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HOUSTON AREA HIV SERVICES
RYAN WHITE PLANNING COUNCIL

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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, September 8, 2016
Meeting Location: 2223 W. Loop South, Room 532
Houston, Texas 77027

I. Call to Order — Steven Vargas, Chair
   A. Welcoming Remarks and Moment of Reflection — RW Planning Council
   B. Adoption of the Agenda
   C. Approval of the Minutes
   D. Training: PrEP — Charlene Flash, MD, Baylor College of Medicine
   E. Training: 2017 Houston Area Comprehensive HIV Prevention and Care Services Plan — Amber Harbolt, Health Planner, Ryan White Office of Support

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. Quality Improvement Committee — Robert Noble and Cecilia Ross, Co-Chairs
      Item: Reports – Part A/MAI Administrative Agent
      Recommended Action: FYI: See the attached:
      - FY16 RW Part A/MAI Procurement Report, dated 08-02-16
      - FY15 Performance Measure Highlights

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

- FY16/17 RW Part B Procurement Report, dated 08-18-16
- FY15/16 DSHS State Services Procurement Report, dated 08-18-16
- Health Insurance Assistance Service Utilization Report, dated 08-05-16
- TRG Consumer Interview Results 2015
- TRG Quality Management Program, dated 08-17-16
- TRG 5-Year Quality Improvement Plan

Item: UTMB-Galveston Outreach/Retention Program
Recommended Action: FYI: Samantha Robinson, RN presented information on the UTMB-Galveston Outreach/Retention in Care Program for which she is a case manager.

Item: FY15 Assessment of the Administrative Mechanism – Pt. A/MAI
Recommended Action: Motion: To approve the attached FY15 Assessment of the Administrative Mechanism – Part A/MAI. No corrective action required.

B. Comprehensive HIV Planning Committee — John Lazo and Nancy Miertschin, Co-Chairs
No report.

C. Priority and Allocations Committee — Peta-gay Ledbetter and Bruce Turner, Co-Chairs
Item: FY 2015 Carryover Funds
Recommended Action: FYI: Verbal update on the possible request for a waiver regarding FY 2015 Ryan White Part A and Minority AIDS Initiative (MAI) carryover funds.

D. Affected Community Committee — Allen Murray and Tana Pradia, Co-Chairs
Item: Committee Training
Recommended Action: FYI: Amber Harbolt, Health Planner for the Office of Support gave a presentation on Standards of Care, what they are and how they impact consumers.

Item: 2016 Monthly Meeting Schedule
Recommended Action: FYI: See the attached list of 2016 committee meetings and training topics.

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

E. Operations Committee — Curtis Bellard and Teresa Pruitt, Co-Chairs

Item: 2017 Council Applicants
Recommended Action: FYI: The Committee members Interviewed four individuals applying for Council membership in 2017. They will interview additional applicant(s) in October 2016.

Item: 2017 Council Orientation
Recommended Action: FYI: The 2017 all-day Council Orientation will be held at Trevisio's Restaurant on Thursday, January 26, 2017.

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

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

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

VII. Announcements

VIII. Adjournment

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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, August 11, 2016
2223 W. Loop South, Room 532; Houston, Texas 77027

MEMBERS PRESENT	MEMBERS PRESENT	OTHERS PRESENT
Steven Vargas, Chair	Rodney Mills	Viviana Santibanez
Tracy Gorden, Vice-Chair	Allen Murray	Andrew Motz
Carol Suazo, Secretary	Robert Noble	Denis Kelly
Rodriga Avila	Shital Patel	
Connie Barnes	Tana Pradia	**STAFF PRESENT**
Melody Barr	Teresa Pruitt	*Ryan White Grant Administration*
Curtis Bellard	Leslie Raneri	Carin Martin
David Benson	Cecilia Ross	
Ardry Skeet Boyle	Gloria Sierra	*The Resource Group*
Bianca Burley	Larry Woods	Sha'Terra Johnson-Fairley
Evelio Salinas Escamilla	Isis Torrente	
Herman Finley	David Watson	*Office of Support*
Paul Grunenwald		Tori Williams
Angela F. Hawkins	**MEMBERS ABSENT**	Amber Harbolt
Arlene Johnson	Ted Artiaga, excused	Diane Beck
J. Hoxi Jones	Ella Collins-Nelson, excused	
John Lazo	Amber David	
Peta-gay Ledbetter	Denny Delgado	
Nancy Miertschin	C. Bruce Turner	

Call to Order: Steven Vargas, Chair, called the meeting to order at 12:05 p.m.

During the welcoming remarks, Vargas said that Ruth Atkinson will be moving out of the state to live closer to her family and has resigned from the Council. Assistant Coordinator Eric Moreno has resigned from the Office of Support in order to take part time work. The visit with Hila went very well. She enjoyed meeting with us and plans to say good things about the Houston Planning Council when she presents the results of her assessment of all Planning Councils/Planning bodies at the All Grantee's conference in Washington DC in August. The 2016 Project LEAP graduation was great! One thing that we did that was different this year was to have former LEAP graduates attend and say

something wise or supportive to the new graduates. Many thanks to all who volunteered and to those who attended. It was a wonderful event and I am happy to hear that a number of the LEAP graduates have applied to be Council and CPG members. Today, the Planning Council is hopefully going to vote to concur with the 2017 Houston Area Comprehensive HIV Prevention and Care Services Plan. Our partner organizations are being asked to do the same thing.

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

Approval of the Minutes: ***Motion #2****: it was moved and seconded (Pruitt, Johnson) to approve the July 14, 2016 minutes.* **Motion carried.** Abstentions: Barr, Jones, Ledbetter, Raneri.

Training – 2017 Houston Area Comprehensive HIV Prevention and Care Services Plan: Harbolt presented information pertaining to the Comprehensive Plan.

Public Comment and Announcements: See attached comments.

Reports from Committees:
Quality Improvement Committee: No report.

Comprehensive HIV Planning Committee: John Lazo, Co-Chair, reported on the following:
Speaker's Bureau Workgroup Report: Steven Vargas presented at the Spring Klein Chamber of Commerce meeting on June 16th. See the attached Speaker's Bureau Engagement Evaluation for the event. The Committee discussed feedback regarding HIV-related topics attendees would like to see offered in the future. The workgroup will meet today after the Council meeting.

Nancy Miertschin, Co-Chair, reported on the following:
2016 Needs Assessment Update: Committee discussed a possible future inquiry into the needs of survey respondents reporting hepatitis C co-infection. Harbolt noted that the data weighting strategy (sex at birth, primary race/ethnicity, and age range) developed in June appeared to make the sample data much more representative of the local epidemic. The Committee anticipates reviewing the Needs Assessment Report in September.

Discussion of Committee Name Change: The Committee discussed the possibility of changing its name due to recurring name confusion between the Comprehensive HIV Planning Committee and the Comprehensive Plan Leadership Team. The Committee moved to keep its name and recommend the Leadership Team address this concern when the next comprehensive plan process convenes.

2017 Comprehensive Plan: The Comprehensive Plan Leadership Team met on July 25th and approved the attached components of the 2017 Comprehensive Plan – Integrated HIV Prevention and Care Plan Section. On July 29th, the Committee reviewed and concurred with the 2017 Plan components.

2017 Comprehensive Plan: ***Motion #3:*** *Concur with the attached 2017 Comprehensive Plan – Integrated HIV Prevention and Care Plan Section components: 2017 Comprehensive Plan Vision and Mission; Guiding Principles; Plan Goals; System Objectives; and Strategy Goals, Solutions, Benchmarks, and Activities.* **Motion carried unanimously**.

Priority and Allocations Committee: Peta gay Ledbetter, Co-Chair, reported on the following:
FY 2015 Carryover Funds: ***Motion #4:*** *Motion A: Approve allocation increases using FY 2015 Ryan White Part A and Minority AIDS Initiative (MAI) carryover funds – see attached updated chart for allocation details.* **Motion carried.** Abstentions: Barr, Escamilla, Finley, Miertschin, Noble, Patel, Sierra, Woods.

FY 2015 Carryover Funds: ***Motion #5:*** *Motion B: Move $232,533 in MAI and $35,378 in Part A funds into the Ryan White Grant Administration administrative budget for any or all of the following projects: a.) data mining related to retention in care; b.) mass advertising that links people to care; c.) HIV-related training for agency front line and administrative staff; and d.) feasibility study/studies related to the new Outreach service category, including alternate data collection methods and a pilot Outreach Program.* **Motion failed.** Abstentions: Barr, Escamilla, Finley, Miertschin, Noble, Patel, Sierra, Woods.

Motion #6: *it was moved and seconded (Lazo, Escamilla) to add Motion C from the attached memo to the agenda as an addendum.* **Motion carried.**

Motion #7: *Motion C: Authorize the Houston Ryan White Part A administrative agency to use $232,533 in MAI and $35,378 in Part A funds to implement a pilot project that would address retention in care and conduct a feasibility study/ies related to the pilot project.* **Motion carried.** Abstentions: Barr, Escamilla, Finley, Miertschin, Noble, Patel, Sierra, Woods.

Affected Community Committee: Tana Pradia, Co-Chair, reported on the following:
Committee Training: The Committee met at Bee Busy Wellness Center and learned about PrEP.

2016 Monthly Meeting Schedule: See the attached list of 2016 committee meetings and training topics.

2016 Community Events: See the attached list of 2016 events at which there will be Council presence.

Operations Committee: Vargas introduced the new committee co-chair, Teresa Pruitt, who reported on the following:
2016 Monthly Council Training Schedule: See the attached list of 2016 Training Topics for 2016 Planning Council meetings. Escamilla said that there needs to be training on how to read the financial reports. Williams said that this is provided at the beginning of each year for committees, she will add it to the Council training.

2016 Council and Committee Attendance: The Operations Committee reviewed the attached 2016 Council and Committee attendance records and instructed staff to contact members who had missed four or more Council or committee meetings.

2016 Quarterly Committee Report: See the attached 2016 Quarterly Committee Report.

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

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

Report from The Resource Group: Sha'Terra Johnson-Fairley summarized the attached report.

Medical Updates: Shital Patel, MD gave an update on the Zika virus. She also said that syphilis is on the rise again so we need to prevent it, find and treat it.

New Business
Ryan White Part C Urban and Part D: Miertschin said that the starting August 23rd, there will be an adolescent clinic at the Northwest Health Center every Tuesday.

HOWPA: Barr said that on July 29th, President Obama signed the Housing Modernization Act which means the formula for awarding funds including HOPWA will change. This change will help the program, and should result in additional funds for the Houston area.

Announcements:

- Gorden said that he has applications for the Poz Living Conference if anyone is interested.
- Hawkins said that August 16th is Heterosexual Men's HIV Awareness Day, please wear a bow tie in acknowledgement of the day.
- Johnson-Fairley said that the LGBT Health Summit will take place the first week of December; it was originally scheduled for September 27th.
- Torrente said that Omega House will be celebrating 30 years with an Open House in August 27th.
- Pradia said that Legacy will have an observance of Heterosexual Men's HIV Awareness Day on August 16, 2016 at 6:30 pm.

Adjournment: The meeting was adjourned at 1:55 p.m.

Respectfully submitted,

_____ _____

Victoria Williams, Director Date

Draft Certified by
Council Chair: _____ Date _____

Final Approval by
Council Chair: _____ Date _____

Council Voting Records for August 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 #1** Agenda **Carried**				**Motion #2** Minutes **Carried**			
MEMBERS	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	MEMBERS	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN
Steven Vargas, Chair				C				C	Rodney Mills		X				X		
Tracy Gorden, Vice-Chair		X				X			Allen Murray		X				X		
Carol Suazo, Secretary		X				X			Robert Noble		X				X		
Melody Barr		X						X	Shital Patel		X				X		
Rodriga Avila		X				X			Tana Pradia		X				X		
Connie Barnes		X				X			Teresa Pruitt		X				X		
Curtis Bellard		X				X			Leslie Raneri		X						X
David Benson		X				X			Cecilia Ross		X				X		
Skeet Boyle		X				X			Gloria Sierra		X				X		
Bianca Burley		X				X			Isis Torrente		X				X		
Evelio Salinas Escamilla		X				X			David Watson		X				X		
Herman Finley		X				X			Larry Woods		X				X		
Angela F. Hawkins		X				X											
Paul Grunenwald		X				X			**MEMBERS ABSENT**								
Arlene Johnson		X				X			Ted Artiaga								
J. Hoxi Jones		X						X	Ella Collins-Nelson								
John Lazo		X				X			Amber David								
Peta-gay Ledbetter		X						X	Denny Delgado								
Nancy Miertschin		X				X			C. Bruce Turner								

Council Voting Records for August 11, 2016

C = Chair of the meeting lm = Left the meeting lr = Left the room VP = Via phone	**Motion #3** 2017 Comp Plan **Carried**				**Motion #4** P&A Motion A **Carried**					**Motion #3** 2017 Comp Plan **Carried**				**Motion #4** P&A Motion A **Carried**			
MEMBERS	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	MEMBERS	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN
Steven Vargas, Chair				C				C	Rodney Mills		X				X		
Tracy Gorden, Vice-Chair		X				X			Allen Murray		X				X		
Carol Suazo, Secretary		X				X			Robert Noble		X						X
Melody Barr		X						X	Shital Patel		X						X
Rodriga Avila		X				X			Tana Pradia		X				X		
Connie Barnes		X				X			Teresa Pruitt		X				X		
Curtis Bellard		X				X			Leslie Raneri		X				X		
David Benson		X				X			Cecilia Ross		X				X		
Skeet Boyle		X				X			Gloria Sierra		X						X
Bianca Burley		X				X			Isis Torrente		X				X		
Evelio Salinas Escamilla		X						X	David Watson		X						X
Herman Finley		X						X	Larry Woods		X						X
Angela F. Hawkins		X				X											
Paul Grunenwald		X				X			**MEMBERS ABSENT**								
Arlene Johnson		X				X			Ted Artiaga								
J. Hoxi Jones		X				X			Ella Collins-Nelson								
John Lazo		X							Amber David								
Peta-gay Ledbetter		X				X			Denny Delgado								
Nancy Miertschin		X						X	C. Bruce Turner								

Council Voting Records for August 11, 2016

C = Chair of the meeting lm = Left the meeting lr = Left the room VP = Via phone	**Motion #5** P&A Motion B **Carried**				**Motion #6** Add Motion C **Carried**				**Motion #7** P&A Motion C **Carried**					**Motion #5** P&A Motion B **Carried**				**Motion #6** Add Motion C **Carried**				**Motion #7** P&A Motion C **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	Rodney Mills			X			X				X		
Tracy Gorden, Vice-Chair			X			X				X			Allen Murray			X			X				X		
Carol Suazo, Secretary			X			X				X			Robert Noble				X		X						X
Melody Barr				X		X						X	Shital Patel				X		X						X
Rodriga Avila			X			X				X			Tana Pradia			X			X				X		
Connie Barnes			X			X				X			Teresa Pruitt			X			X				X		
Curtis Bellard			X			X				X			Leslie Raneri			X			X				X		
David Benson			X			X				X			Cecilia Ross			X			X				X		
Skeet Boyle			X			X				X			Gloria Sierra				X		X						X
Bianca Burley			X			X				X			Isis Torrente			X			X				X		
Evelio Salinas Escamilla				X		X						X	David Watson				X		X						X
Herman Finley				X		X						X	Larry Woods				X		X						X
Angela F. Hawkins			X			X				X															
Paul Grunenwald			X			X				X			**MEMBERS ABSENT**												
Arlene Johnson			X			X				X			Ted Artiaga												
J. Hoxi Jones			X			X				X			Ella Collins-Nelson												
John Lazo			X			X						X	Amber David												
Peta-gay Ledbetter			X			X				X			Denny Delgado												
Nancy Miertschin				X		X				X			C. Bruce Turner												

Quality Improvement Committee Report

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

FY 2016 Ryan White Part A and MAI
Procurement Report

Priority	Service Category	Original Allocation *RWPC Approved Level Funding Scenario*	Award Reconcilation (b)	July Adjustments (carryover)	October Adjustments	Final Quarter Adjustments	Total Allocation	Percent of Grant Award	Amount Procured (a)	Procure-ment Balance	Original Date Procured	Expended YTD	Percent YTD	Percent Expected YTD
1	**Outpatient/Ambulatory Primary Care**	9,746,354	516,252	0	0	0	10,262,606	49.41%	10,262,606	0	[redacted]	813,116	8%	33%
1.a	Primary Care - Public Clinic (a)	3,570,049	73,790	0	0		3,643,839	17.54%	3,643,839	0	3/1/2016	$0	0%	8%
1.b	Primary Care - CBO Targeted to AA (a) (e) (f)	1,066,552	148,743	0	0		1,215,295	5.85%	1,215,295	0	3/1/2016	$243,809	20%	33%
1.c	Primary Care - CBO Targeted to Hispanic (a) (e) (f)	929,215	128,225	0	0		1,057,440	5.09%	1,057,440	0	3/1/2016	$166,270	16%	33%
1.d	Primary Care - CBO Targeted to White/MSM (a) (e)	926,294	78,076	0	0		1,004,370	4.84%	1,004,370	0	3/1/2016	$141,911	14%	33%
1.e	Primary Care - CBO Targeted to Rural (a) (e)	1,143,032	23,626	0	0		1,166,658	5.62%	1,166,658	0	3/1/2016	$177,056	15%	33%
1.f	Primary Care - Women at Public Clinic (a)	1,863,570	38,519	0			1,902,089	9.16%	1,902,089	0	3/1/2016	$0	0%	8%
1.g	Primary Care - Pediatric (a.1)	15,124	313				15,437	0.07%	15,437	0	3/1/2016	$7,200	47%	33%
1.h	Vision	232,518	24,960	0	0		257,478	1.24%	257,478	0	[redacted]	$76,870	30%	33%
2	**Medical Case Management**	2,215,702	0	0	0	0	2,215,702	10.67%	2,215,702	0	[redacted]	440,241	20%	33%
2.a	Clinical Case Management	488,656	0		0		488,656	2.35%	488,656	0	[redacted]	$147,850	30%	33%
2.b	Med CM - Public Clinic (a)	162,622	0	0	0		162,622	0.78%	162,622	0	3/1/2016	$0	0%	8%
2.c	Med CM - Targeted to AA (a) (e)	321,070	0	0	0		321,070	1.55%	321,070	0	3/1/2016	$95,391	30%	33%
2.d	Med CM - Targeted to H/L (a) (e)	321,072	0	0	0		321,072	1.55%	321,072	0	3/1/2016	$37,576	12%	33%
2.e	Med CM - Targeted to W/MSM (a) (e)	107,247	0	0	0		107,247	0.52%	107,247	0	3/1/2016	$22,974	21%	33%
2.f	Med CM - Targeted to Rural (a)	348,760	0	0			348,760	1.68%	348,760	0	3/1/2016	$73,297	21%	33%
2.g	Med CM - Women at Public Clinic (a)	180,311	0	0			180,311	0.87%	180,311	0	3/1/2016	$0	0%	8%
2.h	Med CM - Targeted to Pedi (a.1)	160,051	0	0	0		160,051	0.77%	160,051	0	3/1/2016	$35,559	22%	33%
2.i	Med CM - Targeted to Veterans	80,025	0	0	0		80,025	0.39%	80,025	0	3/1/2016	$27,596	34%	33%
2.j	Med CM - Targeted to Youth	45,888	0	0			45,888	0.22%	45,888	0	3/1/2016	$0	0%	8%
3	**Local Pharmacy Assistance Program (a) (e)**	2,581,440	53,356		0	0	2,634,796	12.68%	2,634,796	0	3/1/2016	$595,492	23%	33%
4	**Oral Health**	166,404	0	0	0	0	166,404	0.80%	196,404	-30,000	3/1/2016	56,100	29%	33%
4.a	Oral Health - Untargeted (c)	0					0	0.00%	0	0	N/A	$0	0%	0%
4.b	Oral Health - Targeted to Rural	166,404	0	0			166,404	0.80%	196,404	-30,000	3/1/2016	$56,100	29%	33%
5	**Mental Health Services (c)**	0	0	0	0	0	0	0.00%	0	0	NA	$0	0%	0%
6	**Health Insurance (c)**	1,029,422	0	0	0	0	1,029,422	4.96%	1,029,422	0	3/1/2016	$318,071	31%	33%
7	**Home and Community-Based Services (c)**	0	0	0	0	0	0	0.00%	0	0	NA	$0	0%	0%
8	**Substance Abuse Services - Outpatient**	45,677	0	0	0	0	45,677	0.22%	45,677	0	3/1/2016	$13,288	29%	33%
9	**Early Intervention Services (c)**	0	0	0	0	0	0	0.00%	0	0	NA	$0	0%	0%
10	**Medical Nutritional Therapy (supplements)**	341,395	0	0	0	0	341,395	1.64%	341,395	0	3/1/2016	$110,851	32%	33%
11	**Hospice Services**	0	0	0	0	0	0	0.00%	0	0	NA	$0	0%	0%
12	**Non-Medical Case Management**	1,440,385	0	0	0	0	1,440,385	6.93%	1,440,385	0	[redacted]	163,415	11%	33%
12.a	Service Linkage targeted to Youth	110,793		0			110,793	0.53%	110,793	0	[redacted]	$3,253	3%	33%
12.b	Service Linkage targeted to Newly-Diagnosed/Not-in-Care	245,497			0		245,497	1.18%	245,497	0	3/1/2016	$8,493	3%	33%
12.c	Service Linkage at Public Clinic (a)	490,886		0	0		490,886	2.36%	490,886	0	3/1/2016	$0	0%	8%
12.d	Service Linkage embedded in CBO Pcare (a) (e)	593,209		0	0		593,209	2.86%	593,209	0	3/1/2016	$151,669	26%	33%
13	**Medical Transportation**	527,362	0	0	0	0	527,362	2.54%	527,362	0	[redacted]	81,220	15%	33%
13.a	Medical Transportation services targeted to Urban	252,680	0	0	0		252,680	1.22%	252,680	0	[redacted]	$63,592	25%	33%
13.b	Medical Transportation services targeted to Rural	97,185	0	0	0		97,185	0.47%	97,185	0	3/1/2016	$17,628	18%	33%
13.c	Transportation vouchering (bus passes & gas cards)	177,497	0	0	0		177,497	0.85%	177,497	0	3/1/2016	$0	0%	0%
14	**Linguistic Services (c)**	0	0	0	0	0	0	0.00%	0	0	NA	$0	0%	0%
15	**Legal Assistance**	293,406	-293,406	0	0	0	0	0.00%	0	0	NA	$0	0%	0%
BEO27516	**Total Service Dollars**	18,387,547	276,202	0	0	0	18,663,749	89.85%	18,693,749	-30,000	[redacted]	2,591,793	14%	33%
	Grant Administration	1,612,704	0	0	0	0	1,612,704	7.76%	1,612,704	0	N/A	404,196	25%	33%
BEO27517	HCPHES/RWGA Section	1,146,388	0	0		0	1,146,388	5.52%	1,146,388	0	N/A	$313,933	27%	33%
PC	County Judge & RWPC Support*	466,316	0		0	0	466,316	2.24%	466,316	0	N/A	90,263	19%	33%
BEO27521	**Quality Management**	495,000	0	0	0	0	495,000	2.38%	495,000	0	N/A	$144,573	29%	33%
		20,495,251	276,202	0	0	0	20,771,453	100.00%	20,801,453	-30,000	[redacted]	3,140,563	15%	33%
								Unallocated	Unobligated					
	Part A Grant Award:	20,771,451	*Carry Over:*			*Total Part A:*	20,771,451	-2	-30,002					

FY 2016 Ryan White Part A and MAI
Procurement Report

Priority	Service Category	Original Allocation *RWPC Approved Level Funding Scenario*	Award Reconcilation (b)	July Adjustments (carryover)	October Adjustments	Final Quarter Adjustments	Total Allocation	Percent of Grant Award	Amount Procured (a)	Procure-ment Balance	Original Date Procured	Expended YTD	Percent YTD	Percent Expected YTD
	[redacted]	Original Allocation	Award Reconcilation (b)	July Adjusments (carryover)	October Adjustments	Final Quarter Adjustments	Total Allocation	Percent	Total Expended on Services	Percent	[redacted]			
	Core (must not be less than 75% of total service dollars)	16,126,394	569,608	0	0	0	16,696,002	89.46%	16,726,002	89.47%				
	Non-Core (may not exceed 25% of total service dollars)	2,261,153	-293,406	0	0	0	1,967,747	10.54%	1,967,747	10.53%				
	Total Service Dollars (does not include Admin and QM)	18,387,547	276,202	0	0	0	18,663,749		18,693,749					
	Total Admin (must be ≤ 10% of total Part A + MAI)	1,612,704	0	0	0	0	1,612,704	7.76%						
	Total QM (must be ≤ 5% of total Part A + MAI)	495,000	0	0	0	0	495,000	2.38%						

MAI Procurement Report

Priority	Service Category	Original Allocation *RWPC Approved Level Funding Scenario*	Award Reconcilation (b)	July Adjustments (carryover)	October Adjustments	Final Quarter Adjustments	Total Allocation	Percent of Grant Award	Amount Procured (a)	Procure-ment Balance	Date of Procure-ment	Expended YTD	Percent YTD	Percent Expected YTD
1	**Outpatient/Ambulatory Primary Care**	2,011,206	46,743	0	0	0	2,057,949	100.00%	2,011,206	46,743	[redacted]	56,100	3%	17%
1.b (MAI)	Primary Care - CBO Targeted to African American	1,016,618	23,627		0	0	1,040,245	50.55%	1,016,618	23,627	3/1/2016	$28,050	3%	17%
1.c (MAI)	Primary Care - CBO Targeted to Hispanic	994,588	23,116		0	0	1,017,704	49.45%	994,588	23,116	3/1/2016	$28,050	3%	17%
	Total MAI Service Funds	2,011,206	46,743	0	0	0	2,057,949	100.00%	2,011,206	46,743	[redacted]	56,100	3%	17%
	Grant Administration	0	0	0	0	0	0	0.00%	0	0	[redacted]	0	0%	0%
	Quality Management	0	0	0	0	0	0	0.00%	0	0	[redacted]	0	0%	0%
	Total MAI Non-service Funds	0	0	0	0	0	0	0.00%	0	0	[redacted]	0	0%	0%
[redacted]	**Total MAI Funds**	2,011,206	46,743	0	0	0	2,057,949	100.00%	2,011,206	46,743	[redacted]	56,100	3%	17%
	MAI Grant Award	2,057,949	*Carry Over:*	0		*Total MAI:*	2,057,949							[redacted]
	Combined Part A and MAI Total	22,506,457												

Footnotes:

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

Harris County
HCPHES
Public Health & Environmental Services

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

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FY 2015 PERFORMANCE MEASURES HIGHLIGHTS

RYAN WHITE GRANT ADMINISTRATION

HARRIS COUNTY

PUBLIC HEALTH & ENVIRONMENTAL SERVICES

(HCPHES)

2223 West Loop South. Houston, Texas 77027

www.hcphes.org

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Highlights from FY 2015 Performance Measures

Clinical Case Management

- During FY 2015, from 3/1/2015 through 2/29/2016, 1,018 clients utilized Part A clinical case management. According to CPCDMS, 402 (40%) of these clients accessed primary care two or more times at least three months apart during this time period after utilizing clinical case management.
- Among these clients, 247 (24%) accessed mental health services at least once during this time period after utilizing clinical case management.

Local Pharmacy Assistance

- Among LPAP clients with viral load tests, 2,549 (74%) clients were virally suppressed during this time period.

Medical Case Management

- During FY 2015, 5,047 clients utilized Part A medical case management. According to CPCDMS, 2,484 (49%) of these clients accessed primary care two or more times at least three months apart during this time period after utilizing medical case management.
- Among these medical case management clients, 599 (12%) accessed mental health services at least once during this time period after utilizing medical case management.
- Among these clients, 2,078 (41%) clients had third-party payer coverage after accessing medical case management.

Non-Medical Case Management / Service Linkage

- During FY 2015, 6,249 clients utilized Part A non-medical case management / service linkage. According to CPCDMS, 2,870 (46%) of these clients accessed primary care two or more times at least three months apart during this time period after utilizing non-medical case management.
- Among these clients, the average number of days between the first service linkage visit and the first primary medical care visit was 29 days during this time period.

Primary Medical Care

- During FY 2015, 6,966 clients utilized Part A primary medical care. According to CPCDMS, 4,019 (76%) of these clients accessed primary care two or more times at least three months apart during this time period.
- Among clients whose initial primary care medical visit occurred during this time period, 299 (21%) had an AIDS diagnosis (CD4 < 200) within the first 90 days of initial enrollment in primary medical care.
- Among clients with viral load tests, 6,962 (74%) clients were virally suppressed during this time period.

Transportation

- Van-Based Transportation:
  - During FY 2015, 464 (69%) clients accessed primary care after utilizing van transportation services.

- Among van-based transportation clients, 345 (51%) clients accessed LPAP services at least once during this time period after utilizing van transportation services.

- Bus Pass Transportation:
  - During FY 2015, 898 (34%) clients accessed primary care after utilizing bus pass services.
  - Among bus pass clients, 440 (17%) clients accessed LPAP services at least once during this time period after utilizing bus pass services.

Ryan White Part A
HIV Performance Measures
FY 2015 Report

Clinical Case Management
All Providers

For FY 2015 (3/1/2015 to 2/29/2016), 1,018 clients utilized Part A clinical case management.

HIV Performance Measures	FY 2014	FY 2015	Change
A minimum of 75% of clients will utilize Part A/B/C/D primary care two or more times at least three months apart after accessing clinical case management	641 (50.6%)	402 (39.5%)	**-11.1%**
Percentage of clinical case management clients who utilized mental health services	298 (23.5%)	247 (24.3%)	**0.8%**
75% of clients for whom there is lab data in the CPCDMS will be virally suppressed (<200)	491 (74.6%)	382 (73.0%)	**-1.6%**
Percentage of clients identified with an active substance abuse condition who received Ryan White funded substance abuse treatment	0 (0.0%)	0 (0.0%)	**0.0%**
Percentage of clients who were homeless or unstably housed	411 (32.5%)	327 (32.1%)	**-0.4%**

According to CPCDMS, 8 (0.8%) clients utilized primary care for the first time and 57 (5.6%) clients utilized mental health services for the first time after accessing clinical case management.

Clinical Chart Review Measures	FY 2014
Percentage of HIV-infected clinical case management clients who had a case management care plan developed and/or updated two or more times in the measurement year	29%

Ryan White Part A
HIV Performance Measures
FY 2015 Report

Legal Services

HIV Performance Measures	FY 2014	FY 2015	Change
Change in the number of permanency planning cases completed over time	63	51	
65% of completed SSI disability, insurance, public benefits and income-related cases will result in access to or continued access to benefits	40 (45.5%)	44 (47.3%)	**1.8%**

Type of Case	Number of Completed Cases FY 2015	Number and Percent of Completed Cases that Resulted in Access (or Continued Access) to Benefits	
SSI Disability	27	20	74%
Insurance	1	1	100%
Public Benefits	7	5	71%
Income-Related	16	7	44%
Other	42	11	26%
Total	**93**	**44**	**47%**

Ryan White Part A
HIV Performance Measures
FY 2015 Report

Local Pharmacy Assistance
All Providers

HIV Performance Measures	FY 2014	FY 2015	Change
75% of clients for whom there is lab data in the CPCDMS will be virally suppressed (<200)	2,631 (74.4%)	2,549 (73.9%)	**-0.5%**

Ryan White Part A
HIV Performance Measures
FY 2015 Report

Medical Case Management
All Providers

For FY 2015 (3/1/2015 to 2/29/2016), 5,047 clients utilized Part A medical case management.

HIV Performance Measures	**FY 2014**	**FY 2015**	**Change**
A minimum of 85% of clients will utilize Part A/B/C/D primary care two or more times at least three months apart after accessing medical case management	2,664 (52.7%)	2,484 (49.2%)	**-3.5%**
Percentage of medical case management clients who utilized mental health services	548 (10.8%)	599 (11.9%)	**1.1%**
Increase in the percentage of clients who have 3rd party payer coverage (e.g. Medicare, Medicaid) after accessing medical case management	2,060 (40.8%)	2,078 (41.2%)	**0.4%**
75% of clients for whom there is lab data in the CPCDMS will be virally suppressed (<200)	2,188 (71.8%)	2,110 (70.9%)	**-0.9%**
Percentage of clients, regardless of age, with a diagnosis of HIV who had at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits	2,171 (23.7%)		
Percentage of clients with a diagnosis of HIV who did not have a medical visit in the last 6 months of the measurement year	664 (24.9%)	545 (23.3%)	**-1.6%**
Percentage of clients who were homeless or unstably housed	1,751 (34.7%)	1,879 (37.2%)	**2.5%**

According to CPCDMS, 194 (3.8%) clients utilized primary care for the first time and 241 (4.8%) clients utilized mental health services for the first time after accessing medical case management.

Clinical Chart Review Measures	**FY 2014**
60% of HIV-infected medical case management clients will have a case management care plan developed and/or updated two or more times in the measurement year	33%

Ryan White Part A
HIV Performance Measures
FY 2015 Report

Medical Nutritional Supplements

HIV Performance Measures	FY 2014	FY 2015	Change
75% of clients for whom there is lab data in the CPCDMS will be virally suppressed (<200)	395 (80.1%)	396 (79.7%)	**-0.4%**
90% of clients diagnosed with wasting syndrome or suboptimal body mass will improve or maintain body mass index (BMI) in the measurement year	N/A	7 (58.3%)	**N/A**

Ryan White Part A
HIV Performance Measures
FY 2015 Report

Oral Health Care
All Providers

HIV Performance Measures	**FY 2015**
75% of diagnosed HIV/AIDS-related and general oral pathologies will be resolved, improved or maintained at most recent follow-up	See Oral Pathology Table

Clinical Chart Review Measures*	**FY 2013**	**FY 2014**
75% of HIV-infected oral health patients will have a dental health history (initial or updated) at least once in the measurement year	73%	97%
75% of HIV-infected oral health patients will have a medical health history (initial or updated) at least once in the measurement year	72%	81%
90% of HIV-infected oral health patients will have a dental treatment plan developed and/or updated at least once in the measurement year	93%	89%
85% of HIV-infected oral health patients will receive oral health education at least once in the measurement year	85%	87%
90% of HIV-infected oral health patients will have a periodontal screen or examination at least once in the measurement year	91%	91%
60% of HIV-infected oral health patients will have a Phase 1 treatment plan that is completed within 12 months	N/A	79%

* To view the full FY 2014 chart review reports, please visit:
http://www.hcphes.org/cms/One.aspx?portalId=73056&pageId=107877

Oral Pathology	Number of Diagnoses	Number with Follow-Up	*Resolved at Follow-up		*Improved at Follow-up		*Same at Follow-up		*Worsened at Follow-up	
			#	%	#	%	#	%	#	%
Atrophic candidiasis										
HIV-related periodontal disease										
Idiopathic thrombocytopenia purpura										
Kaposi's sarcoma										
Lymphomas										
Oral hairy leukoplakia										
Oral ulcerations										
Papilloma										
Pseudomembranous candidiasis										
Salivary gland disease										
Squamous cell carcinoma										
Other										
Total	**0**	**0**								

Ryan White Part A
HIV Performance Measures
FY 2015 Report

Primary Medical Care
All Providers

For FY 2015 (3/1/2015 to 2/29/2016), 6,966 clients utilized Part A primary medical care.

HIV Performance Measures	FY 2014	FY 2015	Change
90% of clients with HIV infection will have two or more medical visits, at least 90 days apart, in an HIV care setting in the measurement year	4,106 (74.9%)	4,019 (76.3%)	**1.4%**
Less than 20% of clients who have a CD-4 < 200 within the first 90 days of initial enrollment in primary medical care	272 (20.0%)	299 (20.6%)	**0.6%**
80% of clients aged six months and older with a diagnosis of HIV/AIDS will have at least two CD-4 cell counts or percentages performed during the measurement year at least three months apart	4,107 (74.9%)	3,683 (69.9%)	**-5.0%**
95% of clients will have Hepatitis C (HCV) screening performed at least once since the diagnosis of HIV infection	5,154 (73.4%)	5,081 (72.9%)	**-0.5%**
Percentage of clients with HIV infection who received an oral exam by a dentist at least once during the measurement year	1,987 (28.3%)	1,729 (24.8%)	**-3.5%**
85% of clients with a diagnosis of HIV will have a test for syphilis performed within the measurement year	6,046 (86.1%)	5,791 (83.2%)	**-2.9%**
95% of clients with HIV infection will be screened for Hepatitis B virus infection status (ever)	5,114 (72.8%)	5,211 (74.8%)	**2.0%**
90% of clients with a diagnosis of HIV/AIDS will have a viral load test performed at least every six months during the measurement year	3,797 (86.6%)	3,405 (78.0%)	**-8.6%**
80% of clients for whom there is lab data in the CPCDMS will be virally suppressed (< 200)	6,928 (72.9%)	6,962 (73.7%)	**0.8%**
Percentage of clients with a diagnosis of HIV who had at least one medical visit in each six-month period of the 24-month measurement period with a minimum of 60 days between medical visits	2,171 (23.7%)		
Percentage of clients with a diagnosis of HIV who did not have a medical visit in the last six months of the measurement year	1,566 (28.6%)	1,394 (26.5%)	**-2.1%**

Clinical Chart Review Measures	FY 2014
100% of Ryan White Part A program-funded outpatient/ambulatory care organizations in the system/network will have a waiting time of 15 or fewer business days for a Ryan White Part A program-eligible patient to receive an initial appointment to enroll in outpatient/ambulatory medical care	Data below
Percentage of Ryan White Part A program-funded outpatient/ambulatory care organizations in the system/network who had a waiting time of 15 or fewer business days for a Ryan White Part A program-eligible patient to receive an appointment for outpatient/ambulatory medical care	Data below

From 3/1/2014 through 2/29/2015, 100% of Ryan White Part A outpatient/ambulatory care organizations provided a waiting time of 15 or fewer business days for a program-eligible patient to receive an initial appointment to enroll in medical care.

Average wait time for initial appointment availability to enroll in outpatient/ambulatory medical care: EMA = 5.7 Days

Agency 1: 5.4
Agency 2: 7.4
Agency 3: 2.7
Agency 4: 8.5
Agency 5: 4.7

From 3/1/2014 through 2/29/2015, 100% of Ryan White Part A outpatient/ambulatory care organizations provided a waiting time of 15 or fewer business days for a program-eligible patient to receive an appointment for medical care.

Average wait time for appointment availability to receive outpatient/ambulatory medical care: EMA = 10.1 Days

Agency 1: 6.6
Agency 2: 10.0
Agency 3: 10.0
Agency 4: 14.0
Agency 5: 10.1

Clinical Chart Review Measures*	FY 2013	FY 2014
100% of clients with a diagnosis of HIV/AIDS will be prescribed Pneumocystis jiroveci pneumonia (PCP) prophylaxis	98.7%	100%
100% of pregnant women with HIV infection will be prescribed antiretroviral therapy	100%	100%
Percentage of female clients with a diagnosis of HIV who have a pap screening in the measurement year	61.2%	63.5%
55% of clients with HIV infection will complete the vaccination series for Hepatitis B	50.3%	55.6%
85% of clients with HIV infection will receive HIV risk counseling within the measurement year	82.8%	77.0%
95% of clients with a diagnosis of HIV will be screened for substance abuse (alcohol and drugs) in the measurement year	97.6%	98.3%
90% of clients with a diagnosis of HIV who were prescribed HIV antiretroviral therapy will have a fasting lipid panel during the measurement year	92.3%	93.1%
65% of clients with a diagnosis of HIV and at risk for sexually transmitted infections will have a test for gonorrhea and chlamydia within the measurement year	62.4%	67.2%
75% of clients with a diagnosis of HIV/AIDS, for whom there was documentation that a TB screening test was performed and results interpreted (for tuberculin skin tests) at least once since the diagnosis of HIV infection	62.0%	71.1%
65% of clients seen for a visit between October 1 and March 31 will receive an influenza immunization OR will report previous receipt of an influenza immunization	62.3%	66.6%
95% of clients will be screened for clinical depression using a standardized tool with follow up plan documented	81.9%	89.3%
90% of clients with HIV infection will have ever received pneumococcal vaccine	84.7%	89.2%
100% of clients will be screened for tobacco use at least one during the two-year measurement period and who received cessation counseling intervention if identified as a tobacco user	99.7%	99.4%
95% of clients with a diagnosis of HIV will be prescribed antiretroviral therapy for the treatment of HIV infection during the measurement year	95.9%	95.3%
85% of clients with a diagnosis of HIV will have an HIV drug resistance test performed before initiation of HIV antiretroviral therapy if therapy started during the measurement year	66.7%	85.0%

* To view the full FY 2014 chart review reports, please visit:
http://www.hcphes.org/cms/One.aspx?portalId=73056&pageId=107877

Ryan White Part A
HIV Performance Measures
FY 2015 Report

Non-Medical Case Management / Service Linkage
All Providers

For FY 2015 (3/1/2015 to 2/29/2016), 6,249 clients utilized Part A non-medical case management.

HIV Performance Measures	**FY 2014**	**FY 2015**	**Change**
A minimum of 70% of clients will utilize Part A/B/C/D primary care two or more times at least three months apart after accessing non-medical case management (service linkage)	3,528 (49.7%)	2,870 (45.9%)	**-3.8%**
Percentage of clients who utilized primary medical care for the first time after accessing service linkage	345 (4.9%)	336 (5.4%)	**0.5%**
Number of days between first ever service linkage visit and first ever primary medical care visit:			
Mean	43	29	**-32.6%**
Median	19	14	**-26.3%**
Mode	7	7	**0.0%**
60% of newly-enrolled clients will have a medical visit in each of the four-month periods of the measurement year	136 (54.6%)	105 (49.3%)	**-5.3%**

Ryan White Part A
HIV Performance Measures
FY 2015 Report

Substance Abuse Treatment

HIV Performance Measures	FY 2015	FY 2016	Change
A minimum of 70% of clients will utilize Parts A/B/C/D primary medical care after accessing Part A-funded substance abuse treatment services*	7 (43.8%)	12 (50.0%)	**6.2%**
55% of clients for whom there is lab data in the CPCDMS will be virally suppressed (<200)	8 (57.1%)	11 (57.9%)	**0.8%**
Change in the rate of program completion over time	See data below		

***Overall, the number of clients who received primary care in FY 2016 was 20 (83.3%), with 12 receiving the services through Ryan White and 8 receiving the services through other insurance such as Medicare.**

Number of clients completing substance abuse treatment program from March 2015 to February 2016: **19**

Number of clients engaged in substance abuse treatment program from March 2015 to February 2016: **24**

Number of clients completing substance abuse treatment from March 2015 to February 2016 who entered treatment in FY 2014: **3**

Number of clients who received treatment in FY 2014 who are still in treatment from March 2015 to February 2016: **0**

Ryan White Part A
HIV Performance Measures
FY 2015 Report

Transportation

Van-Based Transportation	FY 2014	FY 2015	Change
A minimum of 50% of clients will utilize Parts A/B/C/D primary care services after accessing Van Transportation services	417 (68.2%)	464 (68.8%)	**0.6%**
35% of clients will utilize Parts A/B LPAP services after accessing Van Transportation services	353 (57.8%)	345 (51.2%)	**-6.6%**

Bus Pass Transportation	FY 2014	FY 2015	Change
A minimum of 50% of clients will utilize Parts A/B/C/D primary care services after accessing Bus Pass services	1,166 (41.9%)	898 (34.3%)	**-7.6%**
A minimum of 20% of clients will utilize Parts A/B LPAP services after accessing Bus Pass services	600 (21.6%)	440 (16.8%)	**-4.8%**
A minimum of 65% of clients will utilize any RW Part A/B/C/D or State Services service after accessing Bus Pass services	2,404 (86.4%)	1,993 (76.2%)	**-10.2%**

Ryan White Part A
HIV Performance Measures
FY 2015 Report

Vision Care
All Providers

HIV Performance Measures	**FY 2015**
75% of clients with diagnosed HIV/AIDS related and general ocular disorders will resolve, improve or stay the same over time	See ocular disorder table

Clinical Chart Review Measures*	**FY 2013**	**FY 2014**
100% of HIV-infected vision patients will have a medical health history (initial or updated) at least once in the measurement year	99%	100%
100% of HIV-infected vision patients will have a vision history (initial or updated) at least once in the measurement year	99%	100%
100% of HIV-infected vision patients will have a comprehensive eye examination at least once in the measurement year	100%	99%

* To view the full FY 2014 chart review reports, please visit:
http://www.hcphes.org/cms/One.aspx?portalId=73056&pageId=107877

Ocular Disorder	Number of Diagnoses	Number with Follow-up	*Resolved		*Improved		*Same		*Worsened	
			#	%	#	%	#	%	#	%
Accommodation Spasm										
Acute Retinal Necrosis										
Anisocoria										
Bacterial Retinitis	1	0								
Cataract										
Chalazion										
Chorioretinal Scar										
Chorioretinitis										
CMV Retinitis - Active										
CMV Retinitis - Inactive										
Conjunctivitis										
Covergence Excess										
Convergence Insufficiency										
Corneal Edema										
Corneal Erosion										
Corneal Foreign Body										
Corneal Opacity										
Corneal Ulcer										
Cotton Wool Spots										
Diabetic Retinopathy										
Dry Eye Syndrome										
Ecchymosis										
Esotropia										
Exotropia										
Glaucoma										
Glaucoma Suspect										
Iritis										
Kaposi Sarcoma										
Keratitis										
Keratoconjuctivitis										
Keratoconus										
Lagophthalmos										
Macular Hole										
Meibomianitis										
Molluscum Contagiosum										
Optic Atrophy										
Papilledema										

Ocular Disorder	Number of Diagnoses	Number with Follow-up	*Resolved		*Improved		*Same		*Worsened	
			#	%	#	%	#	%	#	%
Paresis of Accommodation										
Pseudophakia										
Refractive Change/Transient										
Retinal Detachment										
Retinal Hemorrhage										
Retinopathy HTN										
Retinal Hole/Tear										
Suspicious Optic Nervehead(s)										
Toxoplasma Retinochoriochitis										
Thyroid Eye Disease										
Visual Field Defect										
Vitreous Degeneration										
Other										
Total	**1**	**0**								

The Houston Regional HIV/AIDS Resource Group, Inc.

FY 1516 DSHS State Services

Procurement Report

September 1, 2015 - August 31, 2016

Chart reflects spending through June 2016

Spending Target: 83%

Revised 8/18/2016

Priority	Service Category	Original Allocation per RWPC	% of Grant Award	Amendment	Contractual Amount	% of Grant Award	Date of Original Procurement	Expended YTD	Percent YTD
6	Mental Health Services	$300,000	15%		$300,000	15%	9/1/2015	$235,163	78%
7	Health Insurance Premiums and Cost Sharing	$1,041,183	53%		$1,041,183	53%	9/1/2015	$772,694	74%
9	Hospice	$414,832	21%		$414,832	21%	9/1/2015	$347,820	84%
11	EIS - Incarcerated	$166,211	8%		$166,211	8%	9/1/2015	$154,341	93%
16	Linguistic Services	$35,000	2%		$35,000	2%	9/1/2015	$25,900	74%
	Total Houston HSDA	1,957,226	100%	$0	$1,957,226	100%		1,535,917	78%

The Houston Regional HIV/AIDS Resource Group, Inc.
FY 1617 Ryan White Part B
Procurement Report
April 1, 2016 - March 31, 2017

Reflects spending through June 2016

Spending Target: 25%

Revised 8/18/2016

Priority	Service Category	Original Allocation per RWPC	% of Grant Award	Amendment*	Contractual Amount	% of Grant Award	Date of Original Procurement	Expended YTD	Percent YTD
6	Oral Health Care	$2,120,346	64%	($34,781)	$2,085,565	64%	4/1/2016	$478,507	23%
7	Health Insurance Premiums and Cost Sharing **	$976,885	29%	($16,122)	$960,763	29%	4/1/2016	$88,780	9%
9	Home and Commuuity Based Health Services	$232,000	7%	($3,840)	$228,160	7%	4/1/2016	$44,320	19%
	Total Houston HSDA	3,329,231	100%	($54,743)	$3,274,488	100%		611,607	18%

* Amendment-Reduction in award amount and each service category has been reduced proportionately

** HIP - Funded by Part A,B, and State Services. Provider is spending grant funds before grant ending date.
Ending dates: State Services 08/31/16, Part A 02/29/17, Part B 03/31/17,

Houston Ryan White Health Insurance Assistance Service Utilization Report

Period Reported: 9/1/2015-6/30/16

Revised: 8/5/2016

	Assisted			NOT Assisted		
Request by Type	Number of Requests (UOS)	Dollar Amount of Requests	Number of Clients (UDC)	*Number of Requests (UOS)*	*Dollar Amount of Requests*	*Number of Clients (UDC)*
Medical Co-Payment	722	$56,584.66	424			*0*
Medical Deductible	667	$143,328.75	407			*0*
Medical Premium	5911	$1,831,883.87	1019			*0*
Pharmacy Co-Payment	5219	$440,600.70	1330			*0*
APTC Tax Liability	0	$0.00				*0*
Out of Network Out of Pocket	0	$0.00	0			*0*
ACA Premium Subsidy Repayment	14	$2,158.00		*NA*	*NA*	*NA*
Totals:	12533	$2,470,239.98		0	$0.00	

Comments: This report represents services provided under all grants.

TRG Consumer Interview Results 2015

Interview and feedback Period March 2015 –March 2016

OVERVIEW

The Consumer Interview Process is used by The Resource Group (TRG) to determine client satisfaction and collect additional feedback from consumers. Client interviews are required as part of the Quality Compliance Reviews (QCR) at each agency in Houston and the fifty-one county areas of East Texas. During the 2015 QCR season ninety-one (91) client interviews were conducted including monolingual Spanish clients, youth as young at 13 with caregivers/guardians. HIV positive clients statues and have been in care ranging from two months though thirty years. The majority of sessions conducted were individual based interviews, while a few were conducted as group interviews.

CROSS-SERVICE TRENDS

Overall, Clients report satisfaction with the services they are receiving. Clients, who are in care, feel comfortable and satisfied with their medical team and care process. A high percentage of clients felt they were leaders on their health care team or an important team member of their team. Some terms used by clients are; Pilot, Copilot and Advocate to describe their participation in their role on their health care team. Clients were more descriptive in their roles with their medical team. Clients stated the medical staff answer questions and explain the things the client does not understand. Case managers were described as "good at helping and explaining things". Statements included;

- "I like getting medications and referrals to other services".
- Clients were also satisfied with their access to medication.
- The only major concerns continuing from the previous year were related to the waiting period between being diagnosed and receiving a recommendation to start medications.
- Comments about the anxiety experienced when waiting for approval of the ADAP application were discussed. One client stated "They say you need the medication to live but the wait seems so long. It's so scary there is nothing anyone can say that will help me until I receive the medications."
- Some clients felt the emergency medication process could be smoother.
- Comments concerning housing include request related to having emergency housing.
- Clients stressed"it could be useful for clients getting out of the hospital or for someone new to the area to have some emergency support"
- Other statements reported HOPWA as being fair and quick in some areas. One statement was "You get a yes or a no."
- Other statements included "I could use help getting disability and housing."

Clients in Houston and throughout East Texas mentioned general communication between staff and consumers at most service agencies needs improvement. Clients were more open about discussing concerns and reporting dissatisfaction. There is a continuing disconnection between

clients and the agency complaint process or how concerns are resolve at some agencies. Some clients continue to report they were not aware of the complaint process for problems with services. Clients expressed concerns of hearing conversations between agency staff or other clients that some clients felt were inappropriate or should not take place in the lobby areas. Some clients were familiar with the agency process and complaint forms. In general, the clients' response included;

- "Medical staff treats me with dignity and respect"
- "They treat me normal I don't feel like I am being reminded of my status."
- "The medical staff ask me am I comfortable with what needs to be done. That make me feel important and it is less stressful to be compliant."
- Some male clients expressed a need for more male staff available to talk to about their sexual health concerns.
- Multiple men at one location stated, "The medical staff, are all beautiful women which makes it hard to talk to them about my personal and sexual concerns".

Services which received the most detailed comments were Mental Health Services, Health Insurance Premium (HIP), Oral Health Care, Home and Community-Based Health Care Services and Early Intervention Services (EIS). There was an increase in statements and conversations related to services in 2015. Most clients were comfortable offering suggestions and recommendation as to how more clients can be reached. In the previous year some recommendations were to have an update meeting and discuss the necessity, value and usage of client feedback. Then mail out the questions and have them returned to TRG. In addition, have online surveys available for clients who may not have the time during their day to complete a survey.

Clients who had complaints expressed their complaints have been addressed and resolved. While a few clients worried that if they complained it may affect their service or that it may take them longer to get an appointment. Clients expressed an explanation of waiting was a good way to communicate. In instances such as the doctor is running late or when calling letting clients know if some is out for the day or for a week. One client stated "I don't mind the waiting, but communication would be helpful so I can decide if I am willing to wait or if I need to reschedule and appointment. I would like my time respected." Phone system problems such as getting a live person and getting medication refills were discussed as problems. One client suggests an exit survey to ask about any complaints or comments at the end of a visit.

The lessons learned and questions which will be added to the questionnaire for 2016 include:

- "Have you ever filed a complaint at this or any Ryan White funded agency? If so was your issue resolved and how do you feel about how your issue was handled? Please tell us about the positive and negatives of your experience."
- The client satisfaction questions are reviewed by TRG consumers and feedback is utilized to improve the evaluation process.

SERVICE-SPECIFIC TRENDS

Oral Health Care

Clients continued to be concerned with multiple appointments to receive dental care. While some clients did not think multiple visits were an issue, an equal amount had concerns for their jobs, time and transportation to return and complete necessary dental work. Some described appointments quick and easy to get. Others expressed difficulties or being asked to call back for appointments. A client stated "getting fillings felt like a quick fix and not a real solution to my dental problems." Other clients stated "I was asked about questions that made me feel like a part of the process. Then I was told information about what problems I should call and notify someone about." And "I drive from out of town can more be done in one appointment. It would be helpful to have an estimate of how many appointments it takes to complete a service. I prefer the drive because I would not like to seek service closer to home because of the stigma of having HIV".

Home and Community-Based Health Care Services

Clients were satisfied with this service. Clients expressed satisfaction with the socialization and activities available through this service. "I am learning to feel comfortable and learning more about my health. Things I did not know had been too ashamed to ask but this is the right setting. I'm over 50 and in my younger days I did not think about my health at all. I even have enough confidence to start a relationship which I thought I never do. The person is not HIV positive but we are getting educated together. I did not think that was at all possible."

Hospice Care Services

There were no issues of note related to this service and due to the nature of the service delivered; consumer interviews were not conducted for this service. It was suggested in 2015 that family members of Hospice clients may want to give feedback. In 2016 a family member agreed to an interview. The family member is satisfied and appreciates the service. It was recommended to have onsite and online surveys available for family members who were willing to provide feedback.

Health Insurance Premium (HIP)

HIP clients were satisfied and appreciative for the availability of the service. Clients stated that HIP was simple to get and easy to use. Clients stated "HIP allows me to go to the doctor. It helps keep me alive. I moved from out of state and had new insurance the staff was helpful and thorough in getting things done and getting what I needed." And "I had insurance through my job. I lost my job and feared losing my doctor. HIP was a process but it restored my insurance and helped me stay with my doctor."

Mental Health Services

Mental health services clients commented on having longer sessions to vent their frustration because having a therapist challenged and empowered them. "My therapist is thorough and helps me face my past" A suggestion was "There should be an exit strategy to know when my therapy is completed" A few clients in the east Texas area shared mental health appointments were hard to get. Clients felt more mental health options are needed and are open to telemedicine mental health sessions as an option.

Early Intervention Services – Incarcerated (EIS)

EIS clients seem to be very knowledgeable and appreciative of access to service. One statement from an incarcerated client said "I was having side effects from the medication and when I talked to the doctor, he listened and made changes. Now I feel better and have not had any other problems."

Linguistic Services

There were no issues related to this service and due to the nature of the service delivered, there are no consumer interviews conducted for this service.

TRG QUALITY MANAGEMENT PROGRAM

2016

By: Tiffany Shepherd

The Resource Group-TRG

- TRG serves as the local administrative agency for six Texas Department of State Health Service (DSHS) Health Service Delivery Areas (HSDAs), supporting a continuum of health and social services in 51 counties of East Texas. Services are provided in cities ranging from Texarkana on the Texas/Arkansas border to Galveston on the Gulf of Mexico.
- Our Quality Management Program encompasses all grantee-specific quality activities, including the formal organizational quality infrastructure (e.g., committee structures with stakeholders, providers and consumer) and quality improvement related activities (performance measurement, QI project and QI training activities).

Definition of QM Plan

- A Quality Management Plan is a written document that outlines the grantee-wide HIV Quality Program, including a clear indication of responsibilities and accountability, performance measurement strategies and goals, and elaboration of processes for ongoing evaluation and assessment of the Program.

Quality Statement

- The Houston Regional HIV/AIDS Resource Group, inc. (TRG) Quality Management program will emphasize standards of care that systematically and comprehensively promote access to and retention in primary medical care and support services for optimal health outcomes. The purpose of Quality Management Plan is to ensure that all consumers receiving services through funds administered by TRG obtain the highest quality of care. This is in support of Ryan White HIV/AIDS Treatment Extension Act 2009 (Public Law 111-87, October 30, 2009), Legislation Section 2604.(h)(5), 2618.(b)(3)(E), 2664.(g)(5) and 2671.(f)(2)©.

Guiding Principles of QM Plan

- Guide the development for effective processes for assessing the quality of care and support services to promote access to care and remove barriers
- Expand consumer involvement in quality activities to lead to increased consumer engagement and improved health outcomes.
- Establish a commitment to quality to build capacity for QI within our Subgrantees to ensure that the delivery of services is equable, appropriate, and accessible for all people living with HIV.
- Collect and analyze targeted performance measures that reflect the required HAB measures to be used for the coordination of QI activities, development of best practices and standards, and the implementation of key activities that will minimize and/or eliminate barriers of impeded communication between Subgrantees and consumers.
- Communicate roles and expectations of quality related activities
- Strengthen partnerships of traditional and non-traditional stakeholders to improve care coordination
- Establish a Person-centered care system where the consumers will be at the core of all plans and services

By identifying opportunities for improvement, collecting and analyzing data, developing and implementing plans and subsequently evaluating those plans we can continuously improve the processes and systems that influence positive health outcomes for PLWHA.

Quality Improvement Infrastructure

- TRG utilizes a network of project-wide individuals and/or groups to facilitate the continuous quality improvement process.

- Key Members Include:
  - TRG RW Providers
  - Consumers
  - Internal and External Stakeholders
  - RWPC

Project-Wide QM Advisory Board	
Committee Member	**Roles and Responsibility**
Quality Compliance Coordinator (Chair)	Knowledge of QM and CQI practices and activities
Program Development Director	Knowledge of systems and grant requirements
Subgrantees Clinicians/Nurse Practitioner	Knowledge of clinical practices. This position is a physician licensed to practice medicine in the State of Texas with expertise in HIV/AIDS care.
Clinical Compliance Evaluator	Knowledge of subcontractor clinical systems and limitations. This position is a registered nurse licensed in the State of Texas with expertise in HIV/AIDS care.
Subgrantees Program Staff	Knowledge of various data collection systems used to gather data for the reporting of established quality management goals.
Consumer Advisory Board Members	Knowledge of community input from Subgrantees processes.
Consumer Relations Coordinator	Knowledge of consumer feedback from CAB processes.

Regional Stakeholder Meetings

- The objective of the stakeholders meetings is to engage area stakeholders, and gather community input to build and sustain optimal healthcare systems to improve the health of people living with HIV/AIDS (PLWHA) and those affected in the East Texas Administrative Service Area.
- We have (3) groups within our HSDA: Galveston, Beaumont and Northeast Texas

Part A Collaboration

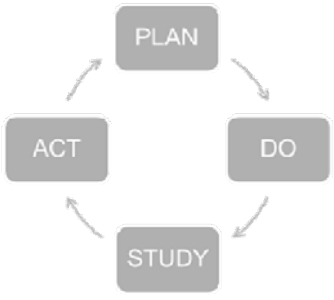
Ryan White A- Houston EMA

- The Resource Group works collaboratively with the Houston EMA Ryan White Part A and the Planning Council body. Quality Management planning, priority setting, and improvement activities developed by this collaboration fully encompass the spectrum of RW funding.

- This collaboration increases alignment of QM activities across all Ryan White programs (Parts A, B, C, D AETC and SPNS) and reduces duplication of QM efforts, ensuring maximum utilization of resources and seamless access to quality HIV care services.

Preferred Methodology

- Model for Improvement
  - PDSA Cycles- The Plan-Do-Study-Act (PDSA) cycle test changes in real work settings. The PDSA cycle guides the test of a change to determine if the change is an improvement.



Performance Measurement

- Performance measurement is the process of collecting, analyzing, and reporting data regarding patient care, health outcomes on an individual or population level, and patient satisfaction. Data Collection methods include but are not limited to:

Client Data System's
Client records
Site Visits
Client/staff interviews
Utilization patterns
Electronic Health Records
Provider Quarterly Reports
Demographic databases
Client/staff surveys

Performance Measurement

- Primary Source of data: The Client Record

- Secondary Source of data: ARIES (CPCDMS); Epi Data from DSHS (Including eHARS); and Client Satisfaction Surveys

(The most complete source of information on diagnosis, treatment, and clinical outcomes of care is the medical record.)

Evaluation

- On an annual basis the QM Program evaluates and reports overall effectiveness of the QM program.
- Evaluation will include:
  1. Assessment of the effectiveness of the QM infrastructure and QI activities in achieving QM goals
  2. Evaluation of QM goals to determine if goals were achieved
  3. Assessment of any overall data trends, identification of strengths and weaknesses and whether performance measures were appropriate.

Evaluation results will be derived from program monitoring processes and results, client satisfaction surveys (internal and external), outcome measures, and QI activities.

Work Plan Objectives

- Administrative tool
- Objectives include:
  - Update and Implementation of QM Plan
  - Strengthen the existing QM Infrastructure
  - Facilitate the implementation of QI activities
  - Ensure that primary care and health-related support services adhere to the most current US Health and Human Services guidelines (HHS), federal and state regulations
  - Provide ongoing TA and training

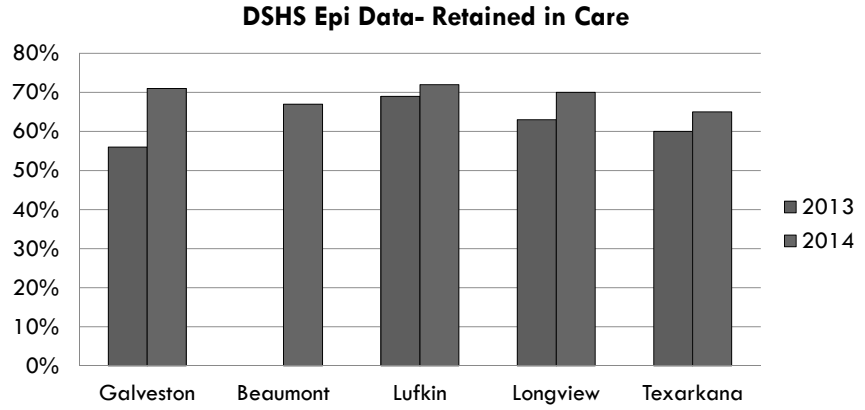
New This Year

- This we will no longer just monitor HAB performance measures as part of the QM Plan.
- The new plan focuses on AIMS or Goals, utilizing performance measures as a part of outcome measurement.
- 2016 is a baseline year for DSHS
- The 2016 will be a 5-year plan

TRG Goals for 2016

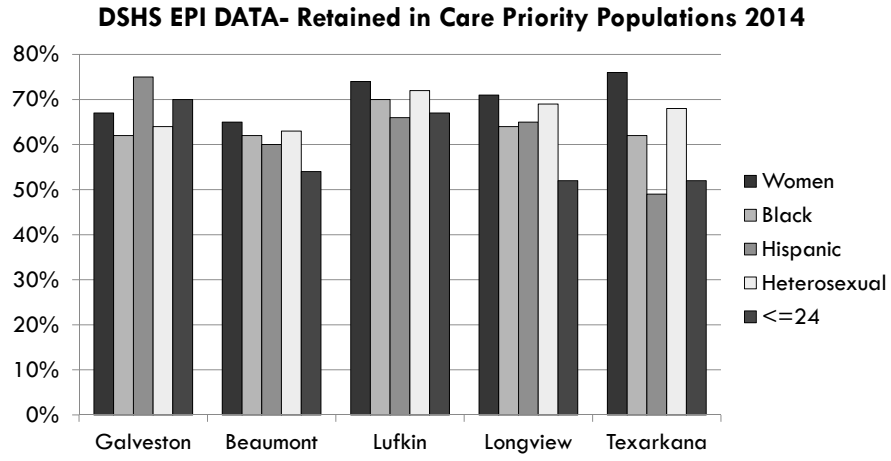
Program	Goal	Measurable Outcome
HIV Care Services	By 2020, 85% of all diagnosed persons with HIV will be retained in care.	1. By 2017 baseline (%) of clients will document at least one medical visit in each 6-month period of the 12- month measurement period. 2. By 2017 baseline of those clients who are assigned to case management, 95% will complete and /or update two or more times in the measurement year

Baseline Data- Retention in Care



Retained in care is defined as least two medical encounters in a 12- month measurement period.

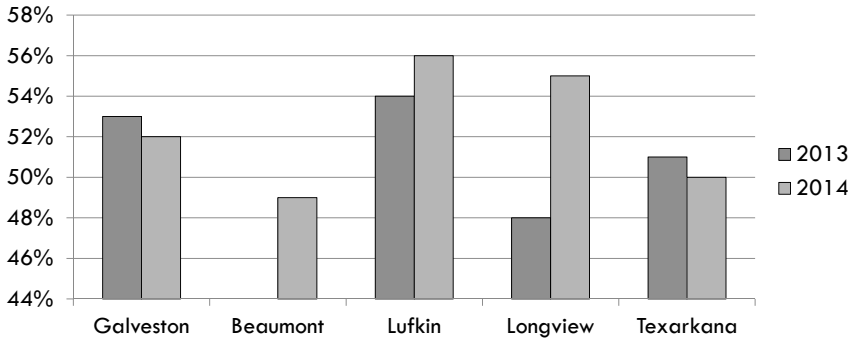
Baseline Data- Retention in Care



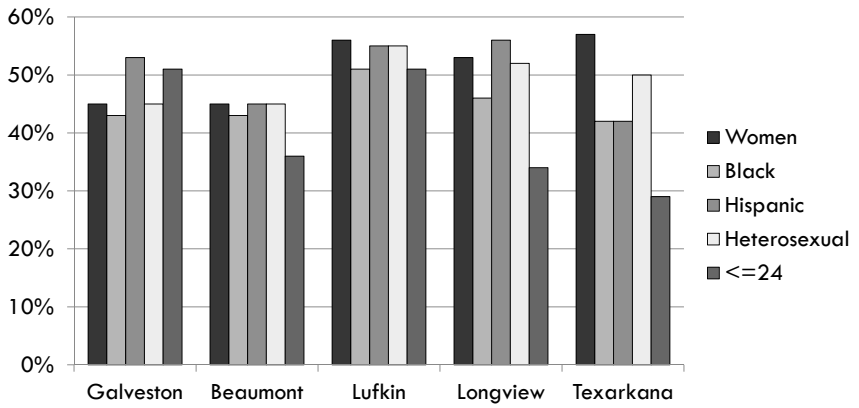
TRG Goals for 2016

Program	Goal	Measurable Outcome
HIV Care Services	By 2020 increase by 20%, the percentage of diagnosed persons who achieved and/or maintain viral load suppression	1. By 2017 the percentage of clients with a viral load test performed at least every six months during the measurement year will increase by 3%. 2. By 2017 baseline (%) of clients will document at least one medical visit in each 6-month period of the 12- month measurement period.

Baseline Data- Viral Load Suppression



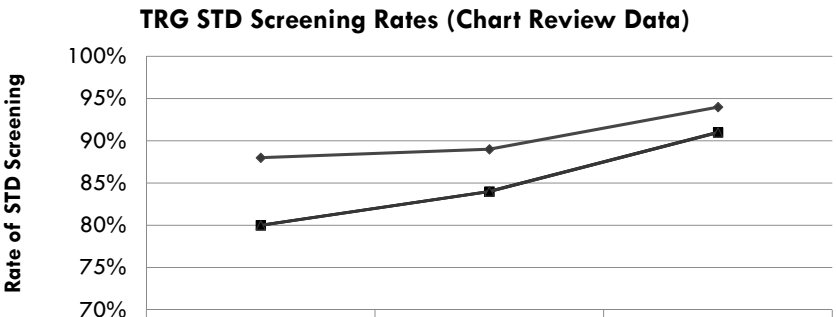
Baseline Data- Viral Load Suppression



TRG AIMS for 2016

Program	Goal	Measurable Outcome
Sexually Transmitted Disease	By 2020, 100% of RW-eligible clients will be screened for Syphilis, Gonorrhea and Chlamydia at least once in a measurement year	1. By 2018, 95% of RW-eligible clients will be screened for Syphilis. 2. By 2018, 95% of RW-eligible clients will be screened for Gonorrhea. 3. By 2018, 95% of RW-eligible clients will be screened for Chlamydia

Baseline Data- STD Screening



	2013	2014	2015
Syphilis	88%	89%	94%
Gonorrhea	80%	84%	91%
Chlamydia	80%	84%	91%

Syphilis test positive at the highest rate, 8% in 2015, up from 5% in 2014.

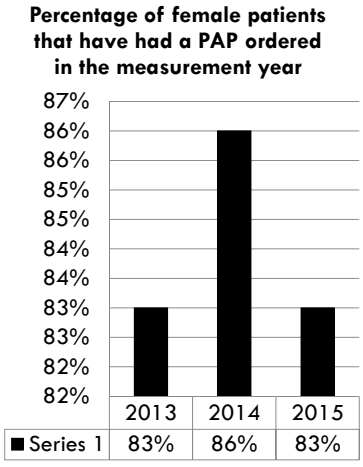
TRG Goals for 2016

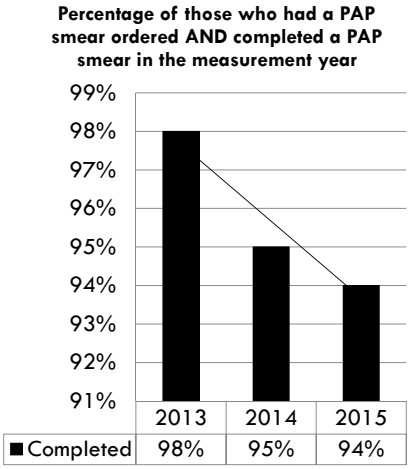
Program	Goal	Measurable Outcome
Women's Health	By 2020, 90% of RW-eligible female clients will be screened for cervical cancer	1. By 2017 increase the percentage of HIV-positive female clients that have had a PAP smear ordered in the measurement year by 5%. 2. By 2017 increase the percentage of HIV-positive female clients that have had a PAP smear ordered and have completed the PAP smear in the measurement year by 5% 3. By 2017, 90% of HIV-positive female clients that have had an abnormal PAP smear will document a referral for follow-up.

TRG Goals for 2016

Program	Goal	Measurable Outcome
Women's Health	By 2020, 90% of RW-eligible female clients over 40 years of age will have had a referral for a mammogram	By 2017 increase the percentage of HIV-positive female clients over 40 years that document a referral for a mammogram by 5%.

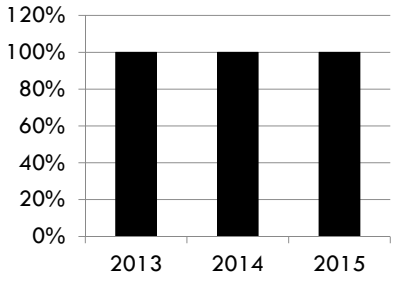
Baseline Data- Cervical Cancer



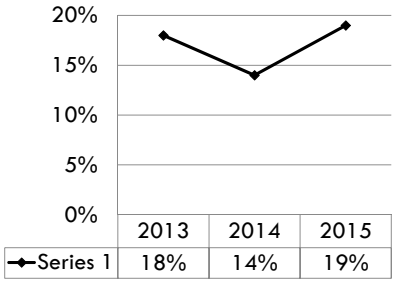


Baseline- Cervical Cancer

Percentage of those who had an abnormal PAP result and were referred for follow-up



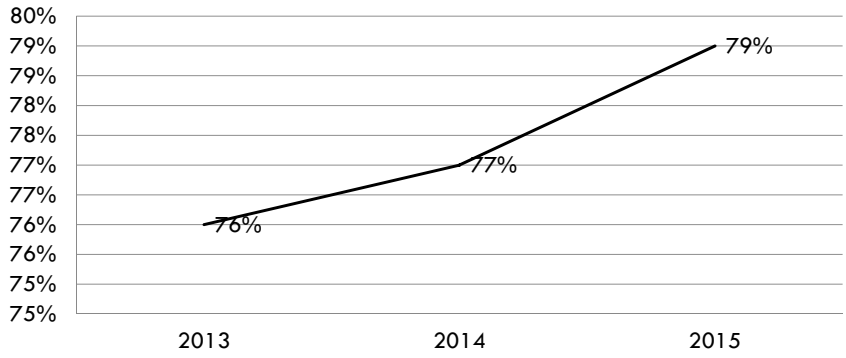
Percentage of those who completed a PAP smear and had an abnormal result



Texas has one of the highest cervical cancer incidence rates in the United States. Additionally, women with HIV are 5 times more likely to be diagnosed with cervical cancer than a uninfected woman.

Baseline Data- Mammogram Referral

Percentage of female clients over 40 years of age that were referred for a mammogram in the measurement year



TRG Goals for 2016

Program	Goal	Measureable Outcome
Case Management	RW-eligible clients who are assigned to case management will document care coordination activities aligned with optimal health outcomes By 2020, all identified measureable case management outcomes will increase by 20%	1. Percentage of HIV-positive clients that have attended at least two medical appointments in the measurement year 2. Percentage of HIV-positive clients who had a medical case management care plan developed and/or updated two or more times in the measurement year will increase by 5%.

TRG Goals for 2016

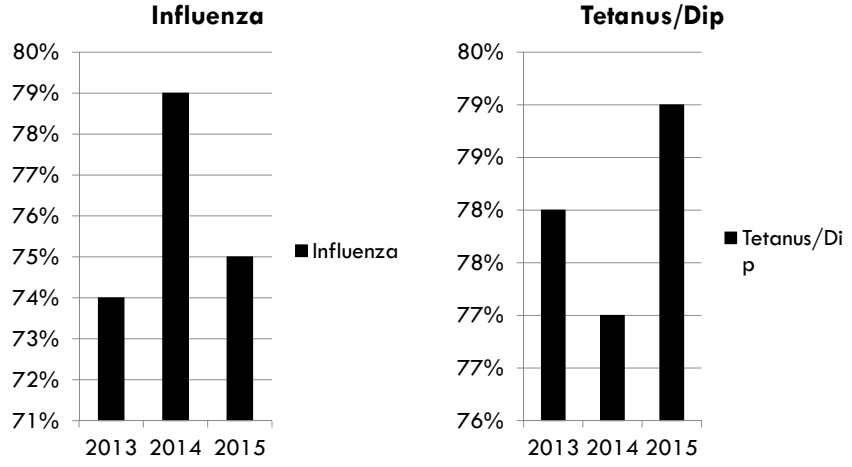
Program	Goal	Measureable Outcome
Case Management	RW-eligible clients who are assigned to case management will document care coordination activities aligned with optimal health outcomes By 2020, all identified measureable case management outcomes will increase by 20%	3. Percentage of HIV-positive clients who had a comprehensive reassessment at least every 6 months 4. Documented client education in the client record will show evidence of medication adherence (with documentation of clients viral load), safer sex and risk reduction, prevention of HIV transmission

TRG Goals

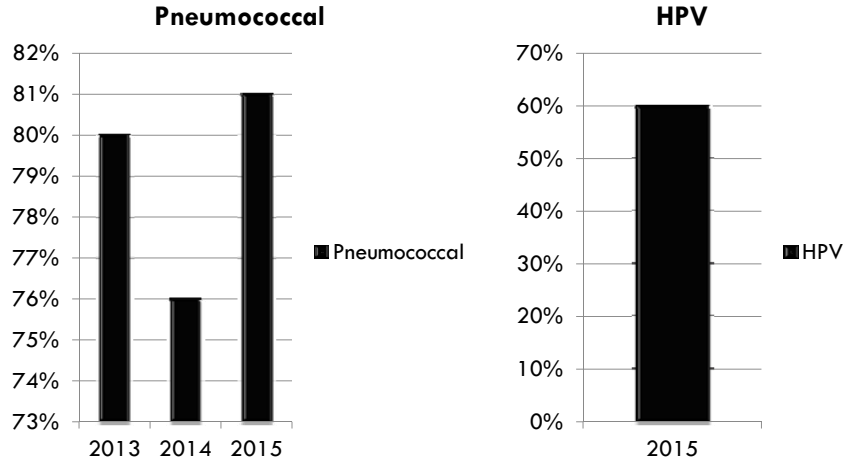
Program	Goal	Measureable Outcome
Immunizations	By 2020, 90% of RW-eligible clients will be vaccinated for the following (according to the proper vaccination schedule): Influenza, Tetanus/Diphtheria, Pneumococcal, Hepatitis A series, Hepatitis B series, and HPV	1. By 2017, the percentage of clients receiving Influenza in the calendar year will increase by 3% 2. By 2017, the percentage of clients receiving Tetanus/Diphtheria vaccination in the past 10 years will increase by 3% 3. By 2017, the percentage of clients receiving Pneumococcal vaccination in the past 5 years will increase by 3%

Program	Goal	Measureable Outcome
Immunizations	By 2020, 90% of RW-eligible clients will be vaccinated for the following (according to the proper vaccination schedule): Influenza, Tetanus/Diphtheria, Pneumococcal, Hepatitis A series, Hepatitis B series, and HPV	By 2017, the percentage of clients who completed the Hepatitis A vaccination series will increase by 3% By 2017, the percentage of clients who completed the Hepatitis B vaccination series will increase by 3% By 2017, the percentage of clients receiving HPV vaccination (13-26) will increase by 5%

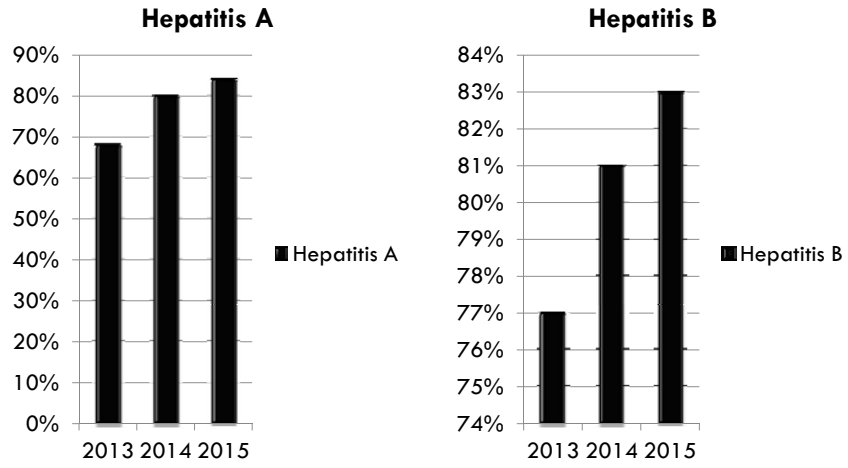
Baseline Data- Immunizations



Baseline- Immunizations



Baseline- Immunizations



Any Questions…

Houston Regional HIV/AIDS Resource Group, Inc.

5-Year Quality Implementation Plan, Goals and Expected Outcomes for HIV Care

Program	Goal	Measurable Outcome	Person Responsible	Resources Needed	Data to be collected
HIV Care Services	By 2020, 85% of all diagnosed persons with HIV will be retained in care.	1. By 2017 baseline (%) of clients will document at least one medical visit in each 6-month period of the 12- month measurement period. 2. By 2017 baseline of those clients who are assigned to case management, 95% will complete and /or update two or more times in the measurement year	QM Coordinator and Clinical Consultant DSHS (Epi data only)	Surveillance and Epidemiology data from DSHS Data from ARIES (CPCDMS data is uploaded into ARIES) Review tools for annual evaluation Client charts/records	The # of PLWH in each HSDA during a 12 month period The # of PLWH retained in care during a 12 month period The # of clients who had at least one medical visit in each 6-month period of the 12 month measurement period The # of clients assigned to case management The # of clients who completed and/or updated two or more times during a 12 month period

	By 2020 increase by 20%, the percentage of diagnosed persons who achieved and/or maintain viral load suppression	1. By 2017 the percentage of clients with a viral load test performed at least every six months during the measurement year will increase by 3%. 2. By 2017 baseline (%) of clients will document at least one medical visit in each 6-month period of the 12- month measurement period. 3.			
Sexually Transmitted Disease	By 2020, 98% of RW-eligible clients will be screened for Syphilis, Gonorrhea and Chlamydia at least once in a measurement year	1. 98% of RW-eligible clients will be screened for Syphilis. 2. 98% of RW-eligible clients will be screened for Gonorrhea. 3. 98% of RW-eligible clients will be screened for Chlamydia			
Women's Health	By 2020, 90% of RW-eligible female clients will be screened for cervical cancer	1. By 2017 increase the percentage of HIV-positive female clients that have had a PAP smear ordered in the measurement year by 5%. 2. By 2017 increase the percentage of HIV-positive female clients that have had a PAP smear ordered and have completed the PAP smear in the measurement year by 5% 3. By 2017, 90% of HIV-positive female clients that have had an abnormal PAP smear will document a referral for follow-up.			

	By 2020, 90% of RW-eligible female clients over 40 years of age will have had a referral for a mammogram	1. By 2017 increase the percentage of HIV-positive female clients over 40 years that document a referral for a mammogram by 5%.			
Case Management	RW-eligible clients who are assigned to case management will document care coordination activities aligned with optimal health outcomes By 2020, all identified measureable case management outcomes will increase by (20%)	1. Percentage of HIV-positive clients that have attended at least two medical appointments in the measurement year 2. Percentage of HIV-positive clients who had a medical case management care plan developed and/or updated two or more times in the measurement year will increase by 5%. 3. Percentage of HIV-positive clients who had a comprehensive reassessment at least every 6 months 4. Documented client education in the client record will show evidence of medication adherence (with documentation of clients viral load), safer sex and risk reduction, prevention of HIV transmission			

Immunizations	By 2020, 90% of RW-eligible clients will be vaccinated for the following (according to the proper vaccination schedule): Influenza, Tetanus/Diphtheria, Pneumococcal, Hepatitis A series, Hepatitis B series, and HPV	1. By 2017, the percentage of clients receiving Influenza in the calendar year will increase by 3% 2. By 2017, the percentage of clients receiving Tetanus/Diphtheria vaccination in the past 10 years will increase by 3% 3. By 2017, the percentage of clients receiving Pneumococcal vaccination in the past 5 years will increase by 3% 4. By 2017, the percentage of clients who completed the Hepatitis A vaccination series will increase by 3% 5. By 2017, the percentage of clients who completed the Hepatitis B vaccination series will increase by 3% 6. By 2017, the percentage of clients receiving HPV vaccination (13-26) will increase by 5%			

DRAFT

Houston Area
Ryan White HIV/AIDS Program
Assessment of the Administrative Mechanism

Part A and Minority AIDS Initiative (MAI)
Fiscal Year 2015

Prepared by
Houston Area Ryan White Planning Council
Office of Support
August 2016

Houston Area
Ryan White HIV/AIDS Program
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Background

The Ryan White CARE Act requires local Planning Councils to "assess the efficiency of the administrative mechanism in rapidly allocating funds to the areas of greatest need within the eligible area."[1] To meet this mandate, a time-specific document review of local procurement, expenditure, and reimbursement processes for Ryan White HIV/AIDS Program funds is conducted annually by local Planning Councils.[2] The observation process is not intended to evaluate either the local administrative agencies for Ryan White funds or the individual service providers funded by Ryan White.[3] Instead, it produces information about procurement, expenditure, and reimbursement processes for the local *system* of Ryan White funding that can be used for overall quality assurance purposes.

In the Houston eligible area, the Ryan White Planning Council has conducted an assessment of the administrative mechanism for Ryan White Part A and Minority AIDS Initiative (MAI) funds each fiscal year beginning in 2006. In 2012, the Planning Council began assessing the administrative mechanism for Part B and Texas State General Funds (State Services) as well. Consequently, the assessment tool used to conduct the assessment was amended to accommodate Part B and State Services processes. The new tool was developed and approved by the Quality Assurance Committee of the Planning Council on March 21, 2013 and approved by the Full Council on April 11, 2013.

Methodology

In July and August 2016, the approved assessment tool was applied to the administrative mechanism for Part A and MAI funds. The approved assessment tool will be applied to the administrative mechanism for Part B and State Services funds in late 2016. The contract periods designated in the tool are:

- Part A and MAI: March 1, 2015 – February 29, 2016 (FY15)
- Part B: #1 April 1, 2014 – August 31, 2014 and #2 September 1, 2014 – March 31, 2015 (FY 2014)
- State Services: September 1, 2013 – August 31, 2014 (FY 2013)

The tool evaluated three areas of each administrative mechanism: (1) the procurement and Request for Proposals (RFP) process, (2) the reimbursement process, and (3) the contract monitoring process. As outlined in the tool, 10 data points and their respective data sources were assessed for each administrative mechanism for the specified time frames. Application of the checklist, including data collection, analysis, and reporting, was performed by the Ryan White Planning Council Office of Support staff. All data and documents reviewed in the process were publicly available. Findings from the assessment process have been reported for each administration mechanism independently and are accompanied by the respective completed assessment tool.

[1]Ryan White Program Manual, Section V, Chapter 1, Page 4
[2]Ibid, Page 7
[3]Ibid, Page 8

Part A and Minority AIDS Initiative (MAI)
Contract Period: March 1, 2015 – February 29, 2016 (FY15)

Summary of Findings

I. Procurement/Request for Proposals Process

a) Traditionally, the Administrative Agent (AA) for Part A and MAI processes extensions of Part A and MAI contracts and positions with Harris County Commissioners Court prior to receipt of the Notice of Grant Award (NGA) from HRSA. As a result of this practice, only six days elapsed between receipt of the first NGA by the AA and contract execution with funded service providers. This practice continued for the FY15 contract period, and as a result there were no lapses in services to consumers.

b) Due to the extensions of Part A and MAI contracts and positions described in (a) above, 100% of the FY15 Part A and MAI grant award was procured to funded service providers by the first day of the contract period (3/1/15), or within the 1st quarter of the contract period. As such, the AA's timely procurement process resulted in no gaps in procured funds to service providers.

c) The AA procured funds in FY15 only to Planning Council-approved Service Categories. Moreover, the amounts of funds procured per Service Category at the beginning of the contract period matched Planning Council-approved final allocations for level funding for FY15. During the contract period, the AA applied Planning Council-approved policies for the shifting of funds within Service Categories, including application of the increased funding scenarios for Part A and MAI, billing reconciliations, and receipt of carry-over funds in approved categories.

d) Beginning in FY12, Part A and MAI services could be contracted for up to four years, with Service Categories rotated for bidding every three years. According to this schedule, Substance Abuse Treatment/Counseling (Substance Abuse Services Outpatient) under Part A was slated for the Request for Proposal (RFP) process during FY15 for FY16 contracts. This Service Category was competitively bid via a RFP process during the FY15 contract period for service contracts beginning in FY16.The RFP issued by the AA for these services contains information about the grant application process, which takes place via the Harris County Purchasing Agent. A pre-proposal conference for the RFP was also held. These steps indicate that the AA maintains a grant award process that provides potential bidders with information on applying for grants through the Purchasing Agent as well as the opportunity to address questions prior to submission.

e) As described in (d) above, the AA issued an RFP during the FY15 contract period for one Part A Service Category. The RFP issued for this service includes the FY16 Planning Council-adopted Service Category definition. This indicates that the AA maintains a grant award process that adheres potential bidders to Planning Council-approved definitions for contracted Service Categories.

f) The AA procured 100% of total service dollars for both Part A and MAI by the end of the contract period, including the addition of reconciliations and carry-over funds.

g) There were unspent service dollars in both Part A and MAI at the end of the FY15 contract period that occurred in Medical Case Management, Substance Abuse Treatment, Non-medical Case Management (Service Linkage), and Primary Care (MAI only). The total amount of unspent service funds for both Part A and MAI was $1,386,671, or 6.64% of the total allocation for service dollars for the contract period. It is important to note that some FY15 billing was outstanding as of August 2016. This

may decrease the total amount of FY15 unspent funds. Unspent funds will be sought for the FY16 contract period as carry-over dollars.

h) In FY15, the AA continued to communicate to the Planning Council the results of the procurement process, including agendizing procurement reports at Committee and Full Council meetings throughout the contract period.

II. Reimbursement Process

i) The average number of days elapsed between receipt of an accurate Contractor Reimbursement Report (CER) from contracted agencies and the issuance of payment by the AA for FY15 was 23 days. Overall, 40% of Part A and/or MAI-contracted agencies were paid within an average of 22 days following receipt of an accurate CER by the AA. All contracted Part A and/or MAI agencies were paid within an average of 25 days following receipt of an accurate invoice.

III. Monitoring Process

j) The AA continued to use the Standards of Care as part of the FY15 contract selection and monitoring process and clearly indicates this in various quality management policies, procedures, and plans, including the AA's Policy and Procedure for Performing Site Visits and the AA's current Quality Management Plan. Moreover, the RFP issued during the FY15 contract period for Part A Substance Abuse Treatment/Counseling (Substance Abuse Services Outpatient) states that the AA will monitor for compliance with Standards of Care during site monitoring visits of contracted agencies.

Administrative Assessment Checklist -- Part A and MAI		Contract Period: 3/1/15 - 2/29/16 (FY15)	
Section I: Procurement/Request for Proposals Process			
Method of Measurement	**Summary of Findings**	**Data Point**	**Data Source(s)**
a) How much time elapsed between receipt of the NGA or funding contract by the AA and contract execution with funded service providers (i.e., 30, 60, 90 days)?	• The Administrative Agent (AA) for Part A and MAI typically processes extensions of Part A and MAI contracts and positions with Commissioners Court prior to receipt of the Notice of Grant Award (NGA) in order to prevent lapses in services to consumers. • For the FY15 contract period, extensions of positions and contract renewals for Part A and MAI service providers were approved at Commissioners Court meetings on 1/27/15. The Part A and MAI NGA was received on 2/18/15 and 5/28/15, and final agreements were executed at the Court meetings on 2/24/15 and amended to reflect the final NGA on 6/13/15. *Conclusion*: Because contract and position extensions were processed by the AA in anticipation of the grant award, 6 days elapsed between receipt of the NGA by the AA and contract execution with funded service providers.	Time between receipt of NGA or funding contract by the AA and when contracts are executed with funded service providers	FY15 Part A and MAI NGA (issued 2/18/15 and 5/28/15) Commissioner's Court Agendas (1/27/15, 2/24/15, 3/10/15, 6/23/15)
b) What percentage of the grant award was procured by the: ☒ 1st quarter? ☐ 2nd quarter? ☐ 3rd quarter?	• FY15 procurement reports from the AA indicate that 100% of total allocated funds in each Service Category were procured by 3/1/15, the first day of the contract period. This is due to the contract and position extensions processed by the AA prior to receipt of the NGA, as described in (a) above. *Conclusion*: Because of contract and position extensions processed by the AA in anticipation of the grant award, 100% of the Part A and MAI grant award was procured by the 1st quarter of the contract period.	Time between receipt of NGA or funding contract by the AA and when funds are procured to contracted service providers	Year-to-date FY15 Part A and MAI Procurement Report provided by the AA to the PC (11/3/15)

Section I: Procurement/Request for Proposals Process			
Method of Measurement	**Summary of Findings**	**Data Point**	**Data Source(s)**
c) Did the awarding of funds in specific categories match the allocations established by the Planning Council?	• The Planning Council makes allocations per Service Category for each upcoming contract period based on the assumption of level funding. It then designs scenarios to be applied in the event of an increase or decrease in funding per the actual NGA. The Planning Council further permits the AA to re-allocate funds within Service Categories (up to 10%) without pre-approval throughout the contract period for standard business practice reasons, such as billing reconciliations, and to apply carry-over funds as directed. In addition, the Planning Council allows the AA to shift funds in the final quarter of the contract period in order to prevent the grantee from leaving more than 5% of its formula funds unspent. • The final FY15 procurement report from the AA (dated 6/8/16) shows that the Service Categories to be funded and the amounts of funds per Service Category procured at the beginning of the contract period matched the final Planning Council-approved allocations for level funding for FY15. Upon receipt of the final NGA, the Increased Funding Scenario was applied for the $874,864 (4.46%) increase in Part A Formula and Supplemental and $80,668 (4.18%) increase in MAI, as was the allowable shifting of funds described above. As a result, total allocations for FY15 did not match the original level-funding allocations approved by the Planning Council, but did match the Final FY15 Allocations Worksheet after application of the Increased Funding Scenario with only minor variability of ≤$1 due to rounding. *Conclusion*: The AA procured funds in FY15 only to Planning Council-approved Service Categories, and the amounts of funds per Service Category procured at the beginning of the contract period were a match to final allocations approved by the Planning Council for level funding. The AA applied Planning Council-approved policies for the shifting of funds within Service Categories during the contract period, including increased funding scenarios, billing reconciliations, and receipt of carry-over funds.	Comparison of the list of service categories awarded funds by the AA to the list of allocations made by the PC	Year-End FY15 Part A and MAI Procurement Report provided by the AA to the PC (6/8/16) PC FY15 Allocations Level Funding Scenario Worksheet (6/27/14) PC Final FY15 Allocations Increase Scenario (6/4/15)

Section I: Procurement/Request for Proposals Process			
Method of Measurement	**Summary of Findings**	**Data Point**	**Data Source(s)**
d) Does the AA have a grant award process which: ☒ Provides bidders with information on applying for grants? ☒ Offers a bidder's conference?	• Beginning in FY12, Part A and MAI services could be contracted for up to four years, with Service Categories rotated for bidding every three years. According to this schedule, Substance Abuse Treatment/Counseling (Substance Abuse Services Outpatient) under Part A was slated for the Request for Proposal (RFP) process during FY15 for FY16 contracts. • The RFP issued on 10/09/15 for the above Service Categories (Job No. 15/0248) contains information about the process for applying for grants through the Harris County Purchasing Agent (see, for example, "Vendor Instructions," page 10, and "Suggestions for Completing Proposals," page 20). • Moreover, a pre-proposal conference for the RFP was held by the AA on 10/21/15 with the stated purpose of "answer[ing] vendor questions regarding the proposal review and award process." *Conclusion*: A review of the RFP issued in FY15 indicates that the AA has maintained a grant award process that provides potential bidders with information on how to apply for grants via the Harris County Purchasing Agent as well as the opportunity to address questions about the grant award process.	Confirmation of communication by the AAs to potential bidders specific to the grant award process	Part A and MAI RFP issued in FY15 for FY16 contracts - Job No. 15/0248 (10/09/15) Courtesy Notice for Pre-Proposal Conference in FY 15 for FY16 contracts (10/09/15)
e) Does the REQUEST FOR PROPOSALS incorporate service category definitions that are consistent with those defined by the Planning Council?	• The RFP issued in FY15 (on 10/09/15) (Job No. 15/0248) for Substance Abuse Treatment/Counseling to be contracted for FY16 includes the FY16 Planning Council-adopted Service Category definitions for this service category (see "Service Category Specifications," pages 27-38). *Conclusion*: The RFP issued in FY15 includes Service Category definitions that are consistent with those defined by the Planning Council.	Confirmation of communication by the AAs to potential bidders specific to PC products	Part A and MAI RFP issued in FY15 for FY16 contracts - Job No. 15/0248 (10/09/15)
f) At the end of the award process, were there still unobligated funds?	• The final FY15 procurement report produced on 7/5/16 shows that 100% of total service dollars for Part A and MAI were procured by the end of the contract period, including the addition of reconciliations and carry-over funds. *Conclusion*: There were no unobligated funds for the contract period.	Comparison of final amounts procured and total amounts allocated in each service category	Year-End FY15 Part A and MAI Procurement Report provided by the AA to the PC (7/5/16)

Section I: Procurement/Request for Proposals Process			
Method of Measurement	**Summary of Findings**	**Data Point**	**Data Source(s)**
g) At the end of the year, were there unspent funds? If so, in which service categories?	• The final FY15 procurement report produced on 6/8/16 shows unspent service dollars as follows: (i) Part A: $809,159 in service dollars with less than 95% expended in the following Service Categories: Medical Case Management Substance Abuse Treatment Non-medical Case Management (Service Linkage) (ii) MAI: $577,521 in service dollars from Primary Medical Care • The total amount of unspent service funds for both Part A and MAI in FY15 was $1,386,671, or 6.64% of the total service dollar allocation. It is important to note that some FY15 billing was outstanding as of August 2016. This may decrease the total amount of FY15 unspent funds. *Conclusion*: There were $1,386,671 in unspent funds in Part A and MAI in the Service Categories listed above. Unspent funds represented 6.64% of the total FY15 Part A and MAI allocation for service dollars.	Review of final spending amounts for each service category	Year-End FY15 Part A and MAI Procurement Report provided by the AA to the PC (7/5/16)
h) Does the ADMINISTRATIVE AGENT have a method of communicating back to the Planning Council the results of the procurement process?	• The Memorandum of Understanding (MOU) (signed 3/1/12) between the CEO, Planning Council, AA, and Office of Support requires the AA to "inform the Council no later than the next scheduled [.] Steering Committee meeting of any allocation changes" (page 4). • In addition, FY15 Part A and MAI procurement reports from the AA were agendized for Planning Council meetings occurring on 11/12/15 and 4/14/16. Results of the procurement process were also provided during the AA report. *Conclusion*: The AA is required to and maintains a method of communicating back to the Planning Council the results of the procurement process, including agendized procurement reports to Committees and Full Council.	Confirmation of communication by the AAs to the PC specific to procurement results	Houston EMA MOU (signed 3/1/12) PC Agendas (11/12/15, 4/14/16)

Section II: Reimbursement Process			
Method of Measurement	**Summary of Findings**	**Data Point**	**Data Source(s)**
i) What is the average number of days that elapsed between receipt of an accurate contractor reimbursement request or invoice and the issuance of payment by the AA? What percent of contractors were paid by the AA after submission of an accurate contractor reimbursement request or invoice: ☐ Within 20 days? ☒ Within 35 days? ☐ Within 50 days?	• The Annual Contractor Reimbursement Report (CER) Tracking Summary for FY15 produced by the AA on 8/12/16 showed an average of 23 days elapsing between receipt of an accurate CER from contracted agencies and the issuance of payment by the AA. However, 40% of contracted agencies were paid within 22 days or less of receipt of a contractor reimbursement request. • 100% of contracted agencies were paid within an average of 25 days following the receipt of an accurate CER. In comparison, 100% of contracted agencies were paid within an average of 23 days in FY14. *Conclusion*: The average number of days elapsing between receipt of an accurate contractor reimbursement request for Part A and/or MAI funds and the issuance of payment by the AA was 23 days. All contracted Part A and/or MAI agencies were paid within an average of 25 days following receipt of an accurate invoice.	Time elapsed between receipt of an accurate contractor reimbursement request or invoice and the issuance of payment by the AA	FY15 Part A and MAI Contractor Reimbursement Report (CER) Tracking Summary (8/12/16)

Section III: Contract Monitoring Process			
Method of Measurement	**Summary of Findings**	**Data Point**	**Data Source(s)**
j) Does the ADMINISTRATIVE AGENT use the Standards of Care as part of the contract monitoring process?	• As described in (d) above, the AA issued an RFP during the FY15 contract period for Substance Abuse Treatment/Counseling (Substance Abuse Services Outpatient) Pages 22-23 of the RFP states that the AA will monitor for compliance with the Standards of Care during site monitoring visits of contracted agencies. Directions to current Standards of Care documents are also provided. • In addition, the AA's Policy and Procedure for Performing Site Visits of contacted agencies used during the FY15 contract period includes the process for reviewing compliance with Standards of Care. • The AA's Quality Management Plan (dated 1/16) states that the RWGA Clinical Quality Improvement Project Coordinator and Quality Management Development Project Coordinator both "[conduct] onsite QM program monitoring of funded services to ensure compliance with RWGA Standards of Care and QM plan" (Page 6). The Plan also states that "Annual site visits are conducted by RWGA at all agencies to ensure compliance with the standards of care" (Page 9). *Conclusion*: The AA uses the Standards of Care as part of the contract monitoring process and clearly indicates this in its quality management policies, procedures, and plans.	Confirmation of use of adopted SOC in contract monitoring activities	Part A and MAI RFP issued in FY15 for FY16 contracts - Job No. 15/0248 (10/09/15) HCPH/RWGA Policy and Procedure for Performing Site Visits (2/21/13) HCPH/RWGA Quality Management Plan (1/16)

Affected Community Committee Report

Consumer Training on Standards of Care

Affected Community Committee Meeting
August 23, 2016

General Standard 3.2: "Agency has Policy and Procedure regarding client Confidentiality […] Providers must implement mechanisms to ensure protection of clients' confidentiality in all processes throughout the agency."

"Mrs. Cranley! You need to sign this HIPAA privacy form before the doctor can look at those warts on your stomach!"

All our nurses now have degrees...unfortunately nurse Filbright's is in the expressive arts!

Primary Medical Care 1.1: "Medical care for HIV infected persons shall be provided by MD, NP, CNS or PA licensed in the State of Texas and has at least two years paid experience in HIV/AIDS care including fellowship."

Oral Health 2.8: "Oral hygiene instructions (OHI) should be provided annually to each client."

To help emphasize good oral hygiene in kids, Dr. Remford installed a dental floss zipline in his office.

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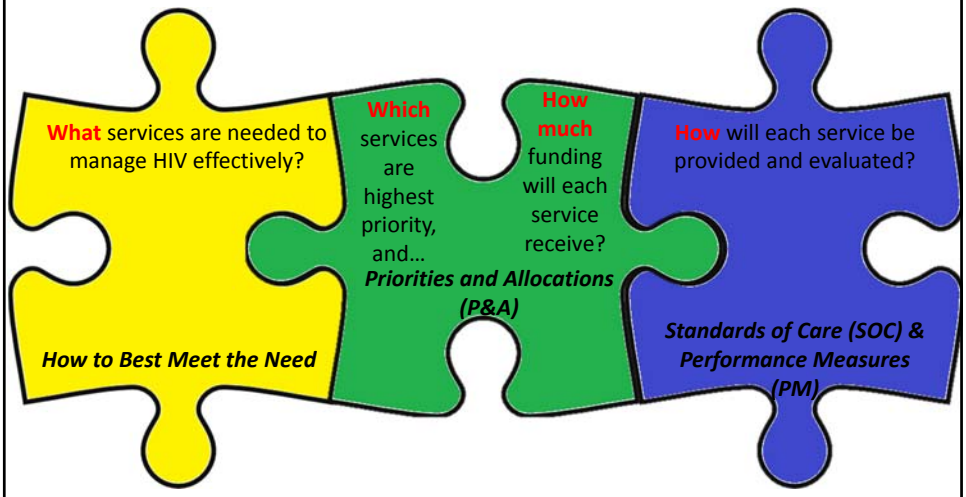
Components of the Process



Houston Has Standards!

If you were planning on buying a car, what are some basic features you would expect to "come standard" with a good quality car?

- A working engine
- Steering wheel
- Brakes
- Seatbelts
- Air conditioner – A must-have in Houston!

Just as you would expect basic features to "come standard" when buying a car, you can also expect basic levels of quality to "come standard" with HIV care services in Houston. We call these Standards of Care (SOC).

Official Definitions

- Standard of Care (SOC)

A *statement* of the minimal acceptable levels of quality in HIV service delivery by Ryan White funded providers in a local jurisdiction.

- Performance Measure (PM)

A *measurement* of the impact of HIV care, treatment, and support services provided by Ryan White funded providers in a local jurisdiction.

A Little Background on SOC…

- First developed in 1999 as a way to monitor provider contracts
- Every year since, workgroups are held to review the Standards with the community that include physicians, nurses, case managers, administrators, and consumers
- Based on
  1. Accepted industry guidelines
  2. On-site program monitoring results, and
  3. Provider and consumer input
- Apply to services funded by Ryan White Parts A and B, and State Services.
- Maintained by the Administrative Agents (AAs)
  - RW/A = Ryan White Grant Administration
  - RW/B and State Services = The HIV Resource Group

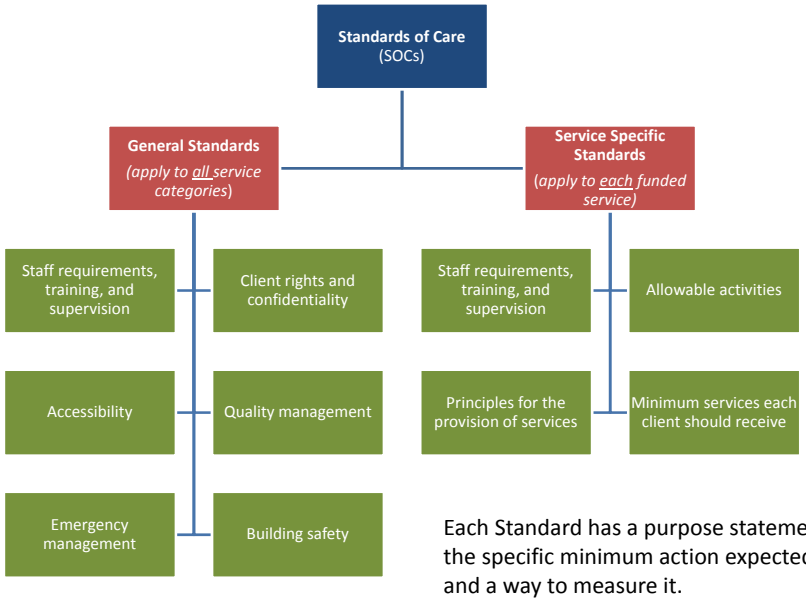
What SOC Are

- A way of letting providers and consumers know what constitutes quality care and services for PLWHA
- A tool for making sure Ryan White-funded services are delivered according to minimum industry standards and guidelines
- One of many data sources for measuring how well Ryan White-funded services are meeting overall community goals

What SOC Aren't

- A way to evaluate how a specific Ryan White-funded agency conducts business *(Agency monitoring is done by the AAs)*
- A way to decide which agency in Houston gets Ryan White money *(RFPs and agency contracts are coordinated by the AAs)*
- Guidelines for HIV services provided by *non*-Ryan White-funded agencies

Organization of the SOCs



Each Standard has a purpose statement, the specific minimum action expected, and a way to measure it.

GENERAL STANDARDS

	Standard	Measure
1.0	**Staff Requirements**	
1.1	Staff Screening (Pre-Employment) Staff providing services to clients shall be screened for appropriateness by provider agency as follows: • Personal/Professional references • Personal interview • Written application Criminal background checks, if required by Agency Policy, must be conducted prior to employment and thereafter for all staff and/or volunteers per Agency policy.	• Review of Agency's Policies and Procedures Manual indicates compliance • Review of personnel and/or volunteer files indicates compliance
1.2	Initial Training: Staff/Volunteers Initial training includes eight (8) hours HIV/AIDS basics, safety issues (fire & emergency preparedness, hazard communication, infection control, universal precautions), confidentiality issues, role of staff/volunteers, agency-specific information (e.g. Drug Free Workplace policy). Initial training must be completed within 60 days of hire.	• Documentation of all training in personnel file. • Specific training requirements are specified in Agency Policy and Procedure • Materials for staff training and continuing education are on file • Staff interviews indicate compliance
1.3	Staff Performance Evaluation Agency will perform annual staff performance evaluation.	• Completed annual performance evaluation kept in employee's file • Signed and dated by employee and supervisor (includes electronic signature)
1.4	Cultural and HIV Mental Health Co-morbidity Competence Training/Staff and Volunteers All staff must receive four (4) hours of cultural competency training and an additional one (1) hour of HIV/Mental Health co-morbidity sensitivity training annually. All new employees must complete these within ninety (90) days of hire.	• Documentation of training is maintained by the agency in the personnel file
1.5	Staff education on eligibility determination and fee schedule Agency must provide training on agency's policies and procedures for eligibility determination and sliding fee	Documentation of training in employee's record

Primary Medical Care

The 2006 CARE Act defines Primary Medical Services as the "provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, nurse specialist, nurse practitioner or other health care professional who is certified in their jurisdiction to prescribe Antiretroviral (ARV) therapy in an outpatient setting….. Services include diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history tasking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions and referral to and provisions of specialty care".

The RW Part A primary care visit consist of a client examination by a qualified Medical Doctor, Nurse Practitioner, Clinical Nurse Specialist and/or Physician Assistant and includes all ancillary services such as eligibility screening, patient medication/treatment education, adherence education, counseling and support; medication access/linkage; and as clinically indicated, OB/GYN specialty procedures, nutritional counseling, routine laboratory and radiology. All primary care services must be provided in accordance with the current U.S. Department of Health and Human Services guidelines

1.0	**Medical Care for persons with HIV disease should reflect competence and experience in both primary care and therapeutics known to be effective in the treatment of HIV infection and is consistent with the most current published U.S. Public Health Service treatment guidelines**	
1.1	Minimum Qualifications Medical care for HIV infected persons shall be provided by MD, NP, CNS or PA licensed in the State of Texas and has at least two years paid experience in HIV/AIDS care including fellowship.	• Credentials on file
1.2	Licensing, Knowledge, Skills and Experience • All staff maintain current organizational licensure (and/or applicable certification) and professional licensure • The agency must keep professional licensure of all staff providing clinical services including physicians, nurses, social workers, etc. • Supervising/attending physicians of the practice show continuous professional development through the following HRSA recommendations for HIV-qualified physicians (www.hivma.org): • Clinical management of at least 25 HIV-infected patients within the last year • Maintain a minimum of 15 hours of HIV-specific CME	• Documentation in personnel record

Organization of the PMs

All **Performance Measures** (PMs) are service-specific

- Each PM is a system-wide measure that helps evaluate the impact of HIV services on the health status of the people living with HIV/AIDS in the Houston area.
- PMs are based on current U.S. Department of Health and Human Services (HHS) Guidelines for HIV/AIDS health care and community input.
- In general, PMs assess the percentage of consumers who, following receipt of a specific service:
  1. Entered into and/or were retained in HIV medical care
  2. Experienced improvement in HIV health indicators like CD4 counts and viral load suppression
  3. Received recommended medical, oral, and optical screening, care, and follow-up
  4. Were screened for and received mental health or substance abuse services if needed
  5. Obtained housing if homeless or unstably housed
  6. Secured 3rd party health care coverage (insurance) if uninsured, and/or
  7. Completed SSI disability, insurance, public benefits and income-related cases resulting in access to or continued access to benefits (legal services only)

Ryan White Part A
HIV Performance Measures
FY 2014 Report

Primary Medical Care
All Providers

For FY 2014 (3/1/2014 to 2/28/2015), 7,024 clients utilized Part A primary medical care.

Primary Care	FY 2013	FY 2014	Change
100% of Ryan White Part A program-funded outpatient/ambulatory care organizations in the system/network will have a waiting time of 15 or fewer business days for a Ryan White Part A program-eligible patient to receive an appointment to enroll in outpatient/ambulatory medical care	Data is not available at this time		
90% of clients with HIV infection will have two or more medical visits, at least 90 days apart, in an HIV care setting in the measurement year	4,200 (78.9%)	4,106 (74.9%)	-4.0%
Percentage of clients with a diagnosis of HIV who did not have a medical visit in the last six months of the measurement year	1,313 (24.7%)	1,566 (28.6%)	3.9%
Percentage of clients with a diagnosis of HIV who had at least one medical visit in each six-month period of the 24-month measurement period with a minimum of 60 days between medical visits	2,379 (27.0%)		

CD-4 Count and Viral Suppression	FY 2013	FY 2014	Change
75% of clients for whom there is lab data in the CPCDMS will show improved or maintained CD-4 counts over time	5,100 (91.9%)	5,321 (92.2%)	0.3%
Percentage of clients who have a CD-4 < 200 within the first 90 days of initial enrollment in primary medical care	294 (23.1%)	272 (20.0%)	-3.1%
Percentage of clients for whom there is lab data in the CPCDMS who are virally suppressed (< 200)	3,846 (75.5%)	4,058 (79.8%)	4.3%
Percentage of clients aged six months and older with a diagnosis of HIV/AIDS, with at least two CD-4 cell counts or percentages performed during the measurement year at least three months apart	3,996 (75.1%)	4,104 (74.9%)	0.2%
Percentage of clients with a diagnosis of HIV/AIDS with a viral load test performed at least every six months during the measurement year	2,586 (56.7%)	2,639 (58.4%)	1.7%

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Take-Home Messages

- Standards of Care set the minimum acceptable levels of *quality* of HIV care, treatment, and support services provided to PLWHA by Ryan White funded providers
- Performance Measures provide a way to evaluate the system-wide impact of HIV services on the health status of the people living with HIV/AIDS in the Houston area.
- SOCs and PMs do *not* evaluate a specific individual provider or agency, nor do they determine which provider/agency receives Ryan White funds
- Consumers have an important role in the SOC/PM process. They review the standards and make recommendation for improvements, and they serve as a voice of the consumer in defining quality of HIV care.

Why does any of this matter in the real world?

Example: Linkage to Care

Standard of Care:
What is the general Standard of Care for linking clients into care?
General Standard 4.11 (Accessibility – Linkage Into Core Services): Agency staff will provide out-of-care clients with individualized information and referral to connect them into ambulatory outpatient medical care and other core medical services.

How will the Administrative Agent know this Standard has been met?
- Documentation of client referral is present in client record
- Review of agency's policies & procedures' manual indicates compliance

Why does any of this matter in the real world?

Example: Linkage to Care

Performance Measure:

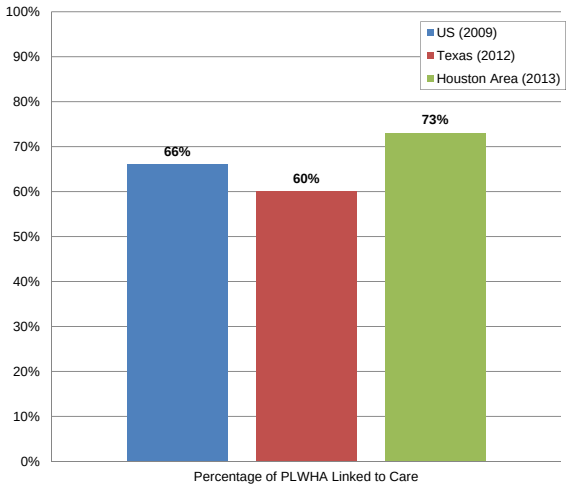
How will the Administrative Agent measure whether efforts to link clients into care have been effective?

Non-Medical Case Management / Service Linkage
All Providers:

1. A minimum of 70% of clients will utilize Part A/B/C/D primary care two or more times at least three months apart after accessing non-medical case management (service linkage)
2. Measure the number of days between first ever service linkage visit and first ever primary medical care visit
3. Assess the percentage of newly-enrolled clients who had a medical visit in each of the four-month periods of the year

Why does any of this matter in the real world?

Establishing SOCs and monitoring PMs help ensure that people living with HIV/AIDS in the Houston Area can expect and receive high quality life-sustaining HIV care and treatment services.



SOC/PM Exercise

Practice with Standards of Care

1. If you wanted to know how quality is defined for <u>all</u> services provided through Ryan White, which type of Standard of Care would you review:
   a. General Standards
   b. Service Specific Standards

Go to the General Standard called <u>4.0 Accessibility</u>.

2. What is the minimum definition of quality for "Cultural Competence?"

3. How does someone know if this minimum standard is met by the agency/provider--what documents are looked at?

Go to the Service Specific Standards for <u>Non-Medical Case Management Services (Service Linkage Worker)</u>.

4. How long does a Service Linkage Worker have to transfer a Not-in-Care and Newly Diagnosed Client into HIV primary care?
   a. 90 days
   b. 120 days
   c. Unlimited

SOC/PM Exercise

Practice with Performance Measures

1. <u>True/False</u>. There are no general Performance Measures. Performance Measures are specific to each service funded through Ryan White.

Go to the Performance Measures for <u>Medical Nutritional Supplements</u>.

2. Ideally, what percentage of clients should have improved or maintained CD-4 counts over time after receiving Medical Nutrition Supplements?
   a. 75%
   b. 80%
   c. 85%
   d. 90%

Go to the Performance Measures for <u>Primary Medical Care</u>.

3. Name 3 Clinical Chart Review Measures.

DRAFT

Schedule of Topics for
2016 Affected Community Committee Meetings

(revised 07-20-16)

Shaded areas indicate an off-site meeting location; black areas = meeting rooms not available

Confirmed	Month 2016	Topic	Speaker/Facilitator	Meeting Location
✓	12 noon, Tues. February 23	• Purpose of the Council and Public Hearings • Participation in Health Fairs • Why meetings are held off-site	Tori Williams	Office of Support
✓	12 noon, Tues. March 17	Joint meeting of the Affected Community, Priority & Allocations and Quality Improvement Committees	Committee Co-Chairs	Office of Support
✓	12 noon, Tues. March 22	***Training for Consumers:*** The RW How To Best Meet the Need Process - Part 1	Tori Williams	Office of Support
✓	1:30 - 4 p.m., Thurs. April 14	How To Best Meet the Need Training – Part 2	Planning Council Chairs	Office of Support
✓	10:30 a.m. – 4 p.m. Tues. April 26 &/or Wed. April 27	How To Best Meet the Need Workgroups	Quality Improvement Committee	Office of Support
✓	12 noon, Tues. May 24	HIV and the Asian Community	Peta-gay Ledbetter, PhD	Hope Clinic 7001 Corporate Dr., #120 Houston, Tx 77036 713 773-0803
✓	6:30 – 8:00 p.m. WEDNESDAY June 15	HIV and the Heterosexual Community Advisory Board (CAB)	Amana Turner	Change Happens 3353 Elgin St. Houston, TX 77004
✓	12 noon, Tues. July 26	PrEP	Adonis May	Bee Busy Wellness Center 8785 West Bellfort Ave. Houston, TX 77031
✓	12 noon, Tues. August 23	***Training for Consumers:*** Standards of Care, Why Should I Care?	Amber Harbolt, Health Planner, Office of Support	Office of Support
✓	12 noon, Tues. Sept. 20	Standards of Care and Performance Measures **Consumer Only** Workgroup	Carin Martin, Manager Ryan White Grant Administration	Office of Support
TENTATIVE	12 noon, Tues. October 25	HIV and the Rural Community	????	Access Health
TENTATIVE	12 noon, Tues. November 22	HIV and Substance Abuse	Pennye Rhodes, PA St. Hope Foundation	St. Hope Foundation, **Conroe**

Possible Topics:

Community Involvement in HIV Clinical Research Trials - Morénike Giwa

Medication Updates – Shital Patel, MD or Ben Barnett, MD OR invite all drug reps. Include info on getting Rx's FDA approved, change to generic status – how does this impact ADAP pricing?

Affected Community Committee
2016 Community Events (as of 08/15/16)

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.
Friday, May 6 6 – 9 pm Contact: H.Finley/J. Humphreys	Houston Splash 2016	Double Tree Hotel – Galleria	Allen, Teresa, Curtis, Arlene, Cecilia **PP: Teresa ; back up Skeet**
Saturday, June 25 Noon – 7:00 pm	Pride Festival	Downtown near City Hall	Shift 1 (11:30 am-2 pm) : **PP Curtis,** Peta Tana, **,** Johnetta Shift 2 (2-4:30 pm) John L, Ruth, Teresa, Allen Shift 3 (4:30-7 pm): **PP Teresa,** John L.,Tracy, Rodney **To be Assigned:** Steven V, Carol, Arlene
Friday, September 16	HIV and Aging Symposium	Montrose Center	**Need 8+ volunteers** Tana, Allen, Curtis, Cecilia, Teresa, Rodney, **PP: Skeet**
Sunday, September 18, 2016	MISS UTOPIA	The Crowne Plaza (Brookhollow) 12801 Northwest Freeway Houston, TX 77040	**Need 3 volunteers** Carol, Peta, Skeet, Tana, Cecilia **PP:__Peta, Curtis, Skeet_**
Tuesday, September 27 Contact: Herman Finley	Gay Men's Health Summit New Name: Live Out Loud	Hiram Clarke Multi Service Center 810 W. Fuqua St., 77045 MAYBE MOVED TO UNITED WAY	Teresa (PP), Curtis, Allen, Cecilia, Arlene
October	Road 2 Success		
Tuesday, December 1	World AIDS Day Events		Most committee members attend events
January 2017	Road 2 Success		
NEW DATE: Saturday, January 21 2017 8:00 a.m. – 2:30 p.m.	HIV Testing and Prevention: Tools for Your Practice	Marriott Hotel- Medical Center 6580 Fannin St. Houston, TX 77030 (713) 796-0080	**CONFIRM IF AVAILABLE FOR NEW DATE:** Curtis, Cecilia, Teresa, Rodney, Isis, Allen, Tracy, Tana

You are invited to attend a Symposium on

"Aging with HIV"

Date: Friday, September 16, 2016
Place: The Montrose Center
401 Branard Street Room 106 & 107
Houston, TX 77006
Time: 8:00 am to 4:00 pm
Parking and Lunch included

Agenda

8:15 - 8:45 am	**Registration**	
8:50 - 9:00 am	**Welcome**	
9:00 - 10:30 am	**HIV and Texans over 50**	**Ann Robbins, PhD**
10:45 - 12:00 pm	**H.A.N.D**	**Scott Letendre, MD**
12:00 - 1:00 pm	**Lunch**	
1:00 - 1:45pm	**Polypharmacy**	**Rustin Crutchley, PharmD, AAHIVP**
1:45 - 2:30 pm	**Internalized HIV Stigma**	**Daniel Garces, MS, LPC, LMFT**
2:30 - 3:15 pm	**Grief and Bereavement**	**Peta-gay Chen Ledbetter, RN, PhD**
3:15 - 3:50 pm	**HIV and Aging**	**Rajagopal Sekhar, MD**
3:50 - 4:00 pm	**Closing Remarks**	

Attendees that work in health care please CLICK HERE

For questions you may contact Nichole Akinbohun
AETC Education and Prevention Clinic Coordinator
Email: nichole.akinbohun@harrishealth.org

Community Attendees that do not work in health care please register here
Montrosecenter.org