priority & Allocations Committee increase funding for all Case Management services specifically to increase salaries to reduce staff turnover.	
2. Update the justification chart, keep the service definition and the financial eligibility the same.	
3.	

Local Service Category:	**Care Coordination (Non-Medical Case Management) Targeting Substance Use Disorder**
Amount Available**:**	**To be determined**
Unit Cost	
Budget Requirements or Restrictions **(TRG Only)**:	Maximum 10% of budget for Administrative Cost. Direct medical costs and Substance Abuse Treatment/Counseling c annot be bi lled under this contract.
DSHS Service Category Definition:	**Care Coordination** is a continuum of services that allow people living with HIV to be served in a holistic method. Services that are a part of the Care Coordination Continuum include case management, (both medical and non-medical, outreach services, referral for health care, and health education/risk reduction. **Non-Medical Case Management (N-MCM)** model is responsive to the immediate needs of a person living with HIV (PLWH) and includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, entitlements, housing, and other needed services. **Non-Medical Case Management Services (N-MCM)** provide guidance and assistance in accessing medical, social, community, legal, financial, and other needed services. N-MCM services may also include assisting eligible persons living with HIV (PLWH) to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, or health insurance Marketplace plans. This service category includes several methods of communication (e.g., face-to-face, phone contact, and any other forms of communication) as deemed appropriate by the Texas DSHS HIV Care Services Group Ryan White Part B program. Limitation: Non-Medical Case Management services do not involve coordination and follow up of medical treatments.
Local Service Category Definition:	***Non-Medical Case Management:*** The purpose of Non-Medical Case Management targeting Substance Use Disorders (SUD) is to assist PLWHs with the procurement of needed services so that the problems associated with living with HIV are mitigated. N-MCM targeting SUD is intended to serve eligible people living with HIV in the Houston EMA/HSDA who are also facing the challenges of substance use disorder. Non-Medical Case Management is a working agreement between a PLWH and a Non-Medical Case Manager for an indeterminate period, based on PLWH need, during which information, referrals and Non-Medical Case Management is provided on an as- needed basis and assists PLWHs who do not require the intensity of Medical Case Management. Non-Medical Case Management is both office-based and field based. N-MCMs are expected to coordinate activities with referral sources where newly-diagnosed or not-in-care PLWH may be identified, including substance use disorder treatment/counseling and/or recovery support personnel. Such incoming referral coordination includes meeting prospective PLWHs at the referring provider location in order to develop rapport with and ensuring sufficient support is available. Non-Medical Case Management also includes follow-up to re-engage lost-to-care patients. Lost-to-care patients are those PLWHs who have not returned

	for scheduled appointments with the provider nor have provided updated information about their current Primary Medical Care provider (in the situation where PLWH may have obtained alternate service from another medical provider). Contractor must document efforts to re-engage lost-to-care patients prior to closing patients in the CPCDMS. Non-Medical Case Management extends the capability of existing programs by providing "hands-on" outreach and linkage to care services to those PLWH who are not currently accessing primary medical care services.
Target Population (age, gender, geographic, race, ethnicity, etc.):	**Non-Medical Case Management targeting SUD** is intended to serve eligible people living with HIV in the Houston EMA/HSDA, especially those underserved or unserved population groups who are also facing the challenges of substance use disorder. The target populations should also include individuals who misuse prescription medication or who use illegal substances or recreational drugs and are also: – Transgender, – Men who have sex with men (MSM), – Women or – Incarcerated/recently released from incarceration.
Services to be Provided:	**Goals:** The primary goal for N-MCM targeting SUD is to improve the health status of PLWHs who use substances by promoting linkages between community-based substance use disorder treatment programs, health clinics and other social service providers. N-MCM targeting SUD shall have a planned and coordinated approach to ensure that PLWHs have access to all available health and social services necessary to obtain an optimum level of functioning. N-MCM targeting SUD shall focus on behavior change, risk and harm reduction, retention in HIV care, and lowering risk of HIV transmission. The expectation is that each Non-Medical Case Management Full Time Equivalent (FTE) targeting SUD can serve approximately 80 PLWHs per year. **Purpose:** To promote Human Immunodeficiency Virus (HIV) disease management and recovery from substance use disorder by providing comprehensive Non-Medical Case Management and support for PWLH who are also dealing with substance use disorder and providing support to their families and significant others. **N-MCM targeting SUD** assists PLWHs with the procurement of needed services so that the problems associated with living with HIV are mitigated. **N-MCM targeting SUD** is a working agreement between a person living with HIV and a Non-Medical Case Manager (N-MCM) for an indeterminate period, based on identified need, during which information, referrals and Non-Medical Case Management is provided on an as- needed basis. The purpose of **N-MCM targeting SUD** is to assist PLWHs who do not require the intensity of *Clinical or Medical Case Management*. **N-MCM targeting SUD** is community-based (i.e. both office- and field-based). This Non-Medical Case Management targets PLWHs who are also dealing with the challenges of substance use disorder. N-MCMs also provide "hands-on" outreach and linkage to care services to those PLWHA who are not currently accessing primary medical care services. Efforts may include coordination with other case management providers to ensure the specialized needs of PLWHs who are dealing with substance use disorder are thoroughly addressed. For this population, this is not a

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

	Subrecipients must document established linkages with agencies that serve PLWH or serve individuals who are members of high-risk population groups (e.g., men who have sex with men, injection drug users, sex-industry workers, youth who are sentenced under the juvenile justice system, inmates of state and local jails and prisons). Contractor must have formal collaborative, referral or Point of Entry (POE) agreements with Ryan White funded HIV primary care providers.
Staff Requirements:	Minimum Qualifications: **Non-Medical Case Management Workers** must have at a minimum a Bachelor's degree from an accredited college or university with a major in social or behavioral sciences. Documented paid work experience in providing services to PLWH may be substituted for the Bachelor's degree requirement on a 1:1 basis (1 year of documented paid experience may be substituted for 1 year of college). All Non-Medical Case Management Workers must have a minimum of one (1) year work experience with PLWHA and/or substance use disorders. Supervision: The Non-Medical Case Management Worker must function within the clinical infrastructure of the applicant agency and receive ongoing supervision that meets or exceeds TRG's published **Non-Medical Case Management Targeting Substance Use Disorder** Standards of Care.
Special Requirements **(TRG Only)**:	Must comply with the Houston EMA/HSDA Standards of Care. The agency must comply with **the DSHS Universal Standards and non-Medical Case Management Standards of Care**. The agency must have policies and procedures in place that comply with the standards ***prior*** to delivery of the service. Contractor must be licensed in Texas to directly provide substance use treatment/counseling. Non-medical Case Management services can be delivered via telehealth and must follow applicable federal and State of Texas privacy laws.

FY 2023 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/09/2022**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Steering Committee**		Date: **06/02/2022**
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Step in Process: **Quality Improvement Committee**		Date: **05/03/2022**
Recommendations:	Approved: Y:_ ___ No: _____ Approved With Changes: _____	If approved with changes list changes below:
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Step in Process: **HTBMTN Workgroup #2**	Date: **04/19/2022**
Recommendations:	Financial Eligibility: None
1. Update the justification chart, keep the service definition and the financial eligibility the same.	
2.	
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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).

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.

FY 2023 RWPC "How to Best Meet the Need" Decision Process

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Step in Process: **Quality Improvement Committee**		Date: **05/03/2022**
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Step in Process: **HTBMTN Workgroup #3**	Date: **04/20/2022**
Recommendations:	Financial Eligibility: 400%
1. Update the justification chart, keep the service definition and the financial eligibility the same.	
2.	
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Local Service Category:	**Health Insurance Premium and Cost Sharing Assistance**
Amount Available**:**	**To be determined**
Budget Requirements or Restrictions **(TRG Only)**:	Contractor must spend no more than 20% of funds on disbursement transactions. The remaining 80% of funds must be expended on the actual cost of the payment(s) disbursed. ADAP dispensing fees are not allowable under this service category.
Local Service Category Definition:	**Health Insurance Premium and Cost Sharing Assistance:** The Health Insurance Premium and Cost Sharing Assistance service category is intended to help people living with HIV (PLWH) maintain continuity of medical care without gaps in health insurance coverage or disruption of treatment. A program of financial assistance for the payment of health insurance premiums and co-pays, co-insurance and deductibles to enable eligible individuals with HIV disease to utilize their existing third party or public assistance (e.g. Medicare) medical insurance. For purposes of this service category, health insurance also includes standalone dental insurance. Co-Payment: A cost-sharing requirement that requires the insured to pay a specific dollar amount for each unit of service. Co-Insurance: A cost-sharing requirement that requires the insured to pay a percentage of costs for covered services/prescription Deductible: A cost-sharing requirement that requires the insured pay a certain amount for health care or prescription, before the prescription drug plan or other insurance begins to pay. Premium: The amount paid by the insured to an insurance company to obtain or maintain and insurance policy. Advance Premium Tax Credit (APTC) Tax Liability: Tax liability associated with the APTC reconciliation; reimbursement cap of 50% of the tax due up to a maximum of $500.
Target Population (age, gender, geographic, race, ethnicity, etc.):	All Ryan White eligible PLWH with 3rd party insurance coverage (COBRA, private policies, Qualified Health Plans, CHIP, Medicaid, Medicare and Medicare Supplemental plans) within the Houston HSDA.
Services to be Provided:	Contractor may provide assistance with: • Insurance premiums, • And deductibles, co-insurance and/or co-payments.
Service Unit Definition **(TRG Only)**:	A unit of service will consist of payment of health insurance premiums, co-payments, co-insurance, deductible, or a combination.
Financial Eligibility:	Affordable Care Act (ACA) Marketplace Plans: 100-400% of federal poverty guidelines. All other insurance plans at or below 400% of federal poverty guidelines. Exception: PLWH who were enrolled prior to November 1, 2015 will maintain their eligibility in subsequent plan years even if below 100% or between 400-500% of federal poverty guidelines.
Eligibility for Services:	People living with HIV in the Houston HSDA and have insurance or be eligible (within local financial eligibility guidelines) to purchase a

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

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Step in Process: **Steering Committee**		Date: **06/02/2022**
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Step in Process: **Quality Improvement Committee**		Date: **05/03/2022**
Recommendations:	Approved: Y:_ ___ No: _____ Approved With Changes: _____	If approved with changes list changes below:
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Step in Process: **HTBMTN Workgroup #2**	Date: **04/19/2022**
Recommendations:	Financial Eligibility: 0 - 400%, ACA plans: must have a subsidy
1. Update the justification chart, keep the service definition and the financial eligibility the same.	
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FY 2020 Houston EMA Ryan White Part A/MAI Service Definition Health Insurance Co-Payments and Co-Insurance Assistance	
HRSA Service Category Title:	**Health Insurance Premium and Cost Sharing Assistance**
Local Service Category Title:	**Health Insurance Co-Payments and Co-Insurance**
Budget Type**:**	**Hybrid Fee for Service**
Budget Requirements or Restrictions:	Agency must spend no more than 20% of funds on disbursement transactions. The remaining 80% of funds must be expended on the actual cost of the payment(s) disbursed.
HRSA Service Category Definition**:**	***Health Insurance Premium & Cost Sharing Assistance*** is the provision of financial assistance for eligible individuals living with HIV to maintain a continuity of health insurance or to receive medical benefits under a health insurance program. This includes premium payments, risk pools, co-payments, and deductibles.
Local Service Category Definition:	A program of financial assistance for the payment of health insurance premiums, deductibles, co-insurance, co-payments and tax liability payments associated with Advance Premium Tax Credit (APTC) reconciliation to enable eligible individuals with HIV disease to utilize their existing third party or public assistance (e.g. Medicare) medical insurance. Co-Payment: A cost-sharing requirement that requires the insured to pay a specific dollar amount for each unit of service. Co-Insurance: A cost-sharing requirement that requires the insured to pay a percentage of costs for covered services/prescription Deductible: A cost-sharing requirement that requires the insured to pay a certain amount for health care or prescription, before the prescription drug plan or other insurance begins to pay. Premium: The amount paid by the insured to an insurance company to obtain or maintain and insurance policy. APTC Tax Liability: The difference paid on a tax return if the advance credit payments that were paid to a health care provider were more than the actual eligible credit.
Target Population (age, gender, geographic, race, ethnicity, etc.):	All Ryan White eligible clients with 3rd party insurance coverage (COBRA, private policies, Qualified Health Plans, CHIP, Medicaid, Medicare and Medicare Supplemental) within the Houston EMA.
Services to be Provided:	Provision of financial assistance with premiums, deductibles, co-insurance, and co-payments. Also includes tax liability payments associated with APTC reconciliation up to 50% of liability with a $500 maximum.
Service Unit Definition(s): **(RWGA only)**	1 unit of service = A payment of a premium, deductible, co-insurance, co-payment or tax liability associated with APTC reconciliation for an HIV-infected person with insurance coverage.

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

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Step in Process: **Quality Improvement Committee**		Date: **05/03/2022**
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Step in Process: **HTBMTN Workgroup #2**	Date: **04/19/2022**
Recommendations:	Financial Eligibility: 0 - 400%, ACA plans: must have a subsidy
1. Update the justification chart, keep the service definition and the financial eligibility the same.	
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Local Service Category:	**Home and Community-Based Health Services (Facility-Based)**
Amount Available**:**	**To be determined**
Unit Cost	
Budget Requirements or Restrictions:	Maximum of 10% of budget for Administrative Cost
DSHS Service Category Definition:	Home and Community-Based Health Care Services are therapeutic, nursing, supportive and/or compensatory health services provided by a licensed/certified home health agency in a home or community-based setting in accordance with a written, individualized plan of care established by a licensed physician. Home and Community-Based Health Services include the following: • **Para–professional care** is the provision of services by a home health aide, personal caretaker, or attendant caretaker. This definition also includes non–medical, non–nursing assistance with cooking and cleaning activities to help PLWH remain in their homes. • **Professional care** is the provision of services in the home by licensed health care workers such as nurses. • **Specialized care** is the provision of services that include intravenous and aerosolized treatment, parenteral feeding, diagnostic testing, and other high–tech therapies. physical therapy, social worker services. Home and Community-Based Health Care Providers work closely with the multidisciplinary care team that includes the PLWH's case manager, primary care provider, and other appropriate health care professionals. Allowable services include: • Durable medical equipment • Home health aide and personal care services • Day treatment or other partial hospitalization services • Home intravenous and aerosolized drug therapy (including prescription drugs administered as part of such therapy) • Routine diagnostic testing • Appropriate mental health, developmental, and rehabilitation services • Specialty care and vaccinations for hepatitis co-infection, provided by public and private entities
Local Service Category Definition:	***Home and Community-based Health Services (facility-based)*** *is* defined as a day treatment program that includes Physician ordered therapeutic nursing, supportive and/or compensatory health services based on a written plan of care established by an interdisciplinary care team that includes appropriate healthcare professionals and paraprofessionals. Services include skilled nursing, nutritional counseling, evaluations and education, and additional therapeutic services and activities. Inpatient hospitals services, nursing home and other long-term care facilities are **NOT** included.
Target Population (age, gender, geographic, race, ethnicity, etc.):	Eligible recipients for home and community-based health services are persons living with HIV residing within the Houston HIV Service Delivery Area (HSDA) who are at least 18 years of age.
Services to be Provided:	Community-Based Health Services are designed to support the increased functioning and the return to self-sufficiency of PLWH through the provision of treatment and activities of daily living. Services must include: • **Skilled Nursing:** Services to include medication administration, medication supervision, medication ordering, filling pill box, wound dressing changes, straight catheter insertion, education of family/significant others in patient

	care techniques, ongoing monitoring of patients' physical condition and communication with attending physicians (s), personal care, and diagnostics testing. • **Other Therapeutic Services:** Services to include recreational activities (fine/gross motor skills and cognitive development), replacement of durable medical equipment, information referral, peer support, and transportation. • **Nutrition:** Services to include evaluation and counseling, supplemental nutrition, and daily nutritious meals. • **Education:** Services to include instructional workshops of HIV related topics and life skills. Services will be provided at least Monday through Friday for a minimum of 10 hours/day.
Service Unit Definition(s):	A unit of service is defined as one (1) visit/day of care for one (1) PLWH for a minimum of four hours. Services consist of medical health care and social services at a licensed adult day.
Financial Eligibility:	Income at or below 400% of Federal Poverty Guidelines
Eligibility for Services:	People living with HIV at least 18 years of age residing within the Houston HSDA.
Agency Requirements:	Must be licensed by the Texas Department of Aging and Disability Services (DADS) as an Adult Day Care provider.
Staff Requirements:	• **Skilled Nursing Services** must be provided by a Licensed Vocational or Registered Nurse. • **Other Therapeutic Services** are provided by paraprofessionals, such as an activities coordinator, and counselors (LPC, LMSW, and LMFTA). • **Nutritional Services** are provided by a Registered Dietician and food managers. • **Education Services** are provided by a health educator.
Special Requirements:	Must comply with the Houston EMA/HSDA Standards of Care. The agency must comply with **the DSHS Home and Community-Based Health Services Standards of Care** and **Houston HSDA**. The agency must have policies and procedures in place that comply with the standards ***prior*** to delivery of the service.

FY 2023 RWPC "How to Best Meet the Need" Decision Process

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Step in Process: **Quality Improvement Committee**		Date: **05/03/2022**
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Step in Process: **HTBMTN Workgroup #3**	Date: **04/20/2022**
Recommendations:	Financial Eligibility: 400%
1. Update the justification chart, keep the service definition and the financial eligibility the same.	
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Local Service Category:	**Hospice Services**
Amount Available**:**	**To be determined**
Unit Cost	
Budget Requirements or Restrictions:	Maximum 10% of budget for Administrative Cost
DSHS Service Category Definition:	Provision of end-of-life care provided by licensed hospice care providers to people living with HIV (PLWH) in the terminal stages of an HIV-related illness, in a home or other residential setting, including a non-acute-care section of a hospital that has been designated and staffed to provide hospice care for terminal patients. Hospice services include, but are not limited to, the palliation and management of the terminal illness and conditions related to the terminal illness. Allowable Ryan White/State Services funded services are: • Room • Board • Nursing care • Mental health counseling, to include bereavement counseling • Physician services • Palliative therapeutics Ryan White/State Service funds may not be used for funeral, burial, cremation, or related expenses. Funds may not be used for nutritional services, durable medical equipment and medical supplies or case management services.
Local Service Category Definition:	Hospice services encompass palliative care for terminally ill PLWH and support services for PLWH and their families. Services are provided by a licensed nurse and/or physical therapist. Additionally, unlicensed personnel may deliver services under the delegation of a licensed nurse or physical therapist, to a PLWH or a PLWH's family as part of a coordinated program. A physician must certify that a patient is terminal, defined under Medicaid hospice regulations as having a life expectancy of 6 months or less. Services must include but are not limited to medical and nursing care, palliative care, and psychosocial support for the patient, as well as a mechanism for bereavement referral for surviving family members. Counseling services provided in the context of hospice care must be consistent with the (Ryan White) definition of mental health counseling. Palliative therapies must be consistent with those covered under respective State Medicaid Program.
Target Population (age, gender, geographic, race, ethnicity, etc.):	People living with HIV and having a life expectancy of 6 months or less residing in the Houston HIV Service Delivery (HSDA).
Services to be Provided:	Services must include but are not limited to medical and nursing care,

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

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

FY 2023 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/09/2022**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Steering Committee**		Date: **06/02/2022**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Improvement Committee**		Date: **05/03/2022**
Recommendations:	Approved: Y:_ ___ No: _____ Approved With Changes: _____	If approved with changes list changes below:
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Step in Process: **HTBMTN Workgroup #3**	Date: **04/20/2022**
Recommendations:	Financial Eligibility: 300%
1. Update the justification chart, keep the service definition and the financial eligibility the same.	
2.	
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Local Service Category:	**Linguistics Services**
Amount Available**:**	**To be determined**
Unit Cost**:**	
Budget Requirements or Restrictions **(TRG Only)**:	Maximum of 10% of budget for Administrative Cost.
DSHS Service Category Definition	Support for Linguistic Services includes interpretation (oral) and translation (written) services, provided by qualified individuals as a component of HIV service delivery between the provider and the people living with HIV (PLWH), when such services are necessary to facilitate communication between the provider and PLWH and/or support delivery of Ryan White-eligible services. Linguistic Services include interpretation/translation services provided by qualified interpreters to people living with HIV (including those who are deaf/hard of hearing and non-English speaking individuals) for the purpose of ensuring communication between PLWH and providers while accessing medical and Ryan White fundable support services that have a direct impact on primary medical care. These standards ensure that language is not barrier to any PLWH seeking HIV related medical care and support; and linguistic services are provided in a culturally appropriate manner. Services are intended to be inclusive of all cultures and sub-cultures and not limited to any particular population group or sets of groups. They are especially designed to assure that the needs of racial, ethnic, and linguistic populations severely impacted by the HIV epidemic receive quality, unbiased services.
Local Service Category Definition:	To provide one hour of interpreter services including, but not limited to, sign language for deaf and /or hard of hearing and native language interpretation for monolingual people living with HIV.
Target Population (age, gender, geographic, race, ethnicity, etc.):	People living with HIV in the Houston HIV Service Delivery Area (HSDA).
Services to be Provided:	Services include language translation and signing for deaf and/or hearing-impaired HIV+ persons. Services exclude Spanish Translation Services.
Service Unit Definition(s) **(TRG Only)**:	A unit of service is defined as one hour of interpreter services to an eligible PLWH.
Financial Eligibility:	Income at or below 300% Federal Poverty Guidelines.
Eligibility for Service:	People living with HIV in the Houston HSDA
Agency Requirements **(TRG Only)**:	Any qualified and interested agency may apply and subcontract actual interpretation services out to various other qualifying agencies.
Staff Requirements:	ASL interpreters must be certified. Language interpreters must have completed a forty (40) hour community interpreter training course approved by the DSHS.
Special Requirements **(TRG Only)**:	Must comply with the Houston HSDA **Linguistic Services Standards of Care**. The agency must comply with **the DSHS Linguistic Services Standards of Care**. The agency must have policies and procedures in place that comply with the standards ***prior*** to delivery of the service.

FY 2023 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/09/2022**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Steering Committee**		Date: **06/02/2022**
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Step in Process: **Quality Improvement Committee**		Date: **05/03/2022**
Recommendations:	Approved: Y:_ ___ No: _____ Approved With Changes: _____	If approved with changes list changes below:
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Step in Process: **HTBMTN Workgroup #3**	Date: **04/20/2022**
Recommendations:	Financial Eligibility: 300%
1. Update the justification chart, keep the service definition and the financial eligibility the same.	
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FY 2020 Houston EMA Ryan White Part A/MAI Service Definition Medical Nutritional Therapy	
HRSA Service Category Title: **RWGA Only**	**Medical Nutritional Therapy**
Local Service Category Title:	**Medical Nutritional Therapy and Nutritional Supplements**
Budget Type: **RWGA Only**	**Hybrid**
Budget Requirements or Restrictions: **RWGA Only**	***Supplements:*** An individual client may not exceed $1,000.00 in supplements annually without **prior** approval by RWGA. ***Nutritional Therapy:*** An individual nutritional education/counseling session lasting a minimum of 45 minutes. Provision of professional (licensed registered dietician) education/counseling concerning the therapeutic importance of foods and nutritional supplements that are beneficial to the wellness and improved health conditions of clients. Medically, it is expected that symptomatic or mildly symptomatic clients will be seen once every 12 weeks while clients with higher acuity will be seen once every 6 weeks.
HRSA Service Category Definition: **RWGA Only**	***Medical nutrition therapy*** is provided by a licensed registered dietitian outside of a primary care visit **and may include the provision of nutritional supplements.**
Local Service Category Definition:	***Supplements:*** Up to a 90-day supply at any given time, per client, of approved nutritional supplements that are listed on the Houston EMA/HSDA Nutritional Supplement Formulary. Nutritional counseling must be provided for each disbursement of nutritional supplements. ***Nutritional Therapy:*** An individual nutritional education/counseling session lasting a minimum of 45 minutes. Provision of professional (licensed registered dietician) education/counseling concerning the therapeutic importance of foods and nutritional supplements that are beneficial to the wellness and improved health conditions of clients. Medically, it is expected that symptomatic or mildly symptomatic clients will be seen once every 12 weeks while clients with higher acuity will be seen once every 6 weeks. Services must be provided under written order from a state licensed medical provider (MD, DO or PA) with prescribing privileges and must be based on a written nutrition plan developed by a licensed registered dietician.
Target Population (age, gender, geographic, race, ethnicity, etc.):	HIV/AIDS infected persons living within the Houston Eligible Metropolitan Area (EMA) or HIV Service Delivery Area (HSDA).
Services to be Provided:	***Supplements:*** The provision of nutritional supplements to eligible clients with a written referral from a licensed physician or PA that specifies frequency, duration and amount and includes a written nutritional plan prepared by a licensed, registered dietician. *Nutritional Supplement Disbursement Counseling* is a component of

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

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

FY 2023 RWPC "How to Best Meet the Need" Decision Process

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Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Steering Committee**		Date: **06/02/2022**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Improvement Committee**		Date: **05/03/2022**
Recommendations:	Approved: Y:_ ___ No: _____ Approved With Changes: _____	If approved with changes list changes below:
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Step in Process: **HTBMTN Workgroup #2**	Date: **04/19/2022**
Recommendations:	Financial Eligibility: 400%
1. Update the justification chart, keep the service definition and the financial eligibility the same.	
2.	
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Local Service Category:	**Mental Health Services**
Amount Available**:**	**To be determined**
Unit Cost	
Budget Requirements or Restrictions **(TRG Only)**:	Maximum of 10% of budget for Administrative Cost.
DSHS Service Category Definition	Mental Health Services include psychological and psychiatric treatment and counseling services offered to individuals with a diagnosed mental illness, conducted in a family/couples, group or individual setting, based on a detailed treatment plan, and provided by a mental health professional licensed or authorized within the State to provide such services, typically including psychiatrists, psychologists, and licensed clinical social workers. Mental health counseling services includes outpatient mental health therapy and counseling (individual and family/couple) provided solely by Mental Health Practitioners licensed in the State of Texas. Mental health services include: • Mental Health Assessment • Treatment Planning • Treatment Provision • Individual psychotherapy • Family psychotherapy • Conjoint psychotherapy • Group psychotherapy • Psychiatric medication assessment, prescription and monitoring • Psychotropic medication management • Drop-In Psychotherapy Groups • Emergency/Crisis Intervention General mental health therapy, counseling and short-term (based on the mental health professional's judgment) bereavement support is available for family members or significant others of people living with HIV.
Local Service Category Definition:	**Individual Therapy/counseling** is defined as 1:1 or family-based crisis intervention and/or mental health therapy provided by a licensed mental health practitioner to an eligible person living with HIV. **Family/Couples Therapy/Counseling** is defined as crisis intervention and/or mental health therapy provided by a licensed mental health practitioner to a family or couple (opposite-sex, same-sex, transgendered or non-gender conforming) that includes an eligible person living with HIV. **Support Groups** are defined as professionally led (licensed therapists or counselor) groups that comprise people living with HIV, family members, or significant others for the purpose of providing emotional support directly related to the stress of caring for people living with HIV.
Target Population (age, gender, geographic, race, ethnicity, etc.):	People living with HIV and affected individuals living within the Houston HIV Service Delivery Area (HSDA).
Services to be Provided:	Agencies are encouraged to have available to PLWH all modes of counseling services, i.e., crisis, individual, family, and group. Sessions may be conducted in-home. Agency must provide professional support group sessions led by a licensed counselor.

Service Unit Definition(s) **(TRG Only)**:	**Individual Crisis Intervention and/or Therapy:** A unit of service is defined as an individual counseling session lasting a minimum of 45 minutes. **Family/Couples Crisis Intervention and/or Therapy:** A unit of service is defined as a family/couples counseling session lasting a minimum of 90 minutes. **Group Therapy:** A unit of service is defined as one (1) eligible PLWH attending 90 minutes of group therapy. The minimum time allowable for a single group session is 90 minutes and maximum time allowable for a single group session is 120 minutes. No more than one unit may be billed per session for an individual or group session. A minimum of three (3) participants must attend a group session in order for the group session to eligible for reimbursement. **Consultation:** One unit of service is defined as 15 minutes of communication with a medical or other appropriate provider to ensure case coordination.
Financial Eligibility:	Income at or below 500% Federal Poverty Guidelines.
Eligibility for Services:	For individual therapy session, person living with HIV or the affected significant other of a person living with HIV, resident of Houston HSDA. Person living with HIV must have a current DSM diagnosis eligible for reimbursement under the State Medicaid Plan. PLWH must not be eligible for services from other programs or providers (i.e. MHMRA of Harris County) or any other reimbursement source (i.e. Medicaid, Medicare, Private Insurance) unless the PLWH is in crisis and cannot be provided immediate services from the other programs/providers. In this case, PLWH may be provided services, if the PLWH applies for the other programs /providers, until the other programs/providers can take over services. Medicaid/Medicare, Third Party Payer and Private Pay status of PLWH receiving services under this grant must be verified by the provider prior to requesting reimbursement under this grant. For support group sessions, PLWH must be either a person living with HIV or the significant other of person living with HIV. Affected significant other is eligible for services only related to the stress of caring for a person living with HIV.
Agency Requirements **(TRG Only)**:	Agency must provide assurance that the mental health practitioner shall be supervised by a licensed therapist qualified by the State to provide clinical supervision. This supervision should be documented through supervision notes. Keep attendance records for group sessions. Must provide 24-hour access to a licensed counselor for current PLWH with

	emotional emergencies. PLWH eligible for Medicaid or 3rd party payer reimbursement may not be billed to grant funds. Medicare Co-payments may be billed to the contract as ½ unit of service. Documentation of at least one therapist certified by Medicaid/Medicare on the staff of the agency must be provided in the proposal. All funded agencies must maintain the capability to serve and seek reimbursement from Medicaid/Medicare throughout the term of their contract. Potential PLWH who are Medicaid/ Medicare eligible may not be denied services by a funded agency based on their reimbursement status (Medicaid/Medicare eligible PLWH may not be referred elsewhere in order that non-Medicaid/Medicare eligible PLWH may be added to this grant). Failure to serve Medicaid/Medicare eligible PLWH based on their reimbursement status will be grounds for the immediate termination of the provider's contract. Must comply with the State Services Standards of Care. Must provide a plan for establishing criteria for prioritizing participation in group sessions and for termination from group participation. Providers and system must be Medicaid/Medicare certified to ensure that Ryan White funds are the payer of last resort.
Staff Requirements:	It is required that counselors have the following qualifications: Licensed Mental Health Practitioner by the State of Texas (LCSW, LMSW, LPC PhD, Psychologist, or LMFT). At least two years' experience working with HIV disease or two years' work experience with chronic care of a catastrophic illness. Counselors providing family sessions must have at least two years' experience in family therapy. Counselors must be covered by professional liability insurance with limits of at least $300,000 per occurrence.
Special Requirements **(TRG Only)**:	All mental health interventions must be based on proven clinical methods and in accordance with legal and ethical standards. The importance of maintaining confidentiality is of critical importance and cannot be overstated unless otherwise indicated based on Federal, state and local laws and guidelines (i.e. abuse, self or other harm). All programs must comply with the Health Insurance Portability and Accountability Act (HIPAA) standards for privacy practices of protected health information (PHI) information. Mental health services can be delivered via telehealth and must follow applicable federal and State of Texas privacy laws. Mental health services that are provided via telehealth must be in accordance with State of Texas mental health provider practice requirements, see Texas Occupations Code, Title 3 Health Professions and chapter 111 for Telehealth & Telemedicine.

	When psychiatry is provided as a mental health service via telehealth then the provider must follow guidelines for telemedicine as noted in Texas Medical Board (TMB) guidelines for providing telemedicine, Texas Administrative Code, Texas Medical Board, Rules, Title 22, Part 9, Chapter 174, RULE §174.1 to §174.12 Medicare and private insurance co-payments are eligible for reimbursement under this grant (in this situation the agency will be reimbursed the PLWH's co-payment only, not the cost of the session which must be billed to Medicare and/or the Third-party payer). Extensions will be addressed on an individual basis when meeting the criteria of counseling directly related to HIV illness. Under no circumstances will the agency be reimbursed more than two (2) units of individual therapy per PLWH in any single 24-hour period. Agency should develop services that focus on the most current Special Populations identified in the *Houston Area Comprehensive Plan for HIV Prevention and Care Services* including Adolescents, Homeless, Incarcerated & Recently Released (IRR), Injection Drug Users (IDU), Men who Have Sex with Men (MSM), and Transgender populations. Additionally, services should focus on increasing access for individuals living in rural counties. Must comply with the Houston EMA/HSDA Standards of Care. The agency must comply with **the DSHS Mental Health Services Standards of Care**. The agency must have policies and procedures in place that comply with the standards ***prior*** to delivery of the service.

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Step in Process: **Steering Committee**		Date: **06/02/2022**
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Step in Process: **Quality Improvement Committee**		Date: **05/03/2022**
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Step in Process: **HTBMTN Workgroup #2**	Date: **04/19/2022**
Recommendations:	Financial Eligibility: 500%
1. Update the justification chart, keep the service definition and the financial eligibility the same.	
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Local Service Category:	**Oral Health Care**
Amount Available:	**To be determined**
Unit Cost**:**	
Budget Requirements or Restrictions **(TRG Only)**:	Maximum of 10% of budget for Administrative Costs
Local Service Category Definition:	Restorative dental services, oral surgery, root canal therapy, fixed and removable prosthodontics; periodontal services includes subgingival scaling, gingival curettage, osseous surgery, gingivectomy, provisional splinting, laser procedures and maintenance. Oral medication (including pain control) for people living with HIV (PLWH) 15 years of age or older must be based on a comprehensive individual treatment plan. Prosthodontics services to people living with HIV including but not limited to examinations and diagnosis of need for dentures, crowns, bridgework and implants, diagnostic measurements, laboratory services, tooth extraction, relines and denture repairs. Emergency procedures will be treated on a walk-in basis as availability and funding allows. Funded Oral Health Care providers are permitted to provide necessary emergency care regardless of a PLWH's annual benefit balance. If a provider cannot provide adequate services for emergency care, the PLWH should be referred to a hospital emergency room.
Target Population (age, gender, geographic, race, ethnicity, etc.):	People living with HIV residing in the Houston HIV Service Delivery Area (HSDA).

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

Service Unit Definition(s) **(TRG Only)**:	General Dentistry: A unit of service is defined as one (1) dental visit which includes restorative dental services, oral surgery, root canal therapy, fixed and removable prosthodontics; periodontal services includes subgingival scaling, gingival curettage, osseous surgery, gingivectomy, provisional splinting, laser procedures and maintenance. Oral medication

	(including pain control) for PLWH 15 years old or older must be based on a comprehensive individual treatment plan. Prosthodontics: A unit of services is defined as one (1) Prosthodontics visit.
Financial Eligibility:	Income at or below 300% Federal Poverty Guidelines. Maximum amount that may be funded by Ryan White/State Services per PLWH is $3,000/year.
Eligibility for Services:	Person living with HIV; Adult resident of Houston HSDA
Agency Requirements **(TRG Only)**:	**To ensure that Ryan White is payer of last resort, Agency and/or dental providers (clinicians) must be Medicaid certified and enrolled in all Dental Plans offered to Texas STAR+PLUS eligible PLWH in the Houston EMA/HSDA**. Agency/providers must ensure Medicaid certification and billing capability for STAR+PLUS eligible PLWH remains current throughout the contract term. Agency must document that the primary PLWH care dentist has 2 years prior experience treating HIV disease and/or on-going HIV educational programs that are documented in personnel files and updated regularly. Dental facility and appropriate dental staff must maintain Texas licensure/certification and follow all applicable OSHA requirements for PLWH management and laboratory protocol.
Staff Requirements:	State of Texas dental license; licensed dental hygienist and state radiology certification for dental assistants.
Special Requirements **(TRG Only)**:	Must comply with the Houston EMA/HSDA Standards of Care. The agency must comply with **the DSHS Oral Health Care Standards of Care**. The agency must have policies and procedures in place that comply with the standards ***prior*** to delivery of the service. Oral Health Care services can be delivered via telehealth and must follow applicable federal and State of Texas privacy laws.

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Step in Process: **Quality Improvement Committee**		Date: **05/03/2022**
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Step in Process: **HTBMTN Workgroup #2**	Date: **04/19/2022**
Recommendations:	Financial Eligibility: 300%
1. Update the justification chart, keep the service definition and the financial eligibility the same.	
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20 Houston EMA Ryan White Part A/MAI Service Definition **Oral Health/Rural**	
HRSA Service Category Title: **RWGA Only**	**Oral Health**
Local Service Category Title:	**Oral Health – <u>Rural (North)</u>**
Budget Type: **RWGA Only**	**Unit Cost**
Budget Requirements or Restrictions: **RWGA Only**	Not Applicable
HRSA Service Category Definition: **RWGA Only**	**Oral health care** includes diagnostic, preventive, and therapeutic services provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries, and other trained primary care providers.
Local Service Category Definition:	Restorative dental services, oral surgery, root canal therapy, fixed and removable prosthodontics; periodontal services includes subgingival scaling, gingival curettage, osseous surgery, gingivectomy, provisional splinting, laser procedures and maintenance. Oral medication (including pain control) for HIV patients 15 years old or older must be based on a comprehensive individual treatment plan. Prosthodontics services to HIV-infected individuals including, but not limited to examinations and diagnosis of need for dentures, diagnostic measurements, laboratory services, tooth extractions, relines and denture repairs.
Target Population (age, gender, geographic, race, ethnicity, etc.):	HIV/AIDS infected individuals residing in Houston Eligible Metropolitan Area (EMA) or Health Service Delivery Area (HSDA) counties other than Harris County. Comprehensive Oral Health services targeted to individuals residing in the northern counties of the EMA/HSDA, including Waller, Walker, Montgomery, Austin, Chambers and Liberty Counties.
Services to be Provided:	Services must include, but are not limited to: individual comprehensive treatment plan; diagnosis and treatment of HIV-related oral pathology, including oral Kaposi's Sarcoma, CMV ulceration, hairy leukoplakia, xerostomia, lichen planus, aphthous ulcers and herpetic lesions; diffuse infiltrative lymphocytosis; standard preventive procedures, including oral hygiene instruction, diet counseling and home care program; oral prophylaxis; restorative care; oral surgery including dental implants; root canal therapy; fixed and removable prosthodontics including crowns, bridges and implants; periodontal services, including subgingival scaling, gingival curettage, osseous surgery, gingivectomy, provisional splinting, laser procedures and maintenance. Proposer must have mechanism in place to provide oral pain medication as prescribed for clients by the dentist.
Service Unit Definition(s): **RWGA Only**	General Dentistry: A unit of service is defined as one (1) dental visit which includes restorative dental services, oral surgery, root

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

FY 2023 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/09/2022**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Steering Committee**		Date: **06/02/2022**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Improvement Committee**		Date: **05/03/2022**
Recommendations:	Approved: Y:_ ___ No: _____ Approved With Changes: _____	If approved with changes list changes below:
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Step in Process: **HTBMTN Workgroup #2**	Date: **04/19/2022**
Recommendations:	Financial Eligibility: 300%
1. Update the justification chart, keep the service definition and the financial eligibility the same.	
2.	
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Local Service Category:	**Referral for Health Care: ADAP Enrollment Worker**
Amount Available**:**	**To be determined**
Unit Cost	
Budget Requirements or Restrictions **(TRG Only)**:	Maximum 10% of budget for Administrative Cost. No direct medical costs may be billed to this grant.
DSHS Service Category Definition:	Direct people living with HIV (PLWH) to a service in person or through telephone, written, or other types of communication, including management of such services where they are not provided as part of Ambulatory Outpatient Medical Care or Case Management Services.
Local Service Category Definition:	AIDS Drug Assistance Program (ADAP) Enrollment Workers (AEWs) are co-located at Ryan-White funded clinics to ensure the efficient and accurate submission of ADAP applications to the Texas HIV Medication Program (THMP). AEWs will meet with all potential ADAP enrollees to explain ADAP program benefits and requirements and assist PLWHs with the submission of complete and accurate ADAP applications. AEWs will ensure benefits continuation through timely completion of annual re-certifications by the last day of the PLWH's birth month and attestations six months later to ensure there is no lapse in ADAP eligibility and/or loss of benefits. Other responsibilities will include: • Track the ADAP application process to ensure submitted applications are processed as quick as possible, including prompt follow-up on pending applications to gather missing or questioned documentation as needed. • Maintain ongoing communication with designated THMP staff to aid in resolution of PLWH inquires and questioned applications; and to ensure any issues affecting pending applications and/or PLWHs are mediated as quickly as possible. AEWs must maintain relationships with the Ryan White ADAP Network (RWAN).
Target Population (age, gender, geographic, race, ethnicity, etc.):	People living with HIV in the Houston HDSA in need of medications through the Texas HIV Medication Program.
Services to be Provided:	Services include but are not limited to provision of education on available benefits programs applicable to the PLWH; completion of ADAP application including enrollment/recertification/six-month attestation; aid the PLWH in gathering all required supporting documentation to complete benefits application(s) including ADAP; provide a streamlined process for submission of completed ADAP applications and/or other benefits applications; assist in benefits continuation including six-month attestation and necessary follow-up; liaison with THMP and the PLWH throughout the ADAP application process
Service Unit Definition(s) **(TRG Only)**:	One unit of service is defined as 15 minutes of direct PLWH services or coordination of application process on behalf of PLWH.
Financial Eligibility:	Income at or below 500% of Federal Poverty Guidelines
Eligibility for Service:	People living with HIV in the Houston HDSA
Agency Requirements **(TRG Only)**:	Agency must be funded for Outpatient Ambulatory Medical Care bundled service category under Ryan White Part A/B/DSHS SS. Agency must obtain and maintain access to TakeChargeTexas, the online system to submit THMP applications.
Staff Requirements:	Not Applicable.
Special Requirements **(TRG Only)**:	The agency must comply with **the DSHS Referral to Healthcare Standards of Care** and **the Houston HSDA Referral for Health Care and Support Services Standards of Care**. The agency must have

	policies and procedures in place that comply with the standards ***prior*** to delivery of the service.

FY 2023 RWPC "How to Best Meet the Need" Decision Process

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Step in Process: **Quality Improvement Committee**		Date: **05/03/2022**
Recommendations:	Approved: Y:_ ___ No: _____ Approved With Changes: _____	If approved with changes list changes below:
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Step in Process: **HTBMTN Workgroup #1**	Date: **04/19/2022**
Recommendations:	Financial Eligibility: AEW=500%, Incarcerated: None
1. Transition Early Intervention Services to Referral for Health Care and Support Services to better align with the scope of services provided.	
2. Update the justification chart, keep the service definition and the financial eligibility the same.	
3.	

FY 2020 Houston EMA Ryan White Part A/MAI Service Definition **Substance Abuse Services - Outpatient**	
HRSA Service Category Title: **RWGA Only**	Substance Abuse Services Outpatient
Local Service Category Title:	Substance Abuse Treatment/Counseling
Budget Type: **RWGA Only**	Fee-for-Service
Budget Requirements or Restrictions: **RWGA Only**	Minimum group session length is 2 hours
HRSA Service Category Definition: **RWGA Only**	***Substance abuse services outpatient*** is the provision of medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) in an outpatient setting, rendered by a physician or under the supervision of a physician, or by other qualified personnel.
Local Service Category Definition:	Treatment and/or counseling HIV-infected individuals with substance abuse disorders delivered in accordance with State licensing guidelines.
Target Population (age, gender, geographic, race, ethnicity, etc.):	HIV-infected individuals with substance abuse disorders, residing in the Houston Eligible Metropolitan Area (EMA/HSDA).
Services to be Provided:	Services for all eligible HIV/AIDS patients with substance abuse disorders. Services provided must be integrated with HIV-related issues that trigger relapse. All services must be provided in accordance with the Texas Department of Health Services/Substance Abuse Services (TDSHS/SAS) Chemical Dependency Treatment Facility Licensure Standards. Service provision must comply with the applicable treatment standards.
Service Unit Definition(s): **RWGA Only**	**Individual Counseling:** One unit of service = one individual counseling session of at least 45 minutes in length with one (1) eligible client. **A single session lasting longer than 45 minutes qualifies as only a single unit** – no fractional units are allowed. Two (2) units are allowed for initial assessment/orientation session. **Group Counseling:** One unit of service = 60 minutes of group treatment for one eligible client. A single session must last a minimum of 2 hours. Support Groups are defined as professionally led groups that are comprised of HIV-positive individuals, family members, or significant others for the purpose of providing Substance Abuse therapy.
Financial Eligibility:	Refer to the RWPC's approved *Financial Eligibility for Houston EMA/HSDA Services.*
Client Eligibility:	HIV-infected individuals with substance abuse co-morbidities/ disorders.
Agency Requirements:	Agency must be appropriately licensed by the State. All services must be provided in accordance with applicable Texas Department of State Health Services/Substance Abuse Services (TDSHS/SAS) Chemical Dependency Treatment Facility Licensure Standards. Client must not be eligible for services from other programs or providers (i.e. MHMRA of

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

FY 2023 RWPC "How to Best Meet the Need" Decision Process

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Step in Process: **Quality Improvement Committee**		Date: **05/03/2022**
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Step in Process: **HTBMTN Workgroup #2**	Date: **04/19/2022**
Recommendations:	Financial Eligibility: 500%
1. Create a workgroup to look at the collaboration question for the Integrated Plan.	
2. Update the justification chart, keep the service definition and the financial eligibility the same.	
3.	

FY 2020 Houston EMA Ryan White Part A/MAI Service Definition Medical Transportation (Van Based)	
HRSA Service Category Title: **RWGA Only**	**Medical Transportation**
Local Service Category Title:	**a. Transportation targeted to Urban** **b. Transportation targeted to Rural**
Budget Type: **RWGA Only**	**Hybrid Fee for Service**
Budget Requirements or Restrictions: **RWGA Only**	• Units assigned to Urban Transportation must only be used to transport clients whose residence is in Harris County. • Units assigned to Rural Transportation may only be used to transport clients who reside in Houston EMA/HSDA counties other than Harris County. • Mileage reimbursed for transportation is based on the documented distance in miles from a client's Trip Origin to Trip Destination **as documented by a standard Internet-based mapping program (i.e. Google Maps, Map Quest, Yahoo Maps) approved by RWGA.** Agency must print out and file in the client record a trip plan from the appropriate Internet-based mapping program that clearly delineates the mileage between Point of Origin and Destination (and reverse for round trips). This requirement is subject to audit by the County. • Transportation to employment, employment training, school, or other activities not directly related to a client's treatment of HIV disease is not allowable. Clients may not be transported to entertainment or social events under this contract. • Taxi vouchers must be made available for documented emergency purposes and to transport a client to a disability hearing, emergency shelter or for a documented medical emergency. • Contractor must reserve 7% of the total budget for Taxi Vouchers. • Maximum monthly utilization of taxi vouchers cannot exceed 14% of the total amount of funding reserved for Taxi Vouchers. • Emergencies warranting the use of Taxi Vouchers include: van service is unavailable due to breakdown, scheduling conflicts or inclement weather or other unanticipated event. A spreadsheet listing client's 11-digit code, age, date of service, number of trips, and reason for emergency should be kept on-site and available for review during Site Visits. • **Contractor must provide RWGA a copy of the agreement between Contractor and a licensed taxi vendor by March 30, 2015.** • All taxi voucher receipts must have the taxi company's name, the driver's name and/or identification number, number of miles driven, destination (to and from), and exact cost of trip. The Contractor will add the client's 11-digit code to the receipt and include all receipts with the monthly Contractor Expense Report (CER).

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

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

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

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

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Step in Process: **Quality Improvement Committee**		Date: **05/03/2022**
Recommendations:	Approved: Y:_ ___ No: _____ Approved With Changes: _____	If approved with changes list changes below:
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Step in Process: **HTBMTN Workgroup #3**	Date: **04/20/2022**
Recommendations:	Financial Eligibility: 400%
1. Update the justification chart, keep the service definition and the financial eligibility the same.	
2.	
3.	

FY 2020 Houston EMA Ryan White Part A/MAI Service Definition **Vision Care**	
HRSA Service Category Title: **RWGA Only**	**Ambulatory/Outpatient Medical Care**
Local Service Category Title:	**Vision Care**
Budget Type: **RWGA Only**	**Fee for Service**
Budget Requirements or Restrictions: **RWGA Only**	Corrective lenses are not allowable under this category. Corrective lenses may be provided under Health Insurance Assistance and/or Emergency Financial Assistance as applicable/available.
HRSA Service Category Definition: **RWGA Only**	***Outpatient/Ambulatory medical care*** is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings. Services includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). *Primary medical care* for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies. HRSA policy notice 10-02 states funds awarded under Part A or Part B of the Ryan White CARE Act (Program) may be used for optometric or ophthalmic services under Primary Medical Care. Funds may also be used to purchase corrective lenses for conditions related to HIV infection, through either the Health Insurance Premium Assistance or Emergency Financial Assistance service categories as applicable.
Local Service Category Definition:	**Primary Care Office/Clinic Vision Care** is defined as a comprehensive examination by a qualified Optometrist or Ophthalmologist, including Eligibility Screening as necessary. A visit with a credentialed Ophthalmic Medical Assistant for any of the following is an allowable visit: • Routine and preliminary tests including Cover tests, Ishihara Color Test, NPC (Near Point of Conversion), Vision Acuity Testing, Lensometry. • Visual field testing • Glasses dispensing including fittings of glasses, visual acuity testing, measurement, segment height. • Fitting of contact lenses is not an allowable follow-up visit.

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

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Step in Process: **HTBMTN Workgroup #1**	Date: **04/19/2022**
Recommendations:	Financial Eligibility: 400%
1. Update the justification chart, keep the service definition and the financial eligibility the same.	
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DRAFT

TARGETING FOR FY 2023 SERVICE CATEGORIES FOR RYAN WHITE PART A, B, MAI AND STATE SERVICES FUNDING

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

* Geographic targeting in rural area only.

** In an effort to provide a base line that reflects actual client utilization for community based organizations base this percentage on the FY 2021 final expenditures that targeted African Americans, Whites and Hispanics.

*** Geographic targeting in the north only.

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

***** ADAP Eligibility Workers

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, protect, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. *Motion approved by QI 03/15/22*
Part 1: Services offered by Ryan White Part A, Part B, and State Services in the Houston EMA/HSDA as of 03-15-22							
Ambulatory/Outpatient Primary Medical Care (incl. Vision):							
CBO, Adult – Part A, Including LPAP, MCM, EFA-Pharmacy, Outreach & Service Linkage (Includes OB/GYN) *See below for Public Clinic, Rural, Pediatric, Vision* ***Workgroup #1*** ***Motion:** (Kelly/Boyle)* *Votes: Y=9; N=0;* *Abstentions= Aloysius, Castillo, de la Cruz,*	✔ Yes ___No	☒ EIIHA ☒ Unmet Need ☒ Continuum of Care EIIHA: The purpose of the HRSA EIIHA initiative is to identify the status-*unaware* and facilitate their entry into Primary Care Unmet Need: Facilitating entry/reentry into Primary Care reduces unmet need. Additionally, a criterion for met need is evidence of an ART prescription, and clients cannot access LPAP until they are	Epi (2019): An estimated 6,825 people in the EMA are living with HIV and unaware of their status. The current estimate of unmet need in the EMA is 7,187, or 25% of all PLWH. Current # of living HIV cases in EMA: 30,149 Need (2020): Rank w/in funded services: *Primary Care: #1* *LPAP/EFA: #2* *Case Management: #3* *Outreach: #14* Service Utilization (2021):	Primary Care: Medicaid, Medicare, RW Part D, and private providers, including federal health insurance marketplace participants LPAP: ADAP, State Pharmacy Assistance Program, Medicaid, Medicare Part D, RW Health Insurance Assistance, the public clinic's pharmacy program, private sector Patient Assistance Programs, and private	Justify the use of funds: This service category: - Is a HRSA-defined Core Medical Service - Is ranked as the #1 service need by PLWH; and use has increased - Adheres to a medical home model and is bundled with LPAP, Medical Case Management, and Service Linkage - Results in desirable health outcomes for clients who access the service - Referring and linking the	Can we make this service more efficient? No Can we bundle this service? Currently bundled with: EFA, LPAP, Medical Case Management, Outreach and Service Linkage Has a recent capacity issue been identified? No Does this service assist special populations to access primary care?	**Wg Motion 1:** Update the justification chart, keep the service definition and the financial eligibility the same for PriCare=300%, EFA=500%, MCM/SLW/ Outreach=none and increase the financial eligibility for LPAP non-HIV meds to the same as HIV meds=500%.

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Leisher, Kelly, Miertschin, Robinson		enrolled in Primary Care. Continuum of Care*:* Primary Care, MCM, and LPAP support maintenance/retention in care and viral suppression for PLWH.	# clients served: *Primary Care: 9,397 (slight increase v. 2020)* *LPAP: 6,034 (8.54% increase v. 2020)* *Medical Case Mgmt: 5,263 (3.9% decrease v. 2020)* *EFA-Pharmacy: 2,654 (93% increase v. 2020)* *Outreach: 1,119 (27.6% increase v. 2020)* *Non-Medical Case Mgmt, or Service Linkage: 7,581 (8.9% decrease v. 2020)* Outcomes (FY2020): *Primary Care/LPAP:* 79% of Primary Care clients and 78% of LPAP clients were virally suppressed;	pharmacy benefit programs, including federal health insurance marketplace participants Medical Case Management: RW Part C and D Service Linkage: RW Part C and D, HOPWA, and a grant from a private foundation EHE Funding: RWGA received $1,794,295 in HRSA funding for Year 1 implementation of EHE activities. Houston Health Department (HHD) has received funding under PS19-1906 for Accelerating	status-unaware to Primary Care is the goal of the national and local EIIHA initiative - Referring and linking the out-of-care to Primary Care is the goal of reducing unmet need - Facilitates national, state, and local goals related to continuous HIV care, reducing unmet need, and viral load suppression - Addresses specific activities from Strategy #3 of the Comprehensive Plan and addresses certain Special Populations named in the Plan		

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			Medical Case Mgmt: 50% of clients were in continuous HIV care following MCM; 68% of clients who received MCM were virally suppressed; *Outreach:* 34% of clients accessed HIV care w/in 3 mos.; 45% were virally suppressed w/in 12 mos.; *Non-Medical Case Mgmt, or Service Linkage:* 49% of clients were in continuous HIV care following Service Linkage Pops. with difficulty accessing needed services: *Primary Care*: HL, 18-24, 25-	State and Local HIV Planning to End the HIV Epidemic. Several Houston area FQHCs received a combined total of $1,067,555 from HRSA's Ending the HIV Epidemic-Primary Care HIV Prevention (PCHP) Grant. Covered under QHP? ✔ Yes ___No	Is this a duplicative service or activity? - This service is funded locally by other public and private sources for (1) specific Special Populations (e.g., WICY), (2) those meeting income, disability, and/or age-related eligibility criteria, and (3) those with private sector health insurance.		

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			49, Rural, OOC, MSM *LPAP/EFA*: Females (sex at birth), HL, 25-49, Homeless, MSM, Rural *Outreach*: Males (sex at birth), White, 18 – 24, Homeless, MSM, RR, Transgender *Case Management:* Other/multiracial, Black/AA, 18-24, OOC, Transgender, RR, Homeless				

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Public Clinic, Adult – Part A, Including LPAP, MCM, EFA-Pharmacy, Outreach & Service Linkage (Includes OB/GYN) *See below for Rural, Pediatric, Vision* ***Workgroup #1*** ***Motion:** (Kelly/Boyle)* *Votes: Y=9; N=0;* *Abstentions= Aloysius, Castillo, de la Cruz, Leisher, Kelly, Miertschin, Robinson*	✔ Yes ___No	☒ EIIHA ☒ Unmet Need ☒ Continuum of Care EIIHA: The purpose of the HRSA EIIHA initiative is to identify the status-*unaware* and facilitate their entry into Primary Care Unmet Need: Facilitating entry/reentry into Primary Care reduces unmet need. Additionally, a criterion for met need is evidence of an ART prescription, and clients cannot access LPAP until they are enrolled in Primary Care. Continuum of Care: Primary Care, MCM, and LPAP support	Epi (2019): An estimated 6,825 people in the EMA are living with HIV and unaware of their status. The current estimate of unmet need in the EMA is 7,187, or 25% of all PLWH. Current # of living HIV cases in EMA: 30,149 Need (2020): Rank w/in funded services: *Primary Care: #1* *LPAP/EFA: #2* *Case Management: #3* *Outreach: #14* Service Utilization (2021): # clients served: *Primary Care: 9,397 (slight increase v. 2020)* *LPAP: 6,034*	Primary Care: Medicaid, Medicare, RW Part D, and private providers, including federal health insurance marketplace participants LPAP: ADAP, State Pharmacy Assistance Program, Medicaid, Medicare Part D, RW Health Insurance Assistance, the public clinic's pharmacy program, private sector Patient Assistance Programs, and private pharmacy benefit programs, including federal health insurance marketplace participants	Justify the use of funds: This service category: - Is a HRSA-defined Core Medical Service - Is ranked as the #1 service need by PLWH; and use has increased - Adheres to a medical home model and is bundled with LPAP, Medical Case Management, and Service Linkage - Results in desirable health outcomes for clients who access the service - Referring and linking the status-unaware to Primary Care is the goal of the national and local EIIHA initiative	Can we make this service more efficient? No Can we bundle this service? Currently bundled with: EFA, LPAP, Medical Case Management, Outreach and Service Linkage Has a recent capacity issue been identified? No Does this service assist special populations to access primary care?	**Wg Motion 1:** Update the justification chart, keep the service definition and the financial eligibility the same for PriCare=300%, EFA=500%, MCM/SLW/ Outreach=none and increase the financial eligibility for LPAP non-HIV meds to the same as HIV meds=500%.

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		maintenance/retention in care and viral suppression for PLWH.	*(8.54% increase v. 2020)* *Medical Case Mgmt: 5,263 (3.9% decrease v. 2020)* *EFA-Pharmacy: 2,654 (93% increase v. 2020)* *Outreach: 1,119 (27.6% increase v. 2020)* *Non-Medical Case Mgmt, or Service Linkage: 7,581 (8.9% decrease v. 2020)* Outcomes (FY2020): *Primary Care/LPAP:* 79% of Primary Care clients and 78% of LPAP clients were virally suppressed; *Medical Case Mgmt:* 50% of clients were in continuous HIV care following MCM; 68% of clients who received	Medical Case Management: RW Part C and D Service Linkage: RW Part C and D, HOPWA, and a grant from a private foundation EHE Funding: RWGA received $1,794,295 in HRSA funding for Year 1 implementation of EHE activities. Houston Health Department (HHD) has received funding under PS19-1906 for Accelerating State and Local HIV Planning to End the HIV Epidemic. Several Houston area FQHCs received a combined total of $1,067,555 from	- Referring and linking the out-of-care to Primary Care is the goal of reducing unmet need - Facilitates national, state, and local goals related to continuous HIV care, reducing unmet need, and viral load suppression - Addresses specific activities from Strategy #3 of the Comprehensive Plan and addresses certain Special Populations named in the Plan Is this a duplicative service or activity? - This service is funded locally by other public and		

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Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, protect, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency **Can we make this service more efficient? For:** a) Clients b) Providers **Can we bundle this service?** **Has a recent capacity issue been identified?** **Does this service assist special populations to access primary care?** *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. *Motion approved by QI 03/15/22*
			MCM were virally suppressed; *Outreach:* 34% of clients accessed HIV care w/in 3 mos.; 45% were virally suppressed w/in 12 mos.; *Non-Medical Case Mgmt, or Service Linkage:* 49% of clients were in continuous HIV care following Service Linkage Pops. with difficulty accessing needed services: *Primary Care*: HL, 18-24, 25-49, Rural, OOC, MSM *LPAP/EFA*: Females (sex at birth), HL, 25-49, Homeless, MSM, Rural	HRSA's Ending the HIV Epidemic-Primary Care HIV Prevention (PCHP) Grant. Covered under QHP? ✔ Yes ___No	private sources for (1) specific Special Populations (e.g., WICY), (2) those meeting income, disability, and/or age-related eligibility criteria, and (3) those with private sector health insurance.		

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Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, protect, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency **Can we make this service more efficient? For:** a) Clients b) Providers **Can we bundle this service?** **Has a recent capacity issue been identified?** **Does this service assist special populations to access primary care?** *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. *Motion approved by QI 03/15/22*
			Outreach: Males (sex at birth), White, 18 – 24, Homeless, MSM, RR, Transgender *Case Management:* Other/multiracial, Black/AA, 18-24, OOC, Transgender, RR, Homeless				

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Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, protect, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. *Motion approved by QI 03/15/22*
Pediatric – Part A ***Workgroup #1*** ***Motion:** (Kelly/Boyle) Votes: Y=9; N=0; Abstentions= Aloysius, Castillo, de la Cruz, Leisher, Kelly, Miertschin, Robinson*	✔ Yes ___No	☒ EIIHA ☒ Unmet Need ☒ Continuum of Care EIIHA: The purpose of the HRSA EIIHA initiative is to identify the status-*unaware* and facilitate their entry into Primary Care Unmet Need: Facilitating entry/reentry into Primary Care reduces unmet need. Continuum of Care: Primary Care, MCM, and Service Linkage support maintenance/retention in care and viral suppression for PLWH.	Epi (2019): An estimated 6,825 people in the EMA are living with HIV and unaware of their status. The current estimate of unmet need in the EMA is 7,187, or 25% of all PLWH. Current # of living HIV cases in EMA: 30,149 Need (2020): Rank w/in funded services: *Primary Care: #1* *Case Management: #3* Service Utilization (2021): # clients served: *Primary Care: 9,397 (slight increase v. 2020)* *Medical Case Mgmt: 5,263 (3.9% decrease v. 2020)* *Non-Medical Case Mgmt,*	Primary Care: Medicaid, Medicare, RW Part D, and private providers, including federal health insurance marketplace participants Medical Case Management: RW Part C and D Service Linkage: RW Part C and D, HOPWA, and a grant from a private foundation EHE Funding: RWGA received $1,794,295 in HRSA funding for Year 1 implementation of EHE activities. Houston Health Department (HHD) has	Justify the use of funds: This service category: - Is a HRSA-defined Core Medical Service - Is ranked as the #1 service need by PLWH; and use has increased - Adheres to a medical home model and is bundled with Medical Case Management and Service Linkage - Results in desirable health outcomes for clients who access the service - Referring and linking the status-unaware to Primary Care is the goal of the national and local EIIHA initiative - Referring and linking the	Can we make this service more efficient? No Can we bundle this service? Currently bundled with: Medical Case Management and Service Linkage Has a recent capacity issue been identified? No Does this service assist special populations to access primary care?	**Wg Motion:** Update the justification chart, keep the service definition and the financial eligibility the same: PriCare=300%, MCM=none, SLW=none.

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Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, protect, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency **Can we make this service more efficient? For:** a) Clients b) Providers **Can we bundle this service?** **Has a recent capacity issue been identified?** **Does this service assist special populations to access primary care?** *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. *Motion approved by QI 03/15/22*
			or Service Linkage: 7,581 (8.9% decrease v. 2020) Outcomes (FY2020): *Primary Care:* 79% of Primary Care clients were virally suppressed; *Medical Case Mgmt:* 50% of clients were in continuous HIV care following MCM; 68% of clients who received MCM were virally suppressed; *Non-Medical Case Mgmt, or Service Linkage:* 49% of clients were in continuous HIV care following Service Linkage Pops. with difficulty accessing	received funding under PS19-1906 for Accelerating State and Local HIV Planning to End the HIV Epidemic. Several Houston area FQHCs received a combined total of $1,067,555 from HRSA's Ending the HIV Epidemic-Primary Care HIV Prevention (PCHP) Grant. Covered under QHP? ✔ Yes ___No	out-of-care to Primary Care is the goal of reducing unmet need - Facilitates national, state, and local goals related to continuous HIV care, reducing unmet need, and viral load suppression - Addresses specific activities from Strategy #3 of the Comprehensive Plan and addresses certain Special Populations named in the Plan Is this a duplicative service or activity? - This service is funded locally by other public and private sources for (1)		

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			needed services: *Primary Care*: HL, 18-24, 25-49, Rural, OOC, MSM *Case Management:* Other/multiracial, Black/AA, 18-24, OOC, Transgender, RR, Homeless		specific Special Populations (e.g., WICY), (2) those meeting income, disability, and/or age-related eligibility criteria, and (3) those with private sector health insurance.		

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Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, protect, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. *Motion approved by QI 03/15/22*
Vision – Part A ***Workgroup #1*** ***Motion:** (Kelly/Pradia)* *Votes: Y=10; N=0;* *Abstentions= Aloysius*	☑ Yes ☐ No	☐ EIIHA ☐ Unmet Need ☒ Continuum of Care Continuum of Care: Vision services support maintenance/ retention in HIV care by increasing access to care and treatment for HIV-related and general ocular diagnoses. Untreated ocular diagnoses may act as logistical or financial barriers to HIV care.	Epi (2019): Current # of living HIV cases in EMA: 30,149 Need (2020): Rank w/in funded services:#5 Service Utilization (2021): # clients served: 3,059 *(1.6% decrease v. 2020)* Outcomes (FY2020): 750 diagnoses were reported for HIV-related ocular disorders, 97% of which were managed appropriately Pops. with difficulty accessing needed services: Females (sex at birth), Other/multiracial, 18-24, Homeless, OOC	No known alternative funding sources exist for this service Covered under QHP?* ☐ Yes ☑ No *QHPs cover pediatric vision	No known alternative funding sources exist for this service	Can we make this service more efficient? No Can we bundle this service? Currently bundled with Primary Care Has a recent capacity issue been identified? No Does this service assist special populations to access primary care?	**Wg Motion:** Update the justification chart, keep the service definition and the financial eligibility the same: 400%.

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Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, protect, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency **Can we make this service more efficient? For:** a) Clients b) Providers **Can we bundle this service?** **Has a recent capacity issue been identified?** **Does this service assist special populations to access primary care?** *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. *Motion approved by QI 03/15/22*

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Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, protect, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency **Can we make this service more efficient? For:** a) Clients b) Providers **Can we bundle this service?** **Has a recent capacity issue been identified?** **Does this service assist special populations to access primary care?** *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. *Motion approved by QI 03/15/22*
Clinical Case Management - Part A ***Workgroup #1*** ***Motion 1:** (Kelly/Pradia) Votes: Y=10; N=0; Abstentions= Aloysius, Castillo, de la Cruz, Leisher, Kelly, Miertschin, Robinson* ***Motion 2:** (Pradia/Kelly) Votes: Y=10; N=0; Abstentions= Aloysius, Castillo, de la Cruz, Leisher, Kelly, Miertschin, Robinson*	✔ Yes ___No	☐ EIIHA ☒ Unmet Need ☒ Continuum of Care Unmet Need: Among PLWH with a history of unmet need, substance use is the #2 reason cited for falling out-of-care, making CCM is a strategy for preventing unmet need. CCM also addresses local priorities related to mental health and substance abuse co-morbidities Continuum of Care: CCM supports maintenance/ retention in care and viral suppression for PLWH.	Epi (2019): Current # of living HIV cases in EMA: 30,149 Need (2020): Rank w/in funded services:*#3* Service Utilization (2021): # clients served: 1,198 *(7.5% decrease v. 2020)* Outcomes (FY2020): 56% of clients were in continuous care following receipt of CCM. 73% of clients utilizing CCM were virally suppressed. Pops. with difficulty accessing needed services: Other/multiracial, Black/AA, 18-24, OOC, Transgender,	RW Part C EHE Funding: RWGA received $1,794,295 in HRSA funding for Year 1 implementation of EHE activities. Houston Health Department (HHD) has received funding under PS19-1906 for Accelerating State and Local HIV Planning to End the HIV Epidemic. Several Houston area FQHCs received a combined total of $1,067,555 from HRSA's Ending the HIV Epidemic-Primary Care HIV Prevention (PCHP) Grant. Covered under QHP?	Justify the use of funds: This service category: - Is a HRSA-defined Core Medical Service - Is ranked as the #2 service need by PLWH - Results in desirable health outcomes for clients who access the service - Prevents unmet need by addressing co-morbidities related to substance abuse and mental health - Facilitates national, state, and local goals related to continuous HIV care and reducing unmet need - Addresses a system-level objective (#8) from the Comprehensive Plan and	Can we make this service more efficient? No Can we bundle this service? No Has a recent capacity issue been identified? No Does this service assist special populations to access primary care?	**Wg Motion 1:** Recommend that the Priority & Allocations Committee increase funding for all Case Management services specifically to increase salaries to reduce staff turnover. **Wg Motion 2:** Update the justification chart, keep the service definition and the financial eligibility the same: none.

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Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, protect, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. *Motion approved by QI 03/15/22*
			RR, Homeless	___Yes ✔ No	addresses certain Special Populations named in the Plan Is this a duplicative service or activity? - This service is funded locally by other RW Parts for specific Special Populations and for clients served by specific funded agencies/programs only		

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, protect, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency **Can we make this service more efficient? For:** a) Clients b) Providers **Can we bundle this service?** **Has a recent capacity issue been identified?** **Does this service assist special populations to access primary care?** *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. *Motion approved by QI 03/15/22*
Case Management – Non-Medical - Part A (Service Linkage at testing sites) ***Workgroup #1*** ***Motion 1:** (Kelly/Pradia) Votes: Y=10; N=0; Abstentions= Aloysius, Castillo, de la Cruz, Leisher, Kelly, Miertschin, Robinson* ***Motion 2:** (Pradia/Kelly) Votes: Y=10; N=0; Abstentions= Aloysius, Castillo, de la Cruz,*	___Yes ✔ No	☒ EIIHA ☒ Unmet Need ☒ Continuum of Care EIIHA: The EMA's EIIHA Strategy identifies Service Linkage as a local strategy for attaining Goals #3-4 of the national EIIHA initiative. Additionally, linking the newly diagnosed into HIV care via strategies such as Service Linkage fulfills the national, state, and local goal of linkage to HIV medical care ≤ 1 month of diagnosis. In 2018, 40% of the newly diagnosed in the EMA were *not* linked within this timeframe. Unmet Need: Service Linkage	Epi (2019): Current # of living HIV cases in EMA: 30,149 Need (2020): Rank w/in funded services:*#3* Service Utilization (2021): # clients served: 127 *(6% decrease v. 2020)* Outcomes (FY2020): Following Service Linkage, 49% of clients were in continuous HIV care, and 50% accessed HIV primary care for the first time Pops. with difficulty accessing needed services: Other/multiracial, Black/AA, 18-24, OOC, Transgender,	RW Part C and D, HOPWA, and a grant from a private foundation EHE Funding: RWGA received $1,794,295 in HRSA funding for Year 1 implementation of EHE activities. Houston Health Department (HHD) has received funding under PS19-1906 for Accelerating State and Local HIV Planning to End the HIV Epidemic. Several Houston area FQHCs received a combined total of $1,067,555 from HRSA's Ending the HIV Epidemic-Primary Care HIV Prevention (PCHP) Grant.	Justify the use of funds: This service category: - Is a HRSA-defined Support Service - Results in desirable health outcomes for clients who access the service - Is a strategy for attaining national EIIHA goals locally - Prevents the newly diagnosed from having unmet need - Facilitates national, state, and local goals related to linkage to care Is this a duplicative service or activity? - This service is funded locally by other RW Parts	Can we make this service more efficient? No Can we bundle this service? No Has a recent capacity issue been identified? No Does this service assist special populations to access primary care?	**Wg Motion 1:** Recommend that the Priority & Allocations Committee increase funding for all Case Management services specifically to increase salaries to reduce staff turnover. **Wg Motion 2:** Update the justification chart, keep the service definition and the financial eligibility the same: none.

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, protect, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency **Can we make this service more efficient? For:** a) Clients b) Providers **Can we bundle this service?** **Has a recent capacity issue been identified?** **Does this service assist special populations to access primary care?** *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. *Motion approved by QI 03/15/22*
Leisher, Kelly, Miertschin, Robinson		at HIV testing sites is specifically designed to prevent newly diagnosed PLWH from falling out-of-care by facilitating entry into HIV primary care immediately upon diagnosis. In 2015, 12% of the newly diagnosed PLWH were not linked to care by the end of the year. Continuum of Care: Service Linkage supports linkage to care, maintenance/retention in care and viral suppression for PLWH.	RR, Homeless	Covered under QHP? ___Yes ✔ No	for specific Special Populations and for clients served by specific funded agencies/programs only		

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, protect, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. *Motion approved by QI 03/15/22*
Early Intervention Services (EIS)‡ (Incarcerated) ***Workgroup #1*** ***Motion 1:*** *(Kelly/Pradia) Votes: Y=7; N=0; Abstentions= Aloysius, Castillo, de la Cruz, Leisher, Kelly, Miertschin, Robinson.*	✔ Yes ___No	☒ EIIHA ☒ Unmet Need ☒ Continuum of Care EIIHA: Local jail policy mandates HIV testing within 14 days of incarceration, thereby identifying status-unaware members of this population. From 2016-2018, an estimated 693 PLWH were released from TDCJ into Harris County. During incarceration, 100% are linked to HIV care. EIS ensures that the newly diagnosed identified in jail maintain their HIV care post-release by bridging re-entering PLWH into community-based primary	Epi (2018): Current # of living HIV cases in EMA: 29,078 Need (2020): Rank w/in funded services: *#13* Service Utilization (2020): # clients served: 572 *(15% decrease v. 2019)* Chart Review (2019): Of the client records reviewed, 97% of clients had a discharge plan present and 9% of all client records reviewed had documentation that the client accessed HIV care after release. Pops. with difficulty accessing	RW Part C provides non-targeted EIS EHE Funding: RWGA received $1,794,295 in HRSA funding for Year 1 implementation of EHE activities. Houston Health Department (HHD) has received funding under PS19-1906 for Accelerating State and Local HIV Planning to End the HIV Epidemic. Several Houston area FQHCs received a combined total of $1,067,555 from HRSA's Ending the HIV Epidemic-Primary Care HIV Prevention (PCHP) Grant.	Justify the use of funds: This service category: - Is a HRSA-defined Core Medical Service - Results in desirable outcomes for clients who access the service - Links those newly diagnosed in a local EMA jail to community-based HIV primary care upon release, thereby maintaining linkage to care for and preventing unmet need in this Special Population - Addresses specific activities from Strategy #3 of the Comprehensive Plan and addresses certain	Can we make this service more efficient? No Can we bundle this service? No Has a recent capacity issue been identified? No Does this service assist special populations to access primary care?	**Wg Motion:** Transition Early Intervention Services to Referral for Health Care and Support Services to better align with the scope of services provided. *See Referral for Health Care and Support Services*

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, protect, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency **Can we make this service more efficient? For:** a) Clients b) Providers **Can we bundle this service?** **Has a recent capacity issue been identified?** **Does this service assist special populations to access primary care?** *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. *Motion approved by QI 03/15/22*
		care. This is accomplished through care coordination by EIS staff in partnership with community-based providers/MOUs. Unmet Need: PLWH re-entering the community are at risk of lapsing their HIV care upon release from incarceration. EIS helps to prevent unmet need among this population by bridging re-entering PLWH into community-based primary care post-release. This is accomplished through care coordination by EIS staff in partnership with community-based providers/MOUs.	needed services: Other / multiracial, White, 25-49, RR, Homeless, Transgender, MSM	Covered under QHP? ___Yes ✔ No	Special Populations named in the Plan Is this a duplicative service or activity? - No, there is no known alternative funding for this service as designed		

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, protect, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency **Can we make this service more efficient? For:** a) Clients b) Providers **Can we bundle this service?** **Has a recent capacity issue been identified?** **Does this service assist special populations to access primary care?** *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. *Motion approved by QI 03/15/22*
		Continuum of Care: EIS supports linkage to care, maintenance/retention in care and viral suppression for PLWH.					

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Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, protect, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency **Can we make this service more efficient? For:** a) Clients b) Providers **Can we bundle this service?** **Has a recent capacity issue been identified?** **Does this service assist special populations to access primary care?** *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. *Motion approved by QI 03/15/22*
Emergency Financial Assistance - Other ***Workgroup #3*** ***Motion:** (Kelly/Boyle)* *Votes: Y=9; N=0;* *Abstentions=Aloysius, Leisher*	___Yes ✔ No	☐ EIIHA ☐ Unmet Need ☐ Continuum of Care This is a new service that started 03/01/21.	Epi (2018): Current # of living HIV cases in EMA: 29,078 Need (2020): N/A Service Utilization (2021): # clients served: 277	Covered under QHP? ___Yes ✔ No		Can we make this service more efficient? No Can we bundle this service? No Has a recent capacity issue been identified? No Does this service assist special populations to access primary care?	**Wg Motion:** Update the justification chart; keep the service definition and the financial eligibility the same: 400%.

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Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, protect, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. *Motion approved by QI 03/15/22*
Health Insurance Premium & Co-Pay Assistance **Part A, Part B, State Services** ***Workgroup #2*** ***Motion:** (Somoye/Pradia) Votes: Y=10; N=0; Abstentions= Leisher, Heinly, Valdez*	✔ Yes __No	☐ EIIHA ☒ Unmet Need ☒ Continuum of Care Unmet Need: Reductions in unmet need can be aided by *preventing* PLWH from lapsing their HIV care. This service category can directly prevent unmet need by removing financial barriers to HIV care for those who are eligible for public or private health insurance. Currently, 37% of RW clients have some form of health insurance, and 9% have Marketplace coverage. This service will assist those clients to remain in HIV care via all insurance resources; This will	Epi (2019): Current # of living HIV cases in EMA: 30,149 Need (2020): Rank w/in funded services: #7 *% of RW clients with health insurance: 37%* *% of RW clients with Marketplace coverage: 9%* Service Utilization (2021): # clients served: 2,239 *(4% decrease v. 2020)* Outcomes (FY2020): 73.5% of health insurance assistance clients were virally suppressed Pops. with difficulty accessing	No known alternative funding sources exist for this service, though consumers between 100% and 400% FPL may qualify for Advanced Premium Tax Credits (subsidies). COBRA plans seems to have fewer out-of-pocket costs. Covered under QHP? ___Yes ✔ No	Justify the use of funds: This service category: - Is a HRSA-defined Core Medical Service - Has limited or no alternative funding source - Removes potential barriers to entry/retention in HIV care, thereby contributing to EIIHA goals and preventing unmet need - Facilitates national, state, and local goals related to retention in care and reducing unmet need - Supports federal health insurance marketplace participants Is this a duplicative service	Can we make this service more efficient? Yes, see attached service definitions for changes. Can we bundle this service? No Has a recent capacity issue been identified? No Does this service assist special populations to access primary care?	**Wg Motion:** Update the justification chart, keep the service definition and the financial eligibility the same: 0 - 400%, ACA plans: must have a subsidy.

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Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, protect, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. *Motion approved by QI 03/15/22*
		also be utilized to assist federal health insurance marketplace participants. Continuum of Care: Health Insurance Assistance facilitates maintenance/ retention in care and viral suppression by increasing access to non-RW private and public medical and pharmaceutical coverage. The savings yielded by securing non-RW healthcare coverage for PLWH increases the amount of funding available to provide other needed services throughout the Continuum of Care.	needed services: Other / multiracial, HL, 25-49, Transgender, Homeless, MSM, Rural		or activity? - No, there is no known alternative funding for this service as designed		

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, protect, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. *Motion approved by QI 03/15/22*
Home and Community-Based Services‡ (Facility-based) (Adult Day Treatment) ***Workgroup #3*** ***Motion:** (Boyle/Starr)* *Votes: Y=9; N=0;* *Abstentions=Kelly*	___✔___Yes __No	☐ EIIHA ☒ Unmet Need ☒ Continuum of Care Unmet Need: Facilitating entry into/return of the out-of-care into primary care is the intent of reducing unmet need. Adult Day Treatment contributes to this goal by providing a community-based alternative to in-patient care facilities for those with advanced HIV-related health concerns. This, in turn, may prevent those with advanced stage illness or complex HIV-related health concerns from becoming out-of-care. In 2015, 19% of people with a Stage 3 HIV diagnosis	Epi (2018): Current # of living HIV cases in EMA: 29,078 Need (2020): Rank w/in funded services: *#11* Service Utilization (2021): # clients served: 21 *(14% decrease v. 2020)* Chart Review (2019): 82% of clients records had a complete care plan based on the primary medical care provider's order. 90% of records had evaluation of health, psychosocial, functional, and home environment status	Medicaid Covered under QHP? ___Yes ✔No	Justify the use of funds: This service category: - Is a HRSA-defined Core Medical Service; and use has increased - Results in desirable health outcomes for clients who access the service - Helps prevent unmet need for those with advanced HIV-related health concerns - Facilitates national, state, and local goals related to retention in care, reducing unmet need, and viral load suppression Is this a duplicative service or activity?	Can we make this service more efficient? No Can we bundle this service? No Has a recent capacity issue been identified? No Does this service assist special populations to access primary care?	**Wg Motion:** Update the justification chart; keep the service definition and the financial eligibility the same: 400%.

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, protect, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency **Can we make this service more efficient? For:** a) Clients b) Providers **Can we bundle this service?** **Has a recent capacity issue been identified?** **Does this service assist special populations to access primary care?** *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. *Motion approved by QI 03/15/22*
		were out-of-care in the EMA. In addition, the goal of Adult Day Treatment is to return clients to self-sufficient daily functioning, which includes maintenance in HIV care. Continuum of Care: Adult Day Treatment facilitates re-linkage and retention in care for PLWH by providing a community-based alternative to in-patient care facilities for those with advanced HIV-related health concerns, and may prevent those with advanced HIV-related health concerns from falling out-of-care.	Pops. with difficulty accessing needed services: Other / multiracial, 25-49, Transgender, Homeless		- This service is funded locally by one other public source for those meeting income or disability-related eligibility criteria		

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, protect, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. *Motion approved by QI 03/15/22*
Hospice ‡ ***Workgroup #3*** ***Motion:** (Starr/Pradia)* *Votes: Y=9; N=0;* *Abstentions=Kelly*	✔ Yes __No	☐ EIIHA ☒ Unmet Need ☒ Continuum of Care Unmet Need: Facilitating entry into/return of the out-of-care into primary care is the intent of reducing unmet need. Hospice contributes to this goal by providing facility-based skilled nursing and palliative care for those with a terminal diagnosis. This, in turn, may prevent PLWH from becoming out-of-care. In 2015, 19% of people with a Stage 3 HIV diagnosis were out-of-care in the EMA. Hospice ensures clients with co-morbidities remain in HIV care. As a result, this service	Epi (2018): Current # of living HIV cases in EMA: 29,078 Need (2020):N/a Service Utilization (2021): # clients served: 30 *(67% increase v. 2020)* Chart Review (2019): 92% of charts had records of palliative therapy as ordered and 100% had medication administration records on file. Records indicated that bereavement counseling was offered to client's family in 10% of applicable cases. Pops. with difficulty accessing needed services: N/a	Medicaid, Medicare Covered under QHP? ✔ Yes ___No	Justify the use of funds: This service category: - Is a HRSA-defined Core Medical Service - Prevents unmet need among PWA and those with co-occurring conditions - Facilitates national, state, and local goals related to retention in care and reducing unmet need - Addresses a system-level objective (#8) from the Comprehensive Plan and addresses certain Special Populations named in the Plan Is this a duplicative service	Can we make this service more efficient? No Can we bundle this service? No Has a recent capacity issue been identified? No Does this service assist special populations to access primary care? N/A	**Wg Motion:** Update the justification chart; keep the service definition and the financial eligibility the same: 300%.

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, protect, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. *Motion approved by QI 03/15/22*
		also addresses local priorities related to mental health and substance abuse co-morbidities. Continuum of Care: Hospice services support re-linkage and maintenance/retention in care for PLWH by providing facility-based skilled nursing and palliative care for those with a terminal diagnosis, preventing PLWH from falling out of care.			or activity? - This service is funded locally by other public sources for those meeting income, disability, and/or age-related eligibility criteria		

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, protect, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency **Can we make this service more efficient? For:** a) Clients b) Providers **Can we bundle this service?** **Has a recent capacity issue been identified?** **Does this service assist special populations to access primary care?** *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. *Motion approved by QI 03/15/22*
Linguistic Services‡ ***Workgroup #3*** ***Motion:** (Starr/Kelly)* *Votes: Y=8; N=0;* *Abstentions=Aloysius, Leisher*	___Yes ✔ No	☐ EIIHA ☒ Unmet Need ☒ Continuum of Care Unmet Need: Facilitating entry into/return of the out-of-care into primary care is the intent of reducing unmet need. By eliminating language barriers in RW-funded HIV care, this service facilitates entry into care and helps prevent lapses in care for monolingual PLWH. Continuum of Care: Linguistic Services support linkage to care, maintenance/retention in care, and viral suppression by eliminating language barriers and facilitating effective	Epi (2018): Current # of living HIV cases in EMA: 29,078 Need (2020):N/a Service Utilization (2021): # clients served: 50 *(4% decrease v. 2020)* *48% of Linguistics clients were African American / African origin and 36% were Asian American / Asian origin* Pops. with difficulty accessing needed services: N/a	RW providers must have the capacity to serve monolingual Spanish-speakers; Medicaid may provide language translation for *non-Spanish* monolingual clients Covered under QHP? ___Yes ✔ No	Justify the use of funds: This service category: - Is a HRSA-defined Support Service - Has limited or no alternative funding source - Removes potential barriers to entry/retention in HIV care for monolingual PLWH, thereby contributing to EIIHA goals and preventing unmet need - Facilitates national, state, and local goals related to retention in care and reducing unmet need - Linguistic and cultural competence is a Guiding Principle of the	Can we make this service more efficient? No Can we bundle this service? No Has a recent capacity issue been identified? There is no waiting list at this time; however, the need for this service has the potential to exceed capacity due to new cohorts of languages spoken in the EMA/HSDA Does this service assist special populations to access primary care?	**Wg Motion:** Update the justification chart, keep the service definition and the financial eligibility the same: 300%.

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, protect, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency **Can we make this service more efficient? For:** a) Clients b) Providers **Can we bundle this service?** **Has a recent capacity issue been identified?** **Does this service assist special populations to access primary care?** *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. *Motion approved by QI 03/15/22*
		communication for non-Spanish monolingual PLWH.			Comprehensive HIV Plan Is this a duplicative service or activity? - No, there is no known alternative funding for this service as designed		

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, protect, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency **Can we make this service more efficient? For:** a) Clients b) Providers **Can we bundle this service?** **Has a recent capacity issue been identified?** **Does this service assist special populations to access primary care?** *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. *Motion approved by QI 03/15/22*
Medical Nutritional Supplements and Therapy - Part A ***Workgroup #2*** ***Motion:** (Pradia/Somoye) Votes: Y=11; N=0; Abstentions= Leisher, Heinly, Valdez*	✔ Yes ___No	☐ EIIHA ☒ Unmet Need ☒ Continuum of Care Unmet Need: The most commonly cited reason for referral to this service by a RW clinician is to mitigate side effects from HIV medication. Currently, 8% of PLWH report that side effects prevent them from taking HIV medication. This service category eliminates potential barriers to HIV medication adherence by helping to alleviate side effects. In addition, evidence of an ART prescription is a criterion for met need. Continuum of Care: Medical	Epi (2019): Current # of living HIV cases in EMA: 30,149 Need (2020): Rank w/in funded services: *#10* Service Utilization (2021): # clients served: 593 *(4% increase v. 2020)* Outcomes (FY2020): 83% of medical nutritional therapy clients with wasting syndrome or suboptimal body mass improved or maintained their body mass index. 83% of Medical Nutritional Therapy clients were virally suppressed	No known alternative funding sources exist for this service Covered under QHP?* ___Yes ✔ No *Some QHPs may cover prescribed supplements	Justify the use of funds: This service category: - Is a HRSA-defined Core Medical Service - Is ranked as the #9 service need by PLWH - Has limited or no alternative funding source - Results in desirable health outcomes for clients who access the service - Removes barriers to HIV medication adherence, thereby facilitating national, state, and local goals related to viral load suppression Is this a duplicative service or activity?	Can we make this service more efficient? No Can we bundle this service? No Has a recent capacity issue been identified? No Does this service assist special populations to access primary care?	**Wg Motion:** Update the justification chart, keep the service definition and the financial eligibility the same: 400%.

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, protect, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency **Can we make this service more efficient? For:** a) Clients b) Providers **Can we bundle this service?** **Has a recent capacity issue been identified?** **Does this service assist special populations to access primary care?** *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. *Motion approved by QI 03/15/22*
		Nutrition Therapy facilitates viral suppression by allowing PLWH to mitigate HIV medication side effects with supplements, and increasing medication adherence.	Pops. with difficulty accessing needed services: Females (sex at birth), Black/AA, 25-49, Homeless		- Alternative funding for this service may be available through Medicaid.		

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Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, protect, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. *Motion approved by QI 03/15/22*
Mental Health Services‡ (Professional Counseling) ***Workgroup #2*** ***Motion:** (Pradia/Somoye)* *Votes: Y=11; N=0;* *Abstentions= Leisher, Heinly, Valdez*	✔ Yes ___No	☐ EIIHA ☒ Unmet Need ☒ Continuum of Care Unmet Need: Of 29% of 2016 Needs Assessment participants who reported falling out of care for >12 months since first entering care, 9% reported mental health concerns caused the lapse. Over half (57%) of participants recorded having a current mental health condition diagnosis, and 65% reported experiencing at least one mental/emotional distress symptom in the past 12 months to such an extent that they desired professional help.	Epi (2019): Current # of living HIV cases in EMA: 30,149 Need (2020): Rank w/in funded services: *#8* Service Utilization (2021): # clients served: 209 *(9% decrease v. 2020)* Chart Review (2019): 96% of clients had treatment plans reviewed and/or modified at least every 90 days. 100% of charts reviewed contained evidence of appropriate coordination across all medical care team members	RW Part D (targets WICY), Medicaid, Medicare, private providers, and self-pay Some services provided by MHMRA Covered under QHP? ✔ Yes ___No	Justify the use of funds: This service category: - Is a HRSA-defined Core Medical Service - Is ranked as the #7 service need by PLWH - Facilitates national, state, and local goals related to retention in care and preventing unmet need - Addresses a system-level objective (#8) from the Comprehensive Plan and (as a result of the motion) addresses certain Special Populations named in the Plan Is this a duplicative service or activity?	Can we make this service more efficient? No Can we bundle this service? No Has a recent capacity issue been identified? No Does this service assist special populations to access primary care?	**Wg Motion:** Update the justification chart, keep the service definition and the financial eligibility the same: 500%.

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, protect, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. *Motion approved by QI 03/15/22*
		Mental Health Services offers professional counseling for those with a mental health condition/concern, and, as a result, may help reduce lapses in HIV care. Mental Health Services also address local priorities related to mental health co-morbidities. Continuum of Care: Mental Health Services facilitate linkage, maintenance/retention in care, and viral suppression by helping PLWH manage mental and emotional health concerns that may act as barriers to HIV care.	Pops. with difficulty accessing needed services: Females (sex at birth), Other / multiracial, White, RR, Rural, Homeless		- This service is funded locally by other public and private sources for (1) specific Special Populations (e.g., WICY), (2) those meeting income, disability, and/or age-related eligibility criteria, and (3) those with private sector health insurance.		

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Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, protect, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency **Can we make this service more efficient? For:** a) Clients b) Providers **Can we bundle this service?** **Has a recent capacity issue been identified?** **Does this service assist special populations to access primary care?** *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. *Motion approved by QI 03/15/22*
Oral Health Untargeted – Part B Rural (North) – Part A ***Workgroup #2*** ***Motion:** (Pradia/Galley)* *Votes: Y=9; N=0;* *Abstentions= Kelly*	✔ Yes ___No	☐ EIIHA ☐ Unmet Need ☒ Continuum of Care Continuum of Care: Oral Health services support maintenance in HIV care by increasing access to care and treatment for HIV-related and general oral health diagnoses. Untreated oral health diagnoses can create poor health outcomes and may act as a financial barrier to HIV care.	Epi (2019): Current # of living HIV cases in EMA: 30,149 Need (2020): Rank w/in funded services: *#4* Service Utilization (2021): # clients served: 3,420 *(3.5% decrease v. 2020)* Outcomes (FY2019): Oral Health Care – Rural Target: 99% of client charts had evidence of vital signs assessment, 92% had evidence of hard and soft tissue examinations, 94% had evidence of receipt of periodontal screening, and	In FY12, Medicaid Managed Care expanded benefits to include oral health services Covered under QHP*? ___Yes ✔ No *Some QHPs cover pediatric dental; low-cost add-on dental coverage can be purchased in Marketplace	Justify the use of funds: This service category: - Is a HRSA-defined Core Medical Service - Is ranked as the #4 service need by PLWH. Is this a duplicative service or activity? - This service is funded locally by one other public sources for its Managed Care clients only	Can we make this service more efficient? No Can we bundle this service? No Has a recent capacity issue been identified? Yes, clients report waiting lists for this service Does this service assist special populations to access primary care?	**Wg Motion:** Update the justification chart, keep the service definition and the financial eligibility the same: 300%.

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, protect, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency **Can we make this service more efficient? For:** a) Clients b) Providers **Can we bundle this service?** **Has a recent capacity issue been identified?** **Does this service assist special populations to access primary care?** *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. *Motion approved by QI 03/15/22*
			99% had evidence of oral health education. Oral Health Care – Untargeted: 99% had chart evidence for vital signs assessment at initial visit, 99% had updated health histories in their chart, 89% had a signed dental treatment plan established or updated within the last year, and 75% had chart evidence of receipt of oral health education including smoking cessation. Pops. with difficulty accessing needed services: Females (sex at birth), Other / multiracial, White, 25-49, OOC, RR, MSM				

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **Not in care:* *EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, protect, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency **Can we make this service more efficient? For:** a) Clients b) Providers **Can we bundle this service?** **Has a recent capacity issue been identified?** **Does this service assist special populations to access primary care?** *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. *Motion approved by QI 03/15/22*
Program Support: (WITHIN THE ADMINISTRATIVE BUDGET)							
Council Support	___Yes ✔ No						
Project LEAP	___Yes ✔ No						
Blue Book	___Yes ✔ No						

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, protect, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency **Can we make this service more efficient? For:** a) Clients b) Providers **Can we bundle this service?** **Has a recent capacity issue been identified?** **Does this service assist special populations to access primary care?** *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. *Motion approved by QI 03/15/22*
Referral for Health Care and Support Services‡ ***Workgroup #1*** ***Motion 1:** (Kelly/Pradia) Votes: Y=7; N=0; Abstentions= Aloysius, Castillo, de la Cruz, Leisher, Kelly, Miertschin, Robinson.* ***Motion 2:** (Kelly/Pradia) Votes: Y=7; N=0; Abstentions= Aloysius, Castillo, de la Cruz, Leisher, Kelly, Miertschin,*	___Yes ✔ No Referral For Health Care/Support Services – AIDS Drug Assistance Program Enrollment Worker at Ryan White Care Sites will fund one FTE ADAP enrollment worker per Ryan White Part A primary care site. Each ADAP enrollment worker will meet with all potential new ADAP enrollees, explain ADAP program benefits and requirements, and assist clients with submission of complete, accurate ADAP	☐ EIIHA ☒ Unmet Need ☒ Continuum of Care Unmet Need: Assistance submitting complete and accurate ADAP applications and re-certifications reduces unmet need by increasing the proportion of PLWH in the Houston EMA/HSDA with access to HIV medication coverage. Continuum of Care: Increased access to HIV medication coverage supports medication adherence and viral suppression.	Epi (2019): Current # of living HIV cases in EMA: 30,149 Need (2020): Rank w/in funded services: *#6* Service Utilization (2021): # clients served: 6,852 *(2% decrease v. 2020)* Chart Review (2019): 59% of AEW client had charts documented evidence of benefit applications completed as appropriate within 2 weeks the eligibility determination date. 59% had evidence of assistance provided to access health	Beyond assistance offered in the provision of case management care coordination, there is currently no funding to support dedicated ADAP Enrollment Workers at Ryan White primary care sites. Covered under QHP? ___Yes ✔ No	Justify the use of funds: This service category: - Is a HRSA-defined Support Service - State Services-Rebate (SS-R) funding is intended to ensure service continuation or bridge service gaps. - ADAP medication coverage reduces use of LPAP funding. Is this a duplicative service or activity? No	Can we make this service more efficient? Placement of ADAP Enrollment Workers at each Ryan White primary care site will make this service more efficient and accessible than placement at a single site. Can we bundle this service? N/a – this would be the only use of SS-R funding in the Houston EMA/HSDA Has a recent capacity issue been identified? No	**Wg Motion 1:** Transition Early Intervention Services to Referral for Health Care and Support Services to better align with the scope of services provided. **Wg Motion 2:** Update the justification chart, keep the service definition and the financial eligibility the same: 500% and none for incarcerated.

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, protect, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. *Motion approved by QI 03/15/22*
Robinson.	applications, as well as appropriate re-certifications and attestations.		insurance or Marketplace plans. 73% had evidence of completed secondary reviews of ADAP applications before submission to THMP. Pops. with difficulty accessing needed services: Other / multiracial, White, 50+, MSM, Homeless, Transgender, Rural, RR			Does this service assist special populations to access primary care?	

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, protect, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. *Motion approved by QI 03/15/22*
Substance Abuse Treatment – Part A ***Workgroup #2*** ***Motion 1:** (Kelly/Pradia)* *Votes: Y=11; N=0;* *Abstentions= none* ***Motion 2:** (Pradia/Kelly)* *Votes: Y=11; N=0;* *Abstentions= Leisher, Heinly, Valdez*	✔ Yes ___No	☐ EIIHA ☒ Unmet Need ☒ Continuum of Care Unmet Need: Among PLWH with a history of unmet need, substance use is the #2 reason cited for falling out-of-care. Therefore, Substance Abuse Treatment services can directly prevent or reduce unmet need. Substance Abuse Treatment also addresses local priorities related to substance abuse co-morbidities. Continuum of Care: Substance Abuse Treatment facilitates linkage, maintenance/retention in care, and viral suppression by helping PLWH manage	Epi (2019): Current # of living HIV cases in EMA: 30,149 Need (2020): Rank w/in funded services: *#12* Service Utilization (2021): # clients served: 26 *(30% increase v. 2020)* Outcomes (FY2019): 50% of clients accessed primary care at least once after receiving Substance Abuse Treatment services and 89% were virally suppressed. Pops. with difficulty accessing	RW Part C, Medicaid, Medicare, private providers, and self-pay. Some services provided by SAMHSA Covered under QHP? ✔ Yes ___No	Justify the use of funds: This service category: - Is a HRSA-defined Core Medical Service - Removes potential barriers to early entry into HIV care, thereby contributing to EIIHA goals - Prevents unmet need by addressing the #2 cause cited by PLWH for lapses in HIV care - Facilitates national, state, and local goals related to continuous HIV care and reducing unmet need - Addresses a system-level objective (#8) from the Comprehensive Plan and addresses certain Special	Can we make this service more efficient? No Can we bundle this service? No Has a recent capacity issue been identified? No	**Wg Motion 1:** Create a workgroup to look at the collaboration question for the Integrated Plan. **Wg Motion 2:** Update the justification chart, keep the service definition and the financial eligibility the same: 500%.

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, protect, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. *Motion approved by QI 03/15/22*
		substance abuse that may act as barriers to HIV care.	needed services: Black/AA, 18-24, RR, Homeless		Populations named in the Plan Is this a duplicative service or activity? - This service is funded locally by other public and private sources for (1) those meeting income, disability, and/or age-related eligibility criteria, and (2) those with private sector health insurance.		

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, protect, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. *Motion approved by QI 03/15/22*
Case Management – Non-Medical - State Services‡ (Targeting Substance Use Disorders) ***Workgroup #2*** ***Motion:** (Pradia/Kelly)* *Votes: Y=11; N=0;* *Abstentions= Leisher, Heinly, Valdez*	___Yes ✔No	☒ EIIHA ☒ Unmet Need ☒ Continuum of Care EIIHA: The EMA's EIIHA Strategy identifies Service Linkage as a local strategy for attaining Goals #3-4 of the national EIIHA initiative. Additionally, linking the newly diagnosed into HIV care via strategies such as Service Linkage fulfills the national, state, and local goal of linkage to HIV medical care ≤ 3 months of diagnosis. In 2015, 19% of the newly diagnosed in the EMA were *not* linked within this timeframe. Unmet Need: Service Linkage	Epi (2019): Current # of living HIV cases in EMA: 30,149 Need (2020): Rank of all types of case management w/in funded services: *#3* Service Utilization (2021): # clients served: 315 (443% increase v. 2020*) *Service delivery began on 09/01/19 Pops. with difficulty accessing needed services: *Case Management:* Other/multiracial, Black/AA, 18-24, OOC, Transgender, RR, Homeless	This service was previously funded under SAMHSA. Covered under QHP? ___Yes ✔No	Justify the use of funds: This service category: - Is a HRSA-defined Support Service - Results in desirable health outcomes for clients who access the service - Is a strategy for attaining national EIIHA goals locally - Prevents the newly diagnosed from having unmet need - Facilitates national, state, and local goals related to linkage to care Is this a duplicative service or activity? - This service is funded locally by other RW Parts	Can we make this service more efficient? No Can we bundle this service? No Has a recent capacity issue been identified? No Does this service assist special populations to access primary care?	**Wg Motion:** Update the justification chart, keep the service definition and the financial eligibility the same: none.

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, protect, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency **Can we make this service more efficient? For:** a) Clients b) Providers **Can we bundle this service?** **Has a recent capacity issue been identified?** **Does this service assist special populations to access primary care?** *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. *Motion approved by QI 03/15/22*
		at HIV testing sites is specifically designed to prevent newly diagnosed PLWH from falling out-of-care by facilitating entry into HIV primary care immediately upon diagnosis. In 2015, 12% of the newly diagnosed PLWH were not linked to care by the end of the year. Continuum of Care: Service Linkage supports linkage to care, maintenance/retention in care and viral suppression for PLWH.			for specific Special Populations and for clients served by specific funded agencies/programs only		

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, protect, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency **Can we make this service more efficient? For:** a) Clients b) Providers **Can we bundle this service?** **Has a recent capacity issue been identified?** **Does this service assist special populations to access primary care?** *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. *Motion approved by QI 03/15/22*
Transportation – Pt A (Van-based, bus passes & gas vouchers) ***Workgroup #3*** ***Motion:** (Starr/Kelly)* *Votes: Y=10; N=0;* *Abstentions=none*	___Yes ✔ No	☐ EIIHA ☒ Unmet Need ☒ Continuum of Care Unmet Need: Lack of transportation is the *fourth* most commonly-cited barrier among PLWH to accessing HIV core medical services. Transportation services eliminate this barrier to care, thereby supporting PLWH in continuous HIV care. Continuum of Care: Transportation supports linkage, maintenance/retention in care, and viral suppression by helping PLWH attend HIV primary care visits, and other vital services.	Epi (2018): Current # of living HIV cases in EMA: 29,078 Need (2020): Rank w/in funded services: *#9* Service Utilization (2021): # clients served: *Van-based: 1,118* *(12% decrease v. 2020)* *Bus pass: 1,260* *(7% decrease v. 2020)* Outcomes (FY2020): 67% of clients accessed primary care at least once after using van transportation; and 37% of clients accessed primary care after using bus	Medicaid, RW Part D (small amount of funds for parking and other transportation needs), and by other public sources for (1) specific Special Populations (e.g., WICY), and (2) those meeting income, disability, and/or age-related eligibility criteria. COVID-19 funding provides ridesharing with no financial eligibility. Covered under QHP*? ___Yes ✔ No	Justify the use of funds: This service category: - Is a HRSA-defined Support Service - Is ranked as the #2 need among Support Services by PLWH - Results in clients accessing HIV primary care - Removes potential barriers to entry/retention in HIV care, thereby contributing to EIIHA goals and preventing unmet need - Facilitates national, state, and local goals related to continuous HIV care and reducing unmet need	Can we make this service more efficient? No Can we bundle this service? No Has a recent capacity issue been identified? No Does this service assist special populations to access primary care?	**Wg Motion:** Update the justification chart; keep the service definition and the financial eligibility the same: 400%.

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade. **Ending the HIV Epidemic*: The local plan to end new HIV transmissions by addressing four strategies – diagnose, treat, protect, and respond.	Documentation of Need (Sources of Data include: 2020 Needs Assessment, 2017-2021 Comp Plan, 2016 Ending the HIV Epidemic Plan, 2018 Outcome Measures, 2018 Chart Reviews, Clinical Quality Management Committee reports, Special Studies, Surveys and HIV and COVID-19 related documents and more) Which populations experience disproportionate need for and/or barriers to accessing this service?	Identify non-Ryan White Part A, Part B/ non-State Services, or Ending the HIV Epidemic initiative funding sources to identify if there is duplicate/alternative funding or the need to fill in a gap. Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Clients b) Providers Can we bundle this service? Has a recent capacity issue been identified? Does this service assist special populations to access primary care? *Examples:* a) Youth transitioning into adult care b) Recently released individuals c) Postpartum individuals no longer needing OB care d) Transgender individuals e) Other marginalized populations	Recommendation(s) As part of the 2022 Integrated HIV Prevention and Care Services Plan, it is recommended that the Racial Justice Health Services Assessment and the Quality of Life Assessment be developed and piloted. *Motion approved by QI 03/15/22*
			pass services. <u>Pops. with difficulty accessing needed services</u>: Females (sex at birth), Other / multiracial, White, Homeless, OOC, RR		Is this a duplicative service or activity? - This service is funded locally by other public sources for (1) specific Special Populations (e.g., WICY), and (2) those meeting income, disability, and/or age-related eligibility criteria.		

‡ Service Category for Part B/State Services only.

Service Category	Justification for Discontinuing the Service
Part 2: Services *allowed* by HRSA but not offered by Part A, Part B or State Services funding in the Houston EMA/HSDA as of 03-01-22 *(In order for any of the services listed below to be considered for funding, a New Idea Form must be submitted to the Office of Support for the Ryan White Planning Council no later than **5 p.m. on May 2, 2022**. This form is available by calling the Office of Support: 832 927-7926)*	
Buddy Companion/Volunteerism	Low use, need and gap according to the 2002 Needs Assessment (NA).
Childcare Services (In Home Reimbursement; at Primary Care sites)	Primary care sites have alternative funding to provide this service so clients will continue to receive the service through alternative sources.
Food Pantry (Urban)	Service available from alternative sources.
HE/RR	In order to eliminate duplication, eliminate this service but strengthen the patient education component of primary care.
Home and Community-based Health Services (In-home services)	Category unfunded due to difficulty securing vendor.
Housing Assistance (Emergency rental assistance) **Housing Related Services** (Housing Coordination)	According to the HOPWA representative, they provide significant funding for emergency rent and utility assistance. (See City Council approved allocations.) But, HOPWA does not give emergency shelter vouchers because they feel there are shelters for this purpose and because it is more prudent to use limited resources to provide long-term housing.
Minority Capacity Building Program	The Capacity Building program targeted to minority substance abuse providers was a one-year program in FY2004.
Outreach Services	Significant alternative funding.
Psychosocial Support Services (Counseling/Peer)	Duplicates patient education program in primary care and case management. The boundary between peer and client gets confusing and difficult to supervise. Not cost effective, costs almost as much per client as medical services.
Rehabilitation	Service available from alternative sources.

‡ Service Category for Part B/State Services only.

Operations Committee Report

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FY 2022 vs. FY 2023 Council Support Budget Comparison

(as of 05-11-22)

Budget Item	FY 2022 Amount	FY 2023 Amount	Difference	Notes
Employee Fringe	$120,664	To be determined	To be determined	The County has not released the cost of benefits for the next fiscal year.
Travel • Local • Out of EMA	 $ 200 $ 5,800	 $ 800 $ 2,000	 + $ 600 - $3,800	Local: The price of gas has increased significantly. Out of EMA: More and more conferences are being held virtually.
Resource Guide	$ 20,000	$ 0	- $ 20,000	The Blue Book is published bi-annually.
Needs Assessment	$ 0	$ 19,300	+ $ 19,300	This work product is required in 2023/2024
Translation Services – Spanish Speaking	$ 7,000	$13,000	+ $ 6,000	Proyecto VIDA may provide some mono-lingual Spanish speaking Council & Affiliate members.
Public Storage Unit	$ 0	$ 3,000	+ $ 3,000	The Judge's Office paid this expense the first year. It must now be paid with RW funds.
Room Rentals	$ 0	$ 6,000	+ $ 6,000	In 2020, large meeting rooms in the building were remodeled for COVID response purposes. Hence, the need to rent large off-site meeting rooms for Council, Integrated Planning, Project LEAP, Proyecto VIDA and other meetings.
Copier Rental	$ 7,000	$ 9,000	+ $ 2,000	The cost of printing materials are related to oil prices.
TOTALS			+ $ 13,100	

FY 2023 Budget Total	$ 522,255
FY 2022 Budget Total	- 509,155
Difference	+ 13,100

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Houston Ryan White Planning Council
FY 2022 Council Support Budget
March 1, 2023 - February 28, 2024
(as of 05-11-22)

		Subtotal	Total
PERSONNEL		**$267,382**	
RWPC Manager (V. Williams) ($6877/mo. X 12 mos. X 100%) Responsible for overall functioning of planning council, supervises all support staff.	$82,525		
RWPC Health Planner (M. Hudson) ($6493/mo. X 12 mos. X 100%) Responsible for coordinating Comprehensive Planning and Needs Assessment activities. Analyzing and presenting data.	$77,918		
RWPC Coordinator (D. Beck) ($4,900/mo x 12 mos. X 100%) Coordinates support activities for the RW Planning Council and committees. Provides routine administrative duties (minutes, scheduling of meetings, mailouts, etc.).	$58,800		
Assistant Coordinator (R. Avila) ($4011/mo x 12 mos. X 100%) Coordinates support activities for assigned committees. Provides routine administrative duties (minutes, scheduling of meetings, mailouts, etc.)	$48,139		
FRINGE		**$120,664**	
Social Security @ 7.65%	$20,455		
TENTATIVE: Health Insurance (4 x $13,900/FTE)	$55,600		
Retirement @ 14.5%	$38,770		
Workers Compensation @ 0.50%	$1,337		
Supplemental Death Insurance @ 0.50	$1,337		
Unemployment Insurance @ 0.23%	$615		
Incentives/allowances	$2,550		
EQUIPMENT Replace obsolete computers and tablets and purchase equipment needed to allow Ryan White volunteers and students access to virtual meetings	$2,000		

DRAFT

Houston Ryan White Planning Council
FY 2022 Council Support Budget
March 1, 2023 - February 28, 2024
(as of 05-11-22)

		Subtotal	Total
TRAVEL		**$2,800**	
Local Travel: $0.58/mile for Planning Council Support Staff	$800		
Out of EMA travel: Two out of town trips for either Office of Support staff and/or Ryan White volunteers to attend HIV related conferences.	$2,000		
SUPPLIES General consumable office supplies including materials for Council members & public meetings.	$7,109	**$7,109**	
CONTRACTUAL	$0	**$0**	
OTHER		**$122,300**	
HIV Needs Assessment: Expensies related to gathering needs assessment information from 700 consumers and others in the 6-county service area	$19,300		
Reimbursement for Volunteer Expenses: Reimbursement for meals, childcare, travel, gift cards/incentives & other eligible expenses resulting from participation in Council approved/HRSA grant required activities.	$19,000		
Meeting Room Rentals (2-3 meetings per month): Off-site room rentals for Council related meetings. Attendance ranges from 18 - 85 people per meeting.	$6,000		
Advertising for PC Activities: For publication of meeting announcements in community papers; invitations to participate in needs assessment activities and focus groups; advertisments for additional volunteers.	$6,000		
Communications (telephone and computer): For local and long distance phone expenses, equipment and internet charges.	$3,500		
Council Education: For speakers & training costs for ongoing training to insure that key decision-makers receive necessary & relevant information. This includes a January Orientation and a mid-year Council meeting to be held off-site in Harris County.	$4,500		

Houston Ryan White Planning Council
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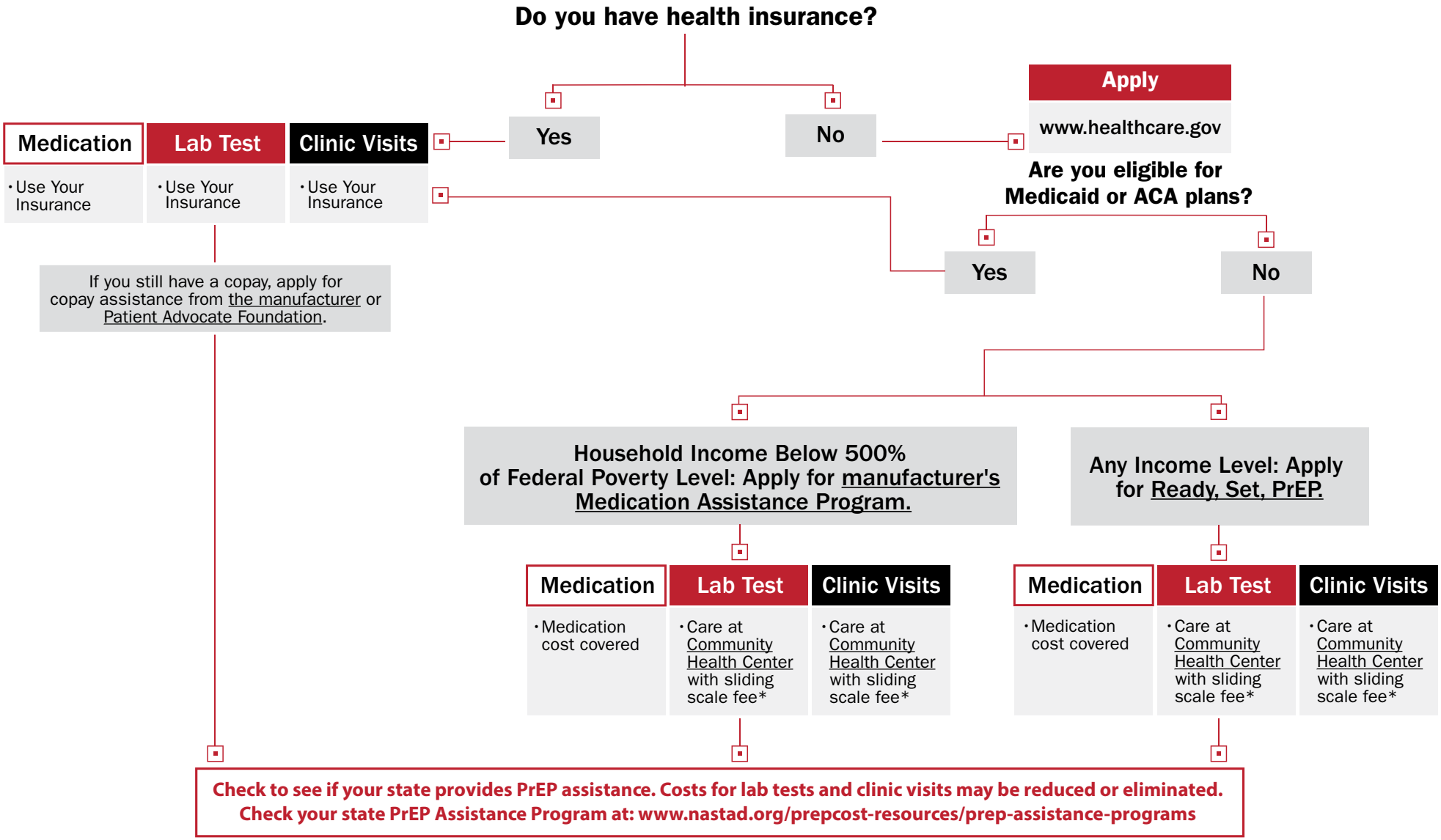
Project LEAP Student Reimbursement: 45 participants for 17-week & 16-week courses including travel, childcare, gift card/incentives & other expenses resulting from participation in required consumer training activities in English and Spanish related to the Ryan White grant.	$9,000	
Project LEAP Education: Training costs for 17 weeks & 16 weeks including facilitation & speaker fees, translators & educational materials in English and Spanish.	$15,000	
Consumer Education: Training costs for up to 5 seminars including speaker fees, translators and educational materials.	$2,500	
Interpreter Services: For Spanish-speaking & sign-language interpretation services during Council meetings, public hearings, focus groups and more.	$13,000	
Fees and Dues: Registration costs for attending meetings, trainings & conferences related to HIV/AIDS health planning.	$500	
English/Spanish Translation (written): For professional translation of Council, Project LEAP & other educational materials into Spanish.	$5,000	
Storage Unit for HIV Resource Directories: Storage for 30,000 directories @ $250/month	$3,000	
Postal Machine Rental & Postage: For mailouts of Committee and Council agendas, minutes and attachments; HIV/AIDS Resource Guides for those who are unable to pickup in person; other office of support communications.	$7,000	
Copier Rental: For rental, service agreement of high-use Xerox machine used for Council and Office of Support.	$9,000	
TOTAL		**$522,255**

FYI

How do I Pay for Pre-Exposure Prophylaxis (PrEP)?



* To find a Community Health Center: findahealthcenter.hrsa.gov

LET'S STOP HIV TOGETHER

Ending the HIV Epidemic

DEPARTMENT OF HEALTH & HUMAN SERVICES READY, SET, PrEP PROGRAM:

The Ready, Set, PrEP program makes PrEP medication available at no cost for qualifying recipients. ***To receive PrEP medication through this program, an individual must:***

- Lack prescription drug coverage
- Be tested for HIV with a negative result
- Have a prescription for PrEP

Individuals or healthcare providers can apply at **https://readysetprep.hiv.gov/**.

KEY TERMS:

ACA - Affordable Care Act
RSP - Ready, Set, PrEP
FPL - Federal Poverty Level
CHC - Community Health Center
PAF - Patient Advocate Foundation

DEFINITIONS:

PrEP: Medication to prevent HIV infection (pre-exposure prophylaxis)

Co-pay: Fixed amount to be paid by insured person per prescription

Co-insurance: Fixed percentage of prescription cost to be paid by insured person

Deductible: Amount of health care cost (including prescriptions) that must be paid by the insured person before insurance begins to cover costs

THE MANUFACTURER'S MEDICATION ASSISTANCE PROGRAM:

People eligible for this program must:

- Be without insurance or have payment declined by their insurance carrier
- Be resident in the US (social security number not required)
- Have family income ≤ 500% of the federal poverty level

PERSONS IN HOUSEHOLD	500% of FEDERAL POVERTY 2020
1	$63,800
2	$86,200
3	$108,600
4	$131,000
5	$153,400
6	$175,800
7	$198,200
8	$220,600

Once enrolled in this program:

- Medication will be sent to the provider, a pharmacy, or the patient's home
- Patients can get their medication at no charge from their provider or pharmacy for as long as they are eligible
- Eligibility must be confirmed every 6 months by the provider

RESOURCES:

PrEP Locator: preplocator.org
Ready, Set, PrEP (RSP): www.readysetprep.hiv.gov/
Affordable Care Act (Obamacare): www.healthcare.gov
Community Health Center Locator: findahealthcenter.hrsa.gov
NASTAD: www.nastad.org/prepcost-resources/prep-assistance-programs
Gilead Advancing Access Program (for co-pay and medication assistance): www.gileadadvancingaccess.com/Patient Advocate
(PAF) Foundation: www.copays.org/diseases/hiv-aids-and-prevention

CDC
LET'S STOP HIV TOGETHER
Ending the HIV Epidemic

This is an official

CDC HEALTH ADVISORY

Distributed via the CDC Health Alert Network
May 20, 2022, 11:30 AM ET
CDCHAN-0466

Monkeypox Virus Infection in the United States and Other Non-endemic Countries—2022

Summary
The Massachusetts Department of Public Health and the Centers for Disease Control and Prevention (CDC) are investigating a confirmed case of monkeypox in the United States. On May 17, 2022, skin lesions that had several features suspicious for monkeypox—firm, well circumscribed, deep-seated, and umbilicated lesions—on a Massachusetts resident prompted specialized Laboratory Response Network (LRN) testing of swab specimens collected from the resident; preliminary testing confirmed the presence of DNA consistent with an orthopoxvirus using Orthopoxvirus generic and non-variola Orthopoxvirus real-time polymerase chain reaction (PCR) assays. This group of viruses includes monkeypox virus (the causative agent of monkeypox). Testing at CDC on May 18 confirmed the patient was infected with a West African strain of monkeypox virus. The patient is currently isolated and does not pose a risk to the public.

Cases of monkeypox have previously been identified in travelers from, or residents of, West African or Central African countries where monkeypox is considered to be endemic. CDC is issuing this Health Alert Network (HAN) Health Advisory to ask clinicians in the United States to be vigilant to the characteristic rash associated with monkeypox. Suspicion for monkeypox should be heightened if the rash occurs in people who 1) traveled to countries with recently confirmed cases of monkeypox, 2) report having had contact with a person or people who have a similar appearing rash or received a diagnosis of confirmed or suspected monkeypox, or 3) is a man who regularly has close or intimate in-person contact with other men, including those met through an online website, digital application (“app”), or at a bar or party. Lesions may be disseminated or located on the genital or perianal area alone. Some patients may present with proctitis, and their illness could be clinically confused with a sexually transmitted infection (STI) like syphilis or herpes, or with varicella zoster virus infection.

Background
Since May 14, 2022, clusters of monkeypox cases, have been reported in several countries that don’t normally have monkeypox. Although previous cases outside of Africa have been associated with travel from Nigeria, most of the recent cases do not have direct travel-associated exposure risks. The United Kingdom Health Security Agency (UKHSA) was the first to announce on May 7, 2022, identification of a recent U.K. case that occurred in a traveler returning from Nigeria. On May 14, 2022, UKHSA announced an unrelated cluster of monkeypox cases in two people living in the same household who have no history of recent travel. On May 16, 2022, UKHSA announced a third temporally clustered group of cases involving four people who self-identify as gay, bisexual, or men who have sex with men (MSM), none of whom have links to the three previously diagnosed patients. Some evidence suggests that cases among MSM may be epidemiologically linked; the patients in this cluster were identified at sexual health clinics. This is an evolving investigation and public health authorities hope to learn more about routes of exposure in the coming days.

Monkeypox is a zoonotic infection endemic to several Central and West African countries. The wild animal reservoir is unknown. Before May 2022, cases outside of Africa were reported either among people with recent travel to Nigeria or contact with a person with a confirmed monkeypox virus infection. However, in May 2022, nine patients were confirmed with monkeypox in England; six were among persons without a history of travel to Africa and the source of these infections is unknown.