2016 Council Attendance

Updated 03-01-16

NUMBER OF COUNCIL MEETINGS HELD IN 2016: 1

Council Members Shaded = retiring from Council on 12/31/16	Number of meetings attended in 2016	Number of meetings unable to attend in 2016
Artiaga, Ted	1	
Atkinson, Ruth	1	
Barnes, Connie	1	
Barr, Melody		
Bellard, Curtis	1	
Benson, David	1	
Boyle, Skeet	1	
Burley, Bianca	1	
Collins-Nelson, Ella	1	
David, Amber	1	
Delgado, Denny	0	1
Escamilla, Evelio	1	
Ethridge, Gene	1	
Finley, Herman	0	1
Gorden, Tracy	1	
Grunenwald, Paul	1	
Harris, Steven	1	
Hawkins, Angela	1	
Johnson, Arlene	0	1
Jones, Hoxi	1	
Lazo, John	1	
Ledbetter, Peta-gay	1	
Miertschin, Nancy	1	
Murray, Allen	1	
Noble, Robert	1	
Patel, Shital	0	1
Pradia, Tana	1	
Pruitt, Teresa	0	1
Raneri, Lesley	1	
Ross, Cecilia	0	1
Sierra, Gloria	1	
Stellenwerf, Stephen	1	
Suazo, Carol	1	
Torrente, Isis	1	
Turner, Bruce	1	
Vargas, Steven	1	
Watson, David	1	
Woods, Bunny	1	

DRAFT

HOUSTON AREA HIV SERVICES
RYAN WHITE PLANNING COUNCIL

<<>>

We envision an educated community where the needs of all HIV/AIDS infected and/or affected individuals are met by accessible, effective, and culturally sensitive health and psychosocial services that are part of a fully coordinated system. The community will continue to intervene responsibly until the end of the epidemic.

The Houston Eligible Metropolitan Area (EMA) Ryan White Planning Council will improve the quality of life and advocate for those infected and/or affected with HIV/AIDS by taking a leadership role in the planning and assessment of HIV resources

AGENDA

12 noon, Thursday, March 3, 2016
Meeting Location: 2223 W. Loop South, Room 532
Houston, Texas 77027

I. Call to Order — Steven Vargas, Chair, RW Planning Council
   A. Welcoming Remarks and Moment of Reflection
   B. Adoption of the Agenda
   C. Approval of the Minutes
   D. Training: Council Jeopardy! — Connie Barnes and Diane Beck
   E. Training: How To Best Meet the Need Process and Training — Robert Noble and Cecilia Ross, Co-Chairs, Quality Improvement Committee

II. Public Comments and Announcements — Carol Suazo, Secretary

(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/AIDS 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/AIDS 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 with HIV/AIDS", 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 the Council Secretary who would be happy to read the comments on behalf of the individual at this point in the meeting. The Chair of the Council has the authority to limit public comment to 1 minute per person. All information from the public must be provided in this portion of the meeting. Council members please remember that this is a time to hear from the community. It is not a time for dialogue. Council members and staff are asked to refrain from asking questions of the person giving public comment.)

III. Reports from Committees
   A. Comprehensive HIV Planning Committee — John Lazo and Nancy Miertschin, Co-Chairs
   Item: Speakers Bureau Workgroup
   Recommended Action: FYI: Lazo reported that the Chamber of Commerce Workgroup has been renamed the Speaker's Bureau Workgroup, and will begin meeting in April, August and December. As of February, 11th, there were six speakers recruited to present on variety of topics, with the goal of adding two alternate speakers in 2016. Six presentations were given in

2015, and three have been scheduled for 2016. Please contact the Office of Support if you wish to be a member of the Workgroup.

Item: Update on the 2016 Needs Assessment
Recommended Action: FYI: The Committee reviewed the 2016 Needs Assessment Sampling Summary through February 11, 2016, see attached.

Item: Update on the 2017 Comprehensive Plan process
Recommended Action: FYI: The Committee reviewed the 2017 Comprehensive Plan Mission and Vision statements, Guiding Principles, Goals and Objectives documents. See attached. Please contact the Office of Support if you are interested in participating on one or more of the Comprehensive Plan Workgroups.

Item: March and April meetings
Recommended Action: FYI: The March and April Comprehensive HIV Planning Committee meetings have been cancelled to allow member participation on the Comprehensive Plan Workgroups, NAG, and the *How to Best Meet the Need* process.

B. Affected Community Committee — Gene Ethridge and Pradia, Co-Chairs

Item: Committee Training
Recommended Action: FYI: See the attached items re: committee training on the purpose of the Council and the role of the committee at public hearings and health fairs. Also questions for role playing at health fairs.

Item: 2016 Greeters
Recommended Action: FYI: See the attached list of 2016 volunteer greeters at monthly Council meetings.

Item: Council Co-Sponsorship
Recommended Action: Motion: It is recommended that the Houston Ryan White Planning Council be a co-sponsor for the HIV and Aging Symposium as outlined in the attached request provided the Council be allowed to have a Ryan White booth at the event.

Item: 2016 Community Events
Recommended Action: FYI: See the attached list of 2016 events at which there will be a Council presence.

C. Quality Improvement Committee — Robert Noble and Cecilia Ross, Co-Chairs

Item: 2016 Reports from Administrative Agent – Part B/SS
Recommended Action: FYI: See the attached 2016 report schedule.

Item: FY 2017 How To Best Meet the Need Workgroup Schedule
Recommended Action: FYI: See the attached schedule. There will be two additional workgroups dedicated to retention in care and serving young MSMs of color. Meeting details to be announced.

Item: Wait List Workgroup
Recommended Action: Motion: Approve the following definition of Wait List Time: The calculation of time from the first appointment given after a request for service until the actual receipt of service. Approve the following definition of Wait List Time: The calculation of time from the first appointment given after a request for service until the actual receipt of service.

D. Priority and Allocations Committee — Peta-gay Ledbetter and Bruce Turner, Co-Chairs

Item: FY 2017 Guiding Principles and Criteria
Recommended Action: Motion: Approve the attached FY 2017 Guiding Principles and Decision Making Criteria.

Item: FY 2017 Priority Setting Process
Recommended Action: Motion: Approve the attached FY 2017 Priority Setting Process.

Item: FY 2016 Policy for Addressing Unobligated and Carryover Funds
Recommended Action: Motion: Approve the attached FY 2016 Policy for Addressing Unobligated and Carryover Funds.

Item: FY 2016 Increase Funding Request Form
Recommended Action: FYI: See the attached, revised Increase Funding Request form. Changes were made to the form in response to information provided in the minutes of the Wait List Workgroup, see attached.

Item: FY 2016 Unspent Funds
Recommended Action: Motion: Send a request for proposals (RFP) for the Legal Assistance service category since the agency receiving Ryan White Part A funds has decline the contract renewal option in the amount of approximately $293,406.

E. Operations Committee — Ruth Atkinson and Curtis Bellard, Co-Chairs

Item: 2016 Texas Open Meetings Act Training
Recommended Action: FYI: If you have never viewed the 60 minute Texas Open Meetings Act video, please see the enclosed flyer. All Council and external committee members are required to view it once in a lifetime and provide the Office of Support with the certificate that proves you took the training. If you have never seen it, or wish to see it again, the Office of Support will be showing it after Council adjourns next week in room 240. Popcorn will be served.

Item: Committee Orientation
Recommended Action: FYI: Per Council policy, members of the Operations Committee signed Statements of Confidentiality forms.

Item: 2016 Council Training Topics
Recommended Action: FYI: See the attached list of 2016 Council training topics.

Item: Council Conflict of Interest Policy and Procedures
Recommended Action: FYI: Committee members spent several meetings reviewing the current Ryan White Planning Council Conflict of Interest policy, the tools being used to manage conflict of interest and a statement made in 2012 by the Harris County Attorney after reviewing the Council policy and procedures against the HRSA Ryan White Part A manual in 2012. Based on the Committee's recent review, it is recommended that no changes be made to the current policy or procedures.

IV. Report from the Office of Support — Tori Williams, Manager

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

VI. Report from The Resource Group — S. Johnson-Fairley, Health Planner

VII. Medical Updates — Shital Patel, MD, Baylor College of Medicine

VIII. New Business (30 seconds/report)

A. Ryan White Part C Urban and Part D — Nancy Miertschin

B. Community Development Advisory Council (CDAC) — Tracy Gorden

C. HOPWA — Melody Barr

D. Community Prevention Group (CPG) — Herman Finley

E. Update from Task Forces:

- African American — S. Johnson-Fairley
- Latino — Steven Vargas
- MSM — Ted Artiaga
- Transgender
- Youth — John Lazo
- Hepatitis C — Steven Vargas
- Sexually Transmitted Infections (STI) — Herman Finley
- Urban AIDS Ministry — Amber David
- Heterosexual HIV Awareness — Ruth Atkinson

F. HIV and Aging — Bruce Turner

G. Texas HIV Medication Advisory Committee — Bruce or Nancy

H. Legislative Updates

I. Texas HIV/AIDS Coalition — Bruce Turner

J. SPNS Grant: HIV and the Homeless Program — Nancy Miertschin

IX. Announcements

X. Adjournment

HOUSTON AREA HIV SERVICES
RYAN WHITE PLANNING COUNCIL

<<>>

We envision an educated community where the needs of all HIV/AIDS infected and/or affected individuals are met by accessible, effective, and culturally sensitive health and psychosocial services that are part of a fully coordinated system. The community will continue to intervene responsibly until the end of the epidemic.

The Houston Eligible Metropolitan Area (EMA) Ryan White Planning Council will improve the quality of life and advocate for those infected and/or affected with HIV/AIDS by taking a leadership role in the planning and assessment of HIV resources.

MINUTES

12 noon, Thursday, February 11, 2016
2223 W. Loop South, Room 532; Houston, Texas 77027

MEMBERS PRESENT	MEMBERS PRESENT	OTHERS PRESENT
Steven Vargas, Chair	Peta-gay Ledbetter	Daniel Harris, TSU SHAPE Initiative
Tracy Gorden, Vice-Chair	Nancy Miertschin	Denis Kelly
Carol Suazo, Secretary	Allen Murray	Alex C. Moses
Ted Artiaga	Robert Noble	Venita Ray
Ruth Atkinson	Tana Pradia	
Connie Barnes	Leslie Raneri	**STAFF PRESENT**
Melody Barr	Gloria Sierra	*Ryan White Grant Administration*
Curtis Bellard	Steven Stellenwerf	Carin Martin
David Benson	Isis Torrente	Heather Keizman
Skeet Boyle	C. Bruce Turner	
Bianca Burley	David Watson	*The Resource Group*
Ella Collins-Nelson	Larry Woods	Sha'Terra Johnson-Fairley
Amber David		
Evelio Salinas Escamilla	**MEMBERS ABSENT**	*Office of Support*
Gene Ethridge	Denny Delgado, excused	Tori Williams
Paul Grunenwald	Herman Finley	Amber Alvarez
Steven Harris	Arlene Johnson	Diane Beck
Angela F. Hawkins	Shital Patel, excused	
J. Hoxi Jones	Teresa Pruitt, excused	
John Lazo	Cecilia Ross, excused	

Call to Order: Steven Vargas, Chair, called the meeting to order at 12:04 p.m.

During the welcoming remarks, Vargas welcomed everyone to the first 2016 Council meeting and stated that attendance is an important part of being commitment to the Council. All must do everything possible to make meetings worth our valuable time. Vargas extended thanks to the members of the Operations Committee who did a fabulous job organizing and hosting the 2016 all-day Council Orientation and thanked everyone who helped with the three Road 2 Success classes. It was a great success, see the enclosed evaluation report. He also thanked everyone who is participating in the NAG, the Leadership Team for the Comprehensive Plan and their workgroups. There continues to be

a robust turnout at all of the meetings and the Council looks forward to receiving and using these important documents. Kevin Moore has resigned from the Planning Council. He has been a dedicated member for over 5 years and we will miss his valuable input.

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

Approval of the Minutes: ***Motion #2****: it was moved and seconded (Harris, Escamilla) to approve the December 3, 2015 minutes.* **Motion carried.** Abstentions: Barnes, David, Pradia, Sierra, Stellenwerf, Torrente.

Training: The Open Meetings Act: Venita Ray, Legacy Community Health, presented the attached PowerPoint.

Public Comment and Announcements: None.

Reports from Committees:
Comprehensive HIV Planning Committee: John Lazo, Co-Chair, reported on the following:
Chamber of Commerce Workgroup: Six presentations were scheduled in 2015, all well attended. Sites included three rotary clubs, one Chamber of Commerce, one professional African American women's group, and one not-for-profit business. Potential new topics will be determined after the Committee has had an opportunity to meet and discuss. As of today, 3 speaking engagements for 2016 have been confirmed. Miertschin said that the name of the workgroup will be changed to the Speakers Bureau Workgroup.

Nancy Miertschin, Co-Chair, reported on the following:
2012 Comprehensive Plan Year 3 Evaluation Report: The Committee reviewed the 2012 Comprehensive Plan Year 3 Evaluation Report. The report includes progress on the implementation of the Comprehensive Plan through the end of 2014. Since the Committee reviewed the report, an adjustment has been made to the calculation for 2014 retention in care on the HIV Treatment Cascade that appears on page 9.

2012 Comprehensive Plan Year 3 Evaluation Report: ***Motion #3:*** *Accept the attached 2012 Comprehensive Plan Year 3 Evaluation Report.* **Motion carried**. Abstentions: Noble, Pradia

2017 Comprehensive Plan Update: The Leadership Team met December 2, 2015 and January 13, 2016 and developed mission and vision statements, guiding principles, and goals for the 2017 plan. The Leadership Team will meet again February 3, 2016 to complete development of plan objectives. The Comprehensive Plan workgroups also met throughout December and January. See the attached foundational documents as well as the list of workgroups and their meeting dates. Please contact the Office of Support if interested in participating on a workgroup.

2016 Needs Assessment Update: The Needs Assessment Group met December 16, 2016 to approve the 2016 Needs Assessment sampling plan and survey tool. Surveying began January 23, 2016. As of January 28th, 15 completed surveys had been collected. See the attached sampling plan and survey tool.

2016 Committee Goals: The Committee updated its goals for 2016. See the attached 2016 Committee Report for 2016 Committee Goals.

2015 Committee Goal Quarterly Report: See the attached 2015 Committee Goal Quarterly Report.

Affected Community Committee: No report.

Quality Improvement Committee: No report.

Priority and Allocations Committee: No report

Operations Committee: Curtis Bellard, Co-Chair, reported on the following.
2016 Council Orientation: The Operations Committee hosted the 2016 Council Orientation on January 21, 2016.

Report from Office of Support: Tori Williams, Manager, 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-Fairley summarized the attached report.

Medical Updates: Miertschin said that several Council members attended the PrEP summit on Friday, February 5, 2016 that was coordinated by Dr. Patel and included 3 additional physicians from Baylor College of Medicine. Topics included PrEP 101, PrEP for women and pre-conception planning for women with HIV. It was good information and would be good for the Council if we could get a shorter version. Vargas said that he spoke to Dr. Patel after the summit about getting a shorter version presented at a Council meeting. Turner said it might be good information for the Comprehensive Plan Leadership Team as well. Burley asked if there were updates on the Zika virus. Grunenwald said the only thing he has heard is that it is recommended to use a condom if you have sex with someone who recently visited the region where the virus comes from. Dr. Harris said that people coming from the region should not donate blood for a month after they return.

New Business:
Ryan White Part C Urban and Part D: Miertschin reported that a new Medical Case Manager was hired at the Northwest Health Center for Part C. The Part D non-compete application is due in March. They will be sending a representative for Part C, Part D and the SPNS project to the Ryan White grantee meeting in Washington, DC this August.

Community Development Advisory Council: Gorden said that the most recent meeting was the same day as Council Orientation so he did not attend.

HOPWA: Barr said that the HOPWA formula has changed to living cases and they hope this means more funding for the Houston area. They will know in March.

Updates from Task Forces:

- **African American:** Johnson-Fairley said that they meet every 2nd Friday of the month. For African American HIV Awareness Day they went to Sunnyside to distribute condoms and information and Change Happens did HIV testing.
- **Latino:** Vargas presented the attached report.
- **MPact:** Artiaga said that they were have scheduled testing events in February for Valentine's Day and the rodeo. They will not do testing during Pride month but will instead focus on PrEP education.
- **Youth:** Lazo reported that they will have a health fair event on April 8, 2016 at Madison High School from 9:15 am until 12:00 pm. The next task force meeting is on March 8, 2016.
- **Hepatitis C:** Vargas presented the attached report.

- **Heterosexual HIV Awareness:** Atkinson presented the attached report.

HIV and Aging: Turner presented the attached report. He stated that they are planning a symposium for the Fall of 2016 and the group is looking for a grant writer.

Texas HIV Medication Advisory Committee: Turner said that the March 4, 2016 meeting is being rescheduled.

Legislative Updates: Leo said that Election Day for the runoff is this Saturday, December 12th. Legacy Community Health received a grant for the end of AIDS from AIDS United and The Ford Foundation. This information will be useful for the Comprehensive Plan.

SPNS Grant: HIV and the Homeless Program: Miertschin reported that recruitment ended February 1, 2016 and Houston has had the highest number of enrollees of all the sites – 158 participants. This grant project has only one more year after September 2016.

Announcements: Jones distributed two handouts: one of form 1095-B and one about managed care for disabled kids age 21 and under. Gorden thanked everyone who helped with the Road 2 Success classes.

Adjournment: The meeting was adjourned at 1:40 p.m.

Respectfully submitted,

_____ _____

Victoria Williams, Manager Date

Draft Certified by
Council Chair: _____ Date _____

Final Approval by
Council Chair: _____ Date _____

Council Voting Records for February 11, 2016

C = Chair of the meeting lm = Left the meeting lr = Left the room VP = Via phone	**Motion #1** Agenda **Carried**				**Motion #2** Minutes **Carried**				**Motion #3** Comp Plan Year-3 Evaluation Report **Carried**					**Motion #1** Agenda **Carried**				**Motion #2** Minutes **Carried**				**Motion #3** Comp Plan Year-3 Evaluation Report **Carried**			
MEMBERS	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	MEMBERS	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN
Steven Vargas, Chair				C				C				C	Nancy Miertschin		X				X				X		
Tracy Gorden, Vice-Chair		X				X				X			Allen Murray	X				X					X		
Carol Suazo		X				X				X			Robert Noble	X				X							X
Ted Artiaga		X				X				X			Tana Pradia		X						X				X
Ruth Atkinson		X				X				X			Leslie Raneri	X				X					X		
Connie Barnes		X						X		X			Gloria Sierra		X						X		X		
Melody Barr		X				X				X			Steven Stellenwerf		X						X		X		
Curtis Bellard		X				X				X			Isis Torrente		X						X		X		
David Benson		X				X				X			C. Bruce Turner		X				X				X		
Skeet Boyle		X				X				X			David Watson		X				X				X		
Bianca Burley arrived 12:20 pm	X				X					X			Larry Woods ja 1:13 pm	X				X				X				
Ella Collins-Nelson		X				X				X															
Amber David		X						X		X															
Evelio Salinas Escamilla		X				X				X															
Gene Ethridge		X				X				X			**MEMBERS ABSENT**												
Paul Grunenwald		X				X				X			Denny Delgado												
Steven Harris		X				X				X			Herman Finley												
Angela F. Hawkins		X				X				X			Arlene Johnson												
J. Hoxi Jones		X				X				X			Shital Patel												
John Lazo		X				X				X			Teresa Pruitt												
Peta-gay Ledbetter		X				X				X			Cecilia Ross												

What is the "How To Best Meet the Need" process?

Council members use data from needs assessments, client utilization reports, alternative funding sources and more to design services that are within HRSA guidelines and best meet the needs of the local consumers.

- MARCH 22: The Affected Community Committee hosts a training for consumers and others on the How To Best Meet the Need process.
- APRIL 14: Members of all committees are invited to come together to review information about service needs and alternative funding sources. The training starts at 1:30 pm, immediately after the April Council meeting adjourns.
- **NEW**: APRIL 19: In 2016, the Council will host two special workgroups to address issues of concern that impact many services. At 10 am there will be a special workgroup to discuss ways to improve retention in care. At 1 pm there will be a special workgroup to look at ways to get and keep young men who have sex with men (MSMs) of color in care. All are welcome to attend.
- APRIL 26 and 27: The Quality Assurance Committee hosts workgroups where all members of the community are invited to review each Ryan White funded service and recommend:
  - If the service should be funded with Ryan White dollars.
  - If the service needs to be changed so that it will better meets the needs of local consumers.
  - The financial eligibility for that service.

  Over for the How To Best Meet the Need workgroup schedule.

  All who attend the workgroup meetings must declare their conflict of interest and, although agencies can send more than one staff person to participate in the workgroup, only one agency representative can vote. No one can vote on a particular service category if they have a conflict of interest with that service category.

EXAMPLE OF A HRSA SERVICE CATEGORY:

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.

FY 2017 *HOW TO BEST MEET THE NEED* WORKGROUP SCHEDULE *(Revised 03/01/16)*

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

TRAINING FOR ALL PARTICIPANTS:

1:30 p.m. ~ Thursday, April 14, 2016 ~ 2223 West Loop South, Room 532

SPECIAL WORKGROUPS:

Tuesday, April 19, 2016 ~ 10 a.m. Retention in Care ~ 1 p.m. Young MSMs of Color
2223 West Loop South, Room 416

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

Workgroup 1	***Workgroup 2***	***Workgroup 3***	***Workgroup 4***
10:30 a.m. **Tuesday, April 26, 2016** Room #532	**1:30 p.m.** **Tuesday, April 26, 2016** Room #532	**3:00 p.m.** **Wednesday, April 27, 2016** Room #416	**11:00 a.m.** **Tuesday, May 17, 2016** Room #240
Group Leaders: Skeet Boyle & Gloria Sierra	**Group Leaders:** Robert Noble & Isis Torrente	**Group Leaders:** Cecilia Ross & Steve Stellenwerf	**Group Leaders:** Ruth Atkinson & Curtis Bellard
SERVICE CATEGORIES:	***SERVICE CATEGORIES:***	***SERVICE CATEGORIES:***	***SERVICE CATEGORIES:***
Ambulatory/Outpatient Medical Care (includes Local Pharmacy Assistance, Medical Case Management and Service Linkage) – Adult and Rural	Health Insurance Premium & Co-pay Assistance	Early Intervention Services (Incarcerated)‡	Blue Book
Ambulatory/Outpatient Medical Care (includes Medical Case Management and Service Linkage) – Pediatric Only	Home & Community-based Health Services (Adult Day Treatment)‡	Legal Assistance	
Clinical Case Management	Hospice	Transportation (Van-based – untargeted & rural)	
Non-Medical Case Management (Service Linkage at Test Sites)	Linguistic Services‡		
Vision Care	Medical Nutritional Therapy and Supplements		
	Mental Health Services (Professional Counseling)‡		
	Oral Health – Rural & Untargeted‡		
	Substance Abuse Treatment/ Counseling		

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

‡ Service Category for Part B/State Services only; Part B/State Services categories are RFP'd every year. **To confirm information for Part B/State Services, call 713 526-1016.**

Comprehensive HIV Planning Committee Report

Houston Area HIV Services Ryan White Planning Council
Comprehensive HIV Planning Committee

2016 Houston Area HIV/AIDS Needs Assessment
Sampling Summary
February 11, 2016

1. Overall Sample Size

	Minimum	Maximum
Sample Size Goal	587	1,024
Current Sample Size	26	26
Percent of Goal	4%	3%

2. Rural Representation

	Goal	Current
Harris County	92%	54%
Non-Harris County	8%	46%

3. Out-of-Care Representation

	Goal	Current
In-Care	75%	100%
Out-of-Care	25%	0%

4. Demographic Proportions

	Goal	Current
Male	75%	62%
Female	25%	35%
White	21%	27%
Black	49%	54%
Hispanic	27%	8%
18 – 24	5%	8%
25 – 49	59%	50%
50+	35%	42%
MSM	55%	42%
IDU	11%	0%
Heterosexual	30%	46%

5. Special Populations

	Current
Rural*	0%
Out of care	0%
Unstable housing	35%
IDU	0%
MSM	42%
Recently Released	4%
Transgender	4%

* Residing in Wharton, Colorado, Austin, or Walker County

2017 Comprehensive Plan Vision and Mission

(Approved by the Leadership Team 12-02-15)

Vision

The greater Houston Area will become a community with an enhanced system of HIV prevention and care. New HIV infections will be reduced to zero. Should new HIV infections occur, every person, regardless of sex, race, color, ethnicity, national origin, age, familial status, marital status, military status, religion, disability, sexual orientation, genetic information, gender identity, pregnancy, or socio-economic circumstance, will have unfettered access to high-quality, life-extending care, free of stigma and discrimination.

Mission

The mission of the Houston Area Comprehensive HIV Prevention and Care Services Plan for 2017-2021 is to work in partnership with the community to provide an effective system of HIV prevention and care services that best meets the needs of populations living with, affected by, or at risk for HIV.

2017 Comprehensive Plan Guiding Principles

(Approved by the Leadership Team 12-02-15)

Guiding Principles

The development of the 2017 Comprehensive Plan will be guided by 10 core principles; that the plan and planning process will:

1. Fully integrate the perspectives, needs, and priorities of both HIV prevention and HIV care.

2. Align with local, state, and national HIV prevention and care plans and initiatives.

3. Be cognizant of changes occurring in the national health care delivery system resulting from the *Patient Protection and Affordable Care Act of 2010* and the Ryan White HIV/AIDS Treatment Extension Act.

4. Assess strategies, including those used internationally, that have effectively reduced HIV infection and could be implemented locally.

5. Assure that federal expectations for Houston Area comprehensive planning and the required deliverables are met while still allowing new or emerging critical areas of need and innovation to be considered.

6. Produce Specific, Measurable, Achievable, Realistic, and Time-phased (SMART) objectives that can be used to guide priority-setting, resource allocation, scopes of work, quality improvement, and other decision-making activities of the Houston Area planning bodies and administrative agents.

7. Balance the need to be comprehensive, data-driven, and reflective of new science, theory, and models with the need for efficiency in regards to resources and timelines.

8. Recognize the importance of and provide opportunities for participation by non-AIDS-service organizations and other non-traditional partners.

9. Honor the populations most impacted by HIV, including the underserved in response to the epidemic's impact on minority and hard-to-reach populations, and those who are uniquely vulnerable to HIV infection due to social, economic, cultural, or structural barriers.

10. Engage with and ensure that people living with and at risk for HIV as well as consumers of prevention and care services have a central voice, clear understanding, and full involvement throughout the process.

2017-2021 Comprehensive Plan Goals & Objectives

(Approved by the Leadership Team 02-03-15)

Goals

To make progress toward an ideal system of HIV prevention and care for the Houston Area, we must:

1. Increase community mobilization around HIV in the Greater Houston Area
2. Prevent and reduce new HIV infections
3. Ensure that all people living with or at risk for HIV have access to early and continuous HIV prevention and care services
4. Reduce the effect of co-occurring conditions that hinder HIV prevention behaviors and adherence to care
5. Reduce disparities in the Houston Area HIV epidemic and address the needs of vulnerable populations
6. Increase community knowledge around HIV in the Greater Houston Area.

Objectives

By 2021, we hope to accomplish the following:

1. Reduce the number of new HIV diagnoses in the Houston Area by at least 25 percent (from 1,338 to 1,004).
2. Maintain and, if possible, increase the percentage of individuals with a positive HIV test result identified through *targeted* HIV testing who are informed of their HIV+ status (beginning at 94.4 percent).
3. Increase the proportion of newly-diagnosed individuals linked to clinical HIV care within one month of their HIV diagnosis to at least 85 percent (from X.X percent).

4.1 Reduce the percentage of new HIV diagnoses with an AIDS diagnosis within one year by at least 25 percent (from 25.9 percent to 19.4 percent).

4.2 Reduce the percentage of new HIV diagnoses with an AIDS diagnosis within one year among Hispanic/Latino men age 35 and up by at least 25 percent (from X.X percent to X.X percent).

5. Increase the percentage of Ryan White HIV/AIDS Program clients who are in continuous HIV care (at least two visits for HIV medical care in 12 months at least three months apart) to at least 90 percent (from 75 percent).
6. Increase the percentage of individuals with diagnosed HIV infection in the Houston Area who are retained in HIV medical care (at least two documented HIV medical care visits, viral load or CD4 tests at least three months apart) to at least 90 percent (from 61.2 percent).
7. Maintain and, if possible, increase the proportion of Ryan White HIV/AIDS Program clients who are virally suppressed (beginning at 80.4 percent).
8. Increase the percentage of individuals with diagnosed HIV infection in the Houston Area who are virally suppressed to at least 80 percent (from 55 percent)
9. Provide PrEP awareness education to at least 2,000 gay and bisexual men of color and females of color each year

Suggested staff revision: Increase the number of gay and bisexual men of color and women of color receiving pre-exposure prophylaxis (PrEP) education to at least 2,000 (beginning at X)

Affected Community Committee Report

Affected Community Committee Training

Purpose of the Planning Council
Participation in Health Fairs
Purpose of Public Hearings

February 23, 2016

Purpose of the Planning Council

- Ryan White's legacy
  - Advocacy
  - Providers
  - Services
  - Educators

Purpose of the Planning Council

- What does the Planning Council do?
  - Reviews data about HIV services
  - Decides which services are provided for persons living with HIV/AIDS in the Houston HSDA
  - Makes a list of the most important services
  - Decides how much money goes to these services
  - Conducts a Needs Assessment
  - Creates a plan to improve HIV services in Houston

Purpose of the Planning Council

- What does the Planning Council NOT do?
  - Review grant applications from agencies
  - Decide which agencies in Houston get money
  - Hire and fire staff at agencies
  - Respond to complaints from consumers about specific agencies
  - Write letters to politicians in Washington
  - March at protests
  - Conduct HIV prevention
- HRSA sets the rules for Planning Councils
  - HRSA says Planning Councils can only focus on services, not specific agencies.
  - The Administrative Agency (Carin's office) monitors grants and agencies.

Participation in Health Fairs

- Tell the public about what the Ryan White Planning Council does
- Tell the public about services by giving out the Blue Book
- Tell the public how to volunteer with the Planning Council

- Give out condoms or HIV prevention materials
- Do HIV prevention
- Tell the public about specific agencies

Purpose of Public Hearings

- Twice a year
- Inform the community about recommended changes that the Planning Council will decide upon.
- Get feedback from consumers of Ryan White services as to how the recommended changes will affect their ability to receive care and support services.
- Community input is vital to all of the Planning Councils processes and is encouraged at every level.
  - Public Hearings are televised to help all PLWHAs participate in the planning process – especially PLWHAs who cannot travel to Planning Council meetings

Affected Community Committee

Questions for Role Playing

(as of 02-24-15)

1. **Who is Ryan White?**

   ANSWER: See the attached description of Ryan White.

   Key words: Indiana teenager
   Hemophiliac with AIDS
   Not allowed to attend school because of his AIDS status
   Became a celebrity by asking for respect, compassion & the chance to live normally
   Died in 1990 - the year Congress named the CARE Act after him

2. **What does the Ryan White Program do?**

   ANSWER: The Ryan White Program is a Federal law that provides funds for local communities to develop and pay for core medical services for people already infected with HIV.

   Key words: Law created by Congress/Federal law
   $20 million/year for the Greater Houston area (Harris and surrounding counties)
   Provides medical services for people living with HIV/AIDS
   Services include: primary medical care, drugs, dental care, mental health care, substance abuse treatment and case management.

3. **What does the Ryan White Planning Council do?**

   ANSWER: The Planning Council is a group of 39 volunteers appointed by Judge Ed Emmett who are responsible for:

   a.) Assessing the needs of PLWH/A (Needs Assessment & special studies)
   b.) Deciding which services are the most important (prioritizing services)
   c.) Creating a community plan to meet these needs (Comprehensive Plan)
   d.) Deciding how much money should be assigned (allocated) to services funded by Ryan White Parts A and B and State Services money.

   Key words: Design the system of care for people who are living with HIV/AIDS
   Allocate funds to address the medical needs of PLWHAs

4. **How much money can I get?**

   ANSWER: If you get medical care, drugs or case management services from places like Thomas Street Health Center, Legacy Community Health Services, HACS, or St. Hope Foundation then Ryan White dollars are probably paying for those services.

   Key words: You get it through the services you receive.

5. **Why did the Council take away or cut back on the _____ program, etc?**

   ANSWER: In 1990, Congress was not as strict about how Ryan White funds could be used. AND, people were also dying within six months of diagnosis. Now, because the drugs are better, more people are living longer and they have a better quality of life. But, the drugs are expensive and Congress is not allocating enough money to keep

up with the number of people who are newly coming into care or living with the disease 10, 20 years. The purpose of the Ryan White Program has always been to get people into medical care. In the last couple of years Congress has become more restrictive in the use of the funds. The Council risks losing funds if they do not allocate 75% of all the money to core medical services (drugs, primary care, dental care, mental health care, substance abuse treatment and case management) and they must allocate the other 25% of the funds to things like transportation to and from medical appointments.

Key words: People with HIV/AIDS are living longer
Fewer dollars available to care for more and more people
Purpose of the money is to provide MEDICAL care

6. Are you positive?

ANSWER: That is a personal question and I don't talk about my personal health with strangers (people I don't know well). OR, if I am, does it matter? OR, Why is it of interest to you? The important thing is for all people to be tested and know their own status.

Key words: None of your business OR
I do know my status, do you know yours?

7. Where do I get help?

ANSWER: The Blue Book lists services available to people with HIV/AIDS in the 10-county area. Let's look up case management and I will show you where someone can go to get a social worker that will help a PWA get services they are eligible for.

Key words: The Blue Book

8. How can I sign up to be an HIV/AIDS volunteer?

ANSWER:
1.) If you want to work one-on-one with PLWHAs, look in the Blue Book under "Volunteer Opportunities" (page 86) and call any of the agencies listed.
2.) To apply to become a member of the Ryan White Planning Council you can:
   a.) Fill out a yellow application form to become an external committee member. If there is a vacancy and you are assigned to a committee, you will be asked to attend a meeting approximately once a month.
   b.) Fill out a green application form to apply to become a member of the Planning Council. If there is a vacancy and Judge Emmett appoints you to the Council you will have to attend monthly Council meetings and at least one monthly committee meeting. It can take many years to be appointed to the Council and sometimes there are not enough vacancies to appoint an applicant. So, we recommend that you apply for both and get to know how the Council works through your involvement on a committee.

Key words: Do you want to work one-on-one with clients or design the system that serves 11,000 clients?

Who was Ryan White?

Ryan White was born December 6, 1971 in Kokomo, Indiana. At three days old he was diagnosed with severe Hemophilia and doctors began treating his condition with a new clotting medication that was made from blood. In December 1984, while in the hospital with pneumonia, Ryan was diagnosed with AIDS – at some point he had been infected with HIV by a tainted batch of medication. His T-cell count was 25.

Ryan on ABC News with Ted Koppel

When his health improved he wanted to return to school, but school administrators voted to keep him out for fear of someone getting AIDS. Thus began a series of court battles lasting nine months, while Ryan attended class by phone. Eventually, he won the right to attend school but the prejudice was still there. He was not welcome anywhere, even at church.

The controversy brought him into the spotlight and he became known as the 'AIDS boy'. Many celebrities supported his efforts. He made numerous appearances around the country and on television promoting the need for AIDS education to fight the stigma faced by those infected by the disease; his hard work resulted in a number of prestigious awards and a made for TV movie.

Ryan at home with his mother, Jeanne, in 1987

For the most part, Ryan was a normal, happy teenager. He had a job and a driver's license, he attended sports functions and dances and his studies were important to him. He looked forward to graduating high school in 1991.

On April 8, 1990, Ryan passed away at Riley Hospital for Children in Indianapolis. He was 18 years old.

In honor of this courageous young man, the United States Congress named the federal law that authorizes government funds for medical care to people living with HIV and AIDS the Ryan White Care Act.

Since 1990, the Houston area has received over $300 million in Ryan White Program funds.

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

What is Project L.E.A.P.?

Project LEAP is a free 17-week class that teaches people how they can help plan for and design the HIV prevention and care services that are provided in the greater Houston area. The class is open to everyone, especially those who are HIV positive.

The goal is to train people living with HIV/AIDS so that they can participate in local HIV/AIDS planning activities by serving on a planning body, such as the Ryan White Planning Council or the City of Houston HIV Prevention Community Planning Group (CPG).

What will I Learn?

Some of the topics covered in class include:

- Parliamentary Procedure (Robert's Rules of Order)
- HIV 101
- The History of HIV in the Houston Area
- HIV trends in the Houston area for populations such as African Americans, Hispanics, Women, Youth, Heterosexuals, Transgender, etc.
- HIV trends in the Houston area and available services for people with mental health issues, substance abuse issues, the homeless and the incarcerated/recently released.
- HIV and Co-infections, HIV and Chronic Diseases, HIV and Stigma
- Designing HIV Services
- The Ryan White Program Service Prioritization and Funding Allocation Process
- HIV Prevention in the Houston Area

Additional class activities may include:

- Attend a Ryan White Planning Council and Committee meeting.
- Attend an HIV Prevention Community Planning Group (CPG) Meeting.
- Attend a community meeting of your choice.
- Leadership skills and team building.
- Introduction to National, State, and Local HIV plans.
- Class Needs Assessment project and presentation to the Planning Council.

When Does the Class Meet?

Wednesdays, 10:00 am – 2:00 pm OR 5:30 pm – 9:30 pm

Lunch or dinner will be provided. Assistance with transportation and child care is available.

How Do I Apply?

A brief application and in-person interview are required. Applications are available by mail, fax, email, and can also be picked up in person or completed online.

If you have questions about Project L.E.A.P. or the application process, please contact the Ryan White Planning Council Office of Support at 713-572-3724 or visit www.rwpcHouston.org

Greeters for 2016 Council Meetings

(Revised: 02-23-16)

Meeting Dates (**Please arrive at 11:45 a.m.** Unless otherwise noted, the meetings are held at 2223 W. Loop South)	**Greeter #1** External Member	**Greeter #2**	**Greeter #3**
Thurs. March 10	Viviana Santibanez	Teresa Pruitt	Arlene Johnson
Thurs. April 14	Johnetta Evans Thomas	Gene Ethridge	Allen Murray
Thurs. May 12	Lionel Pennamon	Gene Ethridge	Teresa Pruitt
Thurs. June 9 **Off-Site Location:**	Johnetta Evans Thomas	Allen Murray	Teresa Pruitt
Thurs. July 14			
Thurs. August 11			
Thurs. September 8			
Thurs. October 13			
Thurs. November 10 External Committee Member Appreciation			
Thurs. December 8			

CO-SPONSORSHIP REQUEST

TO: The Ryan White Affected Community Committee

FROM: HIV and Aging Coalition

DATE: Monday, February 22, 2016

Established in August of 2013 the HIV and Aging Coalition was formed to address major issues impacting those over 50 living with HIV. Monthly we hold educational meetings to reach our community and those that serve us. This year on September 16, 2016 we are hosting a Symposium on HIV and Aging, at the Montrose Center. The full day event will feature National, State and Local speakers addressing social, psychological and medical issues pertinent to aging with HIV.

We will be collaborating with AETC to help guarantee a relevant and successful event, where appropriate CEU's and CME's will be available. If the RWPC agrees to a co-sponsorship we will follow all council guidelines including volunteer assistance, blast fax notifications, etc.

The HIV and Aging Coalition is not as an organization funded by the RW program but we do agree with the goal of educating the public and those living with HIV about the disease.

Thank you for the consideration,

C. Bruce Turner

HOUSTON AREA HIV HEALTH SERVICES
RYAN WHITE PLANNING COUNCIL

EST. JUL 7, 2001 **REV MAY 14, 2009** **POLICY No. 300.01**

LETTERS OF SUPPORT, BUSINESS CARDS AND EVENT CO-SPONSORSHIP

PURPOSE

This policy is to establish the roles and responsibilities of the Ryan White Planning Council when interacting with other organizations, determining events that will be co-sponsored by the Council and determining if a letter of support can be provided by the Council.

AUTHORITY

The authority given to the Operations Committee by the council adoption and approval of By-laws Rev. 12/07 and under the order of the Chief Elected Official (CEO) of Harris County, initiates procedures by which day to day business of the Council is to take place.

BUSINESS CARDS

The Council will have two types of business cards: 1.) As the only authorized spokesperson for the Council, the Chair will have a business card that includes his/her name. 2.) For all other members of the Council, the staff will prepare one generic card that explains how to contact the Office of Support and does not include personal identifying information.

LETTERS OF SUPPORT

When appropriate, letters of support will be written collaboratively between the Council Chair and the Office of Support.

PROCESS

EVENT CO-SPONSORSHIP

The Ryan White Planning Council will consider co-sponsorship of an event when the following has happened:

- Ninety-day advance notice is given so that the Council can review information about the event.
- When the 90-day advance notice is not possible, the Affected Community Committee is authorized to make a recommendation to the Planning Council regarding co-sponsorship of the event.
- Events relating to a State of Emergency will take precedence over other events.

At appropriate Ryan White Planning Council approved events, a booth/table will be set up to distribute information about Council activities as well as applications for Council membership.

If the sponsoring organization requests the use of a Council logo or permission to add the Council's website link to the sponsoring organization's website, the following applies. The Council does not have a logo and is not authorized to use the Harris County logo. Adding the Council's website link to the sponsoring organization's website can only be done when the Chair of the Planning Council and the Manager of the Office of Support have provided written approval for 1.) Adding the link to the other organization's website and 2.) The text describing the link to the Council's website. If the sponsoring agency requests that their logo or website link be added to the Council's website, the Council will only include the agency's website address within the electronic version of the Blue Book which is posted on the Council's website.

Affected Community Committee
2016 Community Events (as of 02-15-16)

Point Person (PP): Committee member who picks up display materials and makes sure they are returned to the Office of Support.

Day, date, times	Event	Location	Participants
Sunday, March 6 1pm-Walk	AIDS Foundation Houston (AFH) AIDS Walk	Houston Park Downtown-1100 Bagby Street, 77002	Allen Murray will distribute Project LEAP flyers.
April date TBD	Gay Men's Health Summit	Hiram Clarke Multi Service Center	Teresa (PP), Curtis, Allen, Cecilia, Arlene
Friday, May 6 6 – 9 pm	Houston Splash Town	Double Tree Hotel – Galleria	Allen, Teresa, Curtis, Arlene, Cecilia **PP: _____**
Saturday, June 25 Noon – 7:00 pm	Pride Festival	Downtown near City Hall	**Need Min. of 7 Volunteers** Tana, John L., Gene , Allen, Teresa, Arlene, Johnetta (1st shift) PP(s) : Arlene, Teresa, Curtis B.
PENDING APPROVAL Friday, September 16	HIV and Aging Symposium	Montrose Center	
October	Road 2 Success		
October	MISS UTOPIA		**Need 3 volunteers**
Tuesday, December 1	**World AIDS Day Events**		Most committee members attend events
January 2017	**Road 2 Success**		

Quality Improvement Committee Report

2016 RWPC Service Utilization Report Due

State Services Contract Years	Ryan White Part B Contract Years
Year 1: 9/1/15 - 8/31/16 Year 2: 9/1/16 - 8/31/17	Year 1: 9/1/15 - 3/31/16 Year 2: 4/1/16 - 3/31/17

2015 Annual Chart Review Reports
Delivered to QI Committee

March 2016

All Monthly & Quarterly Reports delivered on a one-month delay to allow the finalization of data.

Health Insurance Assistance (HIA) Reports
Delivered to QI Committee

Monthly

Service Utilization Reports
Delivered to QI Committee

State Services Service Utilization Reports	
Months Covered	Month Due
September – November	January
September – February	April
September – May	July
September – August	October
Ryan White Part B Service Utilization Reports	
Months Covered	Month Due
September – November	January
September – March	May
April – June	August
April – September	November

Procurement Reports
Delivered to QI Committee

Monthly

Priority and Allocations Committee Report

Priority and Allocations
FY 2017 Guiding Principles and Decision Making Criteria

(Priority and Allocations Committee approved 02-25-16)

Priority setting and allocations must be based on clearly stated and consistently applied principles and criteria. These principles are the basic ideals for action and are based on Health Resources and Services Administration (HRSA) and Department of State Health Services (DSHS) directives. All committee decisions will be made with the understanding that **the Ryan White Program is unable to completely meet all identified needs** and following legislative mandate **the Ryan White Program will be considered funding of last resort.** Priorities are just one of many factors which help determine allocations. All Part A and Part B service categories are considered to be important in the care of people living with HIV/AIDS. Decisions will address at least one or more of the following principles **and** criteria.

Principles are the standards **guiding the discussion** *of all service categories to be prioritized and to which resources are to be allocated. Documentation of these guiding principles in the form of printed materials such as needs assessments, focus group results, surveys, public reports, journals, legal documents, etc. will be used in highlighting and describing service categories (individual agencies are not to be considered). Therefore decisions will be based on service categories that address the following principles, in no particular order:*

Principles

A. Ensuring ongoing client access to a comprehensive system of core services as defined by HRSA
B. Eliminating barriers to core services among affected sub-populations (racial, ethnic and behavioral) and low income, unserved, underserved and severe need populations (rural and urban)
C. Meeting the needs of diverse populations as addressed by the epidemiology of HIV
D. Identify individuals unaware of their status and link them to care and address the needs of those that are aware of their status and not in care.
E. Expressing the needs of the communities with HIV for whom the services are intended

Allocations only

F. Documented or demonstrated cost-effectiveness of services and minimization of duplication
G. Availability of other government and non-governmental resources, including Medicaid, Medicare, CHIP, private insurance and Affordable Care Act related insurance options, local foundations and non-governmental social service agencies

Criteria are the standards on which the committee's decisions will be based. Positive decisions will only be made on service categories that satisfy at least one of the criteria in Step 1 and all criteria in Step 2. Satisfaction will be measured by printed information that address service categories such as needs assessments, focus group results, surveys, reports, public reports, journals, legal documents, etc.

(Continued)

DECISION MAKING CRITERIA STEP 1:

A. Documented service need with consumer perspectives as a primary consideration
B. Documented effectiveness of services with a high level of benefit to people and families living with HIV infection, including quality, cost, and outcome measures when applicable
C. Documented response to the epidemiology of HIV/AIDS in the EMA and HSDA
D. Documented response to emerging needs reflecting the changing local epidemiology of HIV/AIDS while maintaining services to those who have relied upon Ryan White funded services.
E. When allocating unspent and carryover funds, services are of documented sustainability across fiscal years in order to avoid a disruption/discontinuation of services
F. Documented consistency with the current Houston Area Comprehensive HIV Prevention and Care Services Plan and the Continuum of Care and their underlying principles to the extent allowable under the Ryan White Program: to build public support for HIV services; to inform people of their serostatus and, if they test positive, get them into care; to help people maintain their negative status; to help people with HIV improve their health status and quality of life and prevent the progression to AIDS; to help reduce the risk of transmission; and to help people with AIDS improve their health status and quality of life and, if necessary, support the conditions that will allow for death with dignity

DECISION MAKING CRITERIA STEP 2:

A. Services are effective with a high level of benefit to people and families living with HIV, including cost and outcome measures when applicable
B. Services are accessible to all populations infected, affected, or at risk, allowing for differences in need between urban, suburban, and rural consumers as applicable under Part A and B guidelines
C. The Council will minimize duplication of both service provision and administration and services will be coordinated with other systems, including but not limited to HIV prevention, substance use, mental health, and Sexually Transmitted Infections (STIs).
D. Services emphasize access to and use of primary medical and other essential HRSA defined core services
E. Services are appropriate for different cultural and socioeconomic populations, as well as care needs
F. Services are available to meet the needs of all people and families living with or at risk for HIV infection as applicable under Part A and B guidelines
G. Services meet or exceed standards of care
H. Services reflect latest medical advances, when appropriate
I. Services meet a documented need that is not fully supported through other funding streams

PRIORITY SETTING AND ALLOCATIONS ARE SEPARATE DECISIONS. All decisions are expected to address needs of the overall community affected by the epidemic.

FY 2017 Priority Setting Process

(Priority and Allocations Committee approved 02-25-16)

1. Agree on the principles to be used in the decision making process.
2. Agree on the criteria to be used in the decision making process.
3. Agree on the priority-setting process.
4. Agree on the process to be used to determine service categories that will be considered for allocations. (This is done at a joint meeting of members of the Quality Assurance, Priority and Allocations and Affected Community Committees and others, or in other manner agreed upon by the Planning Council).
5. Staff creates an information binder containing documents to be used in the Priority and Allocations Committee decision-making processes. The binder will be available at all committee meetings and copies will be made available upon request.
6. Committee members attend a training session to review the documents contained in the information binder and hear presentations from representatives of other funding sources such as HOPWA, Prevention, Medicaid and others.
7. Staff prepares a table that lists services that received an allocation from Part A or B or State Service funding in the current fiscal year. The table lists each service category by HRSA-defined core/non-core category, need, use and accessibility and includes a score for each of these five items. The utilization data is obtained from calendar year CPCDMS data. The medians of the scores are used as guides to create midpoints for the need of HRSA-defined core and non-core services. Then, each service is compared against the midpoint and ranked as equal or higher (H) or lower (L) than the midpoint.
8. The committee meets to do the following. This step occurs at a single meeting:
   - Review documentation not included in the binder described above.
   - Review and adjust the midpoint scores.
   - After the midpoint scores have been agreed upon by the committee, **public comment** is received.
   - During this same meeting, the midpoint scores are again reviewed and agreed upon, taking public comment into consideration.
   - Ties are broken by using the first non-tied ranking. If all rankings are tied, use independent data that confirms usage from CPCDMS or ARIES.
   - By matching the rankings to the template, a numerical listing of services is established.
   - Justification for ranking categories is denoted by listing principles and criteria.
   - Categories that are not justified are removed from ranking.
   - If a committee member suggests moving a priority more than five places from the previous year's ranking, this automatically prompts discussion and is challenged; any other category that has changed by three places may be challenged; any category that moves less than three places cannot be challenged unless documentation can be shown (not cited) why it should change.
   - The Committee votes upon all challenged categorical rankings.
   - At the end of challenges the entire ranking is approved or rejected by the committee.

(Continued on next page)

9. At a subsequent meeting, the Priority and Allocations Committee goes through the allocations process.
10. Staff removes services from the priority list that are not included on the list of services recommended to receive an allocation from Part A or B or State Service funding. The priority numbers are adjusted upward to fill in the gaps left by services removed from the list.
11. The single list of recommended priorities is presented at a Public Hearing.
12. The committee meets to review public comment and possibly revise the recommended priorities.
13. Once the committee has made its final decision, the recommended single list of priorities is forwarded as the priority list of services for the following year.

2016 Policy for Addressing Unobligated and Carryover Funds

(Priority and Allocations Committee approved 02-25-16)

Background

The Ryan White Planning Council must address two different types of money: Unobligated and Carryover.

Unobligated funds are funds allocated by the Council but, for a variety of reasons, are not put into contracts. Or, the funds are put into a contract but the money is not spent. For example, the Council allocates $700,000 for a particular service category. Three agencies bid for a total of $400,000. The remaining $300,000 becomes unobligated. Or, an agency is awarded a contract for a certain amount of money. Halfway through the grant year, the building where the agency is housed must undergo extensive remodeling prohibiting the agency from providing services for several months. As the agency is unable to deliver services for a portion of the year, it is unable to fully expend all of the funds in the contract. Therefore, these unspent funds become unobligated. The Council is informed of unobligated funds via Procurement Reports provided to the Quality Assurance (QA) and Priority and Allocations (P&A) Committees by the respective Administrative Agencies (AA), HCPHS/ Ryan White Grant Administration and The Resource Group.

Carryover funds are the RW Part A Formula and MAI funds that were unspent in the previous year. Annually, in October, the Part A Administrative Agency will provide the Committee with the estimated total allowable Part A and MAI carryover funds that could be carried over under the Unobligated Balances (UOB) provisions of the Ryan White Treatment Extension Act. The Committee will allocate the estimated amount of possible unspent prior year Part A and MAI funds so the Part A AA can submit a carryover waiver request to HRSA in December.

The Texas Department of State Health Services (DSHS) does not allow carryover requests for unspent Ryan White Part B and State Services funds.

It is also important to understand the following applicable rules when discussing funds:

1.) The Administrative Agencies are allowed to move up to 10% of unobligated funds from one service category to another. But, the 10% rule applies to the amount being moved from one category and the amount being moved into the other category. For example, 10% of an $800,000 service category is $80,000. But, if a $500,000 category needs the money, the Administrative Agent is only allowed to move 10%, or $50,000 into the needy category, leaving $30,000 unobligated.

2.) Due to procurement rules, it is difficult to RFP funds after the mid-point of any given fiscal year.

In the final quarter of the applicable grant year, after implementing the Council-approved October reallocation of unspent funds and utilizing the existing 10% reallocation rule to the extent feasible, the AA may reallocate any remaining unspent funds as necessary to ensure the Houston EMA/HSDA has less than 5% unspent Formula funds and no unspent Supplemental funds. The AA for Part B and *State Services* funding may do the same to ensure no funds are returned to the Texas Department of State Health Services (TDSHS). The applicable AA must inform the Council of these shifts no later than the next scheduled Ryan White Planning Council Steering Committee meeting.

Recommendations for Addressing Unobligated and Carryover Funds:

1.) Requests from Currently Funded Agencies Requesting an Increase in Funds in Service Categories where The Agency Currently Has a Contract: These requests come at designated times during the year. Usually, requests of this nature are addressed using unobligated funds.

A.) In response, the AA will provide funded agencies a standard form to document the request (see attached). The AA will state the amount currently allocated to the service category, state the amount being requested, and state if there are eligible entities in the service category. This form is known as a *Request for Service Category Increase*. The AA will also provide a Summary Sheet listing all requests that are eligible for an increase (e.g. agency is in good standing).

The AA must submit this information to the Office of Support in an appropriate time for document distribution for the April, July and October P&A Committee meetings. The form must be submitted for all requests regardless of the completeness of the request. The AA for Part B and State Services Funding will do the same, but the calendar for the Part B AA to submit the Requests for Service Category Increases to the Office of Support is based upon the current Letter of Agreement. The P&A Committee has the authority to recommend increasing the service category funding allocation, or not. If not, the request "dies" in committee.

2.) Requests for New Ideas: These requests can come from any individual or agency at any time of the year. Usually, they are also addressed using unobligated funds. The individual or agency submits the idea and supporting documentation to the Office of Support. The Office of Support will submit the form(s) as an agenda item at the next QA Committee meeting for informational purposes only, the Office of Support will inform the Committee of the number of incomplete or late requests submitted and the service categories referenced in these requests. The Office of Support will also notify the person submitting the New Idea form of the date and time of the first committee meeting where the request will be reviewed. All committees will follow the RWPC bylaws, policies, and procedures in responding to an "emergency" request.

Response to Requests: Although requests will be accepted at any time of the year, the Priority and Allocations Committee will Review requests at least three times a year (in April, July, and October). The AA will notify all Part A or B agencies when the P&A Committee is preparing to allocate funds.

3.) Committee Process: The Committee will prioritize recommended requests so that the AA can distribute funds according to this prioritized list up until May 31, August 31 and the end of the grant year. After these dates, all requests (recommended or not) become null and void and must be resubmitted to the AA or the Office of Support to be considered in the next funding cycle.

After reviewing requests and studying new trends and needs the committee will review the allocations for the next fiscal year and, after filling identified gaps in the current year, and if appropriate and possible, attempt to make any increase in funding less dramatic by using an incremental allocation in the current fiscal year.

4.) Projected Unspent Formula Funds: Annually in October, the Committee will allocate the projected, current year, unspent, Formula funds so that the Administrative Agent for Part A can report this to HRSA in December.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Resources and Services Administration

HIV/AIDS Bureau

Rockville, MD 20857

JAN 20 2016

Dear Part A Colleagues:

Although the fiscal year (FY) 2016 budget was passed in December 2015, the Health Resources and Services Administration (HRSA) and its HIV/AIDS Bureau (HAB) are waiting for the final and available funding amount for the FY 2016 grant awards.

While HRSA/HAB hoped to provide the final awards, in order to assure funding is available to recipients on March 1, 2016, HRSA/HAB initiated the process to make partial awards available for the effective budget period start date of March 1; these awards will be approximately 80 percent of a recipient's FY 2015 Formula and Minority AIDS Initiative Awards.

A partial notice of awards is due to be released by early February for the effective start date of March 1. Part A recipients are encouraged to work within their existing budget, finance, and procurement systems to ensure that contracts are effective, as of March 1.

Given the fact that full awards cannot be made at this time, we know it is important for Part A recipients to have some information on how their funding in FY 2016 might change when the final funding formula is re-calculated. We understand this important information is needed for use in planning and work to maintain effective contracts and continuity of care for people living with HIV.

HAB conducted a funding scenario analysis for FY 2016, taking into account all factors required under the authorizing legislation to calculate the FY 2016 awards. Using the FY 2015 overall amounts as a base, HAB found only minor fluctuations across all 52 eligible jurisdictions.

HRSA/HAB hope to make the full final awards available as soon as possible. If you have any questions, please contact your project officer.

Sincerely,

Steven R. Young, MSPH
Director
Division of Metropolitan HIV/AIDS Programs

From the 10-15-15 Minutes of the Wait List Workgroup

Requests for Service Category Increase: See attached. Martin said that there is an annual process where (her office looks) at agency spending. The (Priorities and Allocations Committee is) about to reallocate a large amount of funds coming from categories with capacity issues. We need to address why we have to pull back funds if the only capacity issue is due to staffing and we've been told that hiring someone would fix the problem. Turner directed the workgroup to the information about wait lists on the form, he said that agencies tell the administrative agent that they don't have a waiting list and then they show that they do have a waiting list on the request for increased funding form to get more money. Martin said she called the agencies to get more information about this and they just ask the front desk how many people are in the waiting room on standby; they do not actually have a waiting list. This item may need to come off of the form or change it to define waiting list per the standards of care. All agreed.

Request for Service Category Increase
Ryan White Part A and MAI

A.	Name of Agency **(not provided to RWPC)**						
B.	Contract Number **(not provided to RWPC)**						
C.	Service Category Title (per RFP)					Control No.	
D.	Request for Increase under (check one):	Part A:	or	MAI:			
	Request Period (check one):	April:	August:	Oct:	Final Qtr:		
E.	Amount of additional funding Requested:						
F.	Unit of Service: (list only those units and disbursements where an increase is requested)	a. Number of units in current contract:	b. Cost/unit	c. Number of additional units requested:	d. Total: (b x c)		
	1.				$0.00		
	2.				$0.00		
	3.				$0.00		
	4.				$0.00		
	5.				$0.00		
	6.				$0.00		
	7.				$0.00		
	8. Disbursements (list current **amount** in column a. and **requested**amount in column c.)		N/A		$0.00		
	9.Total additional funding (must match E. above):				**$0.00**		
G.	Number of new/additional clients to be served with requested increase.						
H.	Number of clients served under current contract - Agencies must use the CPCDMS to document numbers served. **De-identified CPCDMS-generated reports will be provided to the RWPC by RWGA.**	a. Number of clients served per CPCDMS	b. Percent AA (non-Hispanic)	c. Percent White (non-Hispanic)	d. Percent Hispanic (all races)	e. Percent Male	f. Percent Female
	1. Number of clients that received this service under Part A (or MAI) in FY 2015.* (March 1, 2015 - February 28, 2016) *If agency was funded for service under Part A (or MAI) in FY 2015 - if not, mark these cells as "NA"						
	2. Number of clients that have received this service under Part A (or MAI) in FY 2016. a. April Request Period = Not Applicable b. August Request Period = 03/01/16 - 06/30/16 c. October Request Period = 03/01/16 - 09/30/16 d. 4th Qtr. Request Period = 03/01/16 - 11/30/16						

Request for Service Category Increase
Ryan White Part A and MAI

I.	Additional Information Provided by Requesting Agency (subject to audit by RWGA). Answer all questions that are applicable to agency's current situation.	a. Enter Number of Weeks in this column	b. How many Weeks will this be if full amount of request is received?	c. Comments (do **not** include agency name or identifying information):	
	1. Length of waiting time (in weeks) for an appointment for a **new** client:				
	2. Length of waiting time (in weeks) for an appointment for a **current** client:				
	3. Number of clients on a "waiting list" for services (per Part A SOC):				
	3. Number of clients unable to access services monthly (number unable to make an appointment) (per Part A SOC):				
J.	List all other sources and amounts of funding for **similar** services currently in place with agency:	a. Funding Source:	b. End Date of Contract:	c. Amount	d. Comment (50 words or less):
	1.				
	2.				
	3.				
	4.				
K.	Submit the following documentation at the same time as the request (budget narrative and fee-for-service budgets may be hard copy or fax):				
	Revised Budget Narrative (Table I.A.) corresponding to the revised contract total (amount in Item F.9.d. plus current contract amount).				
	This form must be submitted electronically via email by published deadline to Carin Martin: cmartin@hcphes.org				

Texas HIV/STD Quality Management Plan

2016-2020

Executive Summary

The Quality Management (QM) Program for the Ryan White HIV/AIDS Treatment Extension Act of 2009 is designed to meet the federal mandate for quality management while enhancing and coordinating overall quality assessments of core and supportive services.

The Health Resources and Services Administration (HRSA) defines quality improvement as having a focus on preventing problems and improving and maximizing quality of care and services. Quality Management is a systematic approach to quality improvement (QI). Quality assurance (QA) is defined as a formal and systematic process of identifying problems in service delivery, designing activities to overcome these problems and following up to ensure that corrective actions have been effective and that no new problems have developed.

The Program Evaluation Group manages the program data collection systems and reporting responsibilities for the HIV/STD Prevention and Care Branch (The Branch). Providers report data about the characteristics of the clients served and the services provided. The providers in the state, regardless of the Ryan White Part supporting the funding of the services, use a standard services taxonomy that includes units of service. Local data managers, as well as staff in The Branch, routinely examine these data to determine patterns and trends in service use and changes in client profiles. The QM program is designed to complement these activities by prompting lines of inquiry for analyses and facilitating improvements in areas that do not meet QA requirements. The QM effort uses the strengths of the organization to add more follow up activities and real process improvements to provide a longitudinal assessment of quality of care and services. The identification of a trend in service use that is defined as a quality issue is analyzed with a focus on interventions that could facilitate improvements. These interventions are performed and the resulting outcome is assessed to determine if the quality issue was resolved. The process, using the Model for Improvement Plan, Do, Study, Act (PDSA) is continual until the desired outcome is obtained. For example, if the data trends identify a population that is not responding to medication regimens with lowered viral load counts, a possible intervention could be medication adherence education. Once adherence education is provided to the clients, subsequent viral load data will be reassessed to see if a reduction has been achieved. Ongoing assessment of improvement and refining of the intervention will be performed to continually improve outcomes. In addition, QM is expected to improve documentation of quality improvement efforts and existing quality assurance processes that are ongoing.

Efforts are underway to aggregate performance data over time to assess long term process improvement and design corrective actions that improve care and services. Standards of Care have been drafted for each service category for use by Part A and B providers to be able to uniformly assess performance.

TABLE OF CONTENTS

Contents

THE TEXAS HIV QUALITY MANAGEMENT PLAN

I. Quality Statement

The Texas Department of State Health Services (DSHS) HIV/STD Prevention and Care Branch (The Branch) is committed to promoting the quality of care and services delivered to Persons Living with HIV/AIDS (PLWH). The ultimate goal of the program is to build a Quality Management (QM) structure that is sustainable and used in a dynamic way to improve care and services to ensure optimal wellbeing in support of the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87, October 30, 2009).

Quality management is primarily concerned with enhancing the quality of service delivery, including the Texas HIV Medication Program (THMP), known as the AIDS Drug Assistance Program (ADAP) in Texas. The Branch offers preventive and care services from various funding streams, including HRSA, US Department of Housing and Urban Development (HUD), the State of Texas, and the Centers for Disease Control and Prevention (CDC). These services (along with private insurance, Medicaid and Medicare, etc.) make up the continuum of services available to PLWH clients.

The goals of the QM Program are to:

1. Incorporate surveillance and reporting data from several sources with input from leadership, partners, and clients to improve clinical, operational, and programmatic aspects of care.

2. Refine measurement systems for identifying trends in care and significant events by regularly collecting and recording data and observations relating to the provision of client care across the continuum.

3. Employ assessment procedures to determine efficacy and appropriateness and to judge how well services are delivered and whether opportunities for improvement exist.

4. Focus on improving quality in all of its dimensions by implementing multidisciplinary, data driven project teams and encouraging participatory problem solving.

5. Promote communication, dialogue, and information exchange with regard to findings, analyses, conclusions, recommendations, actions, and evaluations pertaining to performance improvement.

6. Further strive to establish collaborative relationships with community agencies for collectively promoting the general health and welfare of the community served.

II. Quality Management Program Infrastructure

Leadership.

The QM Program is guided by the QM Committee in consultation with the Texas HIV Syndicate, Administrative Agencies (Part A and B-funded), and the Texas HIV Medication Advisory Committee (MAC).

QM Committee. The Branch is responsible for assuring the planning, directing, coordinating and improving healthcare services in the HIV care system for all HIV federal and state-funded services provided to PLWH. As such, The Branch Manager is now the Chair for the QM Committee. In January 2015 the infrastructure of the QM Committee evolved and expanded to include programs that provide services for co-occurring conditions such as mental health, substance use, sexually transmitted diseases (STDs), viral hepatitis, and tuberculous (TB). The committee expanded from 10 members to 28 who work within DSHS:

- HIV Care Services Group
- HIV/STD Prevention Group
- HIV/STD Program Data Evaluation Group
- Testing and Targeted Prevention Intervention Team (TTPIT)
- Public Health Follow Up (PHFU) Team
- Hepatitis Program
- Infectious Disease Prevention Section (IDPS)
- TB/HIV/STD Epidemiology and Surveillance Group
- Health Communications and Community Engagement Group
- Texas HIV Medication Program
- Mental Health/Substance Use Program
- Tuberculous Program

Texas HIV Syndicate. Comprised of Texans involved in HIV prevention and care, the HIV Syndicate membership engages in collective learning through ongoing conversation and exploration of topics that affect local communities, regions, and the state as a whole. Through this ongoing interactive process, the HIV Syndicate seeks to develop a shared knowledge base to influence and improve current prevention and care practices and policies at both the state and local levels.

Two physician providers from this group serve as provider consultants to the QM Committee.

Administrative Agencies. In Texas, DSHS coordinates the Ryan White Part B federal and state-appropriated funds for HIV client services through selected Administrative Agencies (AA). AAs are community-based organizations, governmental entities, and other organizations located within Texas. AAs disburse funds from DSHS through a subcontractor system to provide comprehensive services to PLWH. Each of the seven AAs are required to have a QM Plan that outlines goals, objectives, and strategies/activities specific to the service population.

The Texas HIV Medication Advisory Committee (MAC). This group participates in the quality management process as many of the priorities are treatment related. As practicing clinicians, consumers, and contractors, they provide guidance for clinical and consumer aspects of the THMP.

Considerable departmental integration is required within the quality management structure. Staff participation in meetings, studies, assessments, and reports related to quality activities provide evidence of this collaboration. The quality management documentation is organized using guidance from the Ryan White Care Act, the National Committee on Quality Assurance Standards for Quality Improvement, the Joint Commission for Health Care Organizations Standards for Ambulatory Care, and the DSHS Standards for Public Health Clinics.

Responsibilities of the QM Committee. Responsibilities include recommending standards of care, promoting and assuring adherence to clinical and other guidelines, and approving study designs and protocols related to HIV disease. The meetings are designed to orient the members to the QM requirements, adopt quality policies and procedures, present results, review study designs, assess corrective action requirements and compliance, and make recommendations for quality activities. Meeting quarterly, the committee provides input to and recommends the QM program documentation, annual work plan, and annual evaluation. The role of the QM committee is to facilitate continuous improvements in care and service by reviewing data, bringing forth quality issues, reviewing trends, informing communities, and providing an avenue for input by stakeholders. Minutes are produced for every meeting. Action items that result from the meeting are added to the QM annual work plan as appropriate with specific responsibility assigned and due dates for completion. The minutes are evaluated to ensure actions and follow up occur, and action items for additional study or discussion are followed to completion. The committee may form subcommittees for specific areas of study for program development or corrective action review. The committee will assign subcommittee work as needed to meet stated goals. Subcommittees operate under the same guidance as the full committee. Efforts will be made to use technology whenever possible to minimize travel costs and provide ease of gathering members. A simple majority will be considered a quorum. Decisions will be made by consensus. The Branch Manager will receive recommendations from the QM Committee, will determine the actions to be taken, and will report their decisions to the committee. Management may involve the committee in the implementation of these decisions. The committee will be responsible for facilitating the QI scope of work, providing input on quality issue resolution, and evaluating quality management outputs.

The AAs and the Texas HIV Syndicate have been asked to give input on the QM plan and other products to obtain ideas and comments regarding quality management. Feedback from planning groups is critical to the process of improving care and services. Information will be shared via the DSHS planning structure with planning groups, AAs, clinical contractors, and other medical care and service providers with opportunities to give input and information back to The Branch QM Committee. Quality issues, outcomes, and priorities will be shared with these groups to keep them informed.

Physicians and contractors funded by Ryan White Part B and State Services HIV funds will have a role in providing information and expertise to the QM committee by reviewing information prior to adoption and in the assessment of the quality improvement processes in the care system. Contractors/providers have a contractual obligation to provide access to records and participate in QA processes. Physicians will provide consultation to the process of documenting and implementing the QM program and as consumers of the service delivery contracts. Standards of Care (SOC) and trend information will be available to providers of care and contractors via the HIV/STD web site. Contract compliance with quality management has become a focus with the implementation of the QM processes. This will be reflected in the assessments by contract monitoring staff of contractor performance relative to quality in clinical, support services, the THMP, and administrative functions. The staff of the contractors/physicians will resolve specific issues identified as concerns in the monitoring process. Once corrective action is taken, the issue will be reassessed again to assure that the actions were effective at resolving the identified issue. Needed changes in SOC, policy, or procedures in the contractor documentation will be noted at the reassessment visit. Internal process improvements are also a requirement of the QM system.

Authority

The Texas HIV QM plan is designed to improve services to PLWH in Texas. DSHS defines and publicizes SOC for each of the service categories defined by the Ryan White HIV/AIDS Program (RWHAP) and disseminates evidence-based and promising practices clinical guidelines to promote excellence in service delivery to clients. These SOC are used to define the clinical quality indicators to assess the quality of care for core services. Support services SOC are also used to promote quality and enhance the continuum of care.

Accountability

DSHS is the agency responsible for public health services in Texas. The ultimate accountability for The Branch is the Branch Manager. The Branch Manager is responsible for the management of the HIV prevention, care services, program evaluation, medication program, including QM activities. Other Ryan White Part grantees, community organizations, consumers, providers, advocates, and contractors join the State in providing congruency, accountability, and oversight to the priority of providing quality care to PLWH. The input of these groups is critical to the success of the quality management effort. These combined voices are used to advance the development of consistent standards and measures for the care of HIV disease in Texas.

The Texas HIV Plan for the HIV/STD Prevention and Care Branch and the HIV/STD/TB Epidemiology and Surveillance Branch lists increasing the collection and application of outcome monitoring information for HIV/STD prevention and clinical services as an initiative with the result of using outcome data to improve program performance. Special populations identified as needing improvements in care and services are minority populations, pregnant women, persons recently released from incarceration, homeless, and persons with an AIDS diagnoses. The QM effort will promote process improvement internally and evaluate and provide best practices for contractors in their review of services. The monitoring done by the staff will measure progress toward compliance with SOC for treatment and support services. Process improvement for monitoring will focus on updating standards and review tools to ensure the best measurements of quality of care possible.

Resources

The Texas QM program uses the Model for Improvement framework. The Plan- Do- Study- Act cycle is the preferred method of determining if an intervention or change results in improvement.

- **PDSA Cycles**

The program requires data from providers, consumers' and communities, on-site reviews, teleconferences, reports, studies, and assessments to document the status and improvements in the HIV continuum of care and customer service. QI consultation is available to individuals and organizations involved in contracting for and providing HIV services. QM facilitates system-wide continual improvement while assisting stakeholders/contractors with their own quality program development in their service areas.

Standards of Operation and Service

The Branch uses standards required for federal grantees such as the U.S. Public Health Standards (USPHS) and Guidelines for the Treatment of HIV Disease. DSHS has additional general clinical standards for contractors that are not specific to HIV disease. Clinical and administrative standards are available to the public via the DSHS HIV/STD Program web site. State-level SOC (located at http://www.dshs.state.tx.us/hivstd/taxonomy/default.shtm) for each core and supportive service categories were developed, finalized, and implemented beginning in January 2015. To accompany these SOC, uniform monitoring tools were also written.

The Branch Program Operating Procedures and Standards (POPS) include the clinical, administrative and other requirements for the service delivery system. QM standards are integrated into the Bureau service standards, and additional program measures are under development by the THMP. Confidentiality protections, documented in the regulations, along with standards and policies are a critical part of the quality assessments. The Branch seeks expertise from the State's Health Information Portability and Accountability Act (HIPAA) Privacy Officer and Legal Counsel when information is requested from customers regarding compliance with regulations regarding privacy and child abuse reporting.

Data Management and Measurements

A key resource for the HIV QM (and for most Ryan White and State HIV funded providers) is the AIDS Regional Information and Evaluation System (ARIES), a custom, web-based, centralized HIV/AIDS client management system that provides a single point of entry for client-related data, allows for coordination of client services among providers, meets both HRSA and state care and treatment reporting requirements, and provides comprehensive data for program monitoring and evaluation. ARIES enhances services for clients with HIV by helping providers automate, plan, manage, and report on client data.

Technical Assistance

Technical Assistance (TA) is available through HRSA/HAB, the National Quality Center (NCQ), and other local or national organizations.

THMP QM Data

The QM program is designed to monitor outcomes of care related to medication adherence, treatment efficacy, and the success of support services in improving health status. Monitoring of medication program data is being enhanced to provide the tools used to collect outcome data for the THMP.

QM has initiated a process improvement project to measure current indicators of the quality of customer service and internal processing to design improvement strategies for enrollment and management of pharmacy services.

QM reports and data are used to determine areas where additional improvements are needed. Projects to improve care are planned based on the results of management reporting analysis, medical record review, surveillance, utilization data, and customer satisfaction data. Planning bodies will be supplied with the results of these QM activities and will be offered technical assistance.

III. Performance Measurement

As stated in the National HIV/AIDS Strategy (NHAS) for the United States (July 2015), in 2013, President Obama issued an Executive Order establishing the HIV Care Continuum Initiative. DSHS has embraced this initiative and as such created the Texas HIV Cascades which are outlined in our Texas HIV Plan. In addition, DSHS recognizes that the reduction of HIV-related disparities and health inequities must be eliminated if the prevalence of HIV/AIDS is to decrease over the next several years.

2016 – 2020 QM Plan Goals

DSHS has elected to create a 5-year QM Plan to enable focus on long-range goals while concentrating on the steps needed each year to reach these goals. Since many PLWH have co-occurring conditions, this plan not only includes goals from the HIV Care Services Group, but also from the STD, Hepatitis, and TB programs which further integrates planning and implementation efforts. Special emphasis has been placed on assessing the role of medical case management, non-medical case management and mental health in contributing to clients achieving viral suppression.

Program	Goal
HIV Care Services	85% of all diagnosed persons living with HIV will be retained in care (baseline 70%)
	For all priority groups* 86% of newly diagnosed persons will be linked to HIV medical care within one month of their diagnosis and retained in care within six months of linkage (baseline ranges from 72%-86%)
	For all priority groups* 88% of persons who are retained in HIV medical care will be virally suppressed (baseline ranges from 64%-88%)
Sexually Transmitted Disease	50% of RW-eligible clients will be screened for Chlamydia (baseline 18%)
	50% of RW-eligible clients will be screened for Gonorrhea (baseline 18%)
	75% of RW-eligible clients will be screened for Syphilis (baseline 51%)
Hepatitis	90% of Ryan White clients will receive at least one recorded dose of the hepatitis B vaccine (Exception: the client has chronic hepatitis B or has documented evidence of immunity) (baseline 20.3%)
	98% of Ryan White clients have a documented HCV RNA test for Hepatitis C screening (baseline 80%)
	90% of clients that have disclosed ongoing, high risk behavior will have one antibody screening test documented every six months for Hepatitis C (baseline unknown)
Tuberculous	98% of patients with active and latent tuberculosis will know their HIV test results (baseline 88%)

*Priority groups include the following: Black women, men who have sex with men (MSM), White MSM, Black MSM, and Hispanic MSM

HIV Care Measures. Goals were chosen for renewed emphasis from three categories of the cascade: linkage, retention, and viral suppression. DSHS chose to base performance measures on the

mathematical modeling of David Holtgrave (August 2013)[1]. With level funding and Texas not expanding Medicaid through the Affordable Care Act (ACA), retaining 85% of all diagnosed PLWH (not just those receiving care through Ryan White) seems more attainable than the NHAS 2020 goal of at least 90%. DSHS also adopted the philosophy stated by Holtgrave that all persons should be able to meet the goal regardless of gender, race/ethnicity, sexual orientation, transmission risk, and age. Five of the nine key populations identified by CDC are being targeted during this next five-year period: Black women, men who have sex with men (MSM), white MSM, Black MSM, and Hispanic MSM. To reduce the disproportionate burden among PLWH in Texas, the proportion is based on the highest percentage currently reached by one group for linkage, retention within six months of linkage, and viral suppression.

Sexually Transmitted Disease (STD). PLWH are at higher risk for acquiring STDs, and in turn having an STD infection increases an individual's risk of contracting HIV. STDs are an essential component of HIV prevention because 1) the diagnosis of an STD is an objective biologic marker of unprotected sexual activity that may result in HIV transmission; 2) certain STDs may increase plasma HIV viral load and genital HIV shedding, which may increase the risk of sexual and perinatal HIV transmission; and 3) STD treatment may reduce STD-related morbidity and lower the risk of HIV transmission. The percentage for the STD measures (gonorrhea, chlamydia, and syphilis) were obtained from a review of current ARIES data and from feedback received by HIV Syndicate stakeholders. Initially, DSHS had a much lower percentage increase based solely on ARIES data; HIV Syndicate stakeholders encouraged DSHS to recognize there is a high likelihood that screening for STD is occurring but persons may not be documenting the screening in ARIES.

Hepatitis Measures. Goals were based on two guiding documents: the updated Viral Hepatitis Action Plan developed by the US Health and Humans Services (HHS) and US Healthy People 2020. The Viral Hepatitis Action Plan underscores national goals to our communities while the US Healthy People 2020 is a comprehensive set of national key disease prevention and health promotion objectives. While DSHS recognizes that experts from the Texas HIV Syndicate encouraged focus on treatment rather than screening, the current position from the CDC is on screening and Texas reflects a low percentage of routine hepatitis screening occurring during an outpatient medical visit.

Tuberculous Measure. Tuberculosis (TB) is the world's most deadly disease. It is also the leading killer of persons who are HIV infected. PLWH are more likely to become infected with TB, they are more likely to develop active TB disease, and they are more likely to die of TB than people who are not HIV-infected. Because of the threat TB poses to PLWH, it is imperative that all known cases of TB are promptly and adequately screened for HIV following laboratory or clinical evidence supporting TB infection. Focus will be placed on developing and fully implementing a statewide consolidated STD/HIV/TB data collection system to increase the accuracy, timeliness, and completeness of surveillance reporting and facilitate the sharing of data across these programs. This will greatly impact the overall number of current TB patients who will know their HIV status.

Process in place to develop new QI activities to address identified gaps will be accomplished through:

- Reporting of quality of service improvements and outcomes of care
- Identification of priority needs, populations and gaps in care
- Assessment of linkages in programs and services
- Determination of program efficiency and effectiveness to improve functions and promote systems thinking in the service delivery structure
- Quantitative and qualitative measurements that demonstrate the value of the service delivery programs.

[1] Holtgrave, D. *Development of Year 2020 Goals for the National NIV/AIDS Strategy for the United States.* AIDS Behav Published online: 11 August 2013.

IV. Quality Performance Objectives

RWHAP Annual Implementation Plan.

As required by RWHAP, benchmarks for RW period 4/1/2016 – 3/31/2017 have been established for each funded service category. These benchmarks are located in Appendix A. Data will be analyzed quarterly to assess attainment of benchmarks.

QM Implementation Plans.

One year Implementation Plans for each program goal have been developed for 2016. Following the Model for Improvement PDSA format, these plans include measurable objectives, potential changes to be expected, plan (activities), persons responsible, resources needed, and data to be collected. Updates will be documented on a quarterly basis. These Implementation Plans are located in Appendix B.

Administrative Agency QM Plans.

Within the coming year, AA QM Plans will be analyzed to determine commonalities. This process will enable DSHS to revisit and reflect on the performance measures used regionally and to make recommendations to streamline efforts, maximize the use of existing data systems, reduce data collection and reporting burdens, and align regional efforts to coordinate activities across RWHAP sub-recipients. These QM Plans may be found in Appendices C-I.

V. Participation of Stakeholders

The QM committee assists funded providers with 1) adhering to HIV treatment guidelines, 2) using strategies for improvements that include the support services to enhance access to care and sustain adherence to medical and risk reduction regimens and 3) monitoring epidemiological trends in HIV related conditions with data from demographics and service use. Coordination with evaluation and other quality activities is part of this integrated approach to systemic quality management and strategic planning for Ryan White Services.

Advisory and advocacy groups that include PLWH are part of the process of defining quality indicators and documenting interventions and improvements in the care system and as such are an integral partner. Other external stakeholders with HIV or related expertise (e.g., substance abuse, hepatitis, mental health services providers) and/or QM expertise are consulted.

The mission of the South Central AIDS Education and Training Center (AETC) is to improve the care of PLWH in the regional area by supporting clinical consultation, education & training, especially for clinicians serving minorities and other disproportionately affected populations. DSHS consults with this entity when training is needed.

Communication

QM data and performance measure outcomes are reviewed by the QM Committee during quarterly meetings. AA staff, consumers, providers, and stakeholders as members of the Texas HIV Syndicate will receive updates at biannual meetings.

VI. Evaluation

Evaluation cannot take place until January 2017 since the following was established in 2016: The

- Five-year plan,
- First year implementation plan, and
- Expanded QM committee.

The following will be evaluated in 017:

1) Program outcomes and the relationship between SOC adherence and QM outcomes will be documented to meet the Federal requirements. Three process have been identified to evaluate these QM efforts:
   - Compare annual QI goals with year-end results
   - Use findings to plan following year implementation plan
   - Routinely use organizational assessment tools
2) Outcome evaluation is the assessment of the effectiveness of a service at achieving intended results. Since funding may be increasingly tied to the ability to obtain desired outcomes, progress on meeting performance measures will be critical
3) DSHS implemented standardized SOC January 2015 for each RWHAP service category. To ensure that outcome indicators are assessed and documented consistently a monitoring tool for each service category was also developed. Baseline information will be obtained throughout 2016 on each indicator identified as the basis for future trending.

Capacity Building

Staff participates in the National Quality Center (NQC) and other Ryan White QM trainings offered for grantees as needed. HIV Care Services group staff hold trainings and offer TA on QM (Quality Management 101, QM Plans, using evidenced-based data to improve outcomes) in addition to ad hoc TA that may be requested by individual agencies. Each year, HIV Care Services staff will have at least one meeting with providers to review processes and issues identified from chart abstractions and offer recommendations and provide technical assistance for performance improvement initiatives.

The Texas HIV Cascades will be disseminated and discussed with AAs and stakeholders to increase knowledge and understanding of regional continuum of care outcomes. Further capacity building will occur regarding parity amongst priority populations.

Process to Update QM Plan

Each year the One-Year Implementation Plan is reviewed and updates are made for following year's implementation. The QM Plan is implemented in collaboration by DSHS staff, AAs, and contracted providers. Contracted providers are required to participate in the QI improvement strategies and must submit quarterly reports on their progress through PDSAs that are chosen at the beginning of each grant year.

Appendix A

FY 2016 Ryan White HIV/AIDS Program Part B Implementation Plan

Grantee: Texas Department of State Health Services Federal Fiscal Year 2016

Service Category: AIDS Drug Assistance Program				**Total Allocation** Part B Base: _____ ADAP: **$66,522,804** ADAP Supplemental: _____ Emerging Communities: _____ Minority AIDS Initiative:	
Service Goal: Promote essential medical services and therapies that are consistent with USPHS treatment guidelines to eligible RW persons living with HIV in Texas				**Current Comprehensive Plan:** Improve access to quality care and treatment for HIV infected Texans. Ensure high quality of care. Enhance access to care and reduce disparities.	
1. Objectives: List SMART (specific, measurable, achievable, realistic, and time-phased) objectives that support the service goal listed above	**2. Service Unit Definition:** Define the service unit to be provided for each objective	**3. Quantity**		**4. Time Frame:** Indicate the estimated duration of activity relating to the objective listed.	**5. Funds:** Provide the approximate amount of all Part B funds to be used for each objective by funding source.
		3a) Total Number of people to be served	3b) Total Number of service units to be provided		
a: By March 31, 2017, at least 31,000 persons with HIV will have received at least one prescription through the Texas ADAP.	Per prescription	31,531	31,531	4/1/2016-3/31/2017	$66,522,804

6. Outcomes: For each SMART objective, (1) name at least one client-level outcome/indicator to be tracked for the objective (using the HAB Standard Outcome Measures resource document), (2) provide benchmark (Baseline) data, and (3) provide the data source for tracking progress.

5% increase in viral suppression for all PLWH in Texas. (Baseline – 56%) (ARIES, EHARS)

7. Stage of the HIV Care Continuum related to this service category: More than one Stage may be applicable.

I. Diagnosed ☐ II. Linked to Care ☐ III. Retained in Care ☐ IV. Prescribed Antiretroviral Therapy ☐ V. Virally Suppressed ☒

Service Category: Outpatient/Ambulatory Medical Care				**Total Allocation** Part B Base: **$5,538,906** ADAP: ADAP Supplemental: Emerging Communities: Minority AIDS Initiative:	
Service Goal: Promote essential medical services and therapies that are consistent with USPHS treatment guidelines to all persons living with HIV in Texas				**Current Comprehensive Plan:** Improve access to quality care and treatment for HIV-infected Texans. Ensure high quality of care. Enhance access to care and reduce disparities.	
1. Objectives: List SMART (specific, measurable, achievable, realistic, and time-phased) objectives that support the service goal listed above	**2. Service Unit Definition:** Define the service unit to be provided for each objective	**3. Quantity**		**4. Time Frame:** Indicate the estimated duration of activity relating to the objective listed.	**5. Funds:** Provide the approximate amount of all Part B funds to be used for each objective by funding source.
		3a) Total Number of people to be served	3b) Total Number of service units to be provided		
a: By March 31, 2017, at least 9,400 persons with HIV will receive at least one OAMC (medical visit or laboratory) service.	Per medical visit or test	30,000	52,431	4/1/2016-3/31/2017	$5,538,906
6. Outcomes: For each SMART objective, (1) name at least one client-level outcome/indicator to be tracked for the objective (using the HAB Standard Outcome Measures resource document), (2) provide benchmark (Baseline) data, and (3) provide the data source for tracking progress. 5% increase in number of RW clients accessing medical care with at least 2 medical visits (provider visit or laboratory) reported in the reporting year. (Baseline – 16,800) (ARIES) 2% increase in viral suppression for all PLWH in Texas (Baseline – 76%) (ARIES, EHARS)					
7. Stage of the HIV Care Continuum related to this service category: More than one Stage may be applicable. I. Diagnosed ☐ II. Linked to Care ☐ III. Retained in Care ☒ IV. Prescribed Antiretroviral Therapy ☐ V. Virally Suppressed ☒					

Service Category: Oral Health				**Total Allocation** Part B Base: **$2,819,906** ADAP: ADAP Supplemental: Emerging Communities: Minority AIDS Initiative:	
Service Goal: Promote oral health care and therapies that are consistent with USPHS treatment guidelines to eligible RW persons living with HIV in Texas				**Current Comprehensive Plan:** Improve access to quality care and treatment for HIV-infected Texans. Ensure high quality of care. Enhance access to care and reduce disparities.	
1. Objectives: List SMART (specific, measurable, achievable, realistic, and time-phased) objectives that support the service goal listed above	**2. Service Unit Definition:** Define the service unit to be provided for each objective	**3. Quantity**		**4. Time Frame:** Indicate the estimated duration of activity relating to the objective listed.	**5. Funds:** Provide the approximate amount of all Part B funds to be used for each objective by funding source.
		3a) Total Number of people to be served	3b) Total Number of service units to be provided		
a: By March 31, 2017, oral health care will be provided to at least 9,700 RW eligible HIV positive persons.	Per visit	9,700	50,577	4/1/2016-3/31/2017	$2,819,906

6. Outcomes: For each SMART objective, (1) name at least one client-level outcome/indicator to be tracked for the objective (using the HAB Standard Outcome Measures resource document), (2) provide benchmark (Baseline) data, and (3) provide the data source for tracking progress.

5% increase in the number of RW clients having at least one oral health visit by a dentist in the grant year (Baseline – 24%) (ARIES)

7. Stage of the HIV Care Continuum related to this service category: More than one Stage may be applicable.

I. Diagnosed ☐ II. Linked to Care ☐ III. Retained in Care ☒ IV. Prescribed Antiretroviral Therapy ☐ V. Virally Suppressed ☐

Service Category: Medical Case Management				**Total Allocation** Part B Base: **$2,161,249** ADAP: ADAP Supplemental: Emerging Communities: Minority AIDS Initiative:	
Service Goal: Promote access to medical services to RW eligible persons living with HIV in Texas to that they enter and maintain themselves in medical care				**Current Comprehensive Plan:** Improve access to quality care and treatment for HIV-infected Texans. Ensure high quality of care. Enhance access to care and reduce disparities.	
1. Objectives: List SMART (specific, measurable, achievable, realistic, and time-phased) objectives that support the service goal listed above	**2. Service Unit Definition:** Define the service unit to be provided for each objective	**3. Quantity** 3a) Total Number of people to be served	**3. Quantity** 3b) Total Number of service units to be provided	**4. Time Frame:** Indicate the estimated duration of activity relating to the objective listed.	**5. Funds:** Provide the approximate amount of all Part B funds to be used for each objective by funding source.
a: By March 31, 2017, at least 9,000 RW eligible HIV positive persons have medical case management services.	Per 15 minutes	9,700	50,577	4/1/2016-3/31/2017	$2,161,249

6. Outcomes: For each SMART objective, (1) name at least one client-level outcome/indicator to be tracked for the objective (using the HAB Standard Outcome Measures resource document), (2) provide benchmark (Baseline) data, and (3) provide the data source for tracking progress.

5% increase in number of RW clients having access to MCM services to ensure access to primary medical care and support services as needed. (Baseline – 45%) (ARIES)
5% increase in RW clients with HIV infection on ARVs who were assessed and counseled for treatment adherence two or more times. (Baseline – 30%) (ARIES)
5% increase in RW clients accessing MCM services retained in care (Baseline – unknown but viral suppressed 69%) (ARIES)

7. Stage of the HIV Care Continuum related to this service category: More than one Stage may be applicable.

I. Diagnosed ☐ II. Linked to Care ☒ III. Retained in Care ☒ IV. Prescribed Antiretroviral Therapy ☒ V. Virally Suppressed ☒

Service Category: Health Insurance Premium and Cost Sharing Assistance				**Total Allocation** Part B Base: **$2,358,584** ADAP: _____ ADAP Supplemental: _____ Emerging Communities: _____ Minority AIDS Initiative:	
Service Goal: Promote access to medical services to all PWLH so that they enter and maintain themselves in medical care.				**Current Comprehensive Plan:** Improve access to quality care and treatment for HIV-infected Texans. Ensure high quality of care. Enhance access to care and reduce disparities.	
1. Objectives: List SMART (specific, measurable, achievable, realistic, and time-phased) objectives that support the service goal listed above	**2. Service Unit Definition:** Define the service unit to be provided for each objective	**3. Quantity**		**4. Time Frame:** Indicate the estimated duration of activity relating to the objective listed.	**5. Funds:** Provide the approximate amount of all Part B funds to be used for each objective by funding source.
		3a) Total Number of people to be served	3b) Total Number of service units to be provided		
a: By March 31, 2017 at least 4,500 eligible RW HIV positive persons will maintain health insurance.	Per payment	4,500	12,675	4/1/2016-3/31/2017	$2,358,584
6. Outcomes: For each SMART objective, (1) name at least one client-level outcome/indicator to be tracked for the objective (using the HAB Standard Outcome Measures resource document), (2) provide benchmark (Baseline) data, and (3) provide the data source for tracking progress. Determine Baseline for number of PLWH with health insurance plan (Baseline – unknown) (ARIES) 5% increase in primary medical care due to health insurance coverage (Baseline 68%) (ARIES)					
7. Stage of the HIV Care Continuum related to this service category: More than one Stage may be applicable. I. Diagnosed ☐ II. Linked to Care ☐ III. Retained in Care ☒ IV. Prescribed Antiretroviral Therapy ☒ V. Virally Suppressed ☒					

Service Category: Mental Health Services				**Total Allocation** Part B Base: **$206,431** ADAP: _____ ADAP Supplemental: _____ Emerging Communities: _____ Minority AIDS Initiative:	
Service Goal: Promote oral health care and therapies that are consistent with USPHS treatment guidelines to PLWH in Texas.				**Current Comprehensive Plan:** Improve access to quality care and treatment for HIV-infected Texans. Ensure high quality of care. Enhance access to care and reduce disparities.	
1. Objectives: List SMART (specific, measurable, achievable, realistic, and time-phased) objectives that support the service goal listed above	**2. Service Unit Definition:** Define the service unit to be provided for each objective	**3. Quantity**		**4. Time Frame:** Indicate the estimated duration of activity relating to the objective listed.	**5. Funds:** Provide the approximate amount of all Part B funds to be used for each objective by funding source.
		3a) Total Number of people to be served	3b) Total Number of service units to be provided		
a: March 31, 2017, a minimum of 2,400 PLWH will be provided mental health services.	Per visit	2,400	8,000	4/1/2016-3/31/2017	$206,431

6. Outcomes: For each SMART objective, (1) name at least one client-level outcome/indicator to be tracked for the objective (using the HAB Standard Outcome Measures resource document), (2) provide benchmark (Baseline) data, and (3) provide the data source for tracking progress.

90% of clients in MH services have a documented treatment plan. (Baseline – unknown) (ARIES, chart reviews)
90% of clients referred to mental health will present for mental health services (counseling and treatment) (Baseline – unknown) (ARIES, chart reviews)
5% increase in the number of PLWH clients retained in medical care having accessed mental health services (Baseline – 75%) (ARIES)

7. Stage of the HIV Care Continuum related to this service category: More than one Stage may be applicable.

I. Diagnosed ☐ II. Linked to Care ☐ III. Retained in Care ☒ IV. Prescribed Antiretroviral Therapy ☐ V. Virally Suppressed ☐

Service Category: Home and Community-Based Health Services				**Total Allocation** Part B Base: **$257,778** ADAP: ADAP Supplemental: Emerging Communities: Minority AIDS Initiative:	
Service Goal: Promote access to medical services to RW eligible persons living with HIV.				**Current Comprehensive Plan:** Improve access to quality care and treatment for HIV-infected Texans. Ensure high quality of care. Enhance access to care and reduce disparities.	
1. Objectives: List SMART (specific, measurable, achievable, realistic, and time-phased) objectives that support the service goal listed above	**2. Service Unit Definition:** Define the service unit to be provided for each objective	**3. Quantity**		**4. Time Frame:** Indicate the estimated duration of activity relating to the objective listed.	**5. Funds:** Provide the approximate amount of all Part B funds to be used for each objective by funding source.
		3a) Total Number of people to be served	3b) Total Number of service units to be provided		
a: By March 31, 2017 at least 136 RW eligible clients will be provided home and community-based services	Per visit	136	3,739	4/1/2016-3/31/2017	$257,778

6. Outcomes: For each SMART objective, (1) name at least one client-level outcome/indicator to be tracked for the objective (using the HAB Standard Outcome Measures resource document), (2) provide benchmark (Baseline) data, and (3) provide the data source for tracking progress.

The number of RW clients accessing home and community based health services will remain the same (Baseline – 136) (ARIES)
Increase by 10 the number of clients accessing home and community-based health services being virally suppressed (Baseline – 101) (ARIES)

7. Stage of the HIV Care Continuum related to this service category: More than one Stage may be applicable.

I. Diagnosed ☐ II. Linked to Care ☐ III. Retained in Care ☒ IV. Prescribed Antiretroviral Therapy ☐ V. Virally Suppressed ☒

Service Category: Medical Nutrition Services				**Total Allocation** Part B Base: **$103,250** ADAP: ADAP Supplemental: Emerging Communities: Minority AIDS Initiative:	
Service Goal: Provide medical nutritional services to eligible RW clients to maintain good nutrition to promote optimal health status.				**Current Comprehensive Plan:** Improve access to quality care and treatment for HIV-infected Texans. Ensure high quality of care. Enhance access to care and reduce disparities.	
1. Objectives: List SMART (specific, measurable, achievable, realistic, and time-phased) objectives that support the service goal listed above	**2. Service Unit Definition:** Define the service unit to be provided for each objective	**3. Quantity** 3a) Total Number of people to be served	**3. Quantity** 3b) Total Number of service units to be provided	**4. Time Frame:** Indicate the estimated duration of activity relating to the objective listed.	**5. Funds:** Provide the approximate amount of all Part B funds to be used for each objective by funding source.
a: By March 31, 2017, at least 1,800 RW eligible clients will received nutritional support.	Per visit	1,800	3,800	4/1/2016-3/31/2017	$103,250

6. Outcomes: For each SMART objective, (1) name at least one client-level outcome/indicator to be tracked for the objective (using the HAB Standard Outcome Measures resource document), (2) provide benchmark (Baseline) data, and (3) provide the data source for tracking progress.

90% of clients referred to medical nutrition services will have a nutritional assessment conducted with a Registered Dietitian. (Baseline – unknown) (chart reviews)
Increase by 5 clients who have accessed medical nutrition services having improved health outcomes as evidenced by viral suppression (Baseline – 81) (ARIES)

7. Stage of the HIV Care Continuum related to this service category: More than one Stage may be applicable.

I. Diagnosed ☐ II. Linked to Care ☐ III. Retained in Care ☒ IV. Prescribed Antiretroviral Therapy ☐ V. Virally Suppressed ☒

Service Category: Substance Use (Abuse) Services – Outpatient				**Total Allocation** Part B Base: **$72,975** ADAP: ADAP Supplemental: Emerging Communities: Minority AIDS Initiative:	
Service Goal: Promote oral health care and therapies that are consistent with USPHS treatment guidelines to eligible RW persons living with HIV in Texas				**Current Comprehensive Plan:** Improve access to quality care and treatment for HIV-infected Texans. Ensure high quality of care. Enhance access to care and reduce disparities.	
1. Objectives: List SMART (specific, measurable, achievable, realistic, and time-phased) objectives that support the service goal listed above	**2. Service Unit Definition:** Define the service unit to be provided for each objective	**3. Quantity** 3a) Total Number of people to be served	**3. Quantity** 3b) Total Number of service units to be provided	**4. Time Frame:** Indicate the estimated duration of activity relating to the objective listed.	**5. Funds:** Provide the approximate amount of all Part B funds to be used for each objective by funding source.
a: By March 31, 2017 at least 800 RW eligible clients will have accessed outpatient substance use treatment services	Per visit	800	1,600	4/1/2016-3/31/2017	$72,975

6. Outcomes: For each SMART objective, (1) name at least one client-level outcome/indicator to be tracked for the objective (using the HAB Standard Outcome Measures resource document), (2) provide benchmark (Baseline) data, and (3) provide the data source for tracking progress.

95% of clients in substance abuse-outpatient services have a developed treatment plan with goals and objectives. (Baseline – unknown) (ARIES, chart reviews)
25% of clients accessing substance abuse-outpatient services report decline in substance use. (Baseline – unknown) (ARIES, chart reviews)
5% increase in the number of RW eligible clients accessing substance abuse outpatient services achieving viral suppression (Baseline – 69%) (ARIES)

7. Stage of the HIV Care Continuum related to this service category: More than one Stage may be applicable.

I. Diagnosed ☐ II. Linked to Care ☐ III. Retained in Care ☒ IV. Prescribed Antiretroviral Therapy ☐ V. Virally Suppressed ☒

Service Category: Early Intervention Services				**Total Allocation** Part B Base: **$108,182** ADAP: _____ ADAP Supplemental: _____ Emerging Communities: _____ Minority AIDS Initiative:	
Service Goal: Promote early diagnosis and linkage to care for newly diagnosed HIV positive living in Texas.				**Current Comprehensive Plan:** Improve access to quality care and treatment for HIV-infected Texans. Ensure high quality of care. Enhance access to care and reduce disparities.	
1. Objectives: List SMART (specific, measurable, achievable, realistic, and time-phased) objectives that support the service goal listed above	**2. Service Unit Definition:** Define the service unit to be provided for each objective	**3. Quantity**		**4. Time Frame:** Indicate the estimated duration of activity relating to the objective listed.	**5. Funds:** Provide the approximate amount of all Part B funds to be used for each objective by funding source.
		3a) Total Number of people to be served	3b) Total Number of service units to be provided		
a: By March 31, 2017 at least 100 newly diagnosed HIV positive clients will be linked into care within 3 months.	Per encounter	800	1,000	4/1/2016-3/31/2017	$108,182

6. Outcomes: For each SMART objective, (1) name at least one client-level outcome/indicator to be tracked for the objective (using the HAB Standard Outcome Measures resource document), (2) provide benchmark (Baseline) data, and (3) provide the data source for tracking progress.

Increase by 2% the number of newly diagnosed HIV positive clients in Texas that have at least one visit within 3 months (met need) (Baseline 77%) (ARIES, EHARS)
Increase by 5% the number of newly diagnosed HIV positive clients that have been retained in care with at least 2 visits or labs at least 3 months apart (Baseline 80%) (ARIES, EHARS).

7. Stage of the HIV Care Continuum related to this service category: More than one Stage may be applicable.

I. Diagnosed ☐ II. Linked to Care ☒ III. Retained in Care ☒ IV. Prescribed Antiretroviral Therapy ☐ V. Virally Suppressed ☐

Service Category: Home Health Care Services				**Total Allocation** Part B Base: **$185,500** ADAP: ADAP Supplemental: Emerging Communities: Minority AIDS Initiative:	
Service Goal: Promote medical care to eligible PLWH so that they maintain their health.				**Current Comprehensive Plan:** Improve access to quality care and treatment for HIV-infected Texans. Ensure high quality of care. Enhance access to care and reduce disparities.	
1. Objectives: List SMART (specific, measurable, achievable, realistic, and time-phased) objectives that support the service goal listed above	**2. Service Unit Definition:** Define the service unit to be provided for each objective	**3. Quantity**		**4. Time Frame:** Indicate the estimated duration of activity relating to the objective listed.	**5. Funds:** Provide the approximate amount of all Part B funds to be used for each objective by funding source.
		3a) Total Number of people to be served	3b) Total Number of service units to be provided		
a: By March 31, 2017 no more than 10 RW eligible clients will have accessed home health care services	Per visit	10	28	4/1/2016-3/31/2017	$185,500
6. Outcomes: For each SMART objective, (1) name at least one client-level outcome/indicator to be tracked for the objective (using the HAB Standard Outcome Measures resource document), (2) provide benchmark (Baseline) data, and (3) provide the data source for tracking progress. 90% of RW eligible clients accessing home health services will be virally suppressed (Baseline – 77%) (ARIES, chart reviews)					
7. Stage of the HIV Care Continuum related to this service category: More than one Stage may be applicable. I. Diagnosed ☐ II. Linked to Care ☐ III. Retained in Care ☐ IV. Prescribed Antiretroviral Therapy ☐ V. Virally Suppressed ☒					

Service Category: Hospice				**Total Allocation** Part B Base: **$34,654** ADAP: _____ ADAP Supplemental: _____ Emerging Communities: _____ Minority AIDS Initiative:	
Service Goal: Promote quality of life for end stage HIV or other related disease for PLWH.				**Current Comprehensive Plan:** Improve access to quality care and treatment for HIV-infected Texans. Ensure high quality of care. Enhance access to care and reduce disparities.	
1. Objectives: List SMART (specific, measurable, achievable, realistic, and time-phased) objectives that support the service goal listed above	**2. Service Unit Definition:** Define the service unit to be provided for each objective	**3. Quantity**		**4. Time Frame:** Indicate the estimated duration of activity relating to the objective listed.	**5. Funds:** Provide the approximate amount of all Part B funds to be used for each objective by funding source.
		3a) Total Number of people to be served	3b) Total Number of service units to be provided		
a: By March 31, 2017 no more than 75 clients will have need to access hospice care.	Per day	75	1,2500	4/1/2016-3/31/2017	$34,654
6. Outcomes: For each SMART objective, (1) name at least one client-level outcome/indicator to be tracked for the objective (using the HAB Standard Outcome Measures resource document), (2) provide benchmark (Baseline) data, and (3) provide the data source for tracking progress. 5% increase in the number of RW clients accessing hospice are virally suppressed (Baseline – 59%) (ARIES)					
7. Stage of the HIV Care Continuum related to this service category: More than one Stage may be applicable. I. Diagnosed ☐ II. Linked to Care ☐ III. Retained in Care ☐ IV. Prescribed Antiretroviral Therapy ☐ V. Virally Suppressed ☒					

Service Category: Child Care				**Total Allocation** Part B Base: **$72,883** ADAP: _____ ADAP Supplemental: _____ Emerging Communities: _____ Minority AIDS Initiative:	
Service Goal: Promote quality of life clients with HIV				**Current Comprehensive Plan:** Improve access to quality care and treatment for HIV-infected Texans. Ensure high quality of care. Enhance access to care and reduce disparities.	
1. Objectives: List SMART (specific, measurable, achievable, realistic, and time-phased) objectives that support the service goal listed above	**2. Service Unit Definition:** Define the service unit to be provided for each objective	**3. Quantity**		**4. Time Frame:** Indicate the estimated duration of activity relating to the objective listed.	**5. Funds:** Provide the approximate amount of all Part B funds to be used for each objective by funding source.
		3a) Total Number of people to be served	3b) Total Number of service units to be provided		
a: By March 31, 2017 no more than 20 clients will have need to access child care services to participate in medical care.	Per day	20	100	4/1/2016-3/31/2017	$72,883

6. Outcomes: For each SMART objective, (1) name at least one client-level outcome/indicator to be tracked for the objective (using the HAB Standard Outcome Measures resource document), (2) provide benchmark (Baseline) data, and (3) provide the data source for tracking progress.

5% increase in number of RW clients accessing medical care with at least 2 medical visits (provider visit or laboratory) reported in the reporting year. (Baseline – 16,800) (ARIES)
5% increase in the number of RW eligible clients accessing child care are virally suppressed (Baseline – 67%) (ARIES)

7. Stage of the HIV Care Continuum related to this service category: More than one Stage may be applicable.

I. Diagnosed ☐ II. Linked to Care ☐ III. Retained in Care ☒ IV. Prescribed Antiretroviral Therapy ☐ V. Virally Suppressed ☒

Service Category: Medical Transportation	**Total Allocation** Part B Base: **$447,085** ADAP: _____ ADAP Supplemental: _____ Emerging Communities: _____ Minority AIDS Initiative:
Service Goal: Promote access to essential support services to eligible persons living with HIV in Texas so that they may access and maintain themselves in medical care.	**Reference Current Comprehensive Plan:** Improve access to quality care and treatment for HIV-infected Texans. Ensure high quality of care. Enhance access to care and reduce disparities.

1. Objectives: List SMART (specific, measurable, achievable, realistic, and time-phased) objectives that support the service goal listed above	**2. Service Unit Definition:** Define the service unit to be provided for each objective	**3. Quantity**		**4. Time Frame:** Indicate the estimated duration of activity relating to the objective listed.	**5. Funds:** Provide the approximate amount of all Part B funds to be used for each objective by funding source.
		3a) Total Number of people to be served	3b) Total Number of service units to be provided		
a: By March 31, 2017, medical transportation services will be provided to at least 6,000 eligible RW HIV positive persons	per 1 way trip	6,000	8,712	4/1/2016-3/31/2017	$ 447,085

6. Outcomes: For each SMART objective, (1) name at least one client-level outcome/indicator to be tracked for the objective (using the HAB Standard Outcome Measures resource document), (2) provide benchmark (Baseline) data, and (3) provide the data source for tracking progress.

Maintain the number of persons needing medical transportation services to and from medical appointments (Baseline – 6,089) (ARIES)
Increase by 2% the percentage of RW eligible clients accessing medical transportation services who attended at least 2 medical provider visits per year. (Baseline – unknown) (ARIES)
Increase by 2% the percentage of clients accessing medical transportation services virally suppressed (Baseline – 72%) (ARIES)

7. Stage of the HIV Care Continuum related to this service category: More than one Stage may be applicable.

I. Diagnosed ☐ II. Linked to Care ☐ III. Retained in Care ☒ IV. Prescribed Antiretroviral Therapy ☐ V. Virally Suppressed ☒

Service Category: Legal Services				**Total Allocation** Part B Base: **$19,000** ADAP: ADAP Supplemental: Emerging Communities: Minority AIDS Initiative:	
Service Goal: Promote access to essential support services to eligible persons living with HIV in Texas so that they may access and maintain themselves in medical care.				**Reference Current Comprehensive Plan:** Improve access to quality care and treatment for HIV-infected Texans. Ensure high quality of care. Enhance access to care and reduce disparities.	
1. Objectives: List SMART (specific, measurable, achievable, realistic, and time-phased) objectives that support the service goal listed above	**2. Service Unit Definition:** Define the service unit to be provided for each objective	**3. Quantity**		**4. Time Frame:** Indicate the estimated duration of activity relating to the objective listed.	**5. Funds:** Provide the approximate amount of all Part B funds to be used for each objective by funding source.
		3a) Total Number of people to be served	3b) Total Number of service units to be provided		
a: By March 31, 2017, legal services will be provided to at least 475 RW eligible HIV positive persons.	1 hour of service provided by licensed attorney	475	800	4/1/2016-3/31/2017	$19,000
6. Outcomes: For each SMART objective, (1) name at least one client-level outcome/indicator to be tracked for the objective (using the HAB Standard Outcome Measures resource document), (2) provide benchmark (Baseline) data, and (3) provide the data source for tracking progress. 90% of all RW eligible clients accessing legal services will have completed service plan. (Baseline – unknown) (ARIES, chart review) Increase by 5% the percentage of RW eligible clients accessing legal services being virally suppressed (Baseline – 81%)					
7. Stage of the HIV Care Continuum related to this service category: More than one Stage may be applicable. I. Diagnosed ☐ II. Linked to Care ☐ III. Retained in Care ☒ IV. Prescribed Antiretroviral Therapy ☐ V. Virally Suppressed ☒					

Service Category: Food bank/home delivered meals				**Total Allocation** Part B Base: **$197,182** ADAP: ADAP Supplemental: Emerging Communities: Minority AIDS Initiative:	
Service Goal: To promote access to ancillary support services to eligible persons living with HIV in Texas so that they may access and maintain themselves in medical care.				**Reference Current Comprehensive Plan:** Improve access to quality care and treatment for HIV-infected Texans. Ensure high quality of care. Enhance access to care and reduce disparities.	
1. Objectives: List SMART (specific, measurable, achievable, realistic, and time-phased) objectives that support the service goal listed above	**2. Service Unit Definition:** Define the service unit to be provided for each objective	**3. Quantity**		**4. Time Frame:** Indicate the estimated duration of activity relating to the objective listed.	**5. Funds:** Provide the approximate amount of all Part B funds to be used for each objective by funding source.
		3a) Total Number of people to be served	3b) Total Number of service units to be provided		
a: By March 31, 2017, food bank/home-delivered meals will be provided to at least 5,300 eligible HIV positive persons	per visit	5,300	13,356	4/1/2016-3/31/2017	$197,182

6. Outcomes: For each SMART objective, (1) name at least one client-level outcome/indicator to be tracked for the objective (using the HAB Standard Outcome Measures resource document), (2) provide benchmark (Baseline) data, and (3) provide the data source for tracking progress.

Maintain the number of persons needing food bank/home delivered meals to FY14 levels or below (Baseline – 5,364) (ARIES)
Increase by 2% the percentage of RW eligible clients accessing food bank who attended at least 2 medical provider visits per year. (Baseline – unknown) (ARIES)
Increase by 2% the percentage of clients accessing food bank/home delivered meals virally suppressed (Baseline – 74%) (ARIES)

7. Stage of the HIV Care Continuum related to this service category: More than one Stage may be applicable.

I. Diagnosed ☐ II. Linked to Care ☐ III. Retained in Care ☒ IV. Prescribed Antiretroviral Therapy ☐ V. Virally Suppressed ☒

Service Category: Linguistics Services					**Total Allocation** Part B Base: **$770** ADAP: ADAP Supplemental: Emerging Communities: Minority AIDS Initiative:
Service Goal: To promote access to ancillary support services to eligible persons living with HIV in Texas so that they may access and maintain themselves in medical care.					**Reference Current Comprehensive Plan:** Improve access to quality care and treatment for HIV-infected Texans. Ensure high quality of care. Enhance access to care and reduce disparities.
1. Objectives: List SMART (specific, measurable, achievable, realistic, and time-phased) objectives that support the service goal listed above	**2. Service Unit Definition:** Define the service unit to be provided for each objective	**3. Quantity**		**4. Time Frame:** Indicate the estimated duration of activity relating to the objective listed.	**5. Funds:** Provide the approximate amount of all Part B funds to be used for each objective by funding source.
		3a) Total Number of people to be served	3b) Total Number of service units to be provided		
a: By March 31, 2017, at least 230 RW eligible clients will receive linguistic services	per translation/interpreter services 15 minutes	230	600	4/1/2016-3/31/2017	$ 770

6. Outcomes: For each SMART objective, (1) name at least one client-level outcome/indicator to be tracked for the objective (using the HAB Standard Outcome Measures resource document), (2) provide benchmark (Baseline) data, and (3) provide the data source for tracking progress.

Maintain the same amount of services in FY14 available to RW eligible clients for language services two times per year or as needed. (Baseline – 228) (ARIES)
90% of clients accessing linguistic services are engaged in their medical care and understand their medical treatment plan. (Baseline – unknown) (chart review)
Increase by 2% the percentage of clients needing linguistic services who are virally suppressed (Baseline – 83%) (ARIES)

7. Stage of the HIV Care Continuum related to this service category: More than one Stage may be applicable.

I. Diagnosed ☐ II. Linked to Care ☐ III. Retained in Care ☒ IV. Prescribed Antiretroviral Therapy ☐ V. Virally Suppressed ☐

Service Category: Psychosocial Support Services				**Total Allocation** Part B Base: **$447,085** ADAP: ADAP Supplemental: Emerging Communities: Minority AIDS Initiative:	
Service Goal: To promote access to ancillary support services to eligible persons living with HIV in Texas so that they may access and maintain themselves in medical care.				**Reference Current Comprehensive Plan:** Improve access to quality care and treatment for HIV-infected Texans. Ensure high quality of care. Enhance access to care and reduce disparities.	
1. Objectives: List SMART (specific, measurable, achievable, realistic, and time-phased) objectives that support the service goal listed above	**2. Service Unit Definition:** Define the service unit to be provided for each objective	**3. Quantity**		**4. Time Frame:** Indicate the estimated duration of activity relating to the objective listed.	**5. Funds:** Provide the approximate amount of all Part B funds to be used for each objective by funding source.
		3a) Total Number of people to be served	3b) Total Number of service units to be provided		
a: By March 31, 2017, psychosocial support services will be provided to at least 480 eligible RW HIV positive persons.	Per 15 minutes	480	8,712	4/1/2016-3/31/2017	$ 447,085

6. Outcomes: For each SMART objective, (1) name at least one client-level outcome/indicator to be tracked for the objective (using the HAB Standard Outcome Measures resource document), (2) provide benchmark (Baseline) data, and (3) provide the data source for tracking progress.

Maintain the number of RW eligible clients receiving psychosocial services that are engaged in supportive groups to FY14 levels or below (Baseline – unknown(ARIES)
Increase by 2% the percentage of RW eligible clients in psychosocial services retained in care. (Baseline – unknown) (ARIES)
Increase by 2% the percentage of RW eligible clients virally suppressed (Baseline – 76 %) (ARIES)

7. Stage of the HIV Care Continuum related to this service category: More than one Stage may be applicable.

I. Diagnosed ☐ II. Linked to Care ☐ III. Retained in Care ☒ IV. Prescribed Antiretroviral Therapy ☐ V. Virally Suppressed ☒

Service Category: Emergency Financial Assistance				**Total Allocation** Part B Base: **$17,796** ADAP: _____ ADAP Supplemental: _____ Emerging Communities: _____ Minority AIDS Initiative:	
Service Goal: To promote access to ancillary support services to eligible persons living with HIV in Texas so that they may access and maintain themselves in medical care.				**Reference Current Comprehensive Plan:** Improve access to quality care and treatment for HIV-infected Texans. Ensure high quality of care. Enhance access to care and reduce disparities.	
1. Objectives: List SMART (specific, measurable, achievable, realistic, and time-phased) objectives that support the service goal listed above	**2. Service Unit Definition:** Define the service unit to be provided for each objective	**3. Quantity**		**4. Time Frame:** Indicate the estimated duration of activity relating to the objective listed.	**5. Funds:** Provide the approximate amount of all Part B funds to be used for each objective by funding source.
		3a) Total Number of people to be served	3b) Total Number of service units to be provided		
c: By March 31, 2017 emergency financial assistance will be provided to at least 680 eligible RW HIV positive persons	per payment	680	1,200	4/1/2016-3/31/2017	$17,796

6. Outcomes: For each SMART objective, (1) name at least one client-level outcome/indicator to be tracked for the objective (using the HAB Standard Outcome Measures resource document), (2) provide benchmark (Baseline) data, and (3) provide the data source for tracking progress.

90% of RW eligible clients accessing EFA have documented need and resolution of need addressed in care plan. (Baseline – unknown) (ARIES, chart review)
80% of clients accessing EFA are confirmed in HIV primary medical care as evidenced by 2 medical visits in a year at least 6 months apart. (Baseline – unknown) (ARIES, chart reviews)

7. Stage of the HIV Care Continuum related to this service category: More than one Stage may be applicable.

I. Diagnosed ☐ II. Linked to Care ☐ III. Retained in Care ☒ IV. Prescribed Antiretroviral Therapy ☐ V. Virally Suppressed ☒

Service Category: Outreach	**Total Allocation** Part B Base: **$1,050,607** ADAP: ADAP Supplemental: Emerging Communities: Minority AIDS Initiative:
Service Goal: Promote access to essential support services to eligible persons living with HIV in Texas so that they may access and maintain themselves in medical care.	**Reference Current Comprehensive Plan:** Improve access to quality care and treatment for HIV-infected Texans. Ensure high quality of care. Enhance access to care and reduce disparities.

1. Objectives: List SMART (specific, measurable, achievable, realistic, and time-phased) objectives that support the service goal listed above	**2. Service Unit Definition:** Define the service unit to be provided for each objective	**3. Quantity**		**4. Time Frame:** Indicate the estimated duration of activity relating to the objective listed.	**5. Funds:** Provide the approximate amount of all Part B funds to be used for each objective by funding source.
		3a) Total Number of people to be served	3b) Total Number of service units to be provided		
f: By March 31, 2017 **NON-MAI (Base Formula) funded outreach** services will be provided to at least 3,000 RW eligible HIV positive persons	per encounter	3,000	20,119	4/1/2016-3/31/2017	$ 1,050,607

6. Outcomes: For each SMART objective, (1) name at least one client-level outcome/indicator to be tracked for the objective (using the HAB Standard Outcome Measures resource document), (2) provide benchmark (Baseline) data, and (3) provide the data source for tracking progress.

Increase by 2% the percentage of newly diagnosed RW eligible clients linked into care (Baseline – 81%) (ARIES, EHARS)

7. Stage of the HIV Care Continuum related to this service category: More than one Stage may be applicable.

I. Diagnosed ☐ II. Linked to Care ☒ III. Retained in Care ☐ IV. Prescribed Antiretroviral Therapy ☐ V. Virally Suppressed ☐

Service Category: Health Education and Risk Reduction	**Total Allocation** Part B Base: **$ 110,492** ADAP: _____ ADAP Supplemental: _____ Emerging Communities: _____ Minority AIDS Initiative:
Service Goal: Promote access to essential support services to eligible persons living with HIV in Texas so that they may access and maintain themselves in medical care.	**Reference Current Comprehensive Plan:** Improve access to quality care and treatment for HIV-infected Texans. Ensure high quality of care. Enhance access to care and reduce disparities.

1. Objectives: List SMART (specific, measurable, achievable, realistic, and time-phased) objectives that support the service goal listed above	**2. Service Unit Definition:** Define the service unit to be provided for each objective	**3. Quantity**		**4. Time Frame:** Indicate the estimated duration of activity relating to the objective listed.	**5. Funds:** Provide the approximate amount of all Part B funds to be used for each objective by funding source.
		3a) Total Number of people to be served	3b) Total Number of service units to be provided		
e: By March 31, 2017 **NON MAI (Part B Base Formula) funded Health Education and Risk Reduction** services will be provided to at least 1,700 RW eligible HIV positive persons	per 15 minutes	1,700	3,400	4/1/2016-3/31/2017	$ 110,492

6. Outcomes: For each SMART objective, (1) name at least one client-level outcome/indicator to be tracked for the objective (using the HAB Standard Outcome Measures resource document), (2) provide benchmark (Baseline) data, and (3) provide the data source for tracking progress.

Increase by 2% the percentage of RW eligible clients who have attended at least one health education or risk reduction course (Baseline – unknown) (chart review)
Increase by 2 % the percentage of RW eligible clients who have accessed health education and risk reduction offerings are virally suppressed (Baseline – 77%) (ARIES)

7. Stage of the HIV Care Continuum related to this service category: More than one Stage may be applicable.

I. Diagnosed ☐ II. Linked to Care ☐ III. Retained in Care ☒ IV. Prescribed Antiretroviral Therapy ☐ V. Virally Suppressed ☒

Service Category: Case management – non-medical	**Total Allocation** Part B Base: **$1,514,805** ADAP: _____ ADAP Supplemental: _____ Emerging Communities: _____ Minority AIDS Initiative:
Service Goal: Promote access to essential support services to eligible persons living with HIV in Texas so that they may access and maintain themselves in medical care.	**Reference Current Comprehensive Plan:** Improve access to quality care and treatment for HIV-infected Texans. Ensure high quality of care. Enhance access to care and reduce disparities.

1. Objectives: List SMART (specific, measurable, achievable, realistic, and time-phased) objectives that support the service goal listed above	**2. Service Unit Definition:** Define the service unit to be provided for each objective	**3. Quantity**		**4. Time Frame:** Indicate the estimated duration of activity relating to the objective listed.	**5. Funds:** Provide the approximate amount of all Part B funds to be used for each objective by funding source.
		3a) Total Number of people to be served	3b) Total Number of service units to be provided		
e: By March 31, 2017, non-medical case management services will be provided to at least 18,000 RW eligible HIV positive persons	per 15 minutes	18,000	25,700	4/1/2016-3/31/2017	$ 110,492

6. Outcomes: For each SMART objective, (1) name at least one client-level outcome/indicator to be tracked for the objective (using the HAB Standard Outcome Measures resource document), (2) provide benchmark (Baseline) data, and (3) provide the data source for tracking progress.

Increase by 2 % the percentage of RW eligible clients who have accessed non-medical case management services are retained in care (Baseline – unknown) (ARIES)
Increase by 2% the percentage of RW eligible clients who have accessed non-medical case management services are virally suppressed (Baseline – 71%) (ARIES)

7. Stage of the HIV Care Continuum related to this service category: More than one Stage may be applicable.

I. Diagnosed ☐ II. Linked to Care ☐ III. Retained in Care ☒ IV. Prescribed Antiretroviral Therapy ☐ V. Virally Suppressed ☒

Service Category: Housing Support Services	**Total Allocation** Part B Base: **$ 1,000** ADAP: _____ ADAP Supplemental: _____ Emerging Communities: _____ Minority AIDS Initiative: _____
Service Goal: Promote access to essential support services to eligible persons living with HIV in Texas so that they may access and maintain themselves in medical care.	**Reference Current Comprehensive Plan:** Improve access to quality care and treatment for HIV-infected Texans. Ensure high quality of care. Enhance access to care and reduce disparities.

1. Objectives: List SMART (specific, measurable, achievable, realistic, and time-phased) objectives that support the service goal listed above	**2. Service Unit Definition:** Define the service unit to be provided for each objective	**3. Quantity**		**4. Time Frame:** Indicate the estimated duration of activity relating to the objective listed.	**5. Funds:** Provide the approximate amount of all Part B funds to be used for each objective by funding source.
		3a) Total Number of people to be served	3b) Total Number of service units to be provided		
e: By March 31, 2017, housing support services will be provided to at least 3 RW eligible HIV positive persons	per payment	3	4	4/1/2016-3/31/2017	$ 1,000

6. Outcomes: For each SMART objective, (1) name at least one client-level outcome/indicator to be tracked for the objective (using the HAB Standard Outcome Measures resource document), (2) provide benchmark (Baseline) data, and (3) provide the data source for tracking progress.

Decrease by 1% the percentage of RW eligible clients who have accessed housing support services (Baseline – 4%) (ARIES, chart review)
Increase by 2 % the percentage of RW eligible clients who have accessed housing support services are virally suppressed (Baseline – 70%) (ARIES)

7. Stage of the HIV Care Continuum related to this service category: More than one Stage may be applicable.

I. Diagnosed ☐ II. Linked to Care ☐ III. Retained in Care ☒ IV. Prescribed Antiretroviral Therapy ☐ V. Virally Suppressed ☒

Appendix B

2016 Implementation Plan for HIV Care

AIM (Goal)	Measurable Outcome	Potential Changes	Plan	Person(s) Responsible	Resources Needed	Data To be Collected	Quarterly Review (what was learned)
By 2020, 85% of all diagnosed persons living with HIV will be retained in care (baseline 70%).	By December 31, 2016 95% of DSHS staff has an understanding and working knowledge regarding the profile of who is being retained in care by Health Service Delivery Area (HSDA)	Create awareness of where Texas is in reaching the goal of retention in care within each HSDA.	Conduct analyze of each HSDA related to retention in care. Present and discuss this information to the HIV Prevention and Care Services Group Formulate a profile of the persons being retained in care by HSDA. Formulate a list of factors that may be impacting ability of persons to be retained in care.	HIV Care Services Staff; Planning and Evaluation Group	Surveillance and epidemiology data from ARIES and eHARS	By HSDA, # of PLWH in Texas during a 12 month period By HSDA, # of PLWH retained in care during a 12 month period	

AIM (Goal)	Measurable Outcome	Potential Changes	Plan	Person(s) Responsible	Resources Needed	Data To be Collected	Quarterly Review (what was learned)
	By December 31, 2016 95% of Administrative Agency staff has an understanding and working knowledge the profile of who is being retained in care by Health Service Delivery Area (HSDA)	Create awareness of where Texas is in reaching the goal of retention in care within each HSDA.	Conduct analyze of each HSDA related to retention in care. Present and discuss this information to the HIV Prevention and Care Services Group Formulate a profile of the persons being retained in care by HSDA. Formulate a list of factors that may be impacting ability of persons to be retained in care.	HIV Care Services Staff; Planning and Evaluation Group; Administrative Agency staff	Surveillance and epidemiology data from ARIES and eHARS	By HSDA, # of PLWH in Texas during a 12 month period By HSDA, # of PLWH retained in care during a 12 month period	

AIM (Goal)	Measurable Outcome	Potential Changes	Plan	Person(s) Responsible	Resources Needed	Data To be Collected	Quarterly Review (what was learned)
For all priority groups 86% of newly diagnosed persons will be linked to HIV medical care within one month of their diagnosis and retained in care within six months of linkage (baseline ranges from 72-86%)	By December 31, 2016 95% of DSHS and AA staff has an understanding and working knowledge regarding the profile of newly diagnosed persons who are being linked within one month and who is retained at six months in care by Health Service Delivery Area (HSDA)	Create awareness of where Texas is in reaching the goal of linked and retained in care within each HSDA.	Conduct analyze of each HSDA related to linkage and retention in care. Present and discuss this information to the HIV Prevention and Care Services Group Formulate a profile of the newly diagnosed persons being linked and retained in care by HSDA. Formulate a list of factors that may be impacting ability of newly diagnosed persons to be linked and retained in care. Analyze linkage and retention data to determine successful mapping pathways initially by HSDA	HIV Care Services Staff; Planning and Evaluation Group Administrative Agency Staff	Surveillance and epidemiology data from ARIES and eHARS	By HSDA, # of PLWH in Texas during a 12 month period By HSDA, # of newly diagnosed PLWH linked into care within one month of diagnosis By HSDA, # of newly diagnosed PLWH retained in care at six months	

AIM (Goal)	Measurable Outcome	Potential Changes	Plan	Person(s) Responsible	Resources Needed	Data To be Collected	Quarterly Review (what was learned)
			Analyze data using priority group information, primarily race Embed staff in system of care to determine promising models/barriers to account for disparity				

AIM (Goal)	Measurable Outcome	Potential Changes	Plan	Person(s) Responsible	Resources Needed	Data To be Collected	Quarterly Review (what was learned)
For <u>all priority groups</u> 88% of persons who are retained in HIV medical care will be virally suppressed (baseline ranges from 64% - 88%)	By December 31, 2016 95% of DSHS HIV and Administrative Agency staff has an understanding and working knowledge about retention and viral suppression	Create awareness of where Texas is in reaching the goal of viral suppression within each HSDA.	Conduct analyze of each HSDA related to linkage and retention in care. Present and discuss this information to the HIV Prevention and Care Services Group and Administrative Agency staff Formulate a profile of the PLWH retained in care during the last 12 months and virally suppressed. Formulate a list of factors that may be impacting ability of PLWH to be virally suppressed. Analyze data using priority group information, primarily race	HIV Care Services Staff; Planning and Evaluation Group; Administrative Agency staff	Surveillance and epidemiology data from ARIES and eHARS	By HSDA, # of PLWH in Texas during a 12 month period By HSDA, # of PLWH retained in care during a 12 month period By HSDA, # of PLWH retained in care during a 12 month period and virally suppressed	

AIM (Goal)	Measurable Outcome	Potential Changes	Plan	Person(s) Responsible	Resources Needed	Data To be Collected	Quarterly Review (what was learned)
	By December 31, 2016, DSHS Prevention and Care Services and Administrative Agency staff has an understanding and working knowledge regarding impact of Ryan White/SS and other payer sources has on viral suppression.		Conduct analyzes of all PLWH by payer source in each HSDA related to retention and viral suppression rates. Present and discuss this information to the HIV Prevention and Care Services Group and Administrative Agency staff Formulate a profile of the PLWH retained in care during the last 12 months and virally suppressed by payer source Formulate a list relating to payer source of factors that may be impacting ability of PLWH to be virally suppressed. Analyze data using priority group information, primarily race	HIV Care Services Staff; Planning and Evaluation Group; Administrative Agency staff	Surveillance and epidemiology data from ARIES and eHARS	By HSDA, # of PLWH in Texas during a 12 month period By HSDA, # of PLWH retained in care during a 12 month period and virally suppressed By HSDA and payer source, # of PLWH retained in care during a 12 month period and virally suppressed	

AIM (Goal)	Measurable Outcome	Potential Changes	Plan	Person(s) Responsible	Resources Needed	Data To be Collected	Quarterly Review (what was learned)
	By December 31, 2016, DSHS Prevention and Care Services and Administrative Agency staff has an understanding and working knowledge regarding impact of RW/SS services on retention and viral suppression	Appropriate service category will be used to provide services to RW/SS clients	Conduct chart audits of RW/SS funded clients to determine what core and support services are being provided. Compare results of chart audits with total number of RW/SS clients retained in care and virally suppressed. Conduct analyzes of RW/SS funded clients in each HSDA receiving Outpatient Ambulatory Services, Medical Case Management, non-medical case management and mental health services in comparison to retention and viral suppression rates.	HIV Care Services Staff; Administrative Agency staff	Client charts/records Access to ARIES	Type and # of core and supportive services provided # of RW/SS retained in care during a 12 month period and virally suppressed # of RW/SS retained in care during a 12 month period and virally suppressed	

2016 Implementation Plan for STD – Chlamydia (CT)

AIM (Goal)	Measurable Outcome	Potential Changes	Plan	Person(s) Responsible	Resources Needed	Data To be Collected	Quarterly Review (what was learned)
By 2020, 50% of RW-eligible clients will be screened for Chlamydia (CT) (baseline 18%)	By December 2016, increase to 30% the proportion of PLWH receiving Ryan White/State Services funded services receiving screening for CT (baseline 18%)	More providers will understand the importance of screening for CT on an annual basis.	Identify AA(s) that have higher STD annual screening rates for CT Run analysis of screening rates by AA jurisdiction (Rena Manning or another Epi within Planning and Evaluation Group)	Planning and Evaluation Group Members, Public Health Follow-up Team (SME/Nurse Consultant), Health Communications and Community Engagement Group members, Administrative Agencies	Data from ARIES	# of RW-eligible clients # of RW-eligible clients screened annually for CT	

AIM (Goal)	Measurable Outcome	Potential Changes	Plan	Person(s) Responsible	Resources Needed	Data To be Collected	Quarterly Review (what was learned)
		Documentation using ARIES of CT screening will improve.	Conduct chart audits of RW/SS funded clients to determine if CT screenings are being conducted, but may not be captured in ARIES Conduct chart audits (80% confidence interval ± 8) to determine discordance between CT screening that occurs and documentation of CT screening in ARIES Analyze discordance from results of chart audits and ARIES data	Care Services Team, Planning and Evaluation Group Members, Administrative Agencies (AA)	Data from ARIES Review tool to determine annual CT screening	# of RW-eligible clients # of RW-eligible clients screened annually for CT # of RW-eligible clients whose screening results are entered into ARIES	

2016 Implementation Plan for STD – Syphilis (SY)

AIM (Goal)	Measurable Outcome	Potential Changes	Plan	Person(s) Responsible	Resources Needed	Data To be Collected	Quarterly Review (what was learned)
By 2020, 75% of RW-eligible clients will be screened for Syphilis (SY) (baseline 51%)	By December 2016, increase to 60% the proportion of PLWH receiving Ryan White/State Services funded services receiving screening for SY (baseline 51%)	More providers will understand the importance of screening for SY on an annual basis.	Identify AA(s) that have higher STD annual screening rates for SY Run analysis of screening rates by AA jurisdiction	Planning and Evaluation Group Members, Public Health Follow-up Team (SME/Nurse Consultant), Health Communications and Community Engagement Group members, Administrative Agencies	Data from ARIES	# of RW-eligible clients # of RW-eligible clients screened annually for SY	
AIM (Goal)	**Measurable**	**Potential**	**Plan**	**Person(s)**	**Resources**	**Data To be**	**Quarterly**

	Outcome	Changes		Responsible	Needed	Collected	Review (what was learned)
		Documentation using ARIES of SY screening will improve.	Conduct chart audits of RW/SS funded clients to determine if SY screenings are being conducted, but may not be captured in ARIES Conduct chart audits (80% confidence interval ± 8) to determine discordance between SY screening that occurs and documentation of SY screening in ARIES Analyze discordance from results of chart audits and ARIES data	Care Services Team, Planning and Evaluation Group Members, Administrative Agencies (AA)	Data from ARIES Review tool to determine annual SY screening	# of RW-eligible clients # of RW-eligible clients screened annually for SY # of RW-eligible clients whose screening results are entered into ARIES	

2016 Implementation Plan for STD – Gonorrhea (GT)

AIM (Goal)	Measurable Outcome	Potential Changes	Plan	Person(s) Responsible	Resources Needed	Data To be Collected	Quarterly Review (what was learned)
By 2020, 50% of RW-eligible clients will be screened for Gonorrhea (GT) (baseline 18%)	By December 2016, increase to 30% the proportion of PLWH receiving Ryan White/State Services funded services receiving screening for GT (baseline 18%)	More providers will understand the importance of screening for GT on an annual basis.	Identify AA(s) that have higher STD annual screening rates for GT Run analysis of screening rates by AA jurisdiction	Planning and Evaluation Group Members, Public Health Follow-up Team (SME/Nurse Consultant), Health Communications and Community Engagement Group members, Administrative Agencies	Data from ARIES	# of RW-eligible clients # of RW-eligible clients screened annually for GT	

AIM (Goal)	Measurable Outcome	Potential Changes	Plan	Person(s) Responsible	Resources Needed	Data To be Collected	Quarterly Review (what was learned)
		Documentation using ARIES of GT screening will improve.	Conduct chart audits of RW/SS funded clients to determine if GT screenings are being conducted, but may not be captured in ARIES Conduct chart audits (80% confidence interval ± 8) to determine discordance between GT screening that occurs and documentation of GT screening in ARIES Analyze discordance from results of chart audits and ARIES data	Care Services Team, Planning and Evaluation Group Members, Administrative Agency Staff	Data from ARIES Review tool to determine annual SY screening	# of RW-eligible clients # of RW-eligible clients screened annually for GT # of RW-eligible clients whose screening results are entered into ARIES	

2016 Implementation Plan for Hepatitis B Vaccine

AIM (Goal)	Measurable Outcome	Potential Changes	Plan	Person(s) Responsible	Resources Needed	Data To be Collected	Quarterly Review (what was learned)
90% of Ryan White clients will receive at least one recorded dose of the hepatitis B vaccine, (Exception: the client has chronic hepatitis B or has documented evidence of immunity). (baseline 20.3%)	By December 31, 2016, all DSHS Prevention and Care Services and Administrative Agency staff are aware of the need to input hepatitis B vaccination data and are recording data correctly into ARIES.	Increase awareness and education among staff and providers. Input missing data elements in ARIES.	Assess current HBV vaccination data recorded in ARIES. Develop educational/TA materials for staff and providers promoting HBV vaccination and documentation. Provide TA to service providers to ensure all doses of HBV vaccination are being recorded in ARIES.	HIV Care Services Team Viral Hepatitis Prevention Coordinator Administrative Agency Staff Service Providers	Data from ARIES	HBV Dose 1 HBV Dose 2 HBV Dose 3	90% of Ryan White clients will receive at least one recorded dose of the hepatitis B vaccine, (Exception: the client has chronic hepatitis B or has documented evidence of immunity).

2016 Implementation Plan for Hepatitis C Screening

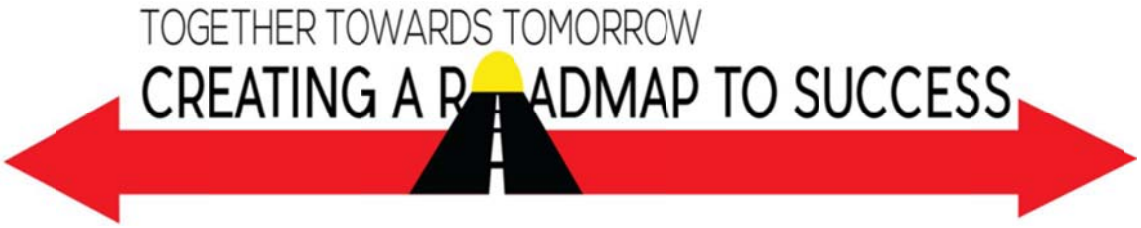
AIM (Goal)	Measurable Outcome	Potential Changes	Plan	Person(s) Responsible	Resources Needed	Data To be Collected	Quarterly Review (what was learned)
98% of Ryan White clients have a documented HCV RNA test for Hepatitis C screening (baseline 80%)	By December 31, 2016, all DSHS Prevention and Care Services and Administrative Agency staff are aware of the need to input hepatitis C testing data and are recording data correctly into ARIES.	Increase awareness and education among staff and providers about HCV and HIV coinfection. Input missing data elements in ARIES.	Assess current HCV testing data recorded in ARIES. Develop educational/TA materials for staff and providers to raise awareness of HIV and HCV coinfection and documentation. Provide TA to service providers to ensure all HCV tests are being recorded in ARIES	Planning and Evaluation Group Members Viral Hepatitis Prevention Coordinator Administrative Agency Staff Service Providers	Data from ARIES	HCV Test	

AIM (Goal)	Measurable Outcome	Potential Changes	Plan	Person(s) Responsible	Resources Needed	Data To be Collected	Quarterly Review (what was learned)
90% of clients that have disclosed ongoing, high risk behavior will have one antibody screening test documented every six months for Hepatitis C.(baseline unknown)	By December 31, 2016, all DSHS Prevention and Care Services and Administrative Agency staff are aware of the need to offer ongoing hepatitis C testing to high risk clients and hepatitis C tests are routinely documented in ARIES.	Increase awareness and education among staff and providers about HCV and HIV coinfection. Input missing data elements in ARIES.	Assess ongoing HCV testing data recorded in patient records if client disclosed ongoing high risk behavior.. Develop educational/TA materials for staff and providers promoting ongoing HCV assessment and testing. Provide TA to service providers to ensure all HCV tests are being recorded in ARIES or patient records.	Planning and Evaluation Group Members Viral Hepatitis Prevention Coordinator Administrative Agency Staff Service Providers	Data from ARIES Data from patient records	Multiple HCV Tests for high risk clients.	

2016 Implementation Plan for Tuberculous (TB)

AIM (Goal)	Measurable Outcome	Potential Changes	Plan	Person(s) Responsible	Resources Needed	Data To be Collected	Quarterly Review (what was learned)
98% of patients with active and latent tuberculous will know their HIV test results (baseline 88%)	By December 2016, 88.75 of patients with active and latent tuberculous will know their HIV status.	The proportion of known TB patients screened for HIV will increase due to improved screening and improved data reporting and documentation procedures.	Successfully implement THISIS and insure uptake and utilization by all local and regional tuberculosis clinics. The Measure Year 1 utilization of THISIS by local and regional TB registries and clinicians. Measure improvement of documentation of HIV screening of known cases of TB. Measure improvement of screening of HIV screening of known cases of TB.	DSHS tuberculosis surveillance programs Local tuberculosis surveillance programs DSHS Tuberculosis Control Program DSHS Refugee Services Local and regional tuberculosis clinical staff	Access to THISIS HIV screening materials	# of known tuberculosis patients HIV test results from screened tuberculosis patients	

FYI



Greetings all,

Below you will find the link for the ***Houston Regional Minority AIDS Initiative Reintegration Summit***

The summit will bring together local stakeholders, community members, service providers, health professional, local leaders and advocates, to strengthen our collective ability to better serve the incarcerated/recently released population, specifically HIV+ ethnic minorities. Through presentations and collaborative conversations we hope to gain knowledge, develop skills and share tools that will help this population remain in care which will ultimately result in virally suppressed communities.

All staff and community members ***must register*** if you plan to attend. Please use the link below to share with others. Registration deadline ***March 22,2016***.

"Together Towards Tomorrow: Creating a Roadmap to Success"

Date: March 23rd, 2016

Time: 9:00am to 4:00pm

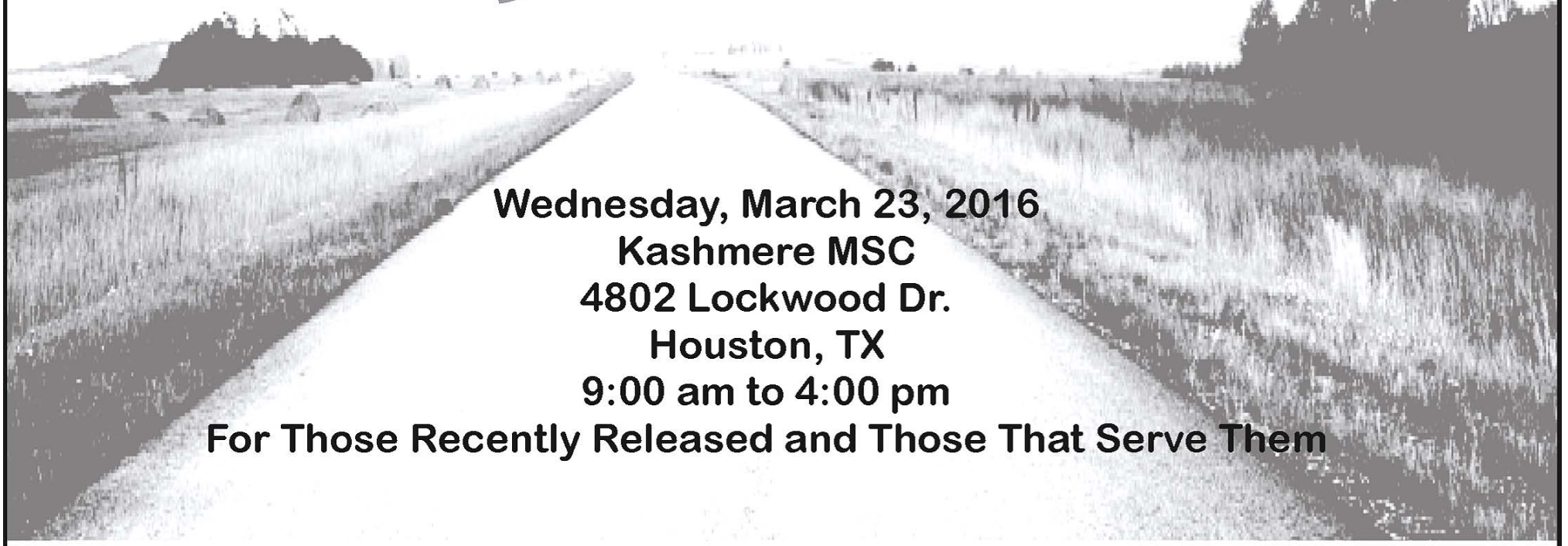
Location: Kashmere Multi-Service Center
4802 Lockwood Drive
Houston, Texas 77026

www.eventbrite.com/e/together-towards-tomorrow-creating-a-roadmap-to-success-registration-21035019309

As always, thank you for your assistance and participation. I look forward to seeing you all!

Valerie Agee
Care Services Consultant for Reentry
Texas Department of State Health Services
512-533-3071
valerie.agee@dshs.state.tx.us

ReIntegration Summit



Wednesday, March 23, 2016
Kashmere MSC
4802 Lockwood Dr.
Houston, TX
9:00 am to 4:00 pm
For Those Recently Released and Those That Serve Them

TOGETHER TOWARDS TOMORROW

CREATING A ROADMAP TO SUCCESS

TEXAS Department of State Health Services

THE RESOURCE GROUP

BETTER TOGETHER
THE GRACE PROJECT NATIONAL CONFERENCE FOR WOMEN LIVING WITH HIV

ABOUT THE GRACE PROJECT CONFERENCE

The Grace Project was inspired by Grace Hunt, a loving and generous woman who counseled women with HIV/AIDS.

The program seeks to encourage hope and hold families together through a supportive net of services including mental health counseling, substance abuse treatment, support building, and education as women are the fastest growing population of new HIV infections. The conference is the centerpiece of the program.

Celebrating the conference's 17th year, the event is designed to bring formerly isolated women living with HIV together. The goal of the conference is to SEE (Support, Educate and Empower) each woman and create future advocates for HIV prevention, health education and awareness.

If you are planning to attend the 2016 conference, you can download and review last year's FAQ and Conference Schedule. These documents will provide you with an idea of what to expect at next year's conference! Frequently Asked Questions guide and the Conference Schedule

SUPPORT

Discover a group of supportive women sharing their stories and encouraging one another.

EDUCATE

Learn tips and techniques to improve your daily life and the lives of those around you.

EMPOWER

Become an advocate for others living with HIV through knowledge and strength.

Become Better Together by joining us for an amazing conference!

With workshops, speakers, and a weekend full of education and support, you will leave the conference with an uplifting sense of power, love, and advocacy for other women living with HIV.

At the conference, you will have an opportunity to enjoy various interest rooms and forums that will provide you with new skills or just an improved outlook on life with HIV.

Register online or download and print the appropriate registration form (In-Town Attendees or Out-of-Town Attendees. If you have questions about the 2016 conference, email graceproject@legacycounseling.org or call 214-520-6308 ext. 384.

PRESENTERS

Each year, the conference offers a wide array of presenters that provide crucial information to improve your life. Past speakers include local advocates, celebrities, physicians, and other health professionals.

INTEREST ROOMS

Interest rooms offer you the opportunity to learn new skills, relax, or improve your general well-being. From computer labs to writing to yoga and prayer, you will find something that works for you and your lifestyle.

WORKSHOPS

Our workshops are designed to empower you with knowledge and information that you can use to improve your own life or the lives of those around you through advocacy.

BE A PART OF THE CONFERENCE

You can support through conference through volunteering, presenting, or donating!

PRESENT

Become a presenter for next year's conference. To be considered, please download our Request for Presenters, complete, and return as instructed on the application. The deadline for submissions is **March 15, 2015**.

VOLUNTEER

Volunteers are the core of our conference. From preparing interest rooms and events to contacting attendees and check-ins, volunteer help is invaluable to the conference. If you are interested in volunteering, complete our online Volunteer Interest form or download and complete the form.

DONATE

Financial support for this conference is essential. You have opportunities ranging from a meal sponsorship to a single $50 donation to provide a scholarship to one attendee. We can work with your budget to develop a comprehensive sponsorship plan. You can also donate today.

Subscribe to our mailing list

* indicates required

Email Address *

First Name *

Last Name

Phone Number

Subscribe

Contact Us

4054 McKinney Ave Suite 102
Dallas, TX 75204
214-520-6308 ext. 384
graceproject@legacycounseling.org

Three Decades at the Heart of Us

Bering Omega Community Services celebrates 30 years.

By Rich Arenschieldt
Photo by Dalton DeHart

"Montrose" is (and always has been) the epicenter of Houston's gay community. Developers may have changed the landscape and its demographic, but since 1926, one entity—Bering United Methodist Church—has remained, steadfast and unflinching in its commitment to the neighborhood. This congregation, originally comprised of German immigrants, has confronted various plagues throughout history (most notably yellow fever and polio). However, the church's most enduring mark on the city's gay landscape is Bering Omega Community Services (BOCS), born within the church and now celebrating its 30th anniversary.

Lary Barton, longtime volunteer and BOCS board member, recalls how their three flagship programs—hospice, adult daycare, and the dental clinic—were created. "At Bering Church, we loved and welcomed everyone—always. In the mid-'80s the leadership and congregation (which, at that time, was mostly heterosexual) realized the community's need for specific unmet services. In response, they began to devote time and resources to caring for those who lived near our campus. It didn't matter that the church's own financial situation was tenuous—we raised funds on a grassroots level to accomplish what was necessary.

"What was profound about this," Barton continues, "is that, suddenly, we were providing support services to people who had previously been productive members of society—well-connected men with professional positions and good incomes. At that time, their diagnosis took their health *and* depleted their resources. What is sometimes forgotten is that there was a sense of absolute hysteria surrounding HIV. Single men—even those that were straight—were being denied services and, if suspected of having HIV, were fired from their jobs. Bering Church, at that time, was one of the few safe places for gays to go.

Additionally, "many men who worked needed someone to look after their ill partners during the day," Barton says. "This was crucial in order for couples to maintain an income, pay their rent, and keep food on the table. To meet this need, Bering started an adult daycare on campus. We provided meals, medicine, and limited medical assistance—something that still happens today."

Bering Omega's end-of-life care testifies to its enduring legacy.

Retired dentist Dr. Ed Cordray remembers a similar initiative—the genesis of Bering Dental Clinic, currently managed by Dr. Mark Nichols, BOCS Vice President of Clinical Affairs.

"Dentist Bruce Smith and I were good friends," Cordray recalls. "We began to be overloaded with patients who were being refused treatment by their own dentists. At that time, many oral manifestations of HIV infection were quite painful and required immediate treatment. We could not turn these patients away, even though many had lost their jobs, income, and insurance. Several local gay dentists treated many people for free.

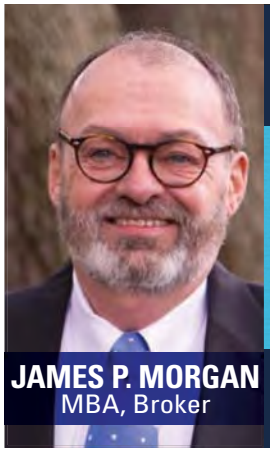
"Bruce and I decided we needed a clinic," Corday says. "Bering Church had some empty classrooms, which they agreed to let us use, and St. Luke's United Methodist provided a large donation for the clinic buildout. We collected used dental equipment [in my pickup truck] and received free labor and materials to prepare the space. Interestingly, many of our donors requested discretion; they wanted to help but could not, for various reasons, be openly associated with an HIV clinic.

"At first, we only saw patients on Fridays," Corday adds. "Then Dr. Mark Nichols appeared [in 1987] and agreed to be the clinic's full-time volunteer. Many people worked to get the clinic open, but Dr. Nichols was its driving force. His guidance transformed it from a small, part-time endeavor into the internationally renowned facility that, today, treats patients and educates clinicians from around the world.

"Initially, local academic institutions were slow to support our work," says Corday. "Then the dental school's newly appointed dean, Dr. Catherine Flaitz, offered her expertise in helping to identify pathogens that affected our patients—she became invaluable to us."

In addition to adult daycare and dentistry, Bering Omega's end-of-life care (through its Omega House hospice) testifies to its enduring legacy. Founder Eleanor Munger asked Rev. Pittman McGehee, dean of Houston's Christ Church Cathedral, for $10,000 [so they could] rent a small house to accommodate those at the end of life. Opened in 1986, the facility has been managed (for most of that time) by one person—its current director, Sandy Stacy, RN. The facility remains true to Munger's original vision: a non-institutionalized, comfortable, spiritual (but nonsectarian) environment where patients are treated with respect and dignity. →

A Dream Team
In 2013, former mayor Annise Parker joined volunteers in painting Omega House, Bering Omega Community Services' hospice-care facility.



Three Decades at the Heart of Us

continued from previous page

When asked how he plans to commemorate this milestone, Joe Fuentes, the current CEO of the recently merged Bering Omega Community Services/HACS, responds, "I'll celebrate when we successfully complete this merger," a process begun two years ago. "Merging both boards of directors, staff, volunteers, and patients has taken some time—when that is finished in January 2016, then we'll celebrate the newly-formed organization."

"Looking back," Fuentes says, "Omega House currently personifies how things have changed. Still used for its original purpose as a hospice, it is currently also available for respite care. People now *leave* the facility to live independently."

When asked to reflect on those first efforts of BOCS, Dr. Ed Cordray sums up the organization's impact: "At that time, people were scared to death; they possessed an almost animalistic fear about so many things. A small group of us confronted an insurmountable problem, and yet we still managed to provide people with what they needed. I'm proud that we were there at a time when everyone else was absent."

Rich Arenschieldt is a frequent contributor to OutSmart magazine.