#

2017 Council Attendance

Updated 05-26-17

NUMBER OF COUNCIL MEETINGS HELD IN 2017: 4

Council Members Shaded = retiring from Council on 12/31/17	Number of meetings attended in 2017	Number of meetings unable to attend in 2017
Ted Artiaga	4	
Connie L. Barnes	2	2
Curtis W. Bellard	4	
David Benson	1	3
Ardry "Skeet" Boyle, Jr.	3	1
Bianca Burley	3	1
Ella Collins-Nelson	4	
Amber David	4	
Johnny Deal	3	1
Evelio Salinas Escamilla	4	
Herman L. Finley III	2	2
Tracy Gorden	4	
Paul E. Grunenwald	1	3
Angela F. Hawkins	4	
Arlene Johnson		4
J. Hoxi Jones	3	1
Denis Kelly	4	
Peta-gay Ledbetter	3	1
Tom Lindstrom	3	1
Osaro Mgbere	3	1
Nancy Miertschin	4	
Rodney Mills	4	
Allen Murray	4	
Robert Noble	3	1
Shital Patel		4
John Poole	3	1
Tana Pradia	4	
Teresa Pruitt	3	1
Venita Ray	2	2
Cecilia Ross	3	1
Viviana Santibanez	4	
Gloria Sierra	4	
Krystal Shultz	4	
Carol Suazo	4	
Isis Torrente	4	
Steven Vargas	4	
Larry Woods	1	3

DRAFT

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, June 8, 2017
Meeting Location: Montrose Center, 401 Branard Street
Houston, Texas 77006

I. Call to Order — Cecilia Ross, Chair, RW Planning Council
   A. Welcome and Moment of Reflection
   B. Adoption of the Agenda
   C. Approval of the Minutes
   D. Training: Project LEAP 2017 Presentations — Project LEAP Students

II. Public Comments and Announcements — Carol Suazo, Secretary

(NOTE: If you wish to speak during the Public Comment portion of the meeting, please sign up on the clipboard at the front of the room. No one is required to give his or her name or HIV/AIDS status. All meetings are audio taped by the Office of Support for use in creating the meeting minutes. The audiotape and the minutes are public record. If you state your name or HIV/AIDS status it will be on public record. If you would like your health status known, but do not wish to state your name, you can simply say: "I am a person with HIV/AIDS", before stating your opinion. If you represent an organization, please state that you are representing an agency and give the name of the organization. If you work for an organization, but are representing yourself, please state that you are attending as an individual and not as an agency representative. Individuals can also submit written comments to the Council Secretary who would be happy to read the comments on behalf of the individual at this point in the meeting. The Chair of the Council has the authority to limit public comment to 1 minute per person. All information from the public must be provided in this portion of the meeting. Council members please remember that this is a time to hear from the community. It is not a time for dialogue. Council members and staff are asked to refrain from asking questions of the person giving public comment.)

III. Reports from Committees
   A. Comprehensive HIV Planning Committee — Isis Torrente and Steven Vargas, Co-Chairs
   Item: Presentation on NHBS and HMMP Data
   Recommended Action: FYI: Dr. Osaro Mgbere and his team presented findings from the National HIV Behavioral Surveillance (NHBS) project and the Houston Medical Monitoring Project (HMMP). NHBS examines HIV-related risk behaviors among HIV negative high-risk populations, while HMMP provides detailed local surveillance data among PLWH from questionnaires and clinical information. See the attached presentations and the updated special study prospectus.

Item: Special Study - Social Determinants of Health Supplement
Recommended Action: FYI: The Committee reviewed questions from the 2014 Needs Assessment that were omitted in the 2016 Needs Assessment Survey tool to identify NHBS/HMMP data elements to mine for the Social Determinants of Health Supplement. In sum, the Committee asked staff to examine barriers and social determinants for PLWH who are not virally suppressed, HIV monitoring test values upon initial entry to care, HIV test

location and testing motivation, types of substance abuse treatment (residential vs. outpatient/other), relationship between employment, insurance, and use of HIA program, compare prevalence of self-reported mental health diagnoses to clinical diagnoses, education attainment, and prevention-specific risks and behaviors. See the attached questions excluded from the 2016 Needs Assessment.

Item: EIIHA Workgroup Recommendations / Data Requests
Recommended Action: FYI: See the attached minutes excerpt from the March 23rd EIIHA Workgroup meeting for data recommendations/requests for the FY18 EIIHA target populations selection process.

Item: Report from the Speaker's Bureau Workgroup
Recommended Action: FYI: See the attached evaluation report from the March speaking engagement. The Speaker's Bureau Workgroup will meet on June 6th. Please see Diane Beck if you would like to be added to the Workgroup.

Item: 2017 Comprehensive Plan: 2017 Q1 Implementation Progress Report
Recommended Action: FYI: See the attached 2017-2021 Comprehensive Plan: 2017 Q1 Implementation Progress Report. By the end of March. 85% of activities slated for implementation in 2017 were completed or had progress made.

Item: 2017 Committee Quarterly Reports
Recommended Action: FYI: See the attached Quarterly Report.

B. Quality Improvement Committee — Robert Noble and Gloria Sierra, Co-Chairs

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

- Part B Procurement, dated 05/10/17 & 04/02/17
- DSHS Procurement, dated 05/10/17 & 04/02/17
- Health Insurance Assistance Utilization, dated 05/02/17 & 04/05/17

Item: FY 2017 Service Definitions
Recommended Action: **Motion:** In FY 2017 and FY 2018, approve the service definition for and bundle Emergency Financial Assistance with Ambulatory Outpatient Medical Care/Local Pharmacy Assistance Program (LPAP) and keep the financial eligibility the same as LPAP at 500% for HIV medications.

Item: FY 2018 Ryan White Part A, Part B and State Services Service Definitions
Recommended Action: **Motion:** Approve the attached FY 2018 Ryan White Part A, Part B and State Services service definitions and the proposed special idea for the Compassionate Care Program (see the attached summary page) and the financial eligibility for each service listed on the table of contents for the service definitions.

Item: FY 2018 Ryan White Part A, Part B and State Services Targeting Chart
Recommended Action: **Motion:** Approve the attached FY 2018 Ryan White Part A, Part B and State Services Targeting Chart.

Item: 2017 Criteria and Proposed Idea Form
Recommended Action: **Motion:** Approve the attached 2017 Criteria and page 1 of the proposed idea form.

Item: 2017 Assessment of the Administrative Mechanism
Recommended Action: **Motion:** Approve the attached checklist for the 2017 Assessment of the Administrative Mechanism

Item: Texas Dept. of State Health Services Standards of Care
Recommended Action: **Motion:** After reviewing, the Quality Improvement Committee recommends no comment on the following standards of care from the Texas Department of State Health Services:

- Mental Health Services
- Psychosocial Support Services
- Other Professional Services

Item: 2017 Quarterly Committee Reports
Recommended Action: FYI: See the attached Quarterly Committee Report.

C. Affected Community Committee — Rodney Mills and Tana Pradia, Co-Chairs
Item: 2017 Road 2 Success/Camino hacia tu Salud
Recommended Action: FYI: The Affected Community Committee is now responsible for working with staff to organize Road 2 Success, a series of 5 seminars for people living with HIV and their caregivers. At least 2 of the seminars are taught in Spanish. See the attached list of Road 2 Success/Camino hacia tu Salud seminars scheduled for 2017. Please see Tori if you speak Spanish and would like to volunteer to assist with the seminars held in Spanish.

Item: 2017 Community Events
Recommended Action: FYI: See the attached list of 2017 Community Events where the Council will have a presence. The Committee is looking for volunteers to help at Pride Festival. Please raise your hand If you would like to help staff a Planning Council booth at the Festival the afternoon of Saturday, June 24th.

Item: 2017 Greeters
Recommended Action: FYI: See the attached list of Greeters at the 2017 Council meetings.

Item: 2017 Quarterly Committee Reports
Recommended Action: FYI: See the attached Quarterly Committee Report.

D. Operations Committee — Curtis Bellard and Nancy Miertschin, Co-Chairs
Item: How To Best Meet the Need – Blue Book
Recommended Action: **Motion**: Approve $17,000 in the FY 2018 Council Support Budget for reprints of the 2018–2019 Blue Book.

Item: FY 2018 Council Support Budget
Recommended Action: **Motion:** Approve the attached FY 2018 Council Support Budget.

Item: Council Bylaws and Policy Review
Recommended Action: FYI: On July 18, 2017, the Operations Committee will be reviewing the attached Petty Cash policy. One of the changes that they will be considering is having members who are employed to submit their work address and hours of employment. If their hours of employment overlap with Council meetings, then they will be required to use their work address as their point of origin for mileage requests. If a member were to feel that the policy does not support their personal situation, they will be welcome to submit a waiver to the the Operations Committee. If anyone wishes to provide public comment on this possible change, please attend the July 18th committee meeting, or send written comments via fax or email to Tori Williams in the Office of Support.

Item: Update on Ryan White Report Training
Recommended Action: FYI: Sixteen Council and External Committee members participated in the Ryan White Cross Committee training on Tuesday, May 23, 2017. Look for announcements regarding future trainings.

Item: Election for the 2017 Vice Chair of the Planning Council
Recommended Action: ELECTION: All nominees are required to state their qualifications before the elections are held for the 2017 Vice Chair of the Planning Council. Additional nominations can be made at this time.

Item: 2017 Quarterly Committee Reports
Recommended Action: FYI: See the attached Quarterly Committee Report.

E. Priority and Allocations Committee — Ella Collins-Nelson and Paul Grunenwald, Co-Chairs
Item: Reports from the Administrative Agent – Part A
Recommended Action: FYI: See the attached reports:

- FY 2016 RW Part A/MAI Procurement, dated 05/25/17
- FY 2016 RW Part A/MAI Service Utilization, dated 05/03/17

Item: Revised FY 2017 Service Priorities
Recommended Action: **Motion:** Revise the FY 2017 Service Priorities by adding Emergency Financial Assistance as priority #17 and Referral for Health Care and Support Services as priority #18 based upon a recommendation from the Quality Improvement Committee that these service be added in FY 2017.

Item: FY 2017 Ryan White Part A Unspent Funds
Recommended Action: **Motion:** Fund request for increased funding Control #3 in the amount of $50,000 with Ryan White Part A funds. Hold the remaining balance of the Ryan White Part A unspent funds in the amount of $58,780 until the next reallocation period.

Item: FY 2017 State Services – Rebate Funds
Recommended Action: **Motion:** Fund requests for Control #B in the amount of $375,000 and Control #A up to the balance of $600,000, with the understanding that unspent funds will be reported to the Council for reallocation at a later date.

Item: 2017 Quarterly Committee Reports
Recommended Action: FYI: See the attached Quarterly Committee Report.

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

VIII. New Business (30 seconds/report)

A. HOPWA — Krystal Shultz

B. Community Prevention Group (CPG) — Herman Finley

C. Update from Task Forces:

- Sexually Transmitted Infections (STI) — Herman Finley
- African American — S. Johnson-Fairley
- Latino — Gloria Sierra
- MSM — Ted Artiaga
- Transgender — Viviana Santibanez

- Hepatitis C — Steven Vargas
- Urban AIDS Ministry — Ella Collins-Nelson
- Youth

D. HIV and Aging

E. Positive Women's Network — Tana Pradia

F. END HIV Houston — Venita Ray

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

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

I. Texas HIV Medication Advisory Committee — Nancy Miertschin

J. Texas HIV Syndicate — Amber Harbolt

K. Legislative Updates

L. Texas HIV/AIDS Coalition

IX. Announcements

X. Adjournment

HOUSTON AREA HIV SERVICES
RYAN WHITE PLANNING COUNCIL

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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, May 11, 2017
2223 W. Loop South, Room 532; Houston, Texas 77027

MEMBERS PRESENT	MEMBERS PRESENT	OTHERS PRESENT
Cecilia Ross, Chair	Allen Murray	
Carol Suazo, Secretary	Tana Pradia	Shelley Lucas, DSHS
Ted Artiaga	Viviana Santibanez	Yitang Dang, HHD
Connie Barnes	Gloria Sierra	Mikel Marshall, ViiV
Curtis Bellard	Krystal Shultz	Shabaura Perryman, Bristol Myers
David Benson	Steven Vargas	
Skeet Boyle		
Bianca Burley	**MEMBERS ABSENT**	**STAFF PRESENT**
Ella Collins-Nelson	Herman Finley	*Ryan White Grant Administration*
Amber David	Paul Grunenwald, excused	Heather Keizman
Johnny Deal	Arlene Johnson	Tasha Traylor
Evelio Salinas Escamilla	Tom Lindstrom, excused	
Tracy Gorden	Robert Noble	*The Resource Group*
Angela F. Hawkins	Shital Patel, excused	Sha'Terra Johnson-Fairley
J. Hoxi Jones	John Poole, excused	
Denis Kelly	Teresa Pruitt, excused	*Office of Support*
Peta-gay Ledbetter	Venita Ray, excused	Tori Williams
Osaro Mgbere	Isis Torrente, excused	Amber Harbolt
Nancy Miertschin	Larry Woods, excused	Diane Beck
Rodney Mills		

Call to Order: Cecilia Ross, Chair, called the meeting to order at 12:06 p.m.
During the opening remarks, Ross thanked Miertschin for chairing the Steering meeting last week; she explained that when the Chair and the Vice Chair of the Council are unavailable, one of the Chairs of the Operations Committee is asked to fill in. The Secretary of the Council is not allowed to chair a meeting. She thanked everyone who participated in the FY 2018 How To Best Meet the Need process. Tori will provide more details, but attendance was high and discussion was rich at both the How To Best Meet the Need training and at the five workgroup meetings.

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

Approval of the Minutes: ***Motion #2****: it was moved and seconded (Kelly, Bellard) to approve the April 23, 2017 minutes.* **Motion carried.** Abstentions: Barnes, Benson, Burley, Mgbere.

Training: Texas Department of State Health Services (DSHS) Legislative and ADAP Updates: Shelley Lucas, Manager, Manager, HIV/STD Prevention and Care Branch at the Texas Department of State Health Services, presented information on the current Texas Legislative Session and changes to the state ADAP program.

Public Comment and Announcements: None.
#
Reports from Committees:
Comprehensive HIV Planning Committee: Steven Vargas, Co-Chair, reported on the following:
Speakers Bureau Workgroup: The April meeting was cancelled since neither co-chair was available to participate. Steven Vargas has agreed to be the new co-chair in place of John Lazo.

Quality Improvement Committee: Gloria Sierra, Co-Chair, reported on the following:
No report. The Committee did not meet in April so that members could participate in the How to Best Meet the Need workgroup meetings.

Affected Community Committee: Rodney Mills, Co-Chair, reported on the following:
No report. The Committee did not meet in April so that members could participate in the How to Best Meet the Need workgroup meetings.

Operations Committee: Curtis Bellard, Co-Chair, reported on the following:
Verbal update on Ryan White Report Training: Miertschin stated that she met with Ross to design a a basic training for interested Council members and also more training per committee.

Council Bylaws and Policy Review: ***Motion #3:*** *Approve the attached revisions to the following Council policies: Standing and Other Committees, 400.01;* Computer Policy, 1100.00*; Election of Officers, 500.01.* **Motion carried unanimously.**

Election Policy: ***Motion #4:*** *If the above recommended changes to the Election of Officers policy (policy 500.01) are approved at the May 11, 2017 Council meeting, then the Operations Committee recommends that the call for nominations for the office of Vice Chair be made at the May 11, 2017 Council meeting with the election taking place at the June 8, 2017 Council meeting.* **Motion carried unanimously.**

Priority and Allocations Committee: Ella Collins-Nelson, Co-Chair, reported on the following:
Reports from the Administrative Agency – Part B/SS: See the attached reports:

- Procurement, Part B and State Services – dated 04/07/17
- Health Insurance Assistance – dated 04/05/17 and 03/06/17

FY 2017 Allocations: The Priority and Allocations Committee tabled allocating/reallocating Part A funds in the amount of $108,780 and State Services-Rebate (SS-R) funding in the amount of $975,000 until their May 2017 committee meeting so that staff can gather additional information,

and in hopes that the final notice of the Ryan White Part A grant award will have been received.

FY 2017 Allocations: ***Motion #5:*** *Approve the attached request for funding in the amount of $16,220 for Road 2 Success 2017.* **Motion carried unanimously.**

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

Report from Ryan White Grant Administration: Heather Keizman, summarized the attached report.

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

New Business:
HOPWA: Shultz said that the HOPWA RFP will be released at the beginning of June.

Updates from Task Forces:
Sexually Transmitted Infections: David said that they passed out a lot of information at the SPLASH event last weekend.

African American: Johnson-Fairley said they also participated in the SPLASH event. The next meeting is tomorrow at noon at the Fifth Ward Multiservice Center on Market Street.

Latino: Sierra said there was no meeting in April; the next meeting will be May 26th at 2pm at the Montrose Center.

MSM: Artiaga submitted the attached report.

Transgender: David said they had a panel at SPLASH about working with the trans community.

Hepatitis C: Vargas said that the annual Hep C workshop on May 4th was well attended.

Urban AIDS Ministry: Collins-Nelson said they meet on the third Friday of the month at 11am at the Third Ward Multiservice Center on Ennis.

Youth: Johnson-Fairley said they tested 90 youth in 3 hours at the Youth HIV Awareness day event on April 19th at Prairie View A&M.

Positive Women's Network: Pradia said they are working to create a women's CAB at Legacy. In July they will start a support group for newly diagnosed women. They meet at Legacy on the 2nd Monday of the month.

END HIV Houston: Vargas said they are creating workgroups on cultural competency.

Texas HIV Syndicate: Harbolt said the first meeting of the year was earlier this week, she will have a full report for the Council in June.

Announcements: Ross said the committee cross training will be on May 23rd at 1pm. Gorden said he is still collecting items to send for kids in Africa. Anyone wishing to donate items will need to get them to him before the last Friday in May.

Adjournment: The meeting was adjourned at 1:29 p.m.

Respectfully submitted,

_____ _____
Victoria Williams, Director Date

Draft Certified by
Council Chair: _____ Date _____

Final Approval by
Council Chair: _____ Date _____

Council Voting Records for May 11, 2017

C = Chair of the meeting ja = Just arrived lm = Left the meeting lr = Left the room VP = Via phone	**Motion #1** Agenda **Carried**				**Motion #2** Minutes **Carried**				**Motion #3** Council Bylaws **Carried**					**Motion #1** Agenda **Carried**				**Motion #2** Minutes **Carried**				**Motion #3** Council Bylaws **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
Cecilia Ross, Chair				C				C				C	Allen Murray		X				X				X		
Carol Suazo, Secretary		X				X				X			Tana Pradia		X				X				X		
Ted Artiaga		X				X				X			Viviana Santibanez		X				X				X		
Connie Barnes		X							X	X			Gloria Sierra		X				X				X		
Curtis Bellard		X				X				X			Krystal Shultz		X				X				X		
David Benson		X							X	X			Steven Vargas		X				X				X		
Skeet Boyle		X				X				X															
Bianca Burley		X							X	X															
Ella Collins-Nelson		X				X				X			**MEMBERS ABSENT**												
Amber David		X				X				X			Herman Finley												
Johnny Deal		X				X				X			Paul Grunenwald												
Evelio Salinas Escamilla		X				X				X			Arlene Johnson												
Tracy Gorden		X				X				X			Tom Lindstrom												
Angela F. Hawkins		X				X				X			Robert Noble												
J. Hoxi Jones		X				X				X			Shital Patel												
Denis Kelly		X				X				X			John Poole												
Peta-gay Ledbetter		X				X				X			Teresa Pruitt												
Osaro Mgbere		X							X	X			Venita Ray												
Nancy Miertschin		X				X				X			Isis Torrente												
Rodney Mills		X				X				X			Larry Woods												

C = Chair of the meeting ja = Just arrived lm = Left the meeting lr = Left the room VP = Via phone	**Motion #4** Election of Vice Chair **Carried**				**Motion #5** R2S funding **Carried**					**Motion #4** Election of Vice Chair **Carried**				**Motion #5** R2S funding **Carried**			
MEMBERS	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN	MEMBERS	ABSENT	YES	NO	ABSTAIN	ABSENT	YES	NO	ABSTAIN
Cecilia Ross, Chair				C				C	Allen Murray		X				X		
Carol Suazo, Secretary		X				X			Tana Pradia		X				X		
Ted Artiaga		X				X			Viviana Santibanez		X				X		
Connie Barnes		X				X			Gloria Sierra		X				X		
Curtis Bellard		X				X			Krystal Shultz		X				X		
David Benson		X				X			Steven Vargas		X				X		
Skeet Boyle		X				X											
Bianca Burley		X				X											
Ella Collins-Nelson		X				X			**MEMBERS ABSENT**								
Amber David		X				X			Herman Finley								
Johnny Deal		X				X			Paul Grunenwald								
Evelio Salinas Escamilla		X				X			Arlene Johnson								
Tracy Gorden		X				X			Tom Lindstrom								
Angela F. Hawkins		X				X			Robert Noble								
J. Hoxi Jones		X				X			Shital Patel								
Denis Kelly		X				X			John Poole								
Peta-gay Ledbetter		X				X			Teresa Pruitt								
Osaro Mgbere		X				X			Venita Ray								
Nancy Miertschin		X				X			Isis Torrente								
Rodney Mills		X				X			Larry Woods								

Comprehensive HIV Planning Committee Report

Special Study Prospectus: Social Determinants of Health Supplement (**Updated 5-3-2017**)

Why is this special study of interest/importance to the Houston HIV Community?	• Several questions related to social determinants of health were trimmed from the 2016 Needs Assessment survey tool, such as question regarding employment, current transportation resources, public assistance, current substance abuse and needle use practices, disability, etc. • Houston Health Department's (**HHD**) Bureau of Epidemiology collects similar data from a large sample for the Houston Medical Monitoring Project (**HMMP**)
Where is the gap in our knowledge about this topic?	• Since several questions related to social determinants of health were trimmed from the 2016 Needs Assessment survey tool, the most recent collection of these data was 2013. • Epidemiological / Surveillance data does not probe most social determinants of health
What do we ultimately want to learn? What are our research questions?	• How do social determinants of health affect PLWH in the Houston area? • How can services be designed to improve HIV care in light of social determinants?
What methodology/methodologies will be used in this special study?	• Working with HHD Bureau of Epidemiology to data mining HMMP database(s). Findings will inform a second special study examining movement into and out of care over time.
Are there any risks for special study participants?	• No, HMMP data collection and de-identification would fall under the purview of HHD Bureau of Epidemiology
What are the potential limitations of this study?	• Depending on the roles of potential community partners, RWPC Office of Support staff & interns may need to learn / re-learn data mining methodologies. • Data likely limited to Houston/Harris County
What is our data analysis process for this special study?	• TBD
Who are the responsible parties and potential community partners who can assist in this special study?	• Comprehensive HIV Planning Committee & Ryan White Planning Council • RWPC Office of Support & Interns • HHD Bureau of Epidemiology (HMMP)
What is a rough timeline for this special study?	• Duration of study will be greatly determined by HHD Bureau of Epidemiology, content of HMMP data, and data mining resources. • Findings will inform a second special study examining movement into and out of care over time (likely ≈20 key informant interviews)
How will the findings of this special study be used?	• The findings of this special study supplement the findings of the 2016 Needs Assessment and potentially enrich the HMMP

Medical Monitoring Project (MMP)

Osaro Mgbere PhD, MS, MPH
Nadia Barahmani MD, PhD, MS

HOUSTON MEDICAL MONITORING PROJECT

HOUSTON HEALTH DEPARTMENT

What is MMP?

HOUSTON HEALTH DEPARTMENT

- The MMP is a special HIV surveillance project designed to learn more about the experiences and needs of people living with HIV (PLWH).
- The project is conducted by state and local health departments in collaboration with the Centers for Disease Control and Prevention (CDC).
  - Houston/Harris County is one of 23 funded sites
  - Project Started in 2005 and is ongoing

Key Questions Answered By MMP

HOUSTON HEALTH DEPARTMENT

- How many PLWH are receiving medical care for HIV?
- How easy is it to access medical care, prevention, and support services?
- What are the met and unmet needs of PLWH?
- How is treatment affecting PLWH?

Significance of MMP

HOUSTON HEALTH DEPARTMENT

- MMP provides representative and accurate data estimates
- MMP provides information about the behaviors, medical care, and health status of PLWH
- MMP data use: HIV-related indicators for Healthy people 2020, Federal agencies, Ryan White planning council (RWPC), prevention planning groups; policy leaders, health care providers, and PLWH

Who participates in MMP?

HOUSTON HEALTH DEPARTMENT

- 2005-2014: PLWH (18 years and older) receiving HIV medical care from HIV care facilities
- 2015 – onward: All adults (18 years and older) diagnosed with HIV in the United States (include in-care, out-of-care and incarcerated persons)

MMP Process

HOUSTON HEALTH DEPARTMENT

- 400 persons are selected each year from the National HIV Surveillance System
- Interview – 45 minutes in-person or telephone (English and Spanish)
- Medical chart review – last 2 years prior to interview date
- Token of appreciation - $60 gift card

What are the Key Areas Covered by MMP?

HOUSTON HEALTH DEPARTMENT

- Demographic characteristics
- Access to care and support services
- HIV treatment and Adherence
- Stigma and discrimination
- Sexual behaviors
- Transmission risk behaviors
- Drug and alcohol use
- Prevention activities

Met and Unmet Need for Support Services Among Persons Receiving HIV Care in Houston/Harris County

HOUSTON MEDICAL MONITORING PROJECT

HOUSTON HEALTH DEPARTMENT

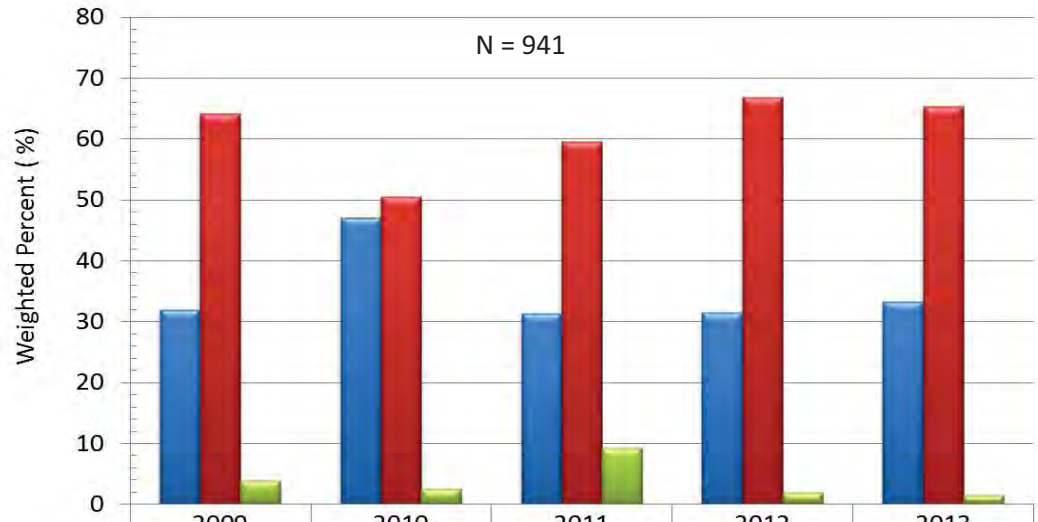
Objective

HOUSTON HEALTH DEPARTMENT

- To identify and estimate the met and unmet needs, and unneeded support services of PLWH in Houston/Harris County, Texas

Figure 1: Health Insurance Status of PLWH in Houston/Harris County, 2009-2013

HOUSTON HEALTH DEPARTMENT



	2009	2010	2011	2012	2013
Uninsured	31.9	47	31.3	31.4	33.2
Insured	64.2	50.5	59.5	66.8	65.4
Uninsured (Ryan White only)	3.9	2.55	9.2	1.9	1.5

Table 1: Met need for support services during the 12 months before the interview - Medical Monitoring Project, 2009-2013 (Top 10 Services)

HOUSTON HEALTH DEPARTMENT

Service	Number of Persons[δ] Who Received Service	Weighted Population Estimate	
		Percent (%)	Rank
Dental Care	484	51.9	1st
Medicine through ADAP	389	40.4	2nd
Public Benefits (Including SSI or SSDI)	356	36.8	3rd
HIV Case Management Services	335	36.4	4th
HIV Prevention Counseling	278	29.2	5th
Transportation Assistance	244	24.6	6th
Mental Health Services	188	20.6	7th
Meal or Food Services	193	19.5	8th
Adherence Support Services	162	16.6	9th
HIV Peer Group Support	109	11.2	10th

[δ] Number of persons are unweighted ; *CI = Confidence Interval; ADAP = AIDS Drug Assistance Program; SSI=Supplemental Security Income; SSDI = Social Security Disability Insurance*

Table 2: Unmet need for support services during the 12 months before the interview - Medical Monitoring Project, 2009-2013 (Top 10 Services)

HOUSTON HEALTH DEPARTMENT

Service	Number of Persons Who Needed Service *	Weighted Population Estimate	
		Percent (%)	Rank
Dental Care	267	26.6	1st
Meal or Food Services	94	9.4	2nd
Transportation Assistance	82	8.7	3rd
Public Benefits (Including SSI or SSDI)	82	8.5	4th
Shelter or Housing Services	76	8.2	5th
HIV Case Management Services	74	7.8	6th
HIV Peer Group Support	43	4.2	7th
Medicine through ADAP	31	3.5	8th
Childcare Services	20	2.1	9th
Home Health Services	17	1.7	10th

* *Number of persons (unweighted) who needed service but did not receive the needed service by the time of interview*
***ADAP** = AIDS Drug Assistance Program; **SSI**=Supplemental Security Income; **SSDI** = Social Security Disability Insurance*

Table 3: Support Services not received and not needed during the 12 months before the interview - Medical Monitoring Project, 2009-2013 (Top 10 Services)

HOUSTON HEALTH DEPARTMENT

Service	Number of Persons Who did not receive Service*	Weighted Population Estimate	
		Percent (%)	Rank
Domestic Violence Services	915	97.6	1st
Child Care Services	905	96.4	2nd
Interpreter Services	889	95.5	3rd
Drug or Alcohol Counseling or Treatment	889	94.7	4th
Home Health Services	870	92.8	5th
HIV Peer Group Support	787	84.6	6th
Shelter or Housing Services	765	81.9	7th
Adherence Support Services	760	81.8	8th
Mental Health Services	722	76.4	9th
Meal or Food Services	652	71.0	10th

* *Number of persons (unweighted) who did not receive service and did not need service* ***ADAP =*** *AIDS Drug Assistance Program;* ***SSI****=Supplemental Security Income;* ***SSDI =*** *Social Security Disability Insurance*

Figure 2: Persons who needed, received, or did not receive support services in the 12 months before the interview – Medical Monitoring Project, Houston/Harris County, 2009-2013

HOUSTON HEALTH DEPARTMENT

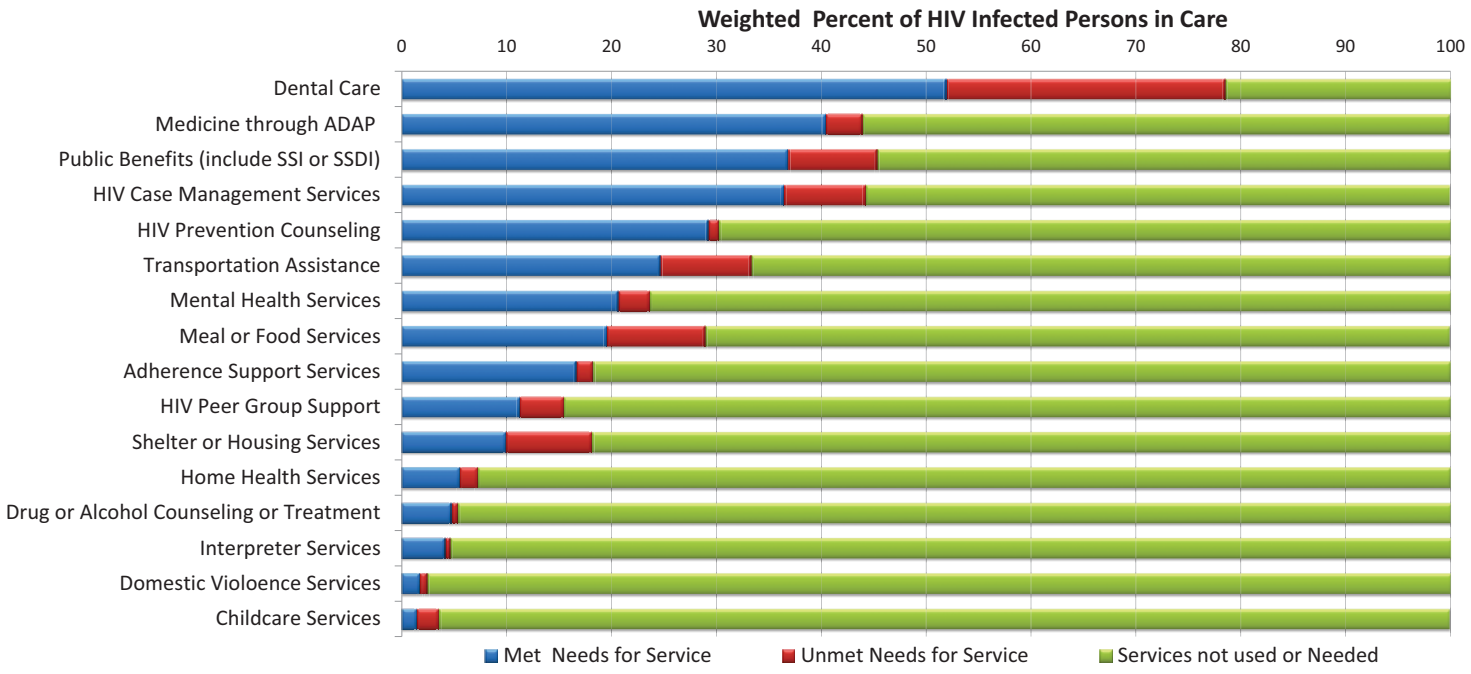


Figure 3: Persons who needed, received, or did not receive support services in the 12 months before the interview – Medical Monitoring Project, United States, 2009

HOUSTON HEALTH DEPARTMENT

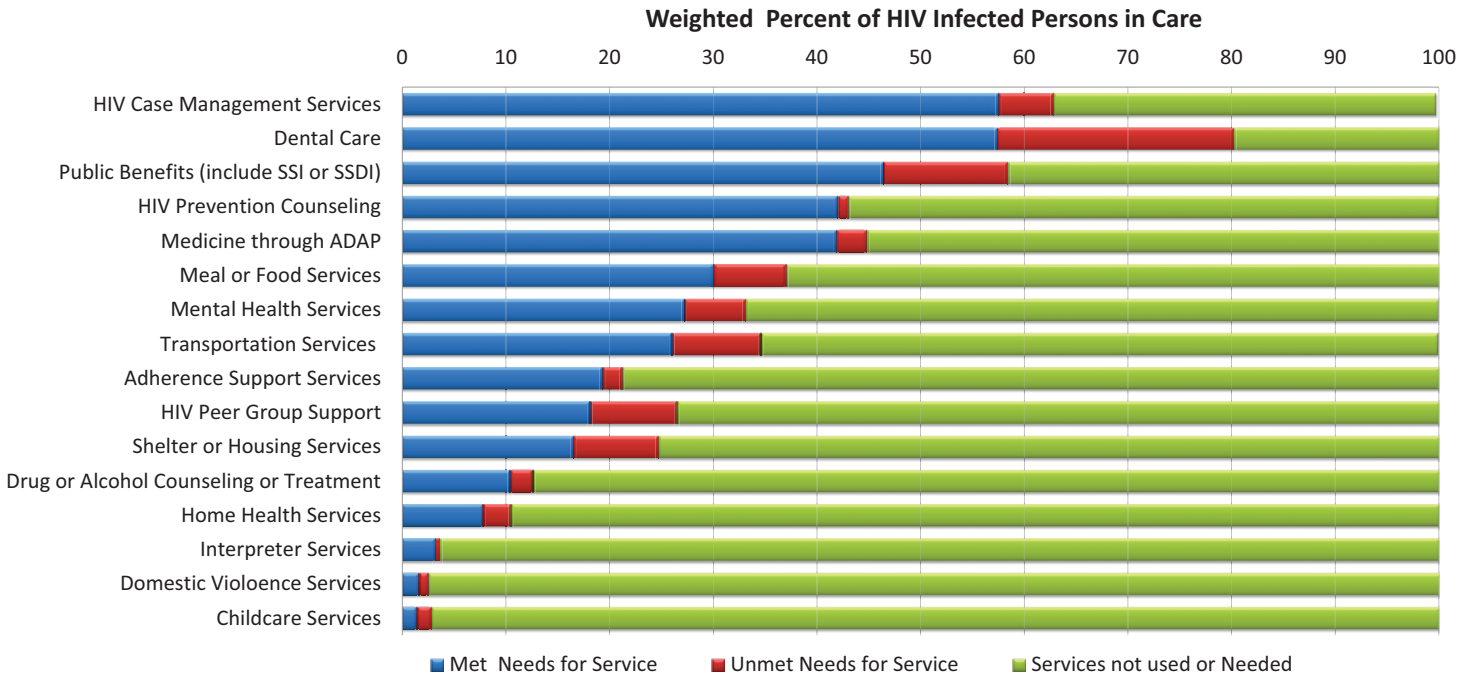
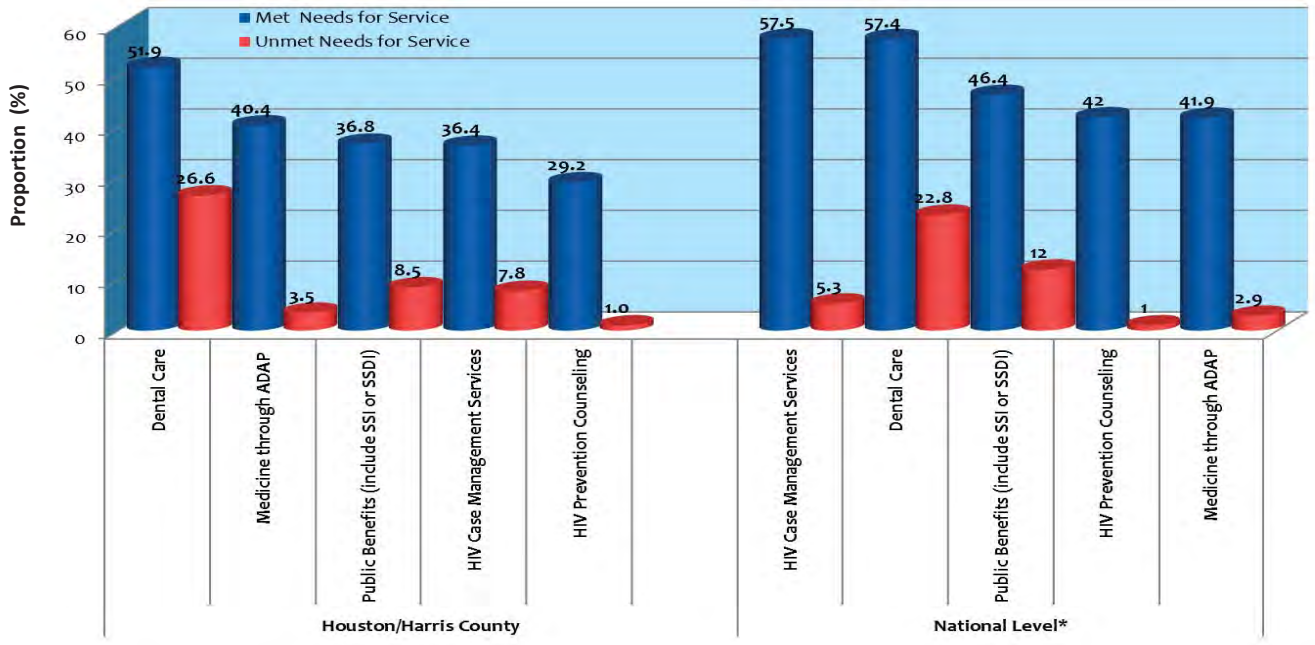


Figure 4: Comparison of Met and Unmet needs in Houston/Harris County and at National level (Top 5 Services)

HOUSTON HEALTH DEPARTMENT



* **Source:** Blair et al. MMWR June 20, 2014 / 63 (ss05): 1-22 [Based on 2009 national data only]

Summary and Conclusions

HOUSTON HEALTH DEPARTMENT

- MMP allows for accurate estimation of met, unmet and unneeded support services by PLWH
- Estimates allow for better understanding of the continuum of care dynamics in Houston/Harris County
- MMP data can be used by RWPC to prioritize and allocate funds to fill gaps in HIV support services especially for marginalized population
- MMP data can be used to highlight disparities in care and services, advocate for needed resources, and to plan HIV intervention programs

Acknowledgement

HOUSTON HEALTH DEPARTMENT

- Houston MMP staff
- Houston MMP CAB and PAB members
- Participating HIV Care Facilities and Sampled Persons
- Houston Health Department
- Clinical Outcomes Team at the Centers for Disease Control and Prevention
- Ryan White Planning Council & Office of Support

HOUSTON MEDICAL MONITORING PROJECT

Questions

HOUSTON HEALTH DEPARTMENT

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Raouf Arafat MD, MPH

Principal Investigator

HOUSTON HEALTH DEPARTMENT

HOUSTONHEALTH.ORG

National HIV Behavioral Surveillance (NHBS)

Zaida Lopez, MPH
Melanie McNeese, PhD

Thursday, May 11, 2017

HOUSTON HEALTH DEPARTMENT

Background

- Funded by CDC
- Areas with the highest HIV prevalence
- Behavioral surveillance among people at increased risk for HIV
- Three rotating annual cycles
  - **MSM** (men who have sex with men)
  - **IDU** (persons who inject drugs)
  - **HET** (heterosexuals at increased risk for HIV)
    - **HRW** (high risk women who exchange sex for money or drugs)

Goals

- NHBS provides behavioral context for trends seen in HIV rates
- Description of behaviors that increase risk of HIV transmission
  - Sexual and drug-use risk behaviors
- Monitor impact of the National HIV/AIDS Strategy
  - Decreasing incidence
  - Improving linkage to care
  - Reducing disparities
- HIV testing behaviors
  - Prevalence and trends

Goals Cont'd.

HOUSTON HEALTH DEPARTMENT

- Prevention
  - Exposure and use of services
  - Impact of services on behavior
  - Identify gaps and missed opportunities for intervention
- HIV prevalence
  - Prevalence and trends in infection
  - Behaviors associated with infection

History

HOUSTON HEALTH DEPARTMENT

- First year of surveillance: 2003
- Houston 1 of 22 funded sites
- Houston 1 of 5 funded HRW sites (2016)

Process

- **Eligibility**
  - At least 18 years of age
  - Resident of the funded MSA
  - Able to complete the survey in English or Spanish
  - Not previously done interview during the same cycle
- **Cycle Specific Eligibility**
  - **MSM:** engaged in oral/anal sex with another man in previous 12 months
  - **IDU:** injected non-prescription drugs in previous 12 months
  - **HET:** 18-60 years old; engaged in vaginal/anal sex with opposite sex partner in previous 12 months; not transgender

Process Cont'd.

- 500 participants per cycle
- Anonymous, standardized questionnaire
- Anonymous HIV testing

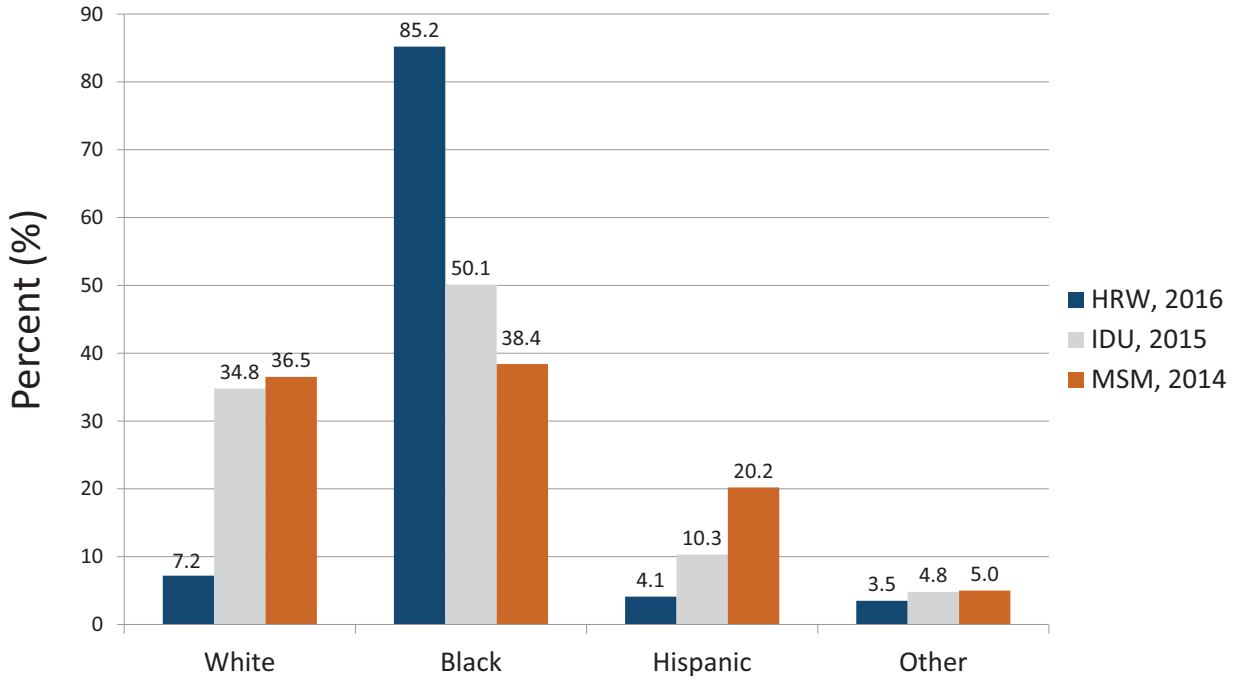
Topics Covered

HOUSTON HEALTH DEPARTMENT

- Demographic Characteristics
- Sexual behaviors
- Drug use
- HIV testing behavior
- Use of prevention services & strategies

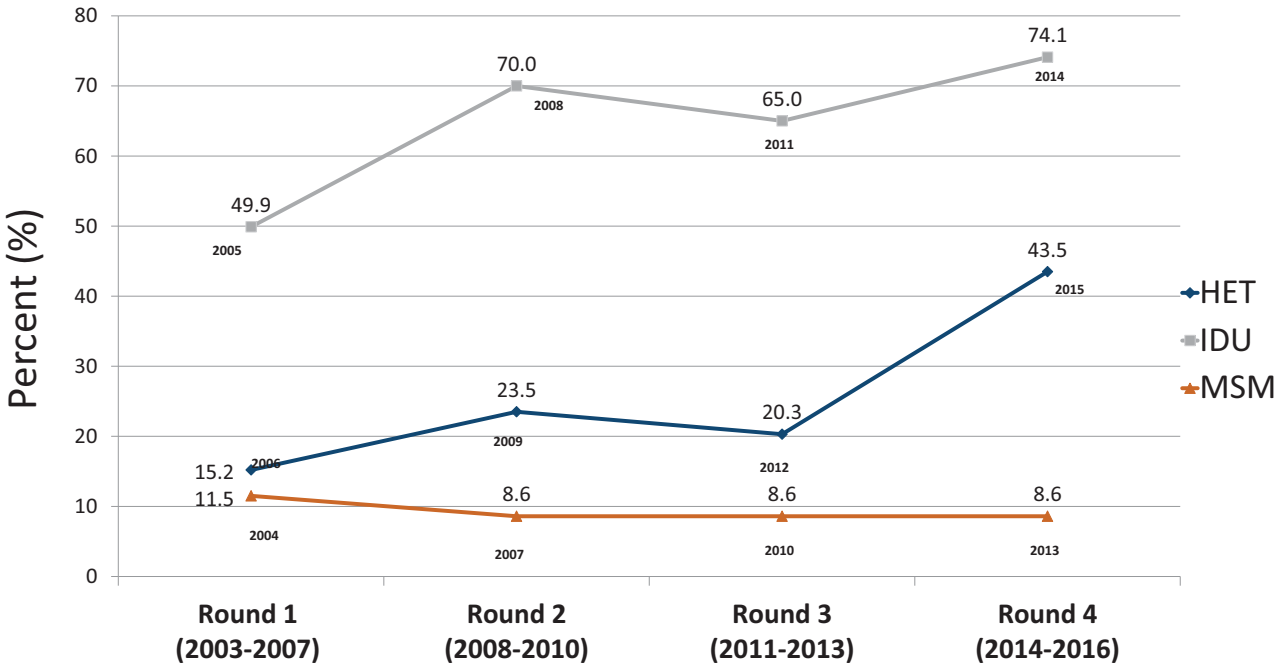
Race/Ethnicity Composition

HOUSTON HEALTH DEPARTMENT



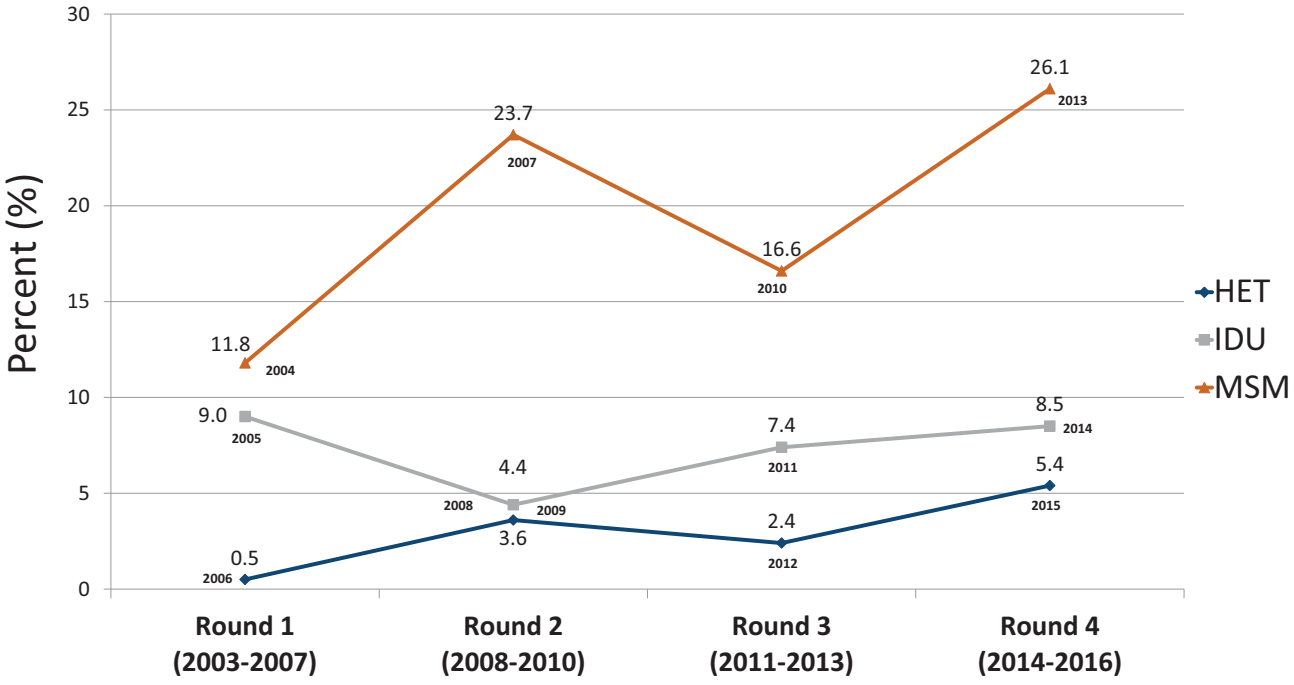
Ever Homeless

HOUSTON HEALTH DEPARTMENT



HIV Status

HOUSTON HEALTH DEPARTMENT



PrEP Overview (HRW & IDU4)

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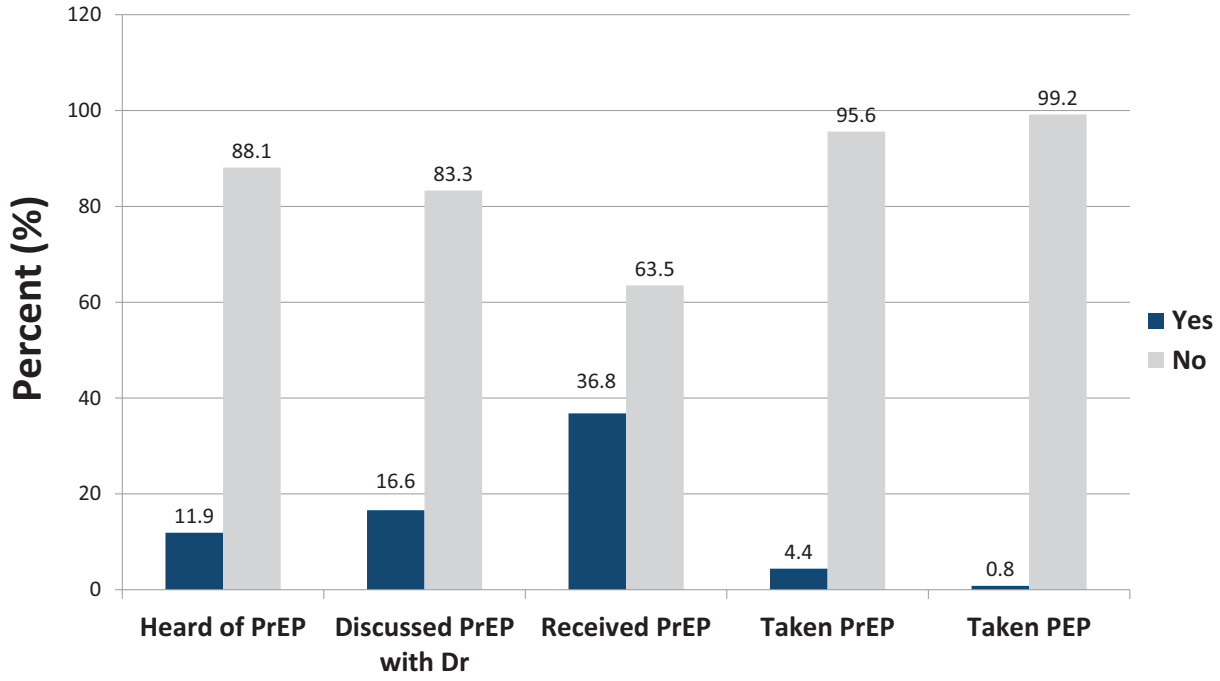
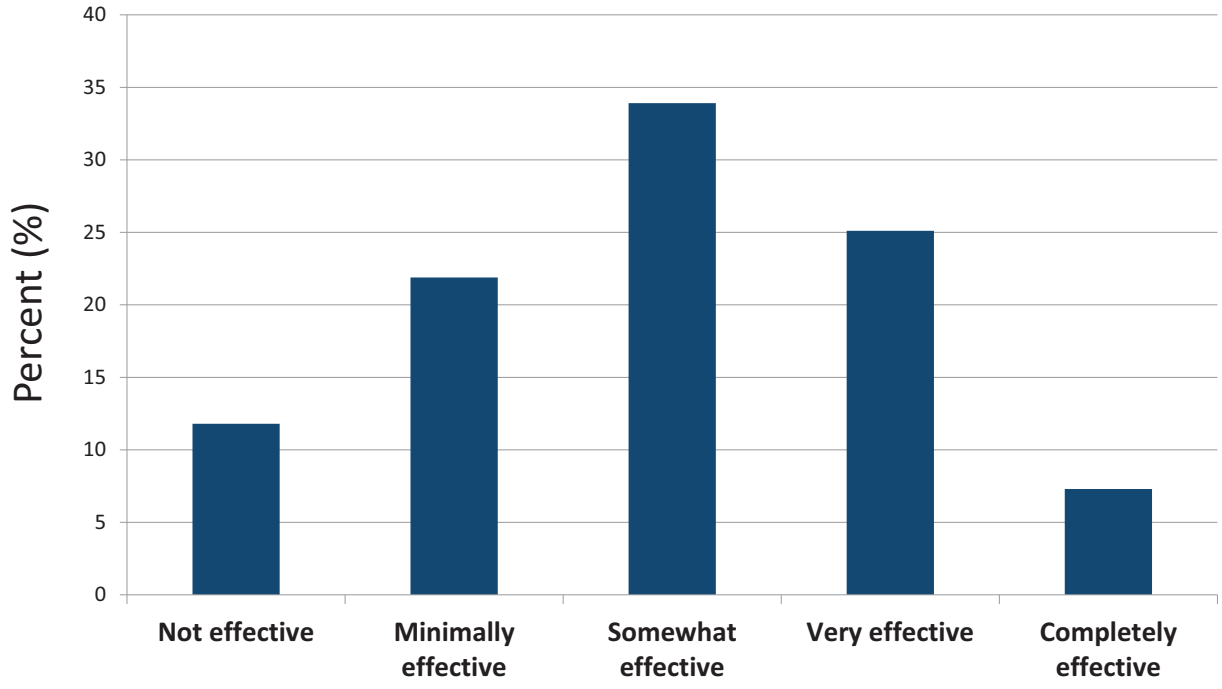


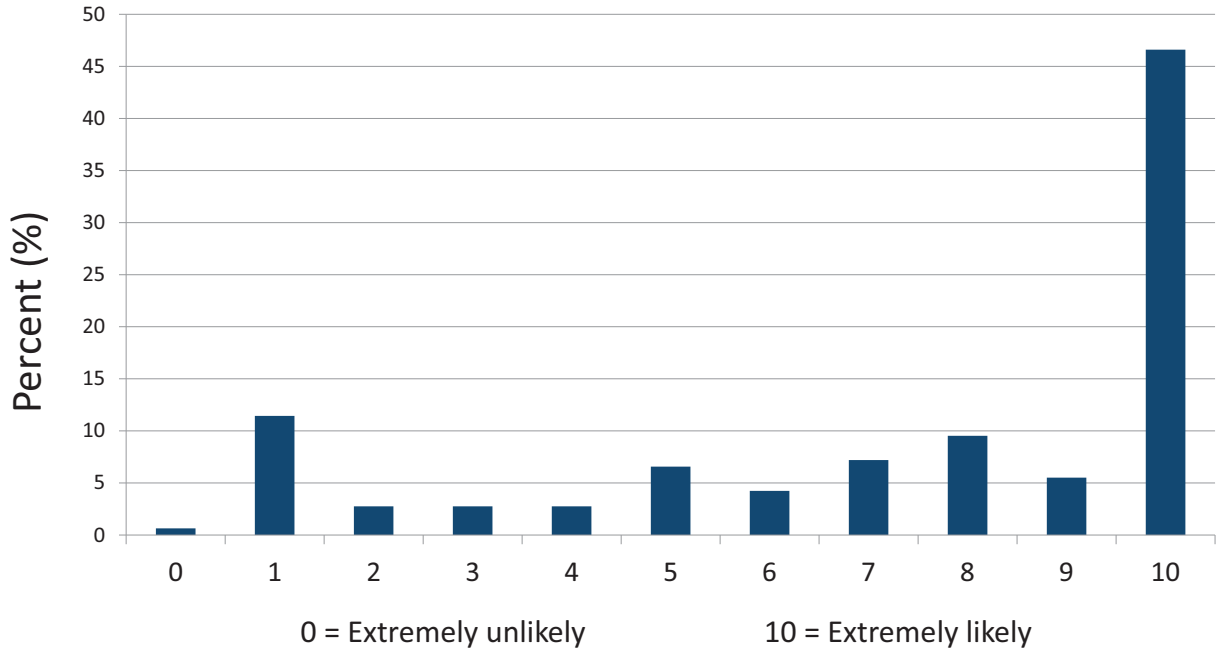
Views on PrEP Effectiveness (HRW & IDU4)

HOUSTON HEALTH DEPARTMENT



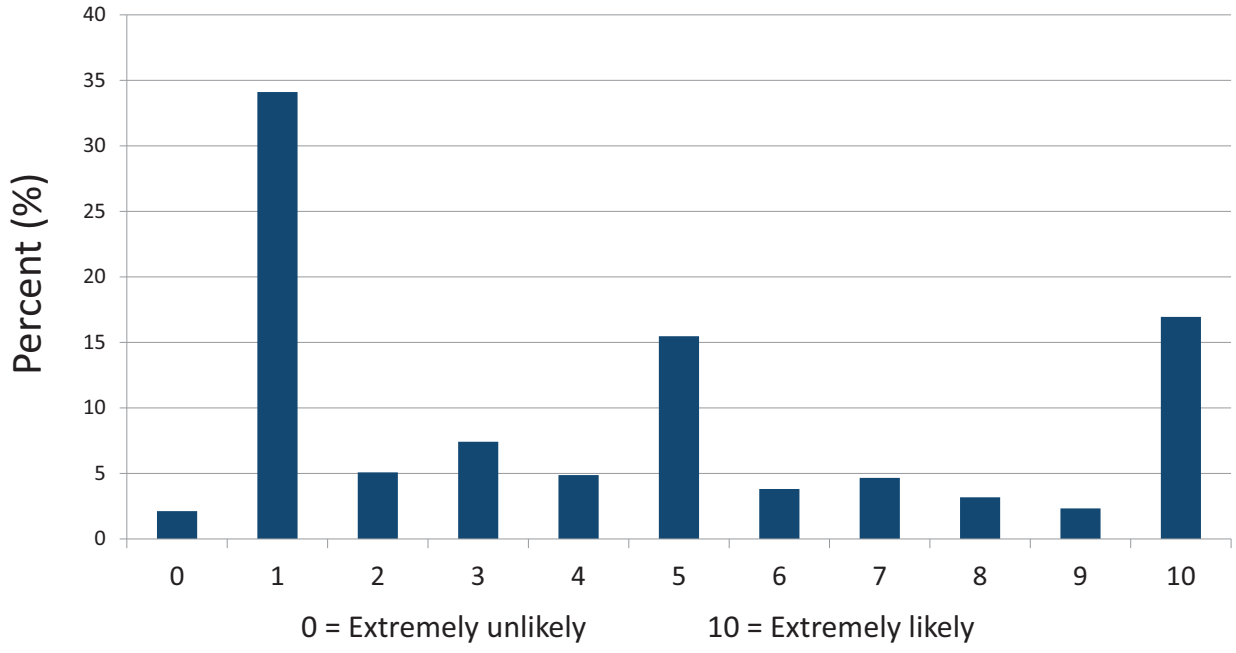
Likelihood of taking PrEP Long-Term (IDU Only)

HOUSTON HEALTH DEPARTMENT



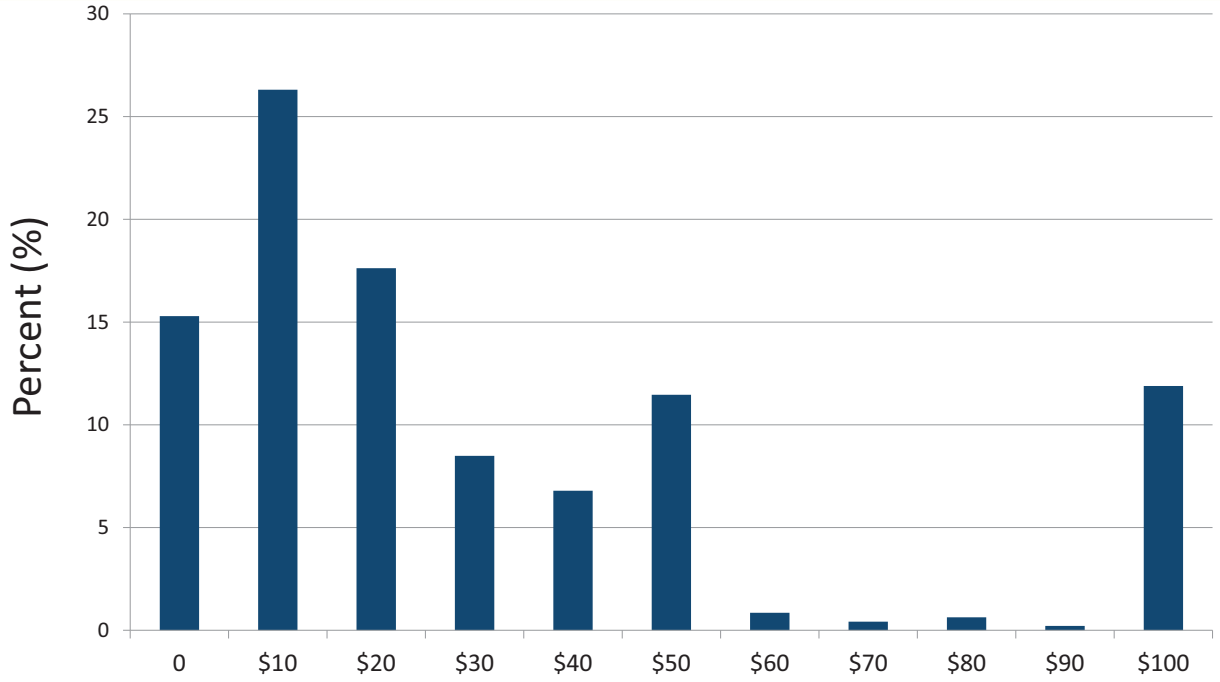
Willingness to pay out of pocket for PrEP (IDU Only)

HOUSTON HEALTH DEPARTMENT



Maximum Monthly Payment for PrEP (IDU Only)

HOUSTON HEALTH DEPARTMENT



Conclusions

HOUSTON HEALTH DEPARTMENT

- Homelessness
  - Lowest among MSM (decreasing)
  - Highest among IDU (increasing)
- PLWH
  - Highest among MSM (increasing)
  - Lowest among HET (increasing)
- Increase knowledge of PrEP/PEP availability & effectiveness
- People interested in PrEP, but not willing to pay for it

Thank You!

HOUSTON HEALTH DEPARTMENT

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Salma Khuwaja MD, Dr.PH
Principal Investigator

HOUSTON HEALTH DEPARTMENT

Questions NOT Included in the 2016 Consumer Needs Assessment

1. **Are you registered with Ryan White using an 11-digit code, also known as CPCDMS?** *(Check one)*

☐ Yes ☐ No ☐ Don't know ☐ Don't remember

   a. ***If you are registered with Ryan White, have you had any difficulty with registration <u>in the past 12 months</u>?*** *(Check all that apply)*

☐ No, I haven't had any trouble registering with Ryan White
☐ N/a, I'm not registered with Ryan White
☐ I didn't have the documents or information I needed to register
☐ I couldn't schedule a registration appointment
☐ I didn't have time to register the last time I was at my agency
☐ It was the first time I had ever registered
☐ Registering every six months is a burden for me
☐ I was told I didn't qualify for Ryan White. If so, why didn't you qualify? *(Check one)*
☐ My income was too high to qualify for Ryan White
☐ I didn't meet the residence requirements
☐ Other: _____

Section 2: When You Were First Diagnosed

2. **Where did you get your HIV diagnosis?** (*For example: The Green Clinic, Jones Hospital, doctor's office, jail/prison, HIP HOP, the health department, etc):*

_____

3. **Why did you get tested for HIV at that time?** *(Check all that apply)*

☐ I felt sick
☐ I had sex with an HIV+ person
☐ I had unprotected sex
☐ A doctor or nurse suggested it
☐ A friend suggested it
☐ A partner suggested it
☐ It was part of a routine check-up
☐ I was in the ER/ hospital
☐ I was in jail/prison
☐ I got tested on a regular basis
☐ They were testing in my community
☐ To get a prize, ticket, or gift card
☐ Other people I knew were becoming infected
☐ As part of my prenatal care
☐ Don't remember
☐ Other: _____

Section 3: Your HIV Care History

4. What kinds of things help you keep up with your HIV medical care?
(Check all that apply)

- ☐ N/a, I have never been in HIV medical care
- ☐ I want to stay healthy and live longer
- ☐ Seeing the benefits of treatment
- ☐ I'm afraid of getting sick
- ☐ To reduce the risk of transmission to others
- ☐ The support of family and friends
- ☐ The support of my partner/ significant other
- ☐ The support of other people who are HIV+
- ☐ My faith, religion, or spirituality
- ☐ Staying sober
- ☐ My HIV doctor, nurse, or clinician
- ☐ My HIV case manager or social worker
- ☐ Reminders I get from my clinic/agency
- ☐ A mentor at my clinic/agency
- ☐ An HIV group or program that I'm in *(e.g., Healthy Relationships, VOCES, Wall Talk, Bro for Life, etc.)*
- ☐ Other:_____

5. Are you <u>currently</u> taking HIV medications (ART)? *(Check one)*

☐ Yes ☐ No ☐ Don't know

<u>If you are currently taking HIV medications,</u> please answer the following questions:

6. *How many pills for HIV do you take every day?*_____

☐ N/a, I do not take HIV medications

7. *How many* times per day *do you take pills for HIV?*_____

☐ N/a, I do not take HIV medications

8. Thinking about the past 4 weeks, on average how would you rate your ability to take all of your HIV pills as your doctor prescribed?
(Check one)

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ Very poor

9. *Has a doctor, nurse, PA, or case manager ever talked to you about staying on schedule with your HIV medications?* *(Check one)*

☐ Yes ☐ No ☐ N/a, I do not take HIV medications

10. *Do you need a doctor, nurse, PA, or case manager to talk with you about staying on schedule with your HIV medications?* *(Check one)*

☐ Yes ☐ No ☐ N/a, I do not take HIV medications

11. What is your current HIV viral load? *(Check one)*

☐ Detectable ☐ Undetectable ☐ Don't know / can't remember

12. What is your current CD4 (t-cell) count? *(Check one)*

☐ Less than 50 ☐ 50 - 199 ☐ 200 - 499 ☐ 500+ ☐ Don't know / can't remember

13. When you first started getting care for HIV, what was your CD4 (t-cell) count? *(Check one)*

☐ Less than 50 ☐ 50 - 199 ☐ 200 - 499 ☐ 500+
☐ Don't know / can't remember ☐ I never got HIV care

Section 4: Other Health Concerns

14. Who do you talk to most often about your HIV diagnosis?
(Check all that apply)

☐ A professional counselor/therapist
☐ A psychiatrist who can prescribe medication
☐ Doctor, nurse, or other clinic staff
☐ Case manager
☐ Friend
☐ Family member
☐ Other people who are HIV+
☐ Pastor/faith leader
☐ Support group led by a peer
☐ Support group led by a professional
☐ Social media/online websites
☐ Other:_____
☐ I don't talk to anyone about my HIV diagnosis

15. Do you have an assigned case manager, social worker, counselor, or a specific person at a clinic, agency, or program whose job it is to help you get HIV services? *(Check one)*

☐ Yes ☐ No ☐ Don't know

Section 5: Substance Use

16. In the past 12 months, have you used any of the following?
(Check all that apply)

☐ Alcohol
☐ Club/party drugs
☐ Cocaine or crack
☐ Hallucinogens
☐ Heroin
☐ Inhalants (poppers, glue)
☐ Marijuana
☐ Methamphetamine (meth)
☐ Prescription drugs not prescribed to you (e.g., painkillers, tranquilizers)
☐ Prescription drugs prescribed to you, but that you use differently than intended
☐ Legal drugs from a shop (e.g., bath salts, fake marijuana)
☐ Other: _____
☐ None of the above
☐ Prefer not to answer

17. In the past 12 months, have any of the following statements applied to you? *(Check one answer for each item below)*

	Yes	No	Prefer not to answer
• **I drank alcohol more than I meant to**	☐	☐	☐
• **I felt I should cut down on my alcohol use**	☐	☐	☐
• **I used drugs more than I meant to**	☐	☐	☐
• **I felt I should cut down on my drug use**	☐	☐	☐

Section 6: Housing and Transportation

18. Where do you sleep <u>most often</u>? *(Check one)*

- ☐ My own house/apartment that I pay for
- ☐ My own house/apartment that is subsidized
- ☐ At the home of friends/family
- ☐ A group home for people who are HIV+
- ☐ A group home, not just for HIV+ people
- ☐ Hotel/motel room that I pay for
- ☐ Hotel/motel room that is subsidized
- ☐ Shelter
- ☐ Car
- ☐ On the street
- ☐ A combination of places, it changes all the time
- ☐ Other:_____

19. *If your housing situation made it difficult for you to get HIV medical care, what were the difficulties?* *(Check all that apply)*

- ☐ I couldn't keep my HIV
- ☐ status private
- ☐ I didn't have a place to store my HIV meds
- ☐ I had to use my money for housing costs, like rent, down payment, security deposit
- ☐ I had to use my money for utilities (water/electricity)
- ☐ I didn't have time because I was looking for housing
- ☐ I had to move, and my clinic wasn't nearby anymore
- ☐ Other:_____

20. What is your primary mode of transportation? *(Check one)*

- ☐ My own car, truck, motorcycle, scooter
- ☐ Public transportation (bus, van, train)
- ☐ Taxi
- ☐ Bicycle
- ☐ Walking
- ☐ A van provided by a clinic or program
- ☐ I borrow a car from friends/family
- ☐ I catch rides with friends/family
- ☐ I have no transportation
- ☐ Other:_____

Section 7: Financial Resources

21. What is your <u>current</u> job status? *(Check all that apply)*

- ☐ Full time employee (more than 30 hours/week)
- ☐ Part time employee (less than 30 hours/week)
- ☐ Temp/contract/seasonal work
- ☐ Odd jobs/work for cash
- ☐ Retired
- ☐ Unemployed
- ☐ Not working due to a disability
- ☐ Student, middle/high school
- ☐ Student, college or graduate school
- ☐ Other:_____

22. <u>In the past 12 months</u>, what income or assistance did you receive?
(Check all that apply)

- ☐ None
- ☐ A pay check for wages/salary
- ☐ Paid in cash or tips
- ☐ Social Security
- ☐ Disability
- ☐ TANF/AFDC
- ☐ Food stamps
- ☐ Rental subsidy/ Section 8
- ☐ Unemployment
- ☐ Worker's Comp
- ☐ VA benefits
- ☐ Other:_____

Section 8: Please Tell Us About Yourself…

- ***If you are Hispanic/Latino, what is your nationality?*** *(Check one)*

☐ N/a, I am not Hispanic/Latino
☐ Dominican
☐ Central American
☐ Cuban
☐ Mexican
☐ South American
☐ Puerto Rican
☐ Spanish/Portuguese
☐ Other:_____

23. How much school have you <u>finished</u>? *(Check one)*

☐ Less than high school
☐ High school diploma
☐ GED
☐ Technical or vocational degree
☐ Associate's degree (AA)
☐ Bachelor's degree (BA, BS)
☐ Master's degree or higher (MA, PhD)
☐ None

24. *If you have been released from jail or prison in the past 12 months, did the following happen?*

- **You had a plan for how to get HIV medical care after discharge** *(Check one)* ☐ Yes ☐ No

- **You were able to refill your HIV meds before they ran out once you were discharged** *(Check one)*

☐ Yes
☐ No, I wasn't able to refill my HIV meds
☐ No, I wasn't on HIV meds

Section 9: Prevention Activities

25. Where did you get your HIV diagnosis? _____

26. *If you received HIV prevention information in the past 12 months, <u>what</u> information did you get?* *(Check all that apply)*

☐ I have not received HIV prevention info
☐ How to prevent transmitting HIV to partners
☐ How viral load is linked to HIV prevention
☐ How to protect myself from being infected with another strain of HIV
☐ How to use a condom or other barrier
☐ How to clean needles or other injection items
☐ How to talk to partners about condom use
☐ How to disclose HIV status to partners
☐ How to maintain my HIV medical care
☐ Other:_____

27. *If you received HIV prevention information in the past 12 months, <u>where</u> did you get the information?* *(Check all that apply)*

☐ I have not received HIV prevention info
☐ From my doctor, nurse, or clinician
☐ From my case manager
☐ From a health educator or outreach worker
☐ In an HIV group or program (e.g., Healthy Relationships, VOCES, Wall Talk, Bro 4 Life, etc.)
☐ From friends or family
☐ From partners/significant others
☐ In school
☐ At my church or faith group
☐ TV
☐ Radio
☐ Billboards and posters
☐ Internet
☐ Cell phone app
☐ Brochure
☐ Hotline
☐ Don't remember
☐ Other:_____

28. How <u>comfortable</u> are you talking to sex partners about using a condom? *(Check one)*

❑ Extremely ❑ Very ❑ Somewhat ❑ A little ❑ Not at all ❑ I do not have sex

29. <u>In the past 12 months</u>, have you done any of the following?

(Check one answer for each item below)

	Yes	No	Don't know	Don't remember	N/a, I don't do this
• **Had sex to get money, drugs, place to sleep, etc.**	☐	☐	☐	☐	☐
• **Had sex while drunk or high**	☐	☐	☐	☐	☐
• **Used someone else's needles to inject yourself**	☐	☐	☐	☐	☐
• **Had sex with someone who shares needles**	☐	☐	☐	☐	☐

Some Final Questions….

30. <u>In the past 12 months</u>, did you get help for yourself from any of the following agencies?

(Check all that apply)

☐ AIDS Foundation Houston (AFH)
☐ Bee Busy Wellness Center
☐ Bering Omega Community Services
☐ Career & Recovery Resources
☐ Covenant House
☐ Fort Bend Family Health (a.k.a., Access Health)
☐ HACS (Houston Area Community Services)
☐ Harris County Jail
☐ Houston Volunteer Lawyers Program
☐ Legacy Community Health Services
☐ Memorial Hermann
☐ The Montrose Center (formerly Montrose Counseling Center)
☐ Positive Efforts
☐ St. Hope Foundation
☐ Texas Children's Hospital
☐ TDCJ
☐ Thomas Street Health Center
☐ VA
☐ Other:_____

DRAFT

Houston Area HIV Services Ryan White Planning Council

FY2018 EIIHA Workgroup
9:00 a.m., Thursday, March 23, 2017
Meeting Location: 2223 W. Loop South, Room 532; Houston, Texas 77027

MINUTES

MEMBERS PRESENT	MEMBERS ABSENT	OTHERS PRESENT
Nettie Johnson, Co-Chair	Nancy Miertschin, excused	Cecilia Ross, RWPC Chair
Allen Murray	Amana Turner	Amber Harbolt, Office of Support
Ardry Boyle	Amy Leonard, excused	Diane Beck, Office of Support
Evelio Escamilla, via phone	Brenda Booker	
Isis Torrente	C. Bruce Turner	
Steven Vargas	David Benson	
Tracy Gorden	Bellard	
	Ella Collins-Nelson	
	Herman Finley, excused	
	J. Hoxi Jones	
	Osaro Mgbere	
	Maggie White, excused	
	Peta-gay Ledbetter	
	Shital Patel	

Call to Order: Nettie Johnson, Co-Chair, called the meeting to order at 9:15 a.m. and asked for a moment of reflection. She welcomed everyone and called for introductions.

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

Public Comment: None.

Overview of EIIHA: See attached PowerPoint. Harbolt said that EIIHA stands for the Early Identification of Individuals with HIV/AIDS. The EIIHA plan is included in the Ryan White Part A Grant Application and a progress report is submitted the following year on the populations that were selected. There is no funding tied to the populations selected for the EIIHA plan. Today we will review the criteria for selection populations that were used last year; we will not have the criteria for this year until the grant guidance is received in July or August.

Criteria for Selecting EIIHA Target Populations: The workgroup reviewed the criteria used for Fiscal Year 2017, see attached.

Data Requests for FY2018: The workgroup reviewed the List of Data that DSHS Typically Provides for Part A Grant Applications and the expanded Target Populations Selection Matrix, see attached. The workgroup would like to keep the expanded matrix table and have actual number and rates of new diagnoses, late diagnosis data for all ethnicities by gender and age.

Next Meeting: The next meeting was tentatively set for Thursday, July 20, 2017 in the afternoon or the morning of August 17, 2017; items to be discussed include review of FY18 EIIHA guidance, adopt criteria for selection of the FY18 EIIHA populations, review target population selection matrix data and selection of the target populations for the FY18 EIIHA plan.

Announcements: Johnson said the Baylor College of Medicine Teen Health Clinic is having a health fair at 10:00 a.m. on April 1st at The Tejano Center for Community Concerns. They are also planning an event for Youth HIV Awareness at Madison High School on April 24th. Murray said that there will be a youth testing event at the Ensemble Theatre on April 11th from 6:30 p.m. to 9 p.m.

Adjournment: The meeting was adjourned at 11:05 a.m.

Submitted by: Approved by:

_____ _____

Amber Harbolt, Office of Support Date Committee Chair Date

Speaker's Bureau Engagement Evaluation - Houston Methodist Willowbrook - 03-22-2017

Eval ID	*What was the most memorable aspect of today's presentation?*	*What, if anything, did you learn from today's presentation that you did not previously know?*	*How relevant was the information presented today to your job or organization? (5=Extremely relevant; 1=Not relevant at all)*	*Based on today's presentation, how likely are you to recommend the Ryan White Planning Council Speakers Bureau to a colleague or another organization? (5=Extremely likely 1=Not likely at all)*	*What HIV-related topics would you like to see offered in the future?*	*Add to RWPC info contact list?*
1	How to help our patients get treatment	Surprised there's so many resources	5	5	Any	Y
2	More knowledge of care in Houston for HIV	Did not know all the support that is provided in addition to general HIV care - dental, transportation, housing, etc.	5	5	N/A	Y
3	New knowledge of process for HIV patients for follow-up care	Didn't know the referral process	5	5	More options for medication asssistance and transportation to appointments	Y
4	Informational	List of clinics	5	4	[missing]	N
5	Learning more about the services offered to the population	The resources available	4	4	[missing]	N
Average	---	---	4.80	4.60	---	---

2017-2021 Comprehensive Plan
2017 Q1 Activities Implementation Progress Report

(Implementation January through March 2017)

Implementation Progress by Strategy

	Not Initiated (NI)	In Progress (P)	Completed (C)	**Total Activities Slated for 2017**
PEI	0	9	2	**11**
Gaps	2	3	1	**6**
SP	1	7	0	**8**
COE	2	6	1	**9**
Total n (%)	**5 (14.7%)**	**25 (73.5%)**	**4 (11.7%)**	**34**

Activities Not Initiated in Q1:

1. **Gaps: *"Revise case management, service linkage, and outreach services Standards of Care and policies to incorporate warm handoff protocols."***
    a. RWGA to conduct inventory of current peer programs at RW funded providers.
2. **Gaps: "*Expand the Road to Success consumer training program to housing sites."***
    a. While holding Road to Success training at housing sites is not feasible, additional efforts will be undertaken to coordinate transportation for housing clients when Road to Success is implemented later this year.
3. **SP: "*Develop an HIV Care Continuum for each Special Population as possible, and disseminate to providers and the public as appropriate*."**
    a. Data availability to create Special Population Care Continua will be evaluated this fall during development of the next Epi Profile.
4. **COE: "*Facilitate an annual Task Force meeting for community-wide coordination of effort.*"**
    a. Not yet initiated, though both CPG and RWPC hosted meetings to review the cross-walk between the Comprehensive Plan and the *Roadmap to Ending the HIV Epidemic in Houston* to coordinate efforts.
5. **COE: "*Extend notification of quarterly case manager trainings to non-funded case managers and social workers at local hospitals (Ben Taub, LBJ, etc.).*"**
    a. RWGA does not have capacity to host training for additional interested organizations.

Implementation Highlights:

1. **PEI: *"Pursue strategies to reduce time period between diagnosis and entry into HIV medical care to facilitate timely linkage to care."* – In Progress**
    a. HHD: The Bureau participates in the joint Prevention/Care frontline meetings in which timelines are re-emphasized and solutions are discussed jointly to ensure timely entry into care. Harris Health System continues to have HHD-funded SLWs stationed to ensure rapid linkage to care for those tested under their routine screening program. This process has recently been enhanced to identify acute infections and fast track those with acute infection into treatment. The HHD supports Harris Health System in this initiative and provides funding for staff involved in these processes.
    b. RWGA: In support of this activity, RWGA tracks availability of primary care appointments for clients entering care; As of 3/24/17, the average wait time across agencies for the initial appointment availability to enroll in outpatient/ambulatory medical care was 7 days (least: 4 days; greatest: 12 days).

c. RWPC-OS: 2/23 – An allocations principle was added to P&A's FY 2018 Guiding Principles and Decision Making Criteria that states decisions will be based on service categories that address the "reduction of [the] time period between diagnosis and entry into HIV medical care to facilitate timely linkage."

2. **Gaps: *"Design Standards of Care ensuring follow-up contact with newly diagnosed consumers throughout first year of diagnosis."* – In Progress**
   a. RWGA QM currently working with CQI and CM Supervisor membership on improvement project related to this activity.
3. **SP: *"Provide training to DIS staff on data collection for transgender and other special population clients."* – In Progress**
   a. A capacity building assistance (CBA) provider has tentatively been selected to provide a transgender-specific data collection training to the Bureau of Epidemiology and the Bureau of HIV/STD and VH Prevention. The formal request will be initiated to CDC in April 2017 with the goal for training completion by July 2017.
4. **COE: *"Sustain current efforts and target the following sectors and groups for coordination of effort activities"*– In Progress**
   a. Advocacy groups: **HHD** - AAMA to support a PrEP Stakeholders Group; PrEP Learning Collaborative hosted by the Black AIDS Institute; **RWPC-OS** - LULAC @ Camino; work with END
   b. Aging (e.g., assisted living, home health care, hospice, etc.): **HHD** - HIV and Aging Coalition @ Sharing Science Symposium; **RWPC-OS** - HIV & Aging Coalition
   c. Alcohol and drug abuse providers and coalitions at the local and regional levels – **Not Initiated**
   d. Business and Chambers of Commerce: **HHD** - HIV testing and education at a barbershop for National Black HIV/AIDS Awareness Day; testing and education event at a local fashion boutique in Third Ward for National Women and Girls' Day; partnership with local cosmetics business, to promote HIV awareness and testing; **RWPC-OS** - Speaker's Bureau
   e. Community centers: **HHD** - Meeting, events, and trainings held at local multi-service centers; **RWPC-OS** - Re-Entry Summit @ Montrose Center
   f. Chronic disease prevention, screening, and self-management programs: **HHD** - Community Health Worker training included chronic disease as a topic area; emphasis on the intersection of chronic disease and HIV/STD at Sharing Science Symposium
   g. Faith communities: **HHD** - St. John's Church/Bread of Life, Inc. ("Get Tested Sunday"); In March, HIV Program Manager spoke to a congregation of approximately 2500 people at Brentwood Baptist Church on the campaign "National Week of Prayer for the Healing of AIDS"; **RWPC-OS** – Urban AIDS Ministry represented among membership
   h. Medical professional associations, medical societies, and practice groups: **HHD** - PrEP Provider Advisory Group; PrEP Outreach Specialist goes out in the field to identify medical providers who are unfamiliar or uncomfortable with prescribing PrEP and engage them to become more PrEP-friendly by providing technical assistance and support; **RWPC-OS** - Harris County Medical Society; AETC
   i. Mental health (e.g., counseling associations, treatment facilities, etc.): **HHD** - A researcher working with Hatch Youth of the Montrose Center presented on "Providing Social Support to Sexual and Gender Minority Youth"; Service Linkage Program works with local mental health providers
   j. New HIV-related providers such as FQHCs and Medicaid Managed Care Organizations (MCOs): HHD - **HHD** PrEP Outreach Specialist

k. Philanthropic organizations: **HHD** - HHD's philanthropic organization/foundation continues to prioritize and raise money for the Bureau's testing efforts
l. Primary education, including schools and school districts: **HHD** - HHD funds Bee Busy, Inc. to operate a targeted comprehensive HIV Education/Risk Reduction program in schools in the Houston Independent School District. The STRAPP (Students Taking Responsibility and Action to Prevent Pregnancy) program is a "locally developed" evidence-based intervention that targets diverse high school youth
m. Secondary education, including researchers, instructors, and student groups: **HHD** - frequent partnering with researchers at Baylor College of Medicine, including the Sharing Science Symposium in January 2017; Bureau provided staff expertise and data to support a research proposal on HPV with UTSPH researchers; Bureau collaborated with researchers from UTSPH and the University of Chicago to submit a R01 proposal on partner services and HIV.
n. Workforce Solutions and other vocational training and rehabilitation programs: **HHD** - TurnAround Houston Initiative; **RWPC-OS** - Workforce Solutions (Blue Books)

RWGA is working to bring substance abuse, law enforcement, trauma and specialists along with HIV positive people to address the case management supervisors and frontline staff so they may better understand what will keep them or what keeps them engaged in care.

TRG: Continuous networking with target sectors and groups. Created a Houston CPG email distribution list for dissemination of RWPC meetings and other HIV related events in the HSDA. Forward contacts to RWPC; as available.

2017 QUARTERLY REPORT
COMPREHENSIVE HIV PLANNING COMMITTEE

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

1. *Assess, evaluate, and make ongoing recommendations for the Comprehensive HIV Plan.

   ongoing.

2. *Determine the size and demographics of the estimated population of individuals who are unaware of their HIV status. looking at data to be used in late Summer or Fall

3. *Work with the community and other committees to develop a strategy for identifying those with HIV who do not know their status, make them aware of their status, and link and refer them into care.

   See above #2, and #1.

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

   Started on 1ST of 2 Special Studies

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

   Coming up later this year.

S Vargas
Committee Chairperson

5/11/2017
Date

Quality Improvement Committee Report

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 March 2017

Spending Target: 100%

Revised 5/12/2017

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	$1,815,322	86%
7	Health Insurance Premiums and Cost Sharing	$976,885	29%	($16,122)	$960,763	29%	4/1/2016	$960,633	98%
9	Home and Community Based Health Services**	$232,000	7%	($3,840)	$228,160	7%	4/1/2016	$165,680	71%
	Total Houston HSDA	3,329,231	100%	($54,743)	$3,274,488	100%		2,941,635	88%

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

** HCBH has had a low census. Census has been impacted by clients being out with extended illnesses.
Focusing on outreach activities in order to increase census, which should coincide with an increase in Ryan White spending.

*** One provider had a vacant dentist position but is currently filling the vacancy while the other provider has some back billing.

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 February 2017

Spending Target: 91%

Revised 4/19/2017

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	$1,534,364	72%
7	Health Insurance Premiums and Cost Sharing **	$976,885	29%	($16,122)	$960,763	29%	4/1/2016	$822,245	84%
9	Home and Community Based Health Services***	$232,000	7%	($3,840)	$228,160	7%	4/1/2016	$228,160	98%
	Total Houston HSDA	3,329,231	100%	($54,743)	$3,274,488	100%		2,584,769	78%

* 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: Part A 02/29/17, Part B 03/31/17, State Services 8/31/17

*** HCBH has had a low census. Census has been impacted by clients being out with extended illnesses.
Focusing on outreach activities in order to increase census, which should coincide with an increase in Ryan White spending.

**** One provider had a vacant dentist position but is currently filling the vacancy while the other provider has some back billing.

The Houston Regional HIV/AIDS Resource Group, Inc.

FY 1617 DSHS State Services

Procurement Report

September 1, 2016 - August 31, 2017

Chart reflects spending through March 2017

Spending Target: 58%

Revised 5/12/2017

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%	9/1/2016	$133,985	45%
7	Health Insurance Premiums and Cost Sharing**	$1,043,312	53%		$1,043,312	53%	9/1/2016	$582,735	56%
9	Hospice ***	$414,832	21%		$414,832	21%	9/1/2016	$159,060	38%
11	EIS - Incarcerated	$166,211	8%		$166,211	8%	9/1/2016	$90,791	55%
16	Linguistic Services	$48,000	2%		$48,000	2%	9/1/2016	$33,625	70%
	Total Houston HSDA	1,972,355	100%	$0	$1,972,355	100%		1,000,196	51%

* Service utilization is lagging

** HIP - Funded by Part A,B, and State Services. Provider is spending grant funds before grant ending date.
Ending dates: Part A 02/29/17, Part B 03/31/17, State Services 8/31/17

*** The agency has seem a drop in clients and is currently performing outreach to increase spending

The Houston Regional HIV/AIDS Resource Group, Inc.

FY 1617 DSHS State Services

Procurement Report

September 1, 2016 - August 31, 2017

Chart reflects spending through February 2017

Spending Target: 50%

Revised 4/19/2017

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%	9/1/2016	$118,313	39%
7	Health Insurance Premiums and Cost Sharing**	$1,043,312	53%		$1,043,312	53%	9/1/2016	$368,419	35%
9	Hospice ***	$414,832	21%		$414,832	21%	9/1/2016	$143,440	35%
11	EIS - Incarcerated	$166,211	8%		$166,211	8%	9/1/2016	$75,935	46%
16	Linguistic Services	$48,000	2%		$48,000	2%	9/1/2016	$30,125	63%
	Total Houston HSDA	1,972,355	100%	$0	$1,972,355	100%		736,231	37%

* Service utilization is lagging

** HIP - Funded by Part A,B, and State Services. Provider is spending grant funds before grant ending date.
Ending dates: Part A 02/29/17, Part B 03/31/17, State Services 8/31/17

*** The agency has seem a drop in clients and is currently performing outreach to increase spending

Houston Ryan White Health Insurance Assistance Service Utilization Report

Period Reported: 9/1/2016-03/31/2017

Revised: 5/2/2017

	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	854	$71,733.81	425			*0*
Medical Deductible	221	$55,279.23	153			*0*
Medical Premium	4293	$1,389,316.71	906			*0*
Pharmacy Co-Payment	1886	$183,600.70	782			*0*
APTC Tax Liability	1	$213.00	1			*0*
Out of Network Out of Pocket	0	$0.00	0			*0*
ACA Premium Subsidy Repayment	0	$0.00	0	*NA*	*NA*	*NA*
Totals:	7255	$1,700,143.45	2267	0	$0.00	

Comments: This report represents services provided under all grants.

Houston Ryan White Health Insurance Assistance Service Utilization Report

Period Reported: 9/1/2016-02/28/2017

Revised: 4/5/2017

	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	363	$50,202.41	217			*0*
Medical Deductible	185	$45,205.99	131			*0*
Medical Premium	3582	$1,136,232.00	878			*0*
Pharmacy Co-Payment	1550	$146,733.79	672			*0*
APTC Tax Liability	1	$213.00	1			*0*
Out of Network Out of Pocket	0	$0.00	0			*0*
ACA Premium Subsidy Repayment	0	$0.00	0	*NA*	*NA*	*NA*
Totals:	5681	$1,378,587.19	1899	0	$0.00	

Comments: This report represents services provided under all grants.

Houston Area HIV Services Ryan White Planning Council
2223 West Loop South, Suite 240, Houston, Texas 77027
713 572-3724 telephone; 713 572-3740 fax
www.rwpchouston.org

FY 2018 How to Best Meet the Need Workgroup Service Category Recommendations Summary (as of 04/27/17)

Those services for which no change is recommended include:

Ambulatory Outpatient Medical Care
Early Intervention Services (targeting the Incarcerated)
Health Insurance Premium and Cost Sharing Assistance
Home and Community Based Health Services (Day Treatment)
Hospice Services
Linguistic Services
Local Pharmacy Assistance Program
Medical Nutritional Therapy/Supplements
Mental Health Services
Oral Health (Untargeted and Targeting the Northern Rural Area)
Substance Abuse Treatment
Transportation
Vision Care

Services with recommended changes include the following:

Case Management (Medical, Clinical, Non-Medical Service Linkage)

- Accept the service category definition as presented and keep financial eligibility the same; and ask the Office of Support to provide training on the Needs Assessment findings to case managers.

Outreach Services: Primary Care Re-Engagement

- Accept the service category definition with the understanding that there will be changes for the Quality Improvement Committee to review, and keep financial eligibility the same.

Proposed services include the following:

Emergency Financial Assistance

- Accept the proposed local service category definition for **Pharmacy Assistance** with the following: change '7-day supply' to '14-day supply with the option for a one-time 14-day refill if needed, with RWGA approval'.
- Accept the proposed special idea for the **Compassionate Care Program**.

Referral for Health Care and Support Services

- Accept the proposed local service category definition for **ADAP Enrollment Workers** with the understanding that it will be updated to address the different agency scenarios.

2017 Special Idea

To be considered, this form must be received by Tori Williams: victoria.williams@cjo.hctx.net or Fax 713 572-3740 before the deadline of 8:00 a.m. on Monday, April 17, 2017. Thank you.

THIS BOX TO BE COMPLETED BY RWPC SUPPORT STAFF ONLY

Control Number: #2 Service Category: TBD

DESCRIPTION OF THE IDEA (this form cannot be more than one page):

Compassionate Care Rx Program

This plan would take effect approximately 7 days after that the patient's physician visit and would provide medications until ADAP (or other) coverage begins.

As DSHS has informed the HIV community, they are continuing to receive a substantial amount of funds from pharmaceutical companies in the form of rebates for medications purchased by ADAP -- approximately $20 million annually.

a non-profit organization which represents a large number of pharmaceutical companies who have joined together to offer a single, common application and prescription processing for patient assistance programs offered by all the separate companies. Initially, provided this service at no cost to patients or pharmacies, however more recently they have begun requiring that an administration fee for each prescription be paid, which presents a barrier to both patients and Ryan White pharmacies.

By utilizing some of the rebate funds being paid to DSHS to pay the administrative fees to for all Ryan White pharmacies, access to the patient assistance program could be made available to a greater number of patients and could be administered much more easily than if each pharmacy were required to enter into a separate contract.

The Resource Group and DSHS would work together to determine the best way to administer the contract. Both organizations have indicated their willingness to pursue this idea if it receives community support.

See attached document which shows how the three funding streams involved would work together to provide seamless provision of medications to patients

LIST AND ATTACH DOCUMENTS THAT SUPPORT THIS IDEA:

Summary of Integrated Plans to PRovide Continuous HIV Medications

ESTIMATED COST FOR 12 MONTHS: $ 720,000

(over)

Summary of Integrated Plans to Provide Continuous HIV Medication

Stage of Med Coverage	Description of Plans	Amount Needed	Funding Source
Initial supply of drugs	• At preliminary screening/eligibility visit, patient begins completing applications for and ADAP • Patient receives a prescription for 7 days of ARV drugs at first visit with physician, provided results of lab tests are available, and picks up drugs on-site. • After patient receives initial prescription, applications are submitted to ADAP and HP.	Est. cost of drugs for 7-day supply: $500 per patient x 500 patients = $250,000 annually	***Part A*** funds for Emergency Financial Assistance would pay cost of initial 7-day supply of drugs.
Intermediate supply of drugs while ADAP application is being processed	• sends 30-day supply of drugs to patient within 7 days of physician visit. • Patients would be allowed to utilize for up to 90 days	For Houston HSDA: Est. 2,000 patients needing intermediate supply of drugs (newly diagnosed, changing meds, reapplying to ADAP) 2,000 x 3 Rx each x $12 per Rx (est.) = $720,000	***DSHS (SS-R)*** State drug rebate funds (SS-R) would be used to cover administrative fee charged by DSHS and TRG will contract with to pay administrative fees for all Ryan White primary care providers in HSDA to have access to patient assistance program.
Ongoing supply of drugs	• Patient picks up ADAP medications at designated pharmacy. • Patient submits renewal information (attestations and reapplications) as required by DSHS.		ADAP

April 14, 2017

(over)

Rx = Prescription
M = Medication

RX Distribution Timeline

Timeline

Until Dec. 2016

0 – 5 days	5 days – 6 mos.	8+ weeks
Some agencies provide M from emergency samples or PAP	Case Mgrs. Apply thru compassionate care COORDINATOR Program NO CHARGE	ADAP

Current/Jan. 2017

0 – 21 days	21 days – 6 mos.	8 + weeks
Some agencies provide M from emergency samples or PAP.	Case Mgrs. apply to individual drug companies thru their compassionate care programs	ADAP

Proposed

0 – 5 days	5 days – 6 mos.	8+ weeks
Emergency Fin. Assist. RW Part A funding	Case Mgrs. Apply Thru compassionate Care COORDINATOR Program State Services – R funding (approx.. $720,000)	ADAP

DAY 1 1 2 3 4 5 6 7 8

WEEK

See Service Definition on Page 105

Referral for Health Care and Support Services

Description:

Referral for Health Care and Support Services directs a client to needed core medical or support services in person or through telephone, written, or other type of communication. This service may include referrals to assist eligible clients to obtain access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, and other state or local health care and supportive services, or health insurance Marketplace plans).

Program Guidance:

Referrals for Health Care and Support Services provided by outpatient/ambulatory health care providers should be reported under the Outpatient/Ambulatory Health Services category.

Referrals for health care and support services provided by case managers (medical and non-medical) should be reported in the appropriate case management service category (i.e., Medical Case Management or Non-Medical Case Management).

Table of Contents

FY 2018 Houston EMA/HSDA Service Categories Definitions
Ryan White Part A, Part B and State Services

FY 2017 Houston EMA Ryan White Part A/MAI Service Definition

Comprehensive Outpatient Primary Medical Care including Medical Case Management, Service Linkage and Local Pharmacy Assistance Program (LPAP) Services (Revision Date: 5/21/15)	
HRSA Service Category Title: **RWGA Only**	1. Outpatient/Ambulatory Medical Care 2. Medical Case Management 3. AIDS Pharmaceutical Assistance (local) 4. Case Management (non-Medical)
Local Service Category Title:	Adult Comprehensive Primary Medical Care - CBO i. Community-based Targeted to African American ii. Community-based Targeted to Hispanic iii. Community-based Targeted to White/MSM
Amount Available: **RWGA Only**	Total estimated available funding: $0.00 (to be determined) 1. Primary Medical Care: $0.00 (including MAI) i. Targeted to African American: $0.00 (incl. MAI) ii. Targeted to Hispanic: $0.00 (incl. MAI) iii. Targeted to White: $0.00 2. LPAP $0.00 3. Medical Case Management: $0.00 i. Targeted to African American $0.00 ii. Targeted to Hispanic $0.00 iii. Targeted to White $0.00 4. Service Linkage: $0.00 Note: The Houston Ryan White Planning Council (RWPC) determines overall annual Part A and MAI service category allocations & reallocations. RWGA has sole authority over contract award amounts.
Target Population:	Comprehensive Primary Medical Care – Community Based i. Targeted to African American: African American ages 13 or older ii. Targeted to Hispanic: Hispanic ages 13 or older iii. Targeted to White: White (non-Hispanic) ages 13 or older
Client Eligibility: Age, Gender, Race, Ethnicity, Residence, etc.	PLWHA residing in the Houston EMA (prior approval required for non-EMA clients). Contractor must adhere to Targeting requirements and Budget limitations as applicable.
Financial Eligibility:	*See FY 2017 Approved Financial Eligibility for Houston EMA/HSDA*
Budget Type: **RWGA Only**	Hybrid Fee for Service
Budget Requirement or Restrictions: **RWGA Only**	**Primary Medical Care:** No less than 75% of clients served in a Targeted subcategory must be members of the targeted population with the following exceptions: 100% of clients served with MAI funds must be members of the targeted population. 10% of funds designated to primary medical care must be reserved for invoicing diagnostic procedures at actual cost. Contractors may not exceed the allocation for each individual service

	component (Primary Medical Care, Medical Case Management, Local Pharmacy Assistance Program and Service Linkage) without prior approval from RWGA. **Local Pharmacy Assistance Program (LPAP):** Houston RWPC guidelines for Local Pharmacy Assistance Program (LPAP) services: Contractor shall offer HIV medications from an approved formulary for a total not to exceed $18,000 per contract year per client. Contractor shall offer HIV-related medications for a total not to exceed $3,000 per contract year per client. These guidelines are determined by the RWPC. The RWPC determines the subcategories that shall include Ryan White LPAP funding. Medications must be provided in accordance with Houston EMA guidelines, HRSA/HAB rules and regulations and applicable Office of Pharmacy Affairs 340B guidelines. At least 75% of the total amount of the budget for LPAP services must be solely allocated to the actual cost of medications and may not include any storage, administrative, processing or other costs associated with managing the medication inventory or distribution.
Service Unit Definition/s: **RWGA Only**	• Outpatient/Ambulatory Medical Care: One (1) unit of service = One (1) primary care office/clinic visit which includes the following: • Primary care physician/nurse practitioner, physician's assistant or clinical nurse specialist examination of the patient, and • Medication/treatment education • Medication access/linkage • OB/GYN specialty procedures (as clinically indicated) • Nutritional assessment (as clinically indicated) • Laboratory (as clinically indicated, not including specialized tests) • Radiology (as clinically indicated, not including CAT scan or MRI) • Eligibility verification/screening (as necessary) • Follow-up visits wherein the patient is not seen by the MD/NP/PA are considered to be a component of the original primary care visit. • Outpatient Psychiatric Services: 1 unit of service = A single (1) office/clinic visit wherein the patient is seen by a State licensed and board-eligible Psychiatrist or qualified Psychiatric Nurse Practitioner. This visit may or may not occur on the same date as a primary care office visit. • Nutritional Assessment and Plan: 1 unit of service = A single comprehensive nutritional assessment and treatment plan performed by a Licensed, Registered Dietician initiated upon a physician's order. Does not include the provision of

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

	adherence) are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication. • **Case Management (non-Medical)** includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does.
Standards of Care:	Contractors must adhere to the most current published Part A/B Standards of Care for the Houston EMA/HSDA. **Services must meet or exceed applicable United States Department of Health and Human Services (DHHS) guidelines for the Treatment of HIV/AIDS.**
Local Service Category Definition/Services to be Provided:	**Outpatient/Ambulatory Primary Medical Care:** Services include on-site physician, physician extender, nursing, phlebotomy, radiographic, laboratory, pharmacy, intravenous therapy, home health care referral, licensed dietician, patient medication education, and patient care coordination. The Contractor must provide continuity of care with inpatient services and subspecialty services (either on-site or through specific referral to appropriate medical provider upon primary care Physician's order). Services provided to women shall further include OB/GYN physician & physician extender services on-site or by referral, OB/GYN services, colposcopy, nursing, phlebotomy, radiographic, laboratory, pharmacy, intravenous therapy, home health care referral, licensed dietician, patient medication/women's health education, patient care coordination, and social services. The Contractor must provide continuity of care with inpatient services and subspecialty services

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

- Social services, including but not limited to, providing women access to child care, transportation vouchers, food vouchers and support groups at the clinic site;

Nutritional Assessment: Services include provision of information about therapeutic nutritional/supplemental foods that are beneficial to the wellness and increased health conditions of clients by a Licensed Dietitian. Services may be provided either through educational or counseling sessions. Clients who receive these services may utilize the Ryan White Part A-funded nutritional supplement provider to obtain recommended nutritional supplements in accordance with program rules. Clients are limited to one (1) nutritional assessment per calendar year without prior approval of RWGA.

Patient Medication Education Services must adhere to the following requirements:

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

Outpatient Psychiatric Services:
The program must provide:

- Diagnostic Assessments: comprehensive evaluation for identification of psychiatric disorders, mental status evaluation, differential diagnosis which may involve use of other clinical and laboratory tests, case formulation, and treatment plans or disposition.
- Emergency Psychiatric Services: rapid evaluation, differential diagnosis, acute treatment, crisis intervention, and referral. Must be available on a 24 hour basis including emergency room referral.
- Brief Psychotherapy: individual, supportive, group, couple, family, hypnosis, biofeedback, and other psychophysiological treatments and behavior modification.

- Psychopharmacotherapy: evaluation and medication treatment of psychiatric disorders, including, but not limited to, anxiety disorders, major depression, pain syndromes, habit control problems, psychosis and organic mental disorders.
- Rehabilitation Services: Physical, psychosocial, behavioral, and/or cognitive training.

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

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

Contractor must offer all medications on the Texas ADAP formulary, for a total not to exceed $18,000.00 per contract year per client. Contractor must provide allowable HIV-related medications (i.e. non-HIV medications) for a total not to exceed $3,000 per contract year per client. Contractor may be reimbursed ADAP dispensing fees (e.g. $5/Rx) in accordance with RWGA business rules for those ADAP clients who are unable to pay the ADAP dispensing fee.

Medical Case Management Services: Services include screening all primary medical care patients to determine each patient's level of need for Medical Case Management services, performing a comprehensive assessment, including an assessment of the patient's health literary, and developing a medical service plan for each client that demonstrates a documented need for such services, monitoring medical service plan to ensure its implementation, and educating client regarding wellness, medication and health care appointment adherence. The Medical Case Manager serves as an advocate for the client and as a liaison with medical providers on behalf of the client. The Medical Case Manager ensures linkage to mental health, substance abuse and other client services as indicated by the medical service plan.

Service Linkage: The purpose of Service Linkage is to assist clients

	with the procurement of needed services so that the problems associated with living with HIV are mitigated. Service Linkage is a working agreement between a client and a Service Linkage Worker for an indeterminate period, based on client need, during which information, referrals and service linkage are provided on an as-needed basis. Service Linkage assists clients who do not require the intensity of Medical Case Management per RWGA Quality Management guidelines. Service Linkage is both office-based and field based. Service Linkage Workers are expected to coordinate activities with referral sources where newly-diagnosed or not-in-care PLWHA may be identified, including 1:1 case conferences with testing site personnel to ensure the successful transition of referrals into Primary Care Services. Such incoming referral coordination includes meeting prospective clients at the referring Provider location in order to develop rapport with individuals prior to the individual's initial Primary Care appointment and ensuring such new intakes to Primary Care services have sufficient support to make the often difficult transition into ongoing primary medical care. Service Linkage also includes follow-up to re-engage lost-to-care patients. Lost-to-care patients are those patients who have not returned for scheduled appointments with Provider nor have provided Provider with updated information about their current Primary Medical Care provider (in the situation where patient may have obtained alternate service from another medical provider). Contractor must document efforts to re-engage lost-to-care patients prior to closing patients in the CPCDMS. Service Linkage extends the capability of existing programs by providing "hands-on" outreach and linkage to care services to those PLWHA who are not currently accessing primary medical care services. Service Linkage includes the issuance of bus pass vouchers and gas cards per published RWGA guidelines. Service Linkage complements and extends the service delivery capability of Medical Case Management services.
Agency Requirements:	**Providers and system must be Medicaid/Medicare certified.** **Eligibility and Benefits Coordination:** Contractor must implement consumer-friendly, culturally and linguistically appropriate new and ongoing patient eligibility verification and benefit coordination processes that ensure accountability with Ryan White Payer of Last Resort requirements while achieving maximum utilization of eligible benefits. Eligibility processes should provide clients with a meaningful understanding of their benefits, expected out-of-pocket expenses and other information needed to ensure full and continued participation in care. **LPAP Services:** Contractor must: Provide pharmacy services on-site or through an established contractual relationship that meets all requirements. Alternate (off-

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

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

	Case Manager and the individual assigned to supervise those Medical Case Managers by 03/30/15, and thereafter within 15 days after hire. **Service Linkage:** The program must utilize Service Linkage Workers who have at a minimum a Bachelor's degree from an accredited college or university with a major in social or behavioral sciences. Documented paid work experience in providing client services to PLWHA may be substituted for the Bachelor's degree requirement on a 1:1 basis (1 year of documented paid experience may be substituted for 1 year of college). All Service Linkage Workers must have a minimum of one (1) year paid work experience with PLWHA. Contractor must maintain the assigned number of Service Linkage FTEs throughout the contract term. **Contractor must provide to RWGA the names of each Service Linkage Worker and the individual assigned to supervise those Service Linkage Workers by 03/30/15, and thereafter within 15 days after hire.** **Supervision of Case Managers:** The Service Linkage Workers and Medical Case Managers must function within the clinical infrastructure of Contractor and receive ongoing supervision that meets or exceeds Houston EMA/HSDA Part A/B Standards of Care for Service Linkage and Medical Case Management as applicable. An MCM may supervise SLWs.
Special Requirements:	**All primary medical care services must meet or exceed current United States DHHS Treatment Guidelines for the treatment and management of HIV disease.** Contractor must provide all required program components - Primary Medical Care, Medical Case Management, Service Linkage (non-medical Case Management) and Local Pharmacy Assistance Program (LPAP) services. **Primary Medical Care Services:** Services funded under this grant cannot be used to supplant insurance or Medicare/Medicaid reimbursements for such services. Clients eligible for such reimbursement may not be billed to this contract. Medicare and private insurance co-payments may be eligible for reimbursement under Ryan White Health Insurance Assistance (HINS) program guidelines. Patients needing such assistance should be referred to the local Ryan White-funded HINS provider for assistance. Under no circumstances may the Contractor bill the County for the difference between the reimbursement from Medicaid, Medicare or Third Party insurance and the fee schedule under the contract. Furthermore, potential clients who are Medicaid/Medicare eligible or have other Third Party payers may not be denied services or referred elsewhere by the Contractor based on their reimbursement status (i.e. Medicaid/Medicare eligible clients may not be referred elsewhere in

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

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

FY 2017 Houston EMA Ryan White Part A/MAI Service Definition

FY 2018 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/08/17**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/01/17**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Assurance Committee**		Date: **05/18/17**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMTN Workgroup**		Date: **04/25/17**
Recommendations:	Financial Eligibility: PriCare=300%, LPAP=300% + 500%, MCM/SLW=none	
1. Accept the service category definition as presented and keep financial eligibility the same; and ask the Office of Support to provide training on the Needs Assessment findings to case managers.		
2.		
3.		

FY 2017 Houston EMA Ryan White Part A/MAI Service Definition

Comprehensive Outpatient Primary Medical Care including Medical Case Management, Service Linkage and Local Pharmacy Assistance Program (LPAP) Services (Revision Date: 5/21/15)	
HRSA Service Category Title: **RWGA Only**	1. Outpatient/Ambulatory Medical Care 2. Medical Case Management 3. AIDS Pharmaceutical Assistance (local) 4. Case Management (non-Medical)
Local Service Category Title:	Adult Comprehensive Primary Medical Care i. Targeted to Public Clinic ii. Targeted to Women at Public Clinic
Amount Available: **RWGA Only**	Total estimated available funding: $0.00 (to be determined) 1. Primary Medical Care: $0.00 (including MAI) i. Targeted to Public Clinic: $0.00 ii. Targeted to Women at Public Clinic: $0.00 2. LPAP $0.00 3. Medical Case Management: $0.00 i. Targeted to Public Clinic: $0.00 ii. Targeted to Women at Public Clinic: $0.00 4. Service Linkage: $0.00 Note: The Houston Ryan White Planning Council (RWPC) determines annual Part A and MAI service category allocations & reallocations. RWGA has sole authority over contract award amounts.
Target Population:	Comprehensive Primary Medical Care – Community Based i. Targeted to Public Clinic ii. Targeted to Women at Public Clinic
Client Eligibility: Age, Gender, Race, Ethnicity, Residence, etc.	PLWHA residing in the Houston EMA (prior approval required for non-EMA clients). Contractor must adhere to Targeting requirements and Budget limitations as applicable.
Financial Eligibility:	*See FY 2015 Approved Financial Eligibility for Houston EMA/HSDA*
Budget Type: **RWGA Only**	Hybrid Fee for Service
Budget Requirement or Restrictions: **RWGA Only**	**Primary Medical Care:** 100% of clients served under the *Targeted to Women at Public Clinic* subcategory must be female 10% of funds designated to primary medical care must be reserved for invoicing diagnostic procedures at actual cost. Contractors may not exceed the allocation for each individual service component (Primary Medical Care, Medical Case Management, Local Pharmacy Assistance Program and Service Linkage) without prior approval from RWGA. **Local Pharmacy Assistance Program (LPAP):** Houston RWPC guidelines for Local Pharmacy Assistance

	Program (LPAP) services: Contractor shall offer HIV medications from an approved formulary for a total not to exceed $18,000 per contract year per client. Contractor shall offer HIV-related medications for a total not to exceed $3,000 per contract year per client. These guidelines are determined by the RWPC. The RWPC determines the subcategories that shall include Ryan White LPAP funding. Medications must be provided in accordance with Houston EMA guidelines, HRSA/HAB rules and regulations and applicable Office of Pharmacy Affairs 340B guidelines. At least 75% of the total amount of the budget for LPAP services must be solely allocated to the actual cost of medications and may not include any storage, administrative, processing or other costs associated with managing the medication inventory or distribution.
Service Unit Definition/s: **RWGA Only**	• Outpatient/Ambulatory Medical Care: One (1) unit of service = One (1) primary care office/clinic visit which includes the following: • Primary care physician/nurse practitioner, physician's assistant or clinical nurse specialist examination of the patient, and • Medication/treatment education • Medication access/linkage • OB/GYN specialty procedures (as clinically indicated) • Nutritional assessment (as clinically indicated) • Laboratory (as clinically indicated, not including specialized tests) • Radiology (as clinically indicated, not including CAT scan or MRI) • Eligibility verification/screening (as necessary) • Follow-up visits wherein the patient is not seen by the MD/NP/PA are considered to be a component of the original primary care visit. • Outpatient Psychiatric Services: 1 unit of service = A single (1) office/clinic visit wherein the patient is seen by a State licensed and board-eligible Psychiatrist or qualified Psychiatric Nurse Practitioner. This visit may or may not occur on the same date as a primary care office visit. • Medication Education: 1 unit of service = A single pharmacy visit wherein a Ryan White eligible client is provided medication education services by a qualified pharmacist. This visit may or may not occur on the same date as a primary care office visit. Maximum reimbursement allowable for a medication education visit may not exceed $50.00 per visit. The visit must include at least one prescription medication being provided to clients. A maximum of one (1) Medication Education Visit may be provided to an individual client per

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

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

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

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

Women's Services must also provide:

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

Nutritional Assessment: Services include provision of information about therapeutic nutritional/supplemental foods that are beneficial to the wellness and increased health conditions of clients by a Licensed Dietitian. Services may be provided either through educational or counseling sessions. Clients who receive these services may utilize the Ryan White Part A-funded nutritional supplement provider to obtain recommended nutritional supplements in accordance with program rules. Clients are limited to one (1) nutritional assessment per calendar year without prior approval of RWGA.

Patient Medication Education Services must adhere to the following requirements:

- Medication Educators must be State Licensed Medical Doctor (MD), Nurse Practitioner (NP), Physician Assistant PA), Nurse (RN, LVN) or Pharmacist. Prior approval must be obtained prior to utilizing any other health care professional not listed above to provide medication education.
- Clients who will be prescribed ongoing medical regimens (i.e. ART) must be assessed for adherence to treatment at every clinical encounter using the EMA's approved adherence assessment tool. Clients with adherence issues related to lack of understanding must receive more education regarding their

	medical regimen. Clients with adherence issues that are behavioral or involve mental health issues must be provided counseling by the Medical Case Manager, Physician or Physician Extender and/or licensed nursing staff and, if clinically indicated, assessment and treatment by a qualified Psychiatrist or Psychiatric Nurse Practitioner. **Outpatient Psychiatric Services:** The program must provide: • Diagnostic Assessments: comprehensive evaluation for identification of psychiatric disorders, mental status evaluation, differential diagnosis which may involve use of other clinical and laboratory tests, case formulation, and treatment plans or disposition. • Emergency Psychiatric Services: rapid evaluation, differential diagnosis, acute treatment, crisis intervention, and referral. Must be available on a 24 hour basis including emergency room referral. • Brief Psychotherapy: individual, supportive, group, couple, family, hypnosis, biofeedback, and other psychophysiological treatments and behavior modification. • Psychopharmacotherapy: evaluation and medication treatment of psychiatric disorders, including, but not limited to, anxiety disorders, major depression, pain syndromes, habit control problems, psychosis and organic mental disorders. • Rehabilitation Services: Physical, psychosocial, behavioral, and/or cognitive training. Screening for Eye Disorders: Contractor must ensure that patients receive appropriate screening and treatment for CMV, glaucoma, cataracts, and other related problems. **Local Medication Assistance Program (LPAP):** LPAP provides pharmaceuticals to patients otherwise ineligible for medications through private insurance, Medicaid/Medicare, State ADAP, SPAP or other sources. Allowable medications are only those on the Houston EMA Ryan White Part A Formulary. Eligible clients may be provided Fuzeon™ on a case-by-case basis with prior approval of Ryan White Grant Administration (RWGA). The cost of Fuzeon™ does not count against a client's annual maximum. HIV-related medication services are the provision of physician or physician-extender prescribed HIV-related medications to prevent serious deterioration of health. Does not include drugs available to the patient from other programs or payers or free of charge (such as birth control and TB medications) or medications available over the

	counter (OTC) without prescription. Contractor must offer all medications on the Texas ADAP formulary, for a total not to exceed $18,000.00 per contract year per client. Contractor must provide allowable HIV-related medications (i.e. non-HIV medications) for a total not to exceed $3,000 per contract year per client. Contractor may be reimbursed ADAP dispensing fees (e.g. $5/Rx) in accordance with RWGA business rules for those ADAP clients who are unable to pay the ADAP dispensing fee. **Medical Case Management Services:** Services include screening all primary medical care patients to determine each patient's level of need for Medical Case Management services, performing a comprehensive assessment, including an assessment of the patient's health literary, and developing a medical service plan for each client that demonstrates a documented need for such services, monitoring medical service plan to ensure its implementation, and educating client regarding wellness, medication and health care appointment adherence. The Medical Case Manager serves as an advocate for the client and as a liaison with medical providers on behalf of the client. The Medical Case Manager ensures linkage to mental health, substance abuse and other client services as indicated by the medical service plan. **Service Linkage:** The purpose of Service Linkage is to assist clients with the procurement of needed services so that the problems associated with living with HIV are mitigated. Service Linkage is a working agreement between a client and a Service Linkage Worker for an indeterminate period, based on client need, during which information, referrals and service linkage are provided on an as-needed basis. Service Linkage assists clients who do not require the intensity of Medical Case Management per RWGA Quality Management guidelines. Service Linkage is both office-based and field based. Service Linkage Workers are expected to coordinate activities with referral sources where newly-diagnosed or not-in-care PLWHA may be identified, including 1:1 case conferences with testing site personnel to ensure the successful transition of referrals into Primary Care Services. Such incoming referral coordination includes meeting prospective clients at the referring Provider location in order to develop rapport with individuals prior to the individual's initial Primary Care appointment and ensuring such new intakes to Primary Care services have sufficient support to make the often difficult transition into ongoing primary medical care. Service

	Linkage also includes follow-up to re-engage lost-to-care patients. Lost-to-care patients are those patients who have not returned for scheduled appointments with Provider nor have provided Provider with updated information about their current Primary Medical Care provider (in the situation where patient may have obtained alternate service from another medical provider). Contractor must document efforts to re-engage lost-to-care patients prior to closing patients in the CPCDMS. Service Linkage extends the capability of existing programs by providing "hands-on" outreach and linkage to care services to those PLWHA who are not currently accessing primary medical care services. Service Linkage includes the issuance of bus pass vouchers and gas cards per published RWGA guidelines. Service Linkage complements and extends the service delivery capability of Medical Case Management services.
Agency Requirements:	**Providers and system must be Medicaid/Medicare certified.** **Eligibility and Benefits Coordination:** Contractor must implement consumer-friendly, culturally and linguistically appropriate new and ongoing patient eligibility verification and benefit coordination processes that ensure accountability with Ryan White Payer of Last Resort requirements while achieving maximum utilization of eligible benefits. Eligibility processes should provide clients with a meaningful understanding of their benefits, expected out-of-pocket expenses and other information needed to ensure full and continued participation in care. **LPAP Services:** Contractor must: Provide pharmacy services on-site or through an established contractual relationship that meets all requirements. Alternate (off-site) approaches must be approved prior to implementation by RWGA. Either directly, or via subcontract with an eligible 340B Pharmacy program entity, must: Ensure a comprehensive financial intake application to determine client eligibility for this program to insure that these funds are used as a last resort for purchase of medications. Ensure the documented capability of interfacing with the Texas HIV Medication Program operated by the Texas Department of State Health Services. This capability must be fully documented and is

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

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

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

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

	weekly, bi-weekly depending on volume of referrals) meet 1:1 to discuss new referrals to primary medical care services. Such case conferences must be documented in the client record and properly entered into the CPCDMS. Use of CPCDMS Data System: Contractor must comply with CPCDMS business rules and procedures. Contractor must enter into the CPCDMS all required clinical data, including but not limited to, HAART treatment including all changes in medication regimens, Opportunistic Infections, screening and treatment for STDs and Hepatitis A, B, C and other clinical screening and treatment data required by HRSA, TDSHS and the County. Contractor must perform Registration updates in accordance with RWGA CPCDMS business rules for all clients wherein Contractor is client's CPCDMS record-owning agency. Contractor must utilize an electronic verification system to verify insurance/3rd party payer status monthly or per visit (whichever is less frequent). **Bus Pass Distribution:** The County will provide Contractor with METRO bus pass vouchers. Bus Pass vouchers must be distributed in accordance with RWGA policies and procedures, standards of care and financial eligibility guidelines. Contractor may only issue METRO bus pass vouchers to clients wherein the Contractor is the CPCDMS record owning Contractor. METRO bus pass vouchers shall be distributed as follows: **Expiration of Current Bus Pass:** In those situation wherein the bus pass expiration date does not coincide with the CPCDMS registration update the Contractor must distribute METRO bus pass vouchers to eligible clients upon the expiration of the current bus pass or when a Value-based bus card has been expended on eligible transportation needs. Contractor may issue METRO bus passes to eligible clients living outside the METRO service area in those situations where the Contractor has documented in the client record that the client will utilize the METRO system to access needed HIV-related health care services located in the METRO service area. **Gas Cards:** Primary Medical Care Contractors must distribute gasoline vouchers to eligible clients residing in the rural service area in accordance with RWGA policies and procedures, standards of care and financial eligibility guidelines. Gas Cards are only available to Rural primary medical care Contractors without prior approval by RWGA.

FY 2017 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/08/17**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/01/17**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Assurance Committee**		Date: **05/18/17**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMTN Workgroup**	Date: **04/25/17**
Recommendations:	Financial Eligibility: PriCare=300%, LPAP=300% + 500%, MCM/SLW=none
1. Accept the service category definition as presented and keep financial eligibility the same; and ask the Office of Support to provide training on the Needs Assessment findings to case managers.	
2.	
3.	

FY 2017 Houston EMA Ryan White Part A/MAI Service Definition

Comprehensive Outpatient Primary Medical Care including Medical Case Management, Service Linkage and Local Pharmacy Assistance Program (LPAP) Services - Rural (Revision Date: 5/21/15)	
HRSA Service Category Title: **RWGA Only**	1. Outpatient/Ambulatory Medical Care 2. Medical Case Management 3. AIDS Pharmaceutical Assistance (local) 4. Case Management (non-Medical)
Local Service Category Title:	Adult Comprehensive Primary Medical Care - Targeted to Rural
Amount Available: **RWGA Only**	Total estimated available funding: $0.00 (to be determined) 1. Primary Medical Care: $0.00 2. LPAP $0.00 3. Medical Case Management: $0.00 4. Service Linkage: $0.00 Note: The Houston Ryan White Planning Council (RWPC) determines overall annual Part A and MAI service category allocations & reallocations. RWGA has sole authority over contract award amounts.
Target Population:	Comprehensive Primary Medical Care – Targeted to Rural
Client Eligibility: Age, Gender, Race, Ethnicity, Residence, etc.	PLWHA residing in the Houston EMA/HSDA counties **other than Harris County** (prior approval required for non-EMA clients). Contractor must adhere to Targeting requirements and Budget limitations as applicable.
Financial Eligibility:	*See FY 2017 Approved Financial Eligibility for Houston EMA/HSDA*
Budget Type: **RWGA Only**	Hybrid Fee for Service
Budget Requirement or Restrictions: **RWGA Only**	**Primary Medical Care:** No less than 75% of clients served in a Targeted subcategory must be members of the targeted population with the following exceptions: 10% of funds designated to primary medical care must be reserved for invoicing diagnostic procedures at actual cost. Contractors may not exceed the allocation for each individual service component (Primary Medical Care, Medical Case Management, Local Pharmacy Assistance Program and Service Linkage) without prior approval from RWGA. **Local Pharmacy Assistance Program (LPAP):** Houston RWPC guidelines for Local Pharmacy Assistance Program (LPAP) services: Contractor shall offer HIV medications from an approved formulary for a total not to exceed $18,000 per contract year per client. Contractor shall offer HIV-related medications for a total not to exceed $3,000 per contract year per client. These guidelines are determined by the RWPC. The RWPC determines the subcategories that shall include Ryan White LPAP funding.

	Medications must be provided in accordance with Houston EMA guidelines, HRSA/HAB rules and regulations and applicable Office of Pharmacy Affairs 340B guidelines. At least 75% of the total amount of the budget for LPAP services must be solely allocated to the actual cost of medications and may not include any storage, administrative, processing or other costs associated with managing the medication inventory or distribution.
Service Unit Definition/s:	• Outpatient/Ambulatory Medical Care: One (1) unit of service = One (1) primary care office/clinic visit which includes the following: • Primary care physician/nurse practitioner, physician's assistant or clinical nurse specialist examination of the patient, and • Medication/treatment education • Medication access/linkage • OB/GYN specialty procedures (as clinically indicated) • Nutritional assessment (as clinically indicated) • Laboratory (as clinically indicated, not including specialized tests) • Radiology (as clinically indicated, not including CAT scan or MRI) • Eligibility verification/screening (as necessary) • Follow-up visits wherein the patient is not seen by the MD/NP/PA are considered to be a component of the original primary care visit. • Outpatient Psychiatric Services: 1 unit of service = A single (1) office/clinic visit wherein the patient is seen by a State licensed and board-eligible Psychiatrist or qualified Psychiatric Nurse Practitioner. This visit may or may not occur on the same date as a primary care office visit. • Nutritional Assessment and Plan: 1 unit of service = A single comprehensive nutritional assessment and treatment plan performed by a Licensed, Registered Dietician initiated upon a physician's order. Does not include the provision of Supplements or other products (clients may be referred to the Ryan White funded Medical Nutritional Therapy provider for provision of medically necessary supplements). The nutritional assessment visit may or may not occur on the same date as a medical office visit. • AIDS Pharmaceutical Assistance (local): A unit of service = a transaction involving the filling of a prescription or any other

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

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

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

and treatment.
- On-site or by referral Colposcopy exams as needed, performed by an OB/GYN physician, or physician extender with a colposcopy provider qualification.
- Social services, including but not limited to, providing women access to child care, transportation vouchers, food vouchers and support groups at the clinic site;

Nutritional Assessment: Services include provision of information about therapeutic nutritional/supplemental foods that are beneficial to the wellness and increased health conditions of clients by a Licensed Dietitian. Services may be provided either through educational or counseling sessions. Clients who receive these services may utilize the Ryan White Part A-funded nutritional supplement provider to obtain recommended nutritional supplements in accordance with program rules. Clients are limited to one (1) nutritional assessment per calendar year without prior approval of RWGA.

Patient Medication Education Services must adhere to the following requirements:

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

Outpatient Psychiatric Services:
The program must provide:
- Diagnostic Assessments: comprehensive evaluation for identification of psychiatric disorders, mental status evaluation, differential diagnosis which may involve use of other clinical and laboratory tests, case formulation, and treatment plans or disposition.

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

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

	Service Linkage complements and extends the service delivery capability of Medical Case Management services.
Agency Requirements:	**Providers and system must be Medicaid/Medicare certified.** **Eligibility and Benefits Coordination:** Contractor must implement consumer-friendly, culturally and linguistically appropriate new and ongoing patient eligibility verification and benefit coordination processes that ensure accountability with Ryan White Payer of Last Resort requirements while achieving maximum utilization of eligible benefits. Eligibility processes should provide clients with a meaningful understanding of their benefits, expected out-of-pocket expenses and other information needed to ensure full and continued participation in care. **LPAP Services:** Contractor must: Provide pharmacy services on-site or through an established contractual relationship that meets all requirements. Alternate (off-site) approaches must be approved prior to implementation by RWGA. Either directly, or via subcontract with an eligible 340B Pharmacy program entity, must: Ensure a comprehensive financial intake application to determine client eligibility for this program to insure that these funds are used as a last resort for purchase of medications. Ensure the documented capability of interfacing with the Texas HIV Medication Program operated by the Texas Department of State Health Services. This capability must be fully documented and is subject to independent verification by RWGA. Ensure medication assistance provided to clients does not duplicate services already being provided in the Houston area. The process for accomplishing this must be fully documented and is subject to independent verification by RWGA. Ensure, either directly or via a 340B Pharmacy Program Provider, at least 2 years of continuous documented experience in providing HIV/AIDS medication programs utilizing Ryan White Program or similar public sector funding. This experience must be documented and is subject to independent verification by RWGA. Ensure all medications are purchased via a qualified participant in the federal 340B Drug Pricing Program and Prime Vendor Program, administered by the HRSA Office of Pharmacy Affairs. Note: failure to maintain 340B or Prime Vendor drug pricing may result in a negative audit finding, cost disallowance or termination of contract awarded. Contractor must maintain 340B Program participation

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

	certifications must be included in the proposal appendices. **Medication and Adherence Education:** The program must utilize an RN, LVN, PA, NP, pharmacist or MD licensed by the State of Texas, who has at least two (2) years paid experience in the preceding five (5) years in HIV/AIDS care, to provide the educational services. Licensed social workers who have at least two (2) years paid experience in the preceding five (5) years in HIV/AIDS care may also provide adherence education and counseling. **Nutritional Assessment (primary care):** Services must be provided by a licensed registered dietician. Dieticians must have a minimum of two (2) years of experience providing nutritional assessment and counseling to PLWHA. **Medical Case Management:** The program must utilize a state licensed Social Worker to provide Medical Case Management Services. The Contractor must maintain the assigned number of Medical Case Management FTEs throughout the contract term. **Contractor must provide to RWGA the names of each Medical Case Manager and the individual assigned to supervise those Medical Case Managers by 03/30/15, and thereafter within 15 days after hire.** **Service Linkage:** The program must utilize Service Linkage Workers who have at a minimum a Bachelor's degree from an accredited college or university with a major in social or behavioral sciences. Documented paid work experience in providing client services to PLWHA may be substituted for the Bachelor's degree requirement on a 1:1 basis (1 year of documented paid experience may be substituted for 1 year of college). All Service Linkage Workers must have a minimum of one (1) year paid work experience with PLWHA. Contractor must maintain the assigned number of Service Linkage FTEs throughout the contract term. **Contractor must provide to RWGA the names of each Service Linkage Worker and the individual assigned to supervise those Service Linkage Workers by 03/30/15, and thereafter within 15 days after hire.** **Supervision of Case Managers:** The Service Linkage Workers and Medical Case Managers must function within the clinical infrastructure of Contractor and receive ongoing supervision that meets or exceeds Houston EMA/HSDA Part A/B Standards of Care for Service Linkage and Medical Case Management as applicable. An MCM may supervise SLWs.
Special Requirements: **RWGA Only**	**All primary medical care services must meet or exceed current United States DHHS Treatment Guidelines for the treatment and management of HIV disease.** Contractor must provide all required program components - Primary

	Medical Care, Medical Case Management, Service Linkage (non-medical Case Management) and Local Pharmacy Assistance Program (LPAP) services. **Primary Medical Care Services:** Services funded under this grant cannot be used to supplant insurance or Medicare/Medicaid reimbursements for such services. Clients eligible for such reimbursement may not be billed to this contract. Medicare and private insurance co-payments may be eligible for reimbursement under Ryan White Health Insurance Assistance (HINS) program guidelines. Patients needing such assistance should be referred to the local Ryan White-funded HINS provider for assistance. Under no circumstances may the Contractor bill the County for the difference between the reimbursement from Medicaid, Medicare or Third Party insurance and the fee schedule under the contract. Furthermore, potential clients who are Medicaid/Medicare eligible or have other Third Party payers may not be denied services or referred elsewhere by the Contractor based on their reimbursement status (i.e. Medicaid/Medicare eligible clients may not be referred elsewhere in order that non-Medicaid/Medicare eligible clients may be added to the contract). Failure to serve Medicaid/Medicare eligible clients based on their reimbursement status will be grounds for the immediate termination of contract. **For primary medical care services targeted to the Latino community at least 50% of the clinical care team must be fluent in Spanish.** **Diagnostic Procedures:** A single Diagnostic Procedure limited to procedures on the approved list of diagnostic procedures (see below) without prior County approval. Approved diagnostic procedures will be reimbursed at invoice cost. Part A and Part A/MAI-funded programs must refer to the RWGA website for the most current list of approved diagnostic procedures and corresponding codes: www.hcphes.org/rwga. **Diagnostic procedures not listed on the website must have prior approval by RWGA.** **Outpatient Psychiatric Services:** Client must not be eligible for services from other programs/providers or any other reimbursement source (i.e. Medicaid, Medicare, private insurance) unless the client is in crisis and cannot be provided immediate services from the other programs/providers. In this case, clients may be provided services, as long as the client applies for the other programs/providers, until the other programs/providers can take over services. Program must be supervised by a Psychiatrist and include diagnostic assessments, emergency evaluations and psycho-pharmacotherapy. **Maintaining Referral Relationships** (Point of Entry Agreements):

	Contractor must maintain appropriate relationships with entities that constitute key points of access to the health care system for individuals with HIV disease, including but not limited to, Harris Health System and other Houston EMA-located emergency rooms, Harris County Jail, Texas Department of Criminal Justice incarceration facilities, Immigration detention centers, substance abuse treatment and detoxification programs, adult and juvenile detention facilities, Sexually Transmitted Disease clinics, federally qualified health centers (FQHC), HIV disease counseling and testing sites, mental health programs and homeless shelters. These referral relationships must be documented with written collaborative agreements, contracts or memoranda of understanding between Contractor and appropriate point of entry entities and are subject to audit by RWGA. Contractor and POE entity staff must regularly (e.g. weekly, bi-weekly depending on volume of referrals) meet 1:1 to discuss new referrals to primary medical care services. Such case conferences must be documented in the client record and properly entered into the CPCDMS. Use of CPCDMS Data System: Contractor must comply with CPCDMS business rules and procedures. Contractor must enter into the CPCDMS all required clinical data, including but not limited to, HAART treatment including all changes in medication regimens, Opportunistic Infections, screening and treatment for STDs and Hepatitis A, B, C and other clinical screening and treatment data required by HRSA, TDSHS and the County. Contractor must perform Registration updates in accordance with RWGA CPCDMS business rules for all clients wherein Contractor is client's CPCDMS record-owning agency. Contractor must utilize an electronic verification system to verify insurance/3rd party payer status monthly or per visit (whichever is less frequent). **Bus Pass Distribution:** The County will provide Contractor with METRO bus pass vouchers. Bus Pass vouchers must be distributed in accordance with RWGA policies and procedures, standards of care and financial eligibility guidelines. Contractor may only issue METRO bus pass vouchers to clients wherein the Contractor is the CPCDMS record owning Contractor. METRO bus pass vouchers shall be distributed as follows: **Expiration of Current Bus Pass:** In those situation wherein the bus pass expiration date does not coincide with the CPCDMS registration update the Contractor must distribute METRO bus pass vouchers to eligible clients upon the expiration of the current bus pass or when a Value-based bus card has been expended on eligible transportation needs. Contractor may issue METRO bus passes to eligible clients living outside the METRO service area in those situations where the Contractor has documented in the client record that the client will

	utilize the METRO system to access needed HIV-related health care services located in the METRO service area. **Gas Cards:** Primary Medical Care Contractors must distribute gasoline vouchers to eligible clients residing in the rural service area in accordance with RWGA policies and procedures, standards of care and financial eligibility guidelines. Gas Cards are only available to Rural primary medical care Contractors without prior approval by RWGA.

FY 2017 Houston EMA Ryan White Part A/MAI Service Definition

FY 2018 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/08/17**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/01/17**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Assurance Committee**		Date: **05/18/17**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMTN Workgroup**		Date: **04/25/17**
Recommendations:	Financial Eligibility: PriCare=300%, LPAP=300% + 500%, MCM/SLW=none	
1. Accept the service category definition as presented and keep financial eligibility the same; and ask the Office of Support to provide training on the Needs Assessment findings to case managers.		
2.		
3.		

FY 2017 Houston EMA/HSDA Ryan White Part A/MAI Service Definition

Comprehensive Outpatient Primary Medical Care including Medical Case Management and Service Linkage Services - Pediatric (Last Review/Approval Date: 6/3/16)	
HRSA Service Category Title: **RWGA Only**	1. Outpatient/Ambulatory Medical Care 2. Medical Case Management 3. Case Management (non-Medical)
Local Service Category Title:	Comprehensive Primary Medical Care Targeted to Pediatric
Target Population:	HIV-infected resident of the Houston EMA 0 – 18 years of age. Provider may continue services to previously enrolled clients until the client's 22nd birthday.
Financial Eligibility:	*See FY 2017 Approved Financial Eligibility for Houston EMA/HSDA*
Budget Type: **RWGA Only**	Hybrid Fee for Service
Budget Requirement or Restrictions: **RWGA Only**	**Primary Medical Care:** 10% of funds designated to primary medical care must be reserved for invoicing diagnostic procedures at actual cost. Contractors may not exceed the allocation for each individual service component (Primary Medical Care, Medical Case Management and Service Linkage) without prior approval from RWGA.
Service Unit Definition/s: **RWGA Only**	• Outpatient/Ambulatory Medical Care: One (1) unit of service = One (1) primary care office/clinic visit which includes the following: • Primary care physician/nurse practitioner, physician's assistant or clinical nurse specialist examination of the patient, and • Medication/treatment education • Medication access/linkage • OB/GYN specialty procedures (as clinically indicated) • Nutritional assessment (as clinically indicated) • Laboratory (as clinically indicated, not including specialized tests) • Radiology (as clinically indicated, not including CAT scan or MRI) • Eligibility verification/screening (as necessary) • Follow-up visits wherein the patient is not seen by the MD/NP/PA are considered to be a component of the original primary care visit. • Outpatient Psychiatric Services: 1 unit of service = A single (1) office/clinic visit wherein the patient is seen by a State licensed and board-eligible Psychiatrist or qualified Psychiatric Nurse Practitioner. This visit may or may not occur on the same date as a primary care office visit. • Medical Case Management: 1 unit of service = 15 minutes of

	direct medical case management services to an eligible PLWHA performed by a qualified medical case manager. • Service Linkage (non-Medical Case Management): 1 unit of service = 15 minutes of direct service linkage services to an eligible PLWHA performed by a qualified service linkage worker.
HRSA Service Category Definition: **RWGA Only**	• **Outpatient/Ambulatory medical care** is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings. Services includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies. • **Medical Case Management** services (including treatment adherence) are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication.

	• **Case Management (non-Medical)** includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does.
Standards of Care:	Contractors must adhere to the most current published Part A/B Standards of Care for the Houston EMA/HSDA. **Services must meet or exceed applicable United States Department of Health and Human Services (DHHS) guidelines for the Treatment of HIV/AIDS.**
Local Service Category Definition/Services to be Provided:	**Outpatient/Ambulatory Primary Medical Care:** Services include on-site physician, physician extender, nursing, phlebotomy, radiographic, laboratory, pharmacy, intravenous therapy, home health care referral, licensed dietician, patient medication education, and patient care coordination. The Contractor must provide continuity of care with inpatient services and subspecialty services (either on-site or through specific referral to appropriate medical provider upon primary care Physician's order). Services provided to women shall further include OB/GYN physician & physician extender services on-site or by referral, OB/GYN services, colposcopy, nursing, phlebotomy, radiographic, laboratory, pharmacy, intravenous therapy, home health care referral, licensed dietician, patient medication/women's health education, patient care coordination, and social services. The Contractor must provide continuity of care with inpatient services and subspecialty services (either on-site or through specific referral protocols to appropriate agencies upon primary care Physician's order). **Outpatient/Ambulatory Primary Medical Care must provide:** • Continuity of care for all stages of adult HIV infection; • Laboratory and pharmacy services including intravenous medications (either on-site or through established referral systems); • Outpatient psychiatric care, including lab work necessary for the prescribing of psychiatric medications when appropriate (either on-site or through established referral systems); • Access to the Texas ADAP program (either on-site or through established referral systems); • Access to compassionate use HIV medication programs (either directly or through established referral systems); • Access to HIV related research protocols (either directly or through established referral systems); • Must at a minimum, comply with Houston EMA/HSDA Part A/B Standards for HIV Primary Medical Care. The Contractor must demonstrate on an ongoing basis the ability

	to provide state-of-the-art HIV-related primary care medicine in accordance with the most recent DHHS HIV treatment guidelines. Rapid advances in HIV treatment protocols require that the Contractor provide services that to the greatest extent possible maximize a patient's opportunity for long-term survival and maintenance of the highest quality of life possible. • On-site Outpatient Psychiatry services. • On-site Medical Case Management services. • On-site Medication Education. • Physical therapy services (either on-site or via referral). • Specialty Clinic Referrals (either on-site or via referral). • On-site pelvic exams as needed for female patients with appropriate follow-up treatment and referral. • On site Nutritional Counseling by a Licensed Dietitian. **Services for females of child bearing age must also provide:** • Well woman care, including but not limited to: PAP, pelvic exam, breast examination, mammography, hormone replacement and education, pregnancy testing, contraceptive services excluding birth control medications. • Obstetric Care: ante-partum through post-partum services, child birth/delivery services. Perinatal preventative education and treatment. • On-site or by referral Colposcopy exams as needed, performed by an OB/GYN physician, or physician extender with a colposcopy provider qualification. • Social services, including but not limited to, providing women access to child care, transportation vouchers, food vouchers and support groups at the clinic site; Patient Medication Education Services must adhere to the following requirements: • Medication Educators must be State Licensed Medical Doctor (MD), Nurse Practitioner (NP), Physician Assistant PA), Nurse (RN, LVN) or Pharmacist. Prior approval must be obtained prior to utilizing any other health care professional not listed above to provide medication education. • Clients who will be prescribed ongoing medical regimens (i.e. ART) must be assessed for adherence to treatment at every clinical encounter using the EMA's approved adherence assessment tool. Clients with adherence issues related to lack of understanding must receive more education regarding their medical regimen. Clients with adherence issues that are behavioral or involve mental health issues must be provided counseling by the Medical Case Manager, Physician or

Physician Extender and/or licensed nursing staff and, if clinically indicated, assessment and treatment by a qualified Psychiatrist or Psychiatric Nurse Practitioner.

Outpatient Psychiatric Services:
The program must provide:

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

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

Medical Case Management Services: Services include screening all primary medical care patients to determine each patient's level of need for Medical Case Management services, performing a comprehensive assessment, including an assessment of the patient's health literary, and developing a medical service plan for each client that demonstrates a documented need for such services, monitoring medical service plan to ensure its implementation, and educating client regarding wellness, medication and health care appointment adherence. The Medical Case Manager serves as an advocate for the client and as a liaison with medical providers on behalf of the client. The Medical Case Manager ensures linkage to mental health, substance abuse and other client services as indicated by the medical service plan.

Service Linkage: The purpose of Service Linkage is to assist clients with the procurement of needed services so that the problems associated with living with HIV are mitigated. Service Linkage is a working agreement between a client and a Service Linkage Worker for an indeterminate period, based on client need, during which information, referrals and service linkage are provided on an as-

	needed basis. Service Linkage assists clients who do not require the intensity of Medical Case Management per RWGA Quality Management guidelines. Service Linkage is both office-based and field based. Service Linkage Workers are expected to coordinate activities with referral sources where newly-diagnosed or not-in-care PLWHA may be identified, including 1:1 case conferences with testing site personnel to ensure the successful transition of referrals into Primary Care Services. Such incoming referral coordination includes meeting prospective clients at the referring Provider location in order to develop rapport with individuals prior to the individual's initial Primary Care appointment and ensuring such new intakes to Primary Care services have sufficient support to make the often difficult transition into ongoing primary medical care. Service Linkage also includes follow-up to re-engage lost-to-care patients. Lost-to-care patients are those patients who have not returned for scheduled appointments with Provider nor have provided Provider with updated information about their current Primary Medical Care provider (in the situation where patient may have obtained alternate service from another medical provider). Contractor must document efforts to re-engage lost-to-care patients prior to closing patients in the CPCDMS. Service Linkage extends the capability of existing programs by providing "hands-on" outreach and linkage to care services to those PLWHA who are not currently accessing primary medical care services. Service Linkage includes the issuance of bus pass vouchers and gas cards per published RWGA guidelines. Service Linkage complements and extends the service delivery capability of Medical Case Management services.
Agency Requirements:	**Providers and system must be Medicaid/Medicare certified.** **Eligibility and Benefits Coordination:** Contractor must implement consumer-friendly, culturally and linguistically appropriate new and ongoing patient eligibility verification and benefit coordination processes that ensure accountability with Ryan White Payer of Last Resort requirements while achieving maximum utilization of eligible benefits. Eligibility processes should provide clients with a meaningful understanding of their benefits, expected out-of-pocket expenses and other information needed to ensure full and continued participation in care. **Case Management Operations and Supervision:** The Service Linkage Workers (SLW) and Medical Case Managers (MCM) must function within the clinical infrastructure of Contractor and receive ongoing supervision that meets or exceeds published Standards of Care. An MCM may supervise SLWs.

Staff Requirements:	Contractor is responsible for ensuring that services are provided by State licensed internal medicine and OB/GYN physicians, specialty care physicians, psychiatrists, registered nurses, nurse practitioners, vocational nurses, pharmacists, physician assistants, clinical nurse specialists, physician extenders with a colposcopy provider qualification, x-ray technologists, State licensed dieticians, licensed social worker and ancillary health care providers in accordance with appropriate State licensing and/or certification requirements and with knowledge and experience of HIV disease. In addition, Contractor must ensure the following staff requirements are met: **Outpatient Psychiatric Services:** Director of the Program must be a Board Certified Psychiatrist. Licensed and/or Certified allied health professionals (Licensed Psychologists, Physicians, Psychiatric Nurse Practitioners, Licensed Master Social Workers, Licensed Professional Counselors, Licensed Marriage and Family Therapists, Certified Alcohol and Drug Abuse Counselors, etc.) must be used in all treatment modalities. Documentation of the Director's credentials, licensures and certifications must be included in the proposal. Documentation of the Allied Health professional licensures and certifications must be included in the proposal appendices. **Medication and Adherence Education:** The program must utilize an RN, LVN, PA, NP, pharmacist or MD licensed by the State of Texas, who has at least two (2) years paid experience in the preceding five (5) years in HIV/AIDS care, to provide the educational services. Licensed social workers who have at least two (2) years paid experience in the preceding five (5) years in HIV/AIDS care may also provide adherence education and counseling. **Medical Case Management:** The program must utilize a state licensed Social Worker to provide Medical Case Management Services. The Contractor must maintain the assigned number of Medical Case Management FTEs throughout the contract term. **Contractor must provide to RWGA the names of each Medical Case Manager and the individual assigned to supervise those Medical Case Managers by 03/30/17, and thereafter within 15 days after hire.** **Service Linkage:** The program must utilize Service Linkage Workers who have at a minimum a Bachelor's degree from an accredited college or university with a major in social or behavioral sciences. Documented paid work experience in providing client services to PLWHA may be substituted for the Bachelor's degree requirement on a 1:1 basis (1 year of documented paid experience may be substituted for 1 year of college). All Service Linkage Workers must have a minimum of one (1) year paid work experience with PLWHA. Contractor must maintain the assigned number of Service Linkage FTEs throughout the contract term. **Contractor must provide to**

	RWGA the names of each Service Linkage Worker and the individual assigned to supervise those Service Linkage Workers by 03/30/17, and thereafter within 15 days after hire. **Supervision of Case Managers:** The Service Linkage Workers and Medical Case Managers must function within the clinical infrastructure of Contractor and receive ongoing supervision that meets or exceeds Houston EMA/HSDA Part A/B Standards of Care for Service Linkage and Medical Case Management as applicable. An MCM may supervise SLWs.
Special Requirements: **RWGA Only**	**All primary medical care services must meet or exceed current United States DHHS Treatment Guidelines for the treatment and management of HIV disease.** Contractor must provide all required program components - Primary Medical Care, Medical Case Management and Service Linkage (non-medical Case Management) services. **Primary Medical Care Services:** Services funded under this grant cannot be used to supplant insurance or Medicare/Medicaid reimbursements for such services. Clients eligible for such reimbursement may not be billed to this contract. Medicare and private insurance co-payments may be eligible for reimbursement under Ryan White Health Insurance Assistance (HINS) program guidelines. Patients needing such assistance should be referred to the local Ryan White-funded HINS provider for assistance. Under no circumstances may the Contractor bill the County for the difference between the reimbursement from Medicaid, Medicare or Third Party insurance and the fee schedule under the contract. Furthermore, potential clients who are Medicaid/Medicare eligible or have other Third Party payers may not be denied services or referred elsewhere by the Contractor based on their reimbursement status (i.e. Medicaid/Medicare eligible clients may not be referred elsewhere in order that non-Medicaid/Medicare eligible clients may be added to the contract). Failure to serve Medicaid/Medicare eligible clients based on their reimbursement status will be grounds for the immediate termination of contract. **Diagnostic Procedures:** A single Diagnostic Procedure limited to procedures on the approved list of diagnostic procedures (see below) without prior County approval. Approved diagnostic procedures will be reimbursed at invoice cost. Part A and Part A/MAI-funded programs must refer to the RWGA website for the most current list of approved diagnostic procedures and corresponding codes: www.hcphes.org/rwga. **Diagnostic procedures not listed on the website must have prior approval by RWGA.** **Outpatient Psychiatric Services:** Client must not be eligible for

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

	shall be distributed as follows: **Expiration of Current Bus Pass:** In those situation wherein the bus pass expiration date does not coincide with the CPCDMS registration update the Contractor must distribute METRO bus pass vouchers to eligible clients upon the expiration of the current bus pass or when a Value-based bus card has been expended on eligible transportation needs. Contractor may issue METRO bus passes to eligible clients living outside the METRO service area in those situations where the Contractor has documented in the client record that the client will utilize the METRO system to access needed HIV-related health care services located in the METRO service area.

FY 2017 Houston EMA/HSDA Ryan White Part A/MAI Service Definition

FY 2018 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/08/17**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
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Step in Process: **Steering Committee**		Date: **06/01/17**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Assurance Committee**		Date: **05/18/17**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMTN Workgroup**	Date: **04/25/17**
Recommendations:	Financial Eligibility: PriCare=300%, MCM/SLW=none
1. Accept the service category definition as presented and keep financial eligibility the same; and ask the Office of Support to provide training on the Needs Assessment findings to case managers.	
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HRSA Service Category:	**Medical Case Management**
Local Service Category:	**Clinical Case Management (CCM)**
Budget Type:	**Fee for Service**
Budget Requirements or Restrictions:	Not applicable.
HRSA Service Category Definition:	***Medical Case Management services (including treatment adherence)*** are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication.
Local Service Category Definition:	**Clinical Case Management**: Identifying and screening clients who are accessing HIV-related services from a clinical delivery system that provides Mental Health treatment/counseling and/or Substance Abuse treatment services; assessing each client's medical and psychosocial history and current service needs; developing and regularly updating a clinical service plan based upon the client's needs and choices; implementing the plan in a timely manner; providing information, referrals and assistance with linkage to medical and psychosocial services as needed; monitoring the efficacy and quality of services through periodic reevaluation; advocating on behalf of clients to decrease service gaps and remove barriers to services helping clients develop and utilize independent living skills and strategies. Assist clients in obtaining needed resources, including bus pass vouchers and gas cards per published HCPH/RWGA policies.
Target Population (age, gender, geographic, race, ethnicity, etc.):	Services will be available to eligible HIV-infected clients residing in the Houston EMA with priority given to clients most in need. All clients who receive services will be served without regard to age, gender, race, color,

	religion, national origin, sexual orientation, or handicap. Services will target low income individuals with HIV/AIDS who demonstrate multiple medical, mental health, substance use/abuse and psychosocial needs including, but not limited to: mental health counseling (i.e. professional counseling), substance abuse treatment, primary medical care, specialized care, alternative treatment, medications, placement in a medical facility, emotional support, basic needs for food, clothing, and shelter, transportation, legal services and vocational services. Services will also target clients who cannot function in the community due to barriers which include, but are not limited to, mental illness and psychiatric disorders, drug addiction and substance abuse, extreme lack of knowledge regarding available services, inability to maintain financial independence, inability to complete necessary forms, inability to arrange and complete entitlement and medical appointments, homelessness, deteriorating medical condition, illiteracy, language/cultural barriers and/or the absence of speech, sight, hearing, or mobility. *Clinical Case Management* is intended to serve eligible clients, especially those underserved or unserved population groups which include: African American, Hispanic/Latino, Women and Children, Veteran, Deaf/Hard of Hearing, Substance Abusers, Homeless and Gay/Lesbian/Transsexual.
Services to be Provided:	Provision of Clinical Case Management activities performed by the Clinical Case Manager. *Clinical Case Management* is a working agreement between a client and a Clinical Case Manager for a defined period of time based on the client's assessed needs. *Clinical Case Management* services include performing a comprehensive assessment and developing a clinical service plan for each client; monitoring plan to ensure its implementation; and educating client regarding wellness, medication and health care compliance in order to maximize benefit of mental health and/or substance abuse treatment services. The *Clinical Case Manager* serves as an advocate for the client and as a liaison with mental health, substance abuse and medical treatment providers on behalf of the client. The Clinical Case Manager ensures linkage to mental health, substance abuse, primary medical care and other client services as indicated by the clinical service plan. The Clinical Case Manager will perform *Mental Health* and *Substance Abuse/Use Assessments* in accordance with RWGA Quality Management guidelines. Service plan must reflect an ongoing discussion of mental health treatment and/or substance abuse treatment, primary medical care and medication adherence, per client need. *Clinical Case Management is* both office and community-based. Clinical Case Managers will interface with the primary medical care delivery system as necessary to ensure services are integrated with, and complimentary to, a client's medical treatment plan.
Service Unit Definition(s):	One unit of service is defined as 15 minutes of direct client services and allowable charges.

Financial Eligibility:	Refer to the RWPC's approved *Financial Eligibility for Houston EMA Services*.
Client Eligibility:	HIV-infected individuals residing in the Houston EMA.
Agency Requirements:	*Clinical Case Management* services will comply with the HCPH/RWGA published Clinical Case Management Standards of Care and policies and procedures as published and/or revised, including linkage to the CPCDMS data system. *Clinical Case Management Services* must be provided by an agency with a documented history of, and current capacity for, providing mental health counseling services or substance abuse treatment services to PLWH/A in the Houston EMA. Subrecipient must clearly demonstrate it has provided mental health treatment services (e.g. professional counseling) or substance abuse treatment services in the previous calendar or grant year to individuals with an HIV diagnosis. Acceptable documentation for such treatment activities includes standardized reporting documentation from the County's *CPCDMS* or Texas Department of State Health Services' *ARIES* data systems, Ryan White Services Report (RSR), SAMSHA or TDSHS/SAS program reports or other verifiable published data. Data submitted to meet this requirement is subject to audit by HCPH/RWGA prior to an award being recommended. **Agency-generated non-verifiable data is not acceptable.** In addition, subrecipient must demonstrate it has the capability to continue providing mental health treatment and/or substance abuse treatment services for the duration of the contract term and any subsequent one-year contract renewals. Acceptable documentation of such continuing capability includes current funding from Ryan White (all Parts), TDSHS HIV-related funding (Ryan White, State Services, State-funded Substance Abuse Services), SAMSHA and other ongoing federal, state and/or public or private foundation HIV-related funding for mental health treatment and/or substance abuse treatment services. Proof of such funding must be available and is subject to independent verification by HCPH/RWGA. Loss of funding and corresponding loss of capacity to provide mental health counseling or substance abuse treatment services as applicable may result in the termination of Clinical Case Management Services awarded under this service category. Continuing eligibility for Clinical Case Management Services funding is explicitly contingent on subrecipient maintaining verifiable capacity to provide mental health counseling or substance abuse treatment services as applicable to PLWH/A during the contract term. **Subrecipient must be Medicaid and Medicare Certified**.
Staff Requirements:	Clinical Case Managers must spend at least 42% (867 hours per FTE) of their time providing direct case management services. Direct case management services include any activities with a client (face-to-face or by

	telephone), communication with other service providers or significant others to access client services, monitoring client care, and accompanying clients to services. Indirect activities include travel to and from a client's residence or agency, staff meetings, supervision, community education, documentation, and computer input. Direct case management activities must be documented in the Centralized Patient Care Data Management System (CPCDMS) according to CPCDMS business rules. *Must comply with applicable HCPH/RWGA Houston EMA/HSDA Part A/B Ryan White Standards of Care:* Minimum Qualifications: **Clinical Case Managers** must have at a minimum a Bachelor's degree from an accredited college or university with a major in social or behavioral sciences and have a current and in good standing State of Texas license (LBSW, LSW, LMSW, LCSW, LPC, LPC-I, LMFT, LMFT-A or higher level of licensure). The Clinical Case Manager may supervise the Service Linkage Worker. CCM targeting Hispanic PLWHA must demonstrate both written and verbal fluency in Spanish. Supervision: The **Clinical Case Manager** (CCM) must function with the clinical infrastructure of the subrecipient and receive supervision in accordance with the CCM's licensure requirements. At a minimum, the CCM must receive ongoing supervision that meets or exceeds HCPH/RWGA published Ryan White Part A/B Standards of Care for Clinical Case Management. If subrecipient also has Service Linkage Workers funded under Ryan White Part A the CCM may supervise the Service Linkage Worker(s). Supervision provided by a CCM that is not client specific is considered **indirect time** and is not billable.
Special Requirements:	Subrecipient must employ full-time Clinical Case Managers. Prior approval must be obtained from RWGA to split full-time equivalent (FTE) CCM positions among other contracts or to employ part-time staff. **Subrecipient must provide to RWGA the names of each Clinical Case Manager and the program supervisor no later than 3/30/17. Subrecipient must inform RWGA in writing of any changes in personnel assigned to contract within seven (7) business days of change.** Subrecipient must comply with CPCDMS data system business rules and procedures. Subrecipient must perform CPCDMS new client registrations and registration updates for clients needing ongoing case management services as well as those clients who may only need to establish system of care eligibility. Subrecipient must issue bus pass vouchers in accordance with HCPHES/RWGA policies and procedures.

FY 2018 RWPC "How to Best Meet the Need" Decision Process

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Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Steering Committee**		Date: **06/01/17**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Assurance Committee**		Date: **05/18/17**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMTN Workgroup**		Date: **04/25/17**
Recommendations:	Financial Eligibility: none	
1. Accept the service category definition as presented and keep financial eligibility the same.		
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Service Linkage at Testing Sites (Revision Date: 03/03/14)	
HRSA Service Category Title: **RWGA Only**	**Non-medical Case Management**
Local Service Category Title:	**A. Service Linkage targeted to Not-In-Care and Newly-Diagnosed PLWHA in the Houston EMA/HDSA** **Not-In-Care PLWHA** are individuals who know their HIV status but have not been actively engaged in outpatient primary medical care services for more than six (6) months. **Newly-Diagnosed** PLWHA are individuals who have learned their HIV status within the previous six months and are not currently receiving outpatient primary medical care or case management services as documented in the CPCDMS data system. **B.** ***Youth targeted Service Linkage, Care and Prevention:*** Service Linkage Services targeted to Youth (13 – 24 years of age), including a focus on not-in-care and newly-diagnosed Youth in the Houston EMA. *Not-In-Care PLWHA are Youth who know their HIV status but have not been actively engaged in outpatient primary medical care services in the previous six (6) months. *Newly-Diagnosed Youth are Youth who have learned their HIV status within the previous six months and are not currently receiving outpatient primary medical care or case management services as documented in the CPCDMS data system.
Budget Type: **RWGA Only**	Fee-for-Service
Budget Requirements or Restrictions: **RWGA Only**	Early intervention services, including HIV testing and Comprehensive Risk Counseling Services (CRCS) must be supported via alternative funding (e.g. TDSHS, CDC) and may not be charged to this contract.
HRSA Service Category Definition: **RWGA Only**	***Case Management (non-Medical)*** includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does. ***Early intervention services (EIS)*** include counseling individuals with respect to HIV/AIDS; testing (including tests to confirm the presence of the disease, tests to diagnose to extent of immune deficiency, tests to provide information on appropriate therapeutic measures); referrals; other clinical and diagnostic services regarding HIV/AIDS; periodic medical evaluations for individuals with HIV/AIDS; and providing therapeutic measures.
Local Service Category Definition:	**A.** ***Service Linkage:*** Providing allowable Ryan White Program outreach and service linkage activities to newly-diagnosed and/or

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

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

	programs with a documented track record of identifying Not-In-Care and/or newly-diagnosed PLWHA by providing "hands-on" outreach and linkage to care services to those PLWHA who are not currently accessing primary medical care services. In order to ensure linkage to an ongoing support system, eligible clients identified funded under this contract, including clients who may obtain their medical services through non-Ryan White-funded programs, must be transferred to a Ryan White-funded Primary Medical Care, Clinical Case Management or Service Linkage program within 90 days of initiation of services as documented in both ECLIPS and CPCDMS data systems. Those clients who choose to access primary medical care from a non-Ryan White source, including private physicians, may receive ongoing service linkage services from provider or must be transferred to a Clinical (CCM) or Primary Care/Medical Case Management site per client need and the preference of the client**.** **GOAL (B):** This effort will continue a program of ***Service Linkage, Care and Prevention to Engage HIV Seropositive Youth*** targeting youth (ages 13-24) with a focus on Youth of color. This service is designed to reach HIV seropositive youth of color not engaged in clinical care and to link them to appropriate clinical, supportive, and preventive services. The specific objectives are to: (1) conduct outreach (service linkage) to assist seropositive Youth learn their HIV status, (2) link HIV-infected Youth with primary care services, and (3) prevent transmission of HIV infection from targeted clients.
Service Unit Definition(s): **RWGA Only**	One unit of service is defined as 15 minutes of direct client services and allowable charges.
Financial Eligibility:	Refer to the RWPC's approved *FY 2015 Financial Eligibility for Houston EMA Services*.
Client Eligibility:	Not-In-Care and/or newly-diagnosed HIV-infected individuals residing in the Houston EMA.
Agency Requirements:	**Service Linkage** services will comply with the HCPHES/RWGA published **Service Linkage** Standards of Care and policies and procedures as published and/or revised, including linkage to the CPCDMS data system. Agency must comply with all applicable City of Houston DHHS *ECLIPS* and RWGA/HCPHES *CPCDMS* business rules and policies & procedures. **Service Linkage** targeted to Not-In-Care and/or newly diagnosed PLWHA must be planned and delivered in coordination with local HIV prevention/outreach programs to avoid duplication of services and be designed with quantified program reporting that will accommodate local effectiveness evaluation. Contractor must document established linkages with agencies that serve HIV-infected clients or serve individuals who are members of high-risk population

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

FY 2018 RWPC "How to Best Meet the Need" Decision Process

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Step in Process: **Steering Committee**		Date: **06/01/17**
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Step in Process: **Quality Assurance Committee**		Date: **05/18/17**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMTN Workgroup**		Date: **04/25/17**
Recommendations:	Financial Eligibility: none	
1. Accept the service category definition as presented and keep financial eligibility the same.		
2.		
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Category Definition - DSHS State Services Grant
September 1, 2016 - August 31, 2017

Local Service Category:	**Early Intervention Services – Incarcerated**
Amount Available**:**	**To be determined**
Unit Cost	
Budget Requirements or Restrictions **(TRG Only)**:	Maximum 10% of budget for Administrative Cost. No direct medical costs may be billed to this grant.
DSHS Service Category Definition:	Support of Early Intervention Services (EIS) that include identification of individuals at points of entry and access to services and provision of: • HIV Testing and Targeted counseling • Referral services • Linkage to care • Health education and literacy training that enable clients to navigate the HIV system of care These services must focus on expanding key points of entry and documented tracking of referrals. Counseling, testing, and referral activities are designed to bring HIV-positive individuals into Outpatient Ambulatory Medical Care. The goal of EIS is to decrease the number of underserved individuals with HIV/AIDS by increasing access to care. EIS also provides the added benefit of educating and motivating clients on the importance and benefits of getting into care. Individuals found to be HIV-negative should be referred to appropriate prevention services.
Local Service Category Definition:	This service includes the connection of incarcerated in the Harris County Jail into medical care, the coordination of their medical care while incarcerated, and the transition of their care from Harris County Jail to the community. Services must include: assessment of the client, provision of client education regarding disease and treatment, education and skills building to increase client's health literacy, establishment of THMP/ADAP post-release eligibility (as applicable), care coordination with medical resources within the jail, care coordination with service providers outside the jail, and discharge planning.
Target Population (age, gender, geographic, race, ethnicity, etc.):	Services are for all HIV/AIDS infected individuals incarcerated in The Harris County Jail.
Services to be Provided:	Services include but are not limited to CPCDMS registration/update, assessment, provision of client education, coordination of medical care services provided while incarcerated, medication regimen transition, multidisciplinary team review, discharge planning, and referral to community resources.
Service Unit Definition(s) **(TRG Only)**:	One unit of service is defined as 15 minutes of direct client services or coordination of care on behalf of client.
Financial Eligibility:	Due to incarceration, no income or residency documentation is required.
Client Eligibility:	HIV-positive incarcerated resident of the Harris County Jail.
Agency Requirements **(TRG Only)**:	As applicable. the agency's facility(s) shall be appropriately licensed or certified as required by Texas Department of State Health Services, for the provision of HIV Early Intervention Services, including phlebotomy services. Agency/staff will establish memoranda of understanding (MOUs) with key points of entry into care to facilitate access to care for those who test positive. Agency must execute Memoranda of Understanding with Ryan White funded Outpatient Ambulatory Medical Care providers. The

Category Definition - DSHS State Services Grant
September 1, 2016 - August 31, 2017

	Administrative Agency must be notified in writing if any OAMC providers refuse to execute an MOU.
Staff Requirements:	Not Applicable.
Special Requirements **(TRG Only)**:	Must comply with the Houston EMA/HSDA Standards of Care. The agency must comply with **the DSHS Early Intervention Services Standards of Care**. The agency must have policies and procedures in place that comply with the standards ***prior*** to delivery of the service.

Category Definition - DSHS State Services Grant
September 1, 2016 - August 31, 2017

FY 2018 RWPC "How to Best Meet the Need" Decision Process

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Step in Process: **HTBMTN Workgroup**	Date: **04/25/17**
Recommendations:	Financial Eligibility: none
1. Accept the service category definition as presented and keep financial eligibility the same.	
2.	
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FY 2018 Houston EMA/HSDA Ryan White Part A Service Definition **Emergency Financial Assistance – Pharmacy Assistance** (Revised April 2017)	
HRSA Service Category Title: **RWGA Only**	Emergency Financial Assistance
Local Service Category Title:	Emergency Financial Assistance – Pharmacy Assistance
Budget Type: **RWGA Only**	Hybrid Fee-for-Service
Budget Requirements or Restrictions: **RWGA Only**	Direct cash payments to clients are not permitted. It is expected that all other sources of funding in the community for emergency financial assistance will be effectively used and that any allocation of RWHAP funds for these purposes will be as the payer of last resort, and for limited amounts, uses, and periods of time. Continuous provision of an allowable service to a client should not be funded through emergency financial assistance.
HRSA Service Category Definition: **RWGA Only**	*Emergency Financial Assistance* provides limited one-time or short-term payments to assist the RWHAP client with an emergent need for paying for essential utilities, housing, food (including groceries, and food vouchers), transportation, and medication. Emergency financial assistance can occur as a direct payment to an agency or through a voucher program.
Local Service Category Definition:	Emergency Financial Assistance – Pharmacy Assistance provides limited one-time and/or short-term 14-day supply of pharmaceuticals to patients otherwise ineligible for medications through private insurance, Medicaid/Medicare, State ADAP, SPAP or other sources. One refill for up to 14-day supply available with RWGA prior approval. Allowable medications are only those on the Houston EMA Ryan White Part A Formulary. HIV-related medication services are the provision of physician or physician-extender prescribed HIV medications to prevent serious deterioration of health. Does not include drugs available to the patient from other programs or payers or free of charge or medications available over the counter (OTC) without prescription. Contractor must offer all medications on the Texas ADAP formulary.
Target Population (age, gender, geographic, race, ethnicity, etc.):	Services will be available to eligible HIV-infected clients residing in the Houston EMA/HSDA.
Services to be Provided:	Contractor must: Provide pharmacy services on-site or through an established contractual relationship that meets all requirements. Alternate (off-site) approaches must be approved prior to implementation by RWGA. Either directly, or via subcontract with an eligible 340B Pharmacy program entity, must: Ensure a comprehensive financial intake application to determine client eligibility for this program to insure that these funds are used as a last resort for purchase of medications. Ensure the documented capability of interfacing with the Texas HIV Medication Program operated by the Texas Department of State Health Services. This

	capability must be fully documented and is subject to independent verification by RWGA. Ensure medication assistance provided to clients does not duplicate services already being provided in the Houston area. The process for accomplishing this must be fully documented and is subject to independent verification by RWGA. Ensure, either directly or via a 340B Pharmacy Program Provider, at least 2 years of continuous documented experience in providing HIV/AIDS medication programs utilizing Ryan White Program or similar public sector funding. This experience must be documented and is subject to independent verification by RWGA. Ensure all medications are purchased via a qualified participant in the federal 340B Drug Pricing Program and Prime Vendor Program, administered by the HRSA Office of Pharmacy Affairs. Note: failure to maintain 340B or Prime Vendor drug pricing may result in a negative audit finding, cost disallowance or termination of contract awarded. Contractor must maintain 340B Program participation throughout the contract term. All eligible medications must be purchased in accordance with Program 340B guidelines and program requirements. Ensure Houston area HIV/AIDS service providers are informed of this program and how the client referral and enrollment processes functions. Contractor must maintain documentation of such marketing efforts. Implement a consistent process to enroll eligible patients in available pharmaceutical company Patient Assistance Programs prior to using Ryan White Part A funded Emergency Financial Assistance – Pharmacy Assistance or LPAP resources. Ensure information regarding the program is provided to PLWHA, including historically under-served and unserved populations (e.g., African American, Hispanic/Latino, Asian, Native American, Pacific Islander) and women not currently obtaining prescribed HIV and HIV-related medications.
Service Unit Definition(s): **RWGA Only**	A unit of service = a transaction involving the filling of a prescription or any other allowable HIV treatment medication need ordered by a qualified medical practitioner. The transaction will involve at least one item being provided for the client, but can be any multiple. The cost of medications provided to the client must be invoiced at actual cost.
Financial Eligibility:	Refer to the RWPC's approved *FY 2017 Financial Eligibility for Houston EMA/HSDA Services*.
Client Eligibility:	PLWHA residing in the Houston EMA (prior approval required for non-EMA clients).
Agency Requirements:	Contractor must provide all required program components - Primary Medical Care, Medical Case Management, Service Linkage (non-medical Case Management), Local Pharmacy Assistance Program (LPAP), and Emergency Financial Assistance-Pharmacy services.
Staff Requirements:	Must meet all applicable Houston EMA/HSDA Part A/B Standards of Care.
Special Requirements: **RWGA Only**	Not Applicable.

FY 2018 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/08/17**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Steering Committee**		Date: **06/01/17**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Assurance Committee**		Date: **05/18/17**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMTN Workgroup**	Date: **04/17/17**
Recommendations:	Financial Eligibility:
1. Accept the proposed local service category definition for **Pharmacy Assistance** with the following: change '7-day supply' to '14-day supply with the option for a one-time 14-day refill if needed, with RWGA approval'.	
2.	
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Service Category Definition
Ryan White Part B Grant -- April 1, 2017 - March 31, 2018
DSHS State Services Grant -- September 1, 2016 - August 31, 2017

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

Service Category Definition
Ryan White Part B Grant -- April 1, 2017 - March 31, 2018
DSHS State Services Grant -- September 1, 2016 - August 31, 2017

Agency Requirements **(TRG Only)**:	Agency must: • Provide a comprehensive financial intake/application to determine client eligibility for this program to insure that these funds are used as a last resort in order for the client to utilize his/her existing insurance or be eligible to purchase a qualified health plan through the Marketplace. • Clients will not be put on wait lists nor will Health Insurance Premium and Cost Sharing Assistance services be postponed or denied due to funding without notifying the Administrative Agency. • Conduct marketing in-services with Houston area HIV/AIDS service providers to inform them of this program and how the client referral and enrollment processes function. • Establish formal written agreements with all Houston HSDA Ryan White-funded (Part A, B, C, D) primary care, mental health and substance abuse provider agencies to enable clients of these agencies to enroll in Health Insurance assistance at his/her primary care, mental health or substance abuse provider site. (i.e. No need for client to physically present to Health Insurance provider.) • Utilizes the RW Planning Council-approved prioritization of cost sharing assistance when limited funds warrant it (premiums take precedence). o **Priority Ranking of Requests (in descending order)**: ▪ HIV medication co-pays and deductibles (medications on the Texas ADAP formulary) ▪ Non-HIV medication co-pays and deductibles ▪ Co-payments for provider visits (eg. physician visit and/or lab copayments) ▪ Medicare Part D (Rx) premiums ▪ APTC Tax Liability ▪ Out of Network out-of-pocket expenses • Utilizes the RW Planning Council –approved consumer out-of-pocket methodology.
Special Requirements **(TRG Only)**:	Must comply with the Houston EMA/HSDA Standards of Care and, pending the most current DSHS guidance, client must: • Purchase Silver Level Plan with formulary equivalency • Take advance premium credit • No assistance for Out of Network out-of-pocket expenses without prior approval of the Administrative Agent. Must comply with DSHS Interim Guidance. Must comply with updated guidance from DSHS. Must comply with the Eastern HASA Health Insurance Assistance Policy and Procedure (HIA-1701).

Service Category Definition
Ryan White Part B Grant -- April 1, 2017 - March 31, 2018
DSHS State Services Grant -- September 1, 2016 - August 31, 2017

FY 2018 RWPC "How to Best Meet the Need" Decision Process

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Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Steering Committee**		Date: **06/01/17**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Assurance Committee**		Date: **05/18/17**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMTN Workgroup**	Date: **04/25/17**
Recommendations:	Financial Eligibility: 0 - 400% and ACA plans must have a subsidy
1. Accept the service category definition as presented and keep financial eligibility the same.	
2.	
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Health Insurance Co-Payments and Co-Insurance Assistance (Revision Date: 5/21/15)	
HRSA Service Category Title:	**Health Insurance Premium and Cost Sharing Assistance**
Local Service Category Title:	**Health Insurance Co-Payments and Co-Insurance**
Budget Type**:**	**Hybrid Fee for Service**
Budget Requirements or Restrictions:	Agency must spend no more than 20% of funds on disbursement transactions. The remaining 80% of funds must be expended on the actual cost of the payment(s) disbursed.
HRSA Service Category Definition**:**	***Health Insurance Premium & Cost Sharing Assistance*** is the provision of financial assistance for eligible individuals living with HIV to maintain a continuity of health insurance or to receive medical benefits under a health insurance program. This includes premium payments, risk pools, co-payments, and deductibles.
Local Service Category Definition:	A program of financial assistance for the payment of health insurance premiums, deductibles, co-insurance, co-payments and tax liability payments associated with Advance Premium Tax Credit (APTC) reconciliation to enable eligible individuals with HIV disease to utilize their existing third party or public assistance (e.g. Medicare) medical insurance. Co-Payment: A cost-sharing requirement that requires the insured to pay a specific dollar amount for each unit of service. Co-Insurance: A cost-sharing requirement that requires the insured to pay a percentage of costs for covered services/prescription Deductible: A cost-sharing requirement that requires the insured to pay a certain amount for health care or prescription, before the prescription drug plan or other insurance begins to pay. Premium: The amount paid by the insured to an insurance company to obtain or maintain and insurance policy. APTC Tax Liability: The difference paid on a tax return if the advance credit payments that were paid to a health care provider were more than the actual eligible credit.
Target Population (age, gender, geographic, race, ethnicity, etc.):	All Ryan White eligible clients with 3rd party insurance coverage (COBRA, private policies, Qualified Health Plans, CHIP, Medicaid, Medicare and Medicare Supplemental) within the Houston EMA.
Services to be Provided:	Provision of financial assistance with premiums, deductibles, co-insurance, and co-payments. Also includes tax liability payments associated with APTC reconciliation up to 50% of liability with a $500 maximum.
Service Unit Definition(s):	1 unit of service = A payment of a premium, deductible, co-

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

FY 2018 RWPC "How to Best Meet the Need" Decision Process

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Step in Process: **Steering Committee**		Date: **06/01/17**
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Step in Process: **Quality Assurance Committee**		Date: **05/18/17**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMTN Workgroup**	Date: **04/25/17**
Recommendations:	Financial Eligibility: 0 - 400% and ACA plans must have a subsidy
1. Accept the service category definition as presented and keep financial eligibility the same.	
2.	
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Service Category Definition - Ryan White Part B Grant
April 1, 2017 - March 31, 2018

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

Service Category Definition - Ryan White Part B Grant
April 1, 2017 - March 31, 2018

	care techniques, ongoing monitoring of patients' physical condition and communication with attending physicians (s), personal care, and diagnostics testing. • **Other Therapeutic Services:** Services to include recreational activities (fine/gross motor skills and cognitive development), replacement of durable medical equipment, information referral, peer support, and transportation. • **Nutrition:** Services to include evaluation and counseling, supplemental nutrition, and daily nutritious meals. • **Education:** Services to include instructional workshops of HIV related topics and life skills. Services will be provided at least Monday through Friday for a minimum of 10 hours/day.
Service Unit Definition(s):	A unit of service is defined as one (1) visit/day of care for one (1) client for a minimum of four hours. Services consist of medical health care and social services at a licensed adult day.
Financial Eligibility:	Income at or below 300% of Federal Poverty Guidelines
Client Eligibility:	HIV positive individuals at least 18 years of age residing within the Houston HSDA.
Agency Requirements:	Must be licensed by the Texas Department of Aging and Disability Services (DADS) as an Adult Day Care provider.
Staff Requirements:	• **Skilled Nursing Services** must be provided by a Licensed Vocational or Registered Nurse. • **Other Therapeutic Services** are provided by paraprofessionals, such as an activities coordinator, and counselors (LPC, LMSW, and LMFTA). • **Nutritional Services** are provided by a Registered Dietician and food managers. • **Education Services** are provided by a health educator.
Special Requirements:	Must comply with the Houston EMA/HSDA Standards of Care. The agency must comply with **the DSHS Home and Community-Based Health Services Standards of Care**. The agency must have policies and procedures in place that comply with the standards ***prior*** to delivery of the service.

Service Category Definition - Ryan White Part B Grant
April 1, 2017 - March 31, 2018

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Step in Process: **Steering Committee**		Date: **06/01/17**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Assurance Committee**		Date: **05/18/17**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMTN Workgroup**	Date: **04/25/17**
Recommendations:	Financial Eligibility: 300%
1. Accept the service category definition as presented and keep financial eligibility the same.	
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Service Category Definition - DSHS State Services Grant
September 1, 2016 - August 31, 2017

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

Service Category Definition - DSHS State Services Grant
September 1, 2016 - August 31, 2017

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

Service Category Definition - DSHS State Services Grant
September 1, 2016 - August 31, 2017

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

Service Category Definition - DSHS State Services Grant
September 1, 2016 - August 31, 2017

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Step in Process: **Steering Committee**		Date: **06/01/17**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Assurance Committee**		Date: **05/18/17**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMTN Workgroup**	Date: **04/25/17**
Recommendations:	Financial Eligibility: 300%
1. Accept the service category definition as presented and keep financial eligibility the same.	
2.	
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Service Category Definition - DSHS State Services Grant
September 1, 2016 - August 31, 2017

Local Service Category:	**Linguistics Services**
Amount Available**:**	**To be determined**
Unit Cost**:**	
Budget Requirements or Restrictions **(TRG Only)**:	Maximum of 10% of budget for Administrative Cost.
DSHS Service Category Definition	Support for Linguistic Services includes interpretation (oral) and translation (written) services, provided by qualified individuals as a component of HIV service delivery between the provider and the client, when such services are necessary to facilitate communication between the provider and client and/or support delivery of Ryan White-eligible services. Linguistic Services include interpretation/translation services provided by qualified interpreters to HIV-positive individuals (including those who are deaf/hard of hearing and non-English speaking individuals) for the purpose of ensuring communication between client and providers while accessing medical and Ryan White fundable support services that have a direct impact on primary medical care. These standards ensure that language is not barrier to any client seeking HIV related medical care and support; and linguistic services are provided in a culturally appropriate manner. Services are intended to be inclusive of all cultures and sub-cultures and not limited to any particular population group or sets of groups. They are especially designed to assure that the needs of racial, ethnic, and linguistic populations severely impacted by the HIV epidemic receive quality, unbiased services.
Local Service Category Definition:	To provide one hour of interpreter services including, but not limited to, sign language for deaf and /or hard of hearing and native language interpretation for monolingual HIV positive clients.
Target Population (age, gender, geographic, race, ethnicity, etc.):	HIV/AIDS-infected individuals living within the Houston HIV Service Delivery Area (HSDA).
Services to be Provided:	Services include language translation and signing for deaf and/or hearing impaired HIV+ persons. Services exclude Spanish Translation Services.
Service Unit Definition(s) **(TRG Only)**:	A unit of service is defined as one hour of interpreter services to an eligible client.
Financial Eligibility:	Income at or below 300% Federal Poverty Guidelines.
Client Eligibility:	HIV positive resident of Houston HSDA
Agency Requirements **(TRG Only)**:	Any qualified and interested agency may apply and subcontract actual interpretation services out to various other qualifying agencies.
Staff Requirements:	ASL interpreters must be certified. Language interpreters must have completed a forty (40) hour community interpreter training course approved by the DSHS.
Special Requirements **(TRG Only)**:	Must comply with the Houston EMA/HSDA Standards of Care. The agency must comply with **the DSHS Linguistic Services Standards of Care**. The agency must have policies and procedures in place that comply with the standards ***prior*** to delivery of the service.

Service Category Definition - DSHS State Services Grant
September 1, 2016 - August 31, 2017

FY 2018 RWPC "How to Best Meet the Need" Decision Process

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Step in Process: **Quality Assurance Committee**		Date: **05/18/17**
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Step in Process: **HTBMTN Workgroup**	Date: **04/25/17**
Recommendations:	Financial Eligibility: 300%
1. Accept the service category definition as presented and keep financial eligibility the same.	
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FY 2017 Houston EMA/HSDA Ryan White Part A Service Definition

Medical Nutritional Therapy (Last Review/Approval Date: 6/3/16)	
HRSA Service Category Title: **RWGA Only**	**Medical Nutritional Therapy**
Local Service Category Title:	**Medical Nutritional Therapy and Nutritional Supplements**
Budget Type: **RWGA Only**	**Hybrid**
Budget Requirements or Restrictions: **RWGA Only**	***Supplements:*** An individual client may not exceed $1,000.00 in supplements annually without **prior** approval by RWGA. ***Nutritional Therapy:*** An individual nutritional education/counseling session lasting a minimum of 45 minutes. Provision of professional (licensed registered dietician) education/counseling concerning the therapeutic importance of foods and nutritional supplements that are beneficial to the wellness and improved health conditions of clients. Medically, it is expected that symptomatic or mildly symptomatic clients will be seen once every 12 weeks while clients with higher acuity will be seen once every 6 weeks.
HRSA Service Category Definition: **RWGA Only**	***Medical nutrition therapy*** is provided by a licensed registered dietitian outside of a primary care visit **and may include the provision of nutritional supplements.**
Local Service Category Definition:	***Supplements:*** Up to a 90-day supply at any given time, per client, of approved nutritional supplements that are listed on the Houston EMA/HSDA Nutritional Supplement Formulary. Nutritional counseling must be provided for each disbursement of nutritional supplements. ***Nutritional Therapy:*** An individual nutritional education/counseling session lasting a minimum of 45 minutes. Provision of professional (licensed registered dietician) education/counseling concerning the therapeutic importance of foods and nutritional supplements that are beneficial to the wellness and improved health conditions of clients. Medically, it is expected that symptomatic or mildly symptomatic clients will be seen once every 12 weeks while clients with higher acuity will be seen once every 6 weeks. Services must be provided under written order from a state licensed medical provider (MD, DO or PA) with prescribing privileges and must be based on a written nutrition plan developed by a licensed registered dietician.
Target Population (age, gender, geographic, race, ethnicity, etc.):	HIV/AIDS infected persons living within the Houston Eligible Metropolitan Area (EMA) or HIV Service Delivery Area (HSDA).
Services to be Provided:	***Supplements:*** The provision of nutritional supplements to eligible clients with a written referral from a licensed physician or PA that specifies frequency, duration and amount and includes a written nutritional plan prepared by a licensed, registered dietician. *Nutritional Supplement Disbursement Counseling* is a component of *Medical Nutritional Therapy*. *Nutritional Supplement Disbursement*

	Counseling is a component of the disbursement transaction and is defined as the provision of information by a licensed registered dietitian about therapeutic nutritional and/or supplemental foods that are beneficial to the wellness and increased health condition of clients provided in conjunction with the disbursement of supplements. Services may be provided either through educational or counseling sessions. Also included in this service are follow up sessions with clients' Primary Care provider regarding the effectiveness of the supplements. The number of sessions for each client shall be determined by a written assessment conducted by the Licensed Dietitian but may not exceed twelve (12) sessions per client per contract year. ***Medical Nutritional Therapy:*** Service must be provided under written order of a state licensed medical provider (MD, DO, PA) with prescribing privileges and must include a written plan developed by state licensed registered dietician. Client must receive a full range of medical nutritional therapy services including, but not limited to, diet history and recall; estimation of nutrition intake; assessment of weight change; calculation of nutritional requirements related to specific medication regimes and disease status, meal preparation and selection suggestions; calorie counts; evaluation of clinically appropriate laboratory results; assessment of medication-nutrient interactions; and bio-impedance assessment. If patient evaluation indicates the need for interventions such as nutritional supplements, appetite stimulants, or treatment of underlying pathogens, the dietician must share such findings with the patient's primary medical provider (MD, DO or PE) and provide recommendations. Clients needing additional nutritional resources will be referred to case management services as appropriate and/or local food banks. Provider must furnish information on this service category to at least the health care providers funded by Ryan White Parts A, B, C and D and TDSHS State Services.
Service Unit Definition(s): **RWGA Only**	***Supplements:*** One (1) unit of service = a single visit wherein an eligible client receives allowable nutritional supplements (up to a 90 day supply) and nutritional counseling by a licensed dietician as clinically indicated. A visit wherein the client receives counseling but no supplements is not a billable disbursement transaction. ***Medical Nutritional Therapy:*** An individual nutritional counseling session lasting a minimum of 45 minutes.
Financial Eligibility:	Refer to the RWPC's approved *FY 2017 Financial Eligibility for Houston EMA Services*.
Client Eligibility:	***Nutritional Supplements:*** HIV-infected and documentation that the client is actively enrolled in primary medical care.

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

FY 2018 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/08/17**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Steering Committee**		Date: **06/01/17**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Assurance Committee**		Date: **05/18/17**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMTN Workgroup**	Date: **04/25/17**
Recommendations:	Financial Eligibility: 300%
1. Accept the service category definition as presented and keep financial eligibility the same.	
2.	
3.	

Service Category Definition - DSHS State Services Grant
September 1, 2016 - August 31, 2017

Local Service Category:	**Mental Health Services**
Amount Available**:**	**To be determined**
Unit Cost	
Budget Requirements or Restrictions **(TRG Only)**:	Maximum of 10% of budget for Administrative Cost.
DSHS Service Category Definition	Mental Health Services include psychological and psychiatric treatment and counseling services offered to individuals with a diagnosed mental illness, conducted in a group or individual setting, based on a detailed treatment plan, and provided by a mental health professional licensed or authorized within the State to provide such services, typically including psychiatrists, psychologists, and licensed clinical social workers. Mental health counseling services includes outpatient mental health therapy and counseling (individual and family) provided solely by Mental Health Practitioners licensed in the State of Texas. Mental health services include: • Mental Health Assessment • Treatment Planning • Treatment Provision • Individual psychotherapy • Family psychotherapy • Conjoint psychotherapy • Group psychotherapy • Psychiatric medication assessment, prescription and monitoring • Psychotropic medication management • Drop-In Psychotherapy Groups • Emergency/Crisis Intervention General mental health therapy, counseling and short-term (based on the mental health professionals judgment) bereavement support is available for non-HIV infected family members or significant others.
Local Service Category Definition:	**Individual Therapy/counseling** is defined as 1:1 or family-based crisis intervention and/or mental health therapy provided by a licensed mental health practitioner to an eligible HIV positive or HIV/AIDS affected individual. **Support Groups** are defined as professionally led (licensed therapists or counselor) groups that comprise HIV positive individuals, family members, or significant others for the purpose of providing emotional support directly related to the stress of caring for an HIV positive person.
Target Population (age, gender, geographic, race, ethnicity, etc.):	HIV/AIDS infected and affected individuals living within the Houston HIV Service Delivery Area (HSDA).
Services to be Provided:	Agencies are encouraged to have available to clients all modes of counseling services, i.e., crisis, individual, family, and group. Sessions may be conducted in-home. Agency must provide professional support group sessions led by a licensed counselor.
Service Unit Definition(s) **(TRG Only)**:	**Individual and Family Crisis Intervention and Therapy:** A unit of service is defined as an individual counseling session lasting a minimum of 45 minutes. **Group Therapy:** A unit of service is defined as one (1) eligible client attending 90 minutes of group therapy. The minimum time allowable for a single group session is 90

Service Category Definition - DSHS State Services Grant
September 1, 2016 - August 31, 2017

	minutes and maximum time allowable for a single group session is 120 minutes. No more than one unit may be billed per session for an individual or group session. A minimum of three (3) clients must attend a group session in order for the group session to eligible for reimbursement. **Consultation:** One unit of service is defined as 15 minutes of communication with a medical or other appropriate provider to ensure case coordination.
Financial Eligibility:	Income at or below 300% Federal Poverty Guidelines.
Client Eligibility:	For individual therapy session, HIV positive or the affected significant other of an HIV positive person, resident of Houston HSDA. HIV positive client must have a current DSM diagnosis eligible for reimbursement under the State Medicaid Plan. Client must not be eligible for services from other programs or providers (i.e. MHMRA of Harris County) or any other reimbursement source (i.e. Medicaid, Medicare, Private Insurance) unless the client is in crisis and cannot be provided immediate services from the other programs/providers. In this case, clients may be provided services, as long as the client applies for the other programs /providers, until the other programs/providers can take over services. Medicaid/Medicare, Third Party Payer and Private Pay status of clients receiving services under this grant must be verified by the provider prior to requesting reimbursement under this grant. For support group sessions, client must be either an HIV positive person or the significant other of an HIV positive person. Affected significant other is eligible for services only related to the stress of caring for an HIV positive significant other.
Agency Requirements **(TRG Only)**:	Agency must provide assurance that the mental health practitioner shall be supervised by a licensed therapist qualified by the State to provide clinical supervision. This supervision should be documented through supervision notes. Keep attendance records for group sessions. Must provide 24-hour access to a licensed counselor for current clients with emotional emergencies. Clients eligible for Medicaid or 3rd party payer reimbursement may not be billed to grant funds. Medicare Co-payments may be billed to the contract as ½ unit of service. Documentation of at least one therapist certified by Medicaid/Medicare on the staff of the agency must be provided in the proposal. All funded agencies must maintain the capability to serve and seek reimbursement from Medicaid/Medicare throughout the term of their contract. Potential clients who are Medicaid/ Medicare eligible may not be denied services by a funded agency based on their reimbursement status (Medicaid/Medicare eligible clients may not be referred elsewhere in order that non-Medicaid/Medicare eligible clients may be added to this grant). Failure to serve Medicaid/Medicare eligible clients based on their reimbursement status will be grounds for the immediate termination of the provider's contract.

Service Category Definition - DSHS State Services Grant
September 1, 2016 - August 31, 2017

	Must comply with the State Services Standards of Care. Must provide a plan for establishing criteria for prioritizing participation in group sessions and for termination from group participation. Providers and system must be Medicaid/Medicare certified to ensure that Ryan White funds are the payer of last resort.
Staff Requirements:	It is required that counselors have the following qualifications: Licensed Mental Health Practitioner by the State of Texas (LCSW, LMSW, LPC PhD, Psychologist, or LMFT). At least two years experience working with HIV disease or two years work experience with chronic care of a catastrophic illness. Counselors providing family sessions must have at least two years experience in family therapy. Counselors must be covered by professional liability insurance with limits of at least $300,000 per occurrence.
Special Requirements **(TRG Only)**:	All mental health interventions must be based on proven clinical methods and in accordance with legal and ethical standards. The importance of maintaining confidentiality is of critical importance and cannot be overstated unless otherwise indicated based on Federal, state and local laws and guidelines (i.e. abuse, self or other harm). All programs must comply with the Health Insurance Portability and Accountability Act (HIPAA) standards for privacy practices of protected health information (PHI) information. Medicare and private insurance co-payments are eligible for reimbursement under this grant (in this situation the agency will be reimbursed the client's co-payment only, not the cost of the session which must be billed to Medicare and/or the Third party payer). Extensions will be addressed on an individual basis when meeting the criteria of counseling directly related to HIV illness. Under no circumstances will the agency be reimbursed more than two (2) units of individual therapy per client in any single 24-hour period. Agency should develop services that focus on the Special Populations identified in the *2012 Houston Area Comprehensive Plan for HIV Prevention and Care Services* including Adolescents, Homeless, Incarcerated & Recently Released (IRR), Injection Drug Users (IDU), Men who Have Sex with Men (MSM), and Transgender populations. Additionally, services should focus on increasing access for individuals living in rural counties. Must comply with the Houston EMA/HSDA Standards of Care. The agency must comply with **the DSHS Mental Health Services Standards of Care**. The agency must have policies and procedures in place that comply with the standards ***prior*** to delivery of the service.

Service Category Definition - DSHS State Services Grant
September 1, 2016 - August 31, 2017

FY 2018 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/08/17**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Steering Committee**		Date: **06/01/17**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Assurance Committee**		Date: **05/18/17**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMTN Workgroup**	Date: **04/25/17**
Recommendations:	Financial Eligibility: 300%
1. Accept the service category definition as presented and keep financial eligibility the same.	
2.	
3.	

Service Category Definition - Ryan White Part B Grant
April 1, 2017 - March 31, 2018

Local Service Category:	**Oral Health Care**
Amount Available:	**To be determined**
Unit Cost**:**	
Budget Requirements or Restrictions **(TRG Only)**:	Maximum of 10% of budget for Administrative Costs
Local Service Category Definition:	Restorative dental services, oral surgery, root canal therapy, fixed and removable prosthodontics; periodontal services includes subgingival scaling, gingival curettage, osseous surgery, gingivectomy, provisional splinting, laser procedures and maintenance. Oral medication (including pain control) for HIV patients 15 years old or older must be based on a comprehensive individual treatment plan. Prosthodontics services to HIV infected individuals including but not limited to examinations and diagnosis of need for dentures, crowns, bridgework and implants, diagnostic measurements, laboratory services, tooth extraction, relines and denture repairs. Emergency procedures will be treated on a walk-in basis as availability and funding allows. Funded Oral Health Care providers are permitted to provide necessary emergency care regardless of a client's annual benefit balance. If a provider cannot provide adequate services for emergency care, the patient should be referred to a hospital emergency room.
Target Population (age, gender, geographic, race, ethnicity, etc.):	HIV/AIDS infected individuals residing within the Houston HIV Service Delivery Area (HSDA).

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

Service Unit Definition(s) **(TRG Only)**:	General Dentistry: A unit of service is defined as one (1) dental visit which includes restorative dental services, oral surgery, root canal therapy, fixed and removable prosthodontics; periodontal services includes subgingival scaling, gingival curettage, osseous surgery, gingivectomy, provisional splinting, laser procedures and maintenance. Oral medication (including pain control) for HIV patients 15 years old or older must be

Service Category Definition - Ryan White Part B Grant
April 1, 2017 - March 31, 2018

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

Service Category Definition - Ryan White Part B Grant
April 1, 2017 - March 31, 2018

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Step in Process: **Council**		Date: **06/08/17**
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Step in Process: **Steering Committee**		Date: **06/01/17**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Assurance Committee**		Date: **05/18/17**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMTN Workgroup**	Date: **04/25/17**
Recommendations:	Financial Eligibility:
1. Accept the service category definition as presented and keep financial eligibility the same.	
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3.	

FY 2017 Houston EMA/HSDA Ryan White Part A/MAI Service Definition

Oral Health/Rural (Last Review/Approval Date: 6/3/16)	
HRSA Service Category Title: **RWGA Only**	**Oral Health**
Local Service Category Title:	**Oral Health – Rural (North)**
Budget Type: **RWGA Only**	**Unit Cost**
Budget Requirements or Restrictions: **RWGA Only**	Not Applicable
HRSA Service Category Definition: **RWGA Only**	**Oral health care** includes diagnostic, preventive, and therapeutic services provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries, and other trained primary care providers.
Local Service Category Definition:	Restorative dental services, oral surgery, root canal therapy, fixed and removable prosthodontics; periodontal services includes subgingival scaling, gingival curettage, osseous surgery, gingivectomy, provisional splinting, laser procedures and maintenance. Oral medication (including pain control) for HIV patients 15 years old or older must be based on a comprehensive individual treatment plan. Prosthodontics services to HIV-infected individuals including, but not limited to examinations and diagnosis of need for dentures, diagnostic measurements, laboratory services, tooth extractions, relines and denture repairs.
Target Population (age, gender, geographic, race, ethnicity, etc.):	HIV/AIDS infected individuals residing in Houston Eligible Metropolitan Area (EMA) or Health Service Delivery Area (HSDA) counties other than Harris County. Comprehensive Oral Health services targeted to individuals residing in the northern counties of the EMA/HSDA, including Waller, Walker, Montgomery, Austin, Chambers and Liberty Counties.
Services to be Provided:	Services must include, but are not limited to: individual comprehensive treatment plan; diagnosis and treatment of HIV-related oral pathology, including oral Kaposi's Sarcoma, CMV ulceration, hairy leukoplakia, xerostomia, lichen planus, aphthous ulcers and herpetic lesions; diffuse infiltrative lymphocytosis; standard preventive procedures, including oral hygiene instruction, diet counseling and home care program; oral prophylaxis; restorative care; oral surgery including dental implants; root canal therapy; fixed and removable prosthodontics including crowns, bridges and implants; periodontal services, including subgingival scaling, gingival curettage, osseous surgery, gingivectomy, provisional splinting, laser procedures and maintenance. Proposer must have mechanism in place to provide oral pain medication as prescribed for clients by the dentist.
Service Unit Definition(s): **RWGA Only**	General Dentistry: A unit of service is defined as one (1) dental visit which includes restorative dental services, oral surgery, root canal therapy, fixed and removable prosthodontics; periodontal

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

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Step in Process: **Steering Committee**		Date: **06/01/17**
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Step in Process: **Quality Assurance Committee**		Date: **05/18/17**
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Step in Process: **HTBMTN Workgroup**	Date: **04/25/17**
Recommendations:	Financial Eligibility: 300%
1. Accept the service category definition as presented and keep financial eligibility the same.	
2.	
3.	

FY 2017 Houston EMA/HSDA Ryan White Part A Service Definition

Outreach Services – Primary Care Re-Engagement (DRAFT)	
HRSA Service Category Title: **RWGA Only**	Outreach Services
Local Service Category Title:	Outreach Services – Primary Care Re-Engagement
Budget Type: **RWGA Only**	Fee-for-Service
Budget Requirements or Restrictions: **RWGA Only**	TBD
HRSA Service Category Definition: **RWGA Only**	*Outreach Services* include the provision of the following three activities: Identification of people who do not know their HIV status and linkage into Outpatient/Ambulatory Health Services, Provision of additional information and education on health care coverage options, Reengagement of people who know their status into Outpatient/Ambulatory Health Services
Local Service Category Definition:	Providing allowable Ryan White Program outreach and service linkage activities to newly-diagnosed and/or Lost-to-Care PLWHA who know their status but are not actively engaged in outpatient primary medical care with information, referrals and assistance with medical appointment setting, mental health, substance abuse and psychosocial services as needed; advocating on behalf of clients to decrease service gaps and remove barriers to services helping clients develop and utilize independent living skills and strategies. Assist clients in obtaining needed resources, including bus pass vouchers and gas cards per published HCPHES/RWGA policies. Outreach services must be conducted at times and in places where there is a high probability that individuals with HIV infection and/or exhibiting high-risk behavior, designed to provide quantified program reporting of activities and outcomes to accommodate local evaluation of effectiveness, planned and delivered in coordination with local and state HIV prevention outreach programs to avoid duplication of effort, targeted to populations known, through local epidemiologic data or review of service utilization data or strategic planning processes, to be at disproportionate risk for HIV infection.
Target Population (age, gender, geographic, race, ethnicity, etc.):	Services will be available to eligible HIV-infected clients residing in the Houston EMA/HSDA with priority given to clients most in need. Services will target clients who cannot function in the community due to barriers which include, but are not limited to, mental illness and psychiatric disorders, drug addiction and substance abuse, extreme lack of knowledge regarding available services, inability to maintain financial independence, inability to complete necessary forms, inability to arrange and complete entitlement and medical appointments, homelessness, deteriorating medical condition, illiteracy, language/cultural barriers and/or the absence of speech, sight, hearing, or mobility.

FY 2017 Houston EMA/HSDA Ryan White Part A Service Definition

Services to be Provided:	Outreach service is field based. Outreach workers are expected to coordinate activities with newly-diagnosed or lost-to-care PLWHA, including locations outside of primary care clinic in order to develop rapport with individuals and ensuring intakes to Primary Care services have sufficient support to make the often difficult transition into ongoing primary medical care. Lost-to-care patients are those patients who have not returned for scheduled appointments with Provider nor have provided Provider with updated information about their current Primary Medical Care provider (in the situation where patient may have obtained alternate service from another medical provider). Contractor must document efforts to re-engage lost-to-care patients prior to closing patients in the CPCDMS.
Service Unit Definition(s): **RWGA Only**	TBD
Financial Eligibility:	Refer to the RWPC's approved *FY 2017 Financial Eligibility for Houston EMA/HSDA Services*.
Client Eligibility:	PLWHA residing in the Houston EMA (prior approval required for non-EMA clients).
Agency Requirements:	Outreach Services must function within the clinical infrastructure of Contractor and receive ongoing supervision that meets or exceeds published Standards of Care.
Staff Requirements:	Must meet all applicable Houston EMA/HSDA Part A/B Standards of Care.
Special Requirements: **RWGA Only**	Not Applicable.

FY 2018 RWPC "How to Best Meet the Need" Decision Process

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Step in Process: **Steering Committee**		Date: **06/01/17**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Assurance Committee**		Date: **05/18/17**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMTN Workgroup**	Date: **04/25/17**
Recommendations:	Financial Eligibility: none
1. Accept the service category definition with the understanding that there will be changes for the Quality Improvement Committee to review, and keep financial eligibility the same.	
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FY 2017 Houston EMA/HSDA State Services-R Service Definition **AIDS Drug Assistance Program Enrollment Worker at RW Care Sites** (Created Date: 4/5/2017)	
DSHS Service Category Title: **TRG Only**	Referral For Health Care/Support Services
Local Service Category Title:	A. Clinic-Based ADAP Enrollment Service Linkage Worker
Budget Type: **TRG Only**	Categorical: 1 FTE per RW Care Site; unless advised otherwise
Budget Requirements or Restrictions: **TRG Only**	Maximum of 10% of budget for Administrative Costs. A Full-Time Equivalent must be proposed at each clinic.
DSHS Service Category Definition: **TRG Only**	***ADAP Enrollment Worker*** Direct a client to a service in person or through telephone, written, or other types of communication, including management of such services where they are not provided as part of Ambulatory Outpatient Medical Care or Case Management Services.
Local Service Category Definition:	C. **PROPOSED:** AIDS Drug Assistance Program (ADAP) Enrollment Service Linkage Workers (SLWs) are collocated at Ryan-White Part A funded clinics to ensure the efficient and accurate submission of ADAP applications to the Texas HIV Medication Program (THMP). ADAP enrollment SLWs will meet with new potential and established ADAP enrollees, explain ADAP program benefits and requirements, assist clients and or staff with the submission of complete, accurate ADAP applications. ADAP enrollment SLWs will ensure all annual Re-Certifications are submitted by the last day of the client's birth month and semi-annual Attestations are completed six months later to ensure there is no lapse in ADAP eligibility and loss of benefits. Other responsibilities will include: • Track the status of all pending applications and promptly follow-up with applicants regarding missing documentation or other needed information to ensure completed applications are submitted as quickly as feasible; • Maintain communication with designated THMP staff to quickly resolve any missing or questioned application information or documentation to ensure any issues affecting pending applications are resolved as quickly as possible; ADAP Enrollment workers will maintain relationships through the Ryan White ADAP Network (RWAN). Guidelines and or instructions will vary according to agency internal processes and as agreed upon by the AA.
Target Population (age, gender, geographic, race, ethnicity, etc.):	HIV/AIDS infected individuals residing within the Houston HIV Service Delivery Area (HSDA).
Services to be Provided:	Meet with new potential and established ADAP enrollees; explain ADAP program benefits and requirements; and assist clients and or staff with the submission of complete, accurate ADAP applications, including but not limited to: • Identifying and screening clients including screening for third party payer and potential abuse; completing the comprehensive THMP intake including determination of client eligibility for the ADAP program in accordance with the THMP eligibility policies including Modified Adjusted Gross Income (MAGI).

	• Obtain, maintain, and submit the required documentation for client application including residency, income, and the THMP Medical Certification Form (MCF). • Conduct the 6-month attestations for all enrolled clients in accordance with THMP policies. Obtain, maintain, and submit to THMP all updated eligibility documentation. • Conduct annual Re-Certifications for enrolled clients in accordance with THMP policies. Obtain, maintain, and submit to THMP all updated eligibility documentation. • Proactively contact current ADAP enrollees 60-90 days prior to the enrollee's re-certification or attestation deadline to ensure all necessary documentation is gathered to complete the re-certification/attestation on or before the deadline. • Ensure annual Re-certifications are submitted by the last day of client's birth month and semi-annual Attestations are completed six months later to ensure there is no lapse in ADAP eligibility and loss of benefits. Provide initial education to applicants about the THMP including, but not limited to: • Discuss the confidentiality of the process including that THMP regards all information in the application as confidential and the information cannot be released, except as allowed by law or as specifically designated by the client. Applicants should realize that their physician and pharmacist would also be aware of their diagnosis. • Discuss how applicants who have been approved by the THMP for assistance may be required to pay a $5.00 co-payment fee per prescription to the participating pharmacy for each month's supply at the time the drug is dispensed and the availability of financial assistance for the dispensing fee. • Discuss how applicants who are eligible for Medicaid assistance benefits must first utilize and exhaust their monthly Medicaid pharmacy benefits in order to be eligible to receive medications from the Program. Medicaid eligible applicants shall be assigned to the nearest available participating THMP pharmacy outlet to receive medication. The pharmacy will not charge the $5.00 co-payment to the patient. • Discuss the use of participating pharmacies and the procedure for how applicants will receive medications through the program. Submit completed applications via the most efficient method available (e.g. the Public Health Information Network or PHIN), including ARIES, once the document upload capability is rolled out. Maintain communication with designated THMP staff to quickly resolve any missing or questioned application information or documentation to ensure any issues affecting pending applications are resolved as quickly as possible. Participate in ongoing training and technical assistance provide by DSHS, THMP, or the RWAN.
Service Unit Definition(s): **TRG Only**	One unit of service is defined as 15 minutes of direct client services and allowable charges.
Financial Eligibility:	Adjusted gross income less than 200% of the Federal Poverty Level* (adjusted annually).

	** A spend-down calculation is applied to applicants' gross incomes to determine an adjusted gross income for eligibility screening.* DSHS THMP Eligibility requirements https://www.dshs.texas.gov/hivstd/meds/
Client Eligibility:	Proof of Texas residency; Proof of being HIV-positive; Uninsured or underinsured for prescription drugs; and under the care of a Texas-licensed physician who prescribes the medication(s). DSHS THMP Eligibility requirements https://www.dshs.texas.gov/hivstd/meds/
Agency Requirements:	Agency will ensure documentation meets TDSHS and Agency requirements all activities performed on behalf of ADAP enrollees including re-certifications and attestations Agency will track the status of all pending applications and promptly follow-up with applicants regarding missing documentation or other needed information to ensure completed applications are submitted as quickly as feasible. Agency will ensure that completed applications undergo secondary review by a peer ADAP Enrollment Worker or Supervisor before submission. This peer or supervisor must meet all requirements of the ADAP enrollment service linkage worker, including required training. Agency will provide aggregated data regarding ADAP enrollment service linkage worker performance measures to TRG as directed.
Staff Requirements:	**Education:** To be defined locally, but must have at minimum a high school degree or equivalency; **Experience:** • Must have documented experience (paid, internship and/or as a volunteer) working with Persons Living with HIV/AIDS or other chronic health conditions. • Experience in performing intake/eligibility, referral/linkage and/or basic assessments of client needs preferred. **Skills**: • Must demonstrate proficiency in the use of PC-based word processing and data entry to ensure ADAP applications and re-certifications are completed accurately in a timely manner; • Must demonstrate the ability to quickly establish rapport with clients in a respectful manner consistent with the health literacy, preferred language, and culture of prospective and current ADAP enrollees; • Must demonstrate general knowledge of, or the ability to learn, health care insurance literacy (third party insurance and Affordable Care Act (ACA) Marketplace plans); • Bilingual (English/Spanish) preferred; • AEWs working in care systems with a high prevalence of non-English speaking clients must be fluent in the preferred language of the high prevalence non-English speaking clients; **Training:** • Must complete all THMP ADAP training modules within 30 days of hire; • Must complete all training required of Agency new hires, including any training required by TDSHS HIV Care Services Branch Standards of Care, within established timeframes;

	• Must complete all annual or periodic training or re-certifications within established timeframes;
Special Requirements: **TRG Only**	There will be 1 FTE; unless advised otherwise, placed at each funded Part A primary care clinic. Meet the established guidance by DSHS for the ADAP Enrollment Worker. Follow the HHSC Uniform Terms and Conditions. THMP regards all information in the application as confidential. No information that could identify a client (including 11-character codes) will be released, except as allowed by law or as specifically designated by the client. THMP regards the information in the application as part of the applicant's medical record. Funded agencies should have physical security and administrative controls to safeguard the confidentiality of the applications and other means of identifying the individual. Applications can be expedited for pregnant women, post-incarcerated persons, minors, those with CD4 counts under 100, and other special circumstances. Eligibility and access to medications for newborn infants and pregnant women is considered a program priority. <u>Required Performance Measures</u> 1. Enroll all ADAP-eligible clients in Texas HIV Medication Program (THMP) within 30 days of initiation of care. 2. Recertify all existing clients in THMP without lapse in coverage. 3. Maintain 95-100% approval rate for initial application submissions 4. Maintain 100% Ryan White Eligibility for all Ryan White clients at the contracted agency. 5. Ensure that up-to-date eligibility information (in compliance with established guidance) is maintained for all clients served. 6. Maintain relationships through the Ryan White ADAP/Eligibility Network (RWAN) to ensure all clients on ADAP in the HSDA are submitting accurate application 7. Utilize CPCDMS and Texas PHIN databases.

FY 2018 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/08/17**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Steering Committee**		Date: **06/01/17**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Assurance Committee**		Date: **05/18/17**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMTN Workgroup**	Date: **04/17/17**
Recommendations:	Financial Eligibility:
1. Accept the proposed local service category definition for ADAP Enrollment Workers with the understanding that it will be updated to address the different agency scenarios.	
2.	
3.	

FY 2017 Houston EMA/HSDA Ryan White Part A/MAI Service Definition

Substance Abuse Services - Outpatient (Last Review/Approval Date: 6/3/16)	
HRSA Service Category Title: **RWGA Only**	Substance Abuse Services Outpatient
Local Service Category Title:	Substance Abuse Treatment/Counseling
Budget Type: **RWGA Only**	Fee-for-Service
Budget Requirements or Restrictions: **RWGA Only**	Minimum group session length is 2 hours
HRSA Service Category Definition: **RWGA Only**	***Substance abuse services outpatient*** is the provision of medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) in an outpatient setting, rendered by a physician or under the supervision of a physician, or by other qualified personnel.
Local Service Category Definition:	Treatment and/or counseling HIV-infected individuals with substance abuse disorders delivered in accordance with State licensing guidelines.
Target Population (age, gender, geographic, race, ethnicity, etc.):	HIV-infected individuals with substance abuse disorders, residing in the Houston Eligible Metropolitan Area (EMA/HSDA).
Services to be Provided:	Services for all eligible HIV/AIDS patients with substance abuse disorders. Services provided must be integrated with HIV-related issues that trigger relapse. All services must be provided in accordance with the Texas Department of Health Services/Substance Abuse Services (TDSHS/SAS) Chemical Dependency Treatment Facility Licensure Standards. Service provision must comply with the applicable treatment standards.
Service Unit Definition(s): **RWGA Only**	**Individual Counseling:** One unit of service = one individual counseling session of at least 45 minutes in length with one (1) eligible client. **A single session lasting longer than 45 minutes qualifies as only a single unit** – no fractional units are allowed. Two (2) units are allowed for initial assessment/orientation session. **Group Counseling:** One unit of service = 60 minutes of group treatment for one eligible client. A single session must last a minimum of 2 hours. Support Groups are defined as professionally led groups that are comprised of HIV-positive individuals, family members, or significant others for the purpose of providing Substance Abuse therapy.
Financial Eligibility:	Refer to the RWPC's approved *FY 2017 Financial Eligibility for Houston EMA/HSDA Services*.
Client Eligibility:	HIV-infected individuals with substance abuse co-morbidities/disorders.
Agency Requirements:	Agency must be appropriately licensed by the State. All services must be provided in accordance with applicable Texas Department of State

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

FY 2018 RWPC "How to Best Meet the Need" Decision Process

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Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Steering Committee**		Date: **06/01/17**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Assurance Committee**		Date: **05/18/17**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMTN Workgroup**	Date: **04/25/17**
Recommendations:	Financial Eligibility: 300%
1. Accept the service category definition as presented and keep financial eligibility the same.	
2.	
3.	

FY 2017 Houston EMA/HSDA Ryan White Part A Service Definition

Medical Transportation (Van Based) (Revision Date: 03/03/14)	
HRSA Service Category Title: **RWGA Only**	**Medical Transportation**
Local Service Category Title:	**a. Transportation targeted to Urban** **b. Transportation targeted to Rural**
Budget Type: **RWGA Only**	**Hybrid Fee for Service**
Budget Requirements or Restrictions: **RWGA Only**	• Units assigned to Urban Transportation must only be used to transport clients whose residence is in Harris County. • Units assigned to Rural Transportation may only be used to transport clients who reside in Houston EMA/HSDA counties other than Harris County. • Mileage reimbursed for transportation is based on the documented distance in miles from a client's Trip Origin to Trip Destination **as documented by a standard Internet-based mapping program (i.e. Google Maps, Map Quest, Yahoo Maps) approved by RWGA.** Agency must print out and file in the client record a trip plan from the appropriate Internet-based mapping program that clearly delineates the mileage between Point of Origin and Destination (and reverse for round trips). This requirement is subject to audit by the County. • Transportation to employment, employment training, school, or other activities not directly related to a client's treatment of HIV disease is not allowable. Clients may not be transported to entertainment or social events under this contract. • Taxi vouchers must be made available for documented emergency purposes and to transport a client to a disability hearing, emergency shelter or for a documented medical emergency. • Contractor must reserve 7% of the total budget for Taxi Vouchers. • Maximum monthly utilization of taxi vouchers cannot exceed 14% of the total amount of funding reserved for Taxi Vouchers. • Emergencies warranting the use of Taxi Vouchers include: van service is unavailable due to breakdown, scheduling conflicts or inclement weather or other unanticipated event. A spreadsheet listing client's 11-digit code, age, date of service, number of trips, and reason for emergency should be kept on-site and available for review during Site Visits. • **Contractor must provide RWGA a copy of the agreement between Contractor and a licensed taxi vendor by March 30, 2015.** • All taxi voucher receipts must have the taxi company's name, the driver's name and/or identification number, number of miles driven, destination (to and from), and exact cost of trip. The Contractor will add the client's 11-digit code to the receipt and include all receipts with the monthly Contractor Expense Report

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

	from the client's principal medical provider (e.g. medical case manager or physician) is required to access van-based transportation, to be renewed every 180 days. **Medical Certifications should be maintained on-site by the provider in a single file (listed alphabetically by 11-digit code) and will be monitored at least annually during a Site Visit.** It is the Contractor's responsibility to determine whether a client resides within the METRO service area. Clients who live outside the METRO service area but within Harris County (e.g. Baytown) are not required to provide a written medical certification to access van-based transportation. All clients living in the Metro service area may receive a maximum of 4 non-certified round trips per year (including taxi vouchers). Non-certified trips will be reviewed during the annual Site Visit. Provider must maintain an up-to-date spreadsheet documenting such trips. The Contractor must implement the general transportation program in accordance with the Transportation Standards of Care that include entering all transportation services into the Centralized Patient Care Data Management System (CPCDMS) and providing eligible children with transportation services to Core Services appointments. Only actual mileage (documented per the selected Internet mapping program) transporting eligible clients from Origin to Destination will be reimbursed under this contract. The Contractor must make reasonable effort to ensure that routes are designed in the most efficient manner possible to minimize actual client time in vehicles.
Target Population (age, gender, geographic, race, ethnicity, etc.):	a. Urban Transportation: HIV/AIDS-infected and Ryan White Part A/B eligible affected individuals residing in Harris County. b. Rural Transportation: HIV/AIDS-infected and Ryan White Part A/B eligible affected individuals residing in Fort Bend, Waller, Walker, Montgomery, Austin, Colorado, Liberty, Chambers and Wharton Counties.
Services to be Provided:	To provide Medical Transportation services to access Ryan White Program defined **Core Services** for eligible individuals. Transportation will include round trips to single destinations and round trips to multiple destinations. Taxi vouchers will be provided to eligible clients only for identified emergency situations. Caregiver must be allowed to accompany the HIV-infected rider. **Eligibility for Transportation Services is determined by the client's County of residence as documented in the CPCDMS**.
Service Unit Definition(s): **RWGA Only**	One (1) unit of service = one (1) mile driven with an eligible client as passenger. Client cancellations and/or no-shows are <u>not</u> reimbursable.
Financial Eligibility:	Refer to the RWPC's approved *FY 2015 Financial Eligibility for Houston EMA Services*.
Client Eligibility:	a. Urban Transportation: Only individuals diagnosed with HIV/AIDS and Ryan White Program eligible HIV-affected individuals residing inside Harris County will be eligible for services.

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

	have completed a State approved "Safe Driving" course. Contractor must maintain documentation of the automobile liability insurance of each vehicle utilized by the program as required by state law. All vehicles must have a current Texas State Inspection. The minimum acceptable limit of automobile liability insurance is $300,000.00 combined single limit. Agency must maintain detailed records of mileage driven and names of individuals provided with transportation, as well as origin and destination of trips. ***It is the Contractor's responsibility to verify the County in which clients reside in.***
Staff Requirements	A picture identification of each driver must be posted in the vehicle utilized to transport clients. Criminal background checks must be performed on all direct service transportation personnel prior to transporting any clients. Drivers must have annual proof of a safe driving record, which shall include history of tickets, DWI/DUI, or other traffic violations. Conviction on more than three (3) moving violations within the past year will disqualify the driver. Conviction of one (1) DWI/DUI within the past three (3) years will disqualify the driver.
Special Requirements: **RWGA Only**	Individuals who qualify for transportation services through Medicaid are not eligible for these transportation services. **Contractor must ensure the following criteria are met for all clients transported by Contractor's transportation program:** Transportation Provider must ensure that clients use transportation services for an appropriate purpose through one of the following three methods: 1. Follow-up hard copy verification between transportation provider and Destination Agency (DA) program confirming use of eligible service(s), or 2. Client provides receipt documenting use of eligible services at Destination Agency on the date of transportation, or 3. Scheduling of transportation services was made by receiving agency's case manager or transportation coordinator. The verification/receipt form must at a minimum include all elements listed below: • Be on Destination Agency letterhead • Date/Time • CPCDMS client code • Name and signature of Destination Agency staff member who attended to client (e.g. case manager, clinician, physician, nurse) • Destination Agency date stamp to ensure DA issued form.

FY 2018 RWPC "How to Best Meet the Need" Decision Process

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Step in Process: **Steering Committee**		Date: **06/01/17**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **Quality Assurance Committee**		Date: **05/18/17**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMTN Workgroup**	Date: **04/25/17**
Recommendations:	Financial Eligibility: 400%
1. Accept the service category definition as presented and keep financial eligibility the same.	
2.	
3.	

FY 2017 Houston EMA/HSDA Ryan White Part A/MAI Service Definition

Vision Care (Last Review/Approval Date: 6/3/16)	
HRSA Service Category Title: **RWGA Only**	**Ambulatory/Outpatient Medical Care**
Local Service Category Title:	**Vision Care**
Budget Type: **RWGA Only**	**Fee for Service**
Budget Requirements or Restrictions: **RWGA Only**	Corrective lenses are not allowable under this category. Corrective lenses may be provided under Health Insurance Assistance and/or Emergency Financial Assistance as applicable/available.
HRSA Service Category Definition: **RWGA Only**	***Outpatient/Ambulatory medical care*** is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings. Services includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). *Primary medical care* for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies. HRSA policy notice 10-02 states funds awarded under Part A or Part B of the Ryan White CARE Act (Program) may be used for optometric or ophthalmic services under Primary Medical Care. Funds may also be used to purchase corrective lenses for conditions related to HIV infection, through either the Health Insurance Premium Assistance or Emergency Financial Assistance service categories as applicable.
Local Service Category Definition:	**Primary Care Office/Clinic Vision Care** is defined as a comprehensive examination by a qualified Optometrist or Ophthalmologist, including Eligibility Screening as necessary. A visit with a credentialed Ophthalmic Medical Assistant for any of the following is an allowable visit: • Routine and preliminary tests including Cover tests, Ishihara Color Test, NPC (Near Point of Conversion), Vision Acuity Testing, Lensometry. • Visual field testing • Glasses dispensing including fittings of glasses, visual acuity testing, measurement, segment height.

	• Fitting of contact lenses is not an allowable follow-up visit.
Target Population (age, gender, geographic, race, ethnicity, etc.):	HIV-infected individuals residing in the Houston EMA/HSDA.
Services to be Provided:	Services must be provided at an eye care clinic or Optometrist's office. Services must include but are not limited to external/internal eye health evaluations; refractions; dilation of the pupils; glaucoma and cataract evaluations; CMV screenings; prescriptions for eyeglasses and over the counter medications; provision of eyeglasses (contact lenses are not allowable); and referrals to other service providers (i.e. Primary Care Physicians, Ophthalmologists, etc.) for treatment of CMV, glaucoma, cataracts, etc. Agency must provide a written plan for ensuring that collaboration occurs with other providers (Primary Care Physicians, Ophthalmologists, etc.) to ensure that patients receive appropriate treatment for CMV, glaucoma, cataracts, etc.
Service Unit Definition(s): **RWGA Only**	One (1) unit of service = One (1) patient visit to the Optometrist, Ophthalmologist or Ophthalmic Assistant.
Financial Eligibility:	Refer to the RWPC's approved *FY 2017 Financial Eligibility for Houston EMA Services*.
Client Eligibility:	HIV-infected resident of the Houston EMA/HSDA.
Agency Requirements:	Providers and system must be Medicaid/Medicare certified to ensure that Ryan White Program funds are the payer of last resort to the extent examinations and eyewear are covered by the State Medicaid program.
Staff Requirements:	Vendor must have on staff a Doctorate of Optometry licensed by the Texas Optometry Board as a Therapeutic Optometrist.
Special Requirements: **RWGA Only**	Vision care services must meet or exceed current U.S. Dept. of Health and Human Services (HHS) guidelines for the treatment and management of HIV disease as applicable to vision care

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Step in Process: **Quality Assurance Committee**		Date: **05/18/17**
Recommendations:	Approved: Y_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
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Step in Process: **HTBMTN Workgroup**	Date: **04/25/17**
Recommendations:	Financial Eligibility: 300%
1. Accept the service category definition as presented and keep financial eligibility the same.	
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DRAFT

TARGETING FOR FY 2018 SERVICE CATEGORIES FOR RYAN WHITE PART A, B, MAI AND STATE SERVICES FUNDING

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

* Geographic targeting in rural area only.

** In an effort to provide a base line that reflects actual client utilization, for community based organizations base this percentage on the FY 2015 final expenditures that targeted African Americans, Whites and Hispanics.

*** Geographic targeting in the north only.

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

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	Documentation of Need (Sources of Data include: 2016 Needs Assessment, 2017-2021 Comp Plan, 2016 Outcome Measures, 2016 Chart Reviews, Special Studies and surveys, etc.)	Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Providers b) Clients Can we bundle this service? Has a recent capacity issue been identified?	Recommendation(s)
Part 1: Services offered by Ryan White Part A, Part B, and State Services in the Houston EMA/HSDA as of 03-17-17							
Ambulatory/Outpatient Primary Medical Care (incl. Vision):							
CBO, Adult – Part A, Including LPAP, MCM & Svc Linkage (Includes OB/GYN) *See below for Public Clinic, Rural, Pediatric, Vision* ***Workgroup 1*** ***Motion #1:*** *(Kelly/Bellard)* *Votes: Y=6; N=2;* *Abstentions = Kelly, Miertschin, Russey*	✔ Yes ___No	☒ EIIHA ☒ Unmet Need ☒ Continuum of Care EIIHA: The purpose of the HRSA EIIHA initiative is to identify the status-*unaware* and facilitate their entry into Primary Care Unmet Need: Facilitating entry/reentry into Primary Care reduces unmet need. Additionally, a criterion for met need is evidence of an ART prescription, and clients cannot access LPAP until they are enrolled in Primary Care. Continuum of Care*:* Primary Care, MCM, and LPAP	Epi: An estimated 5,448 people in the EMA are HIV+ and unaware of their status (2015). The current estimate of unmet need in the EMA is 6,333, or 24% of all PLWH (2015). Need (2016): Current # of living HIV cases in EMA: 26,041 Rank w/in 10 Core Services: *Primary Care: #1* *LPAP: #3* *Case Management: #2* Service Utilization (2015): # clients served: *Primary Care: 8,224 (5% increase v. 2015)* *LPAP: 4*,392	Primary Care: Medicaid, Medicare, RW Part D, and private providers, including federal health insurance marketplace participants LPAP: ADAP, State Pharmacy Assistance Program, Medicaid, Medicare Part D, RW Health Insurance Assistance, the public clinic's pharmacy program, private sector Patient Assistance Programs, and private pharmacy benefit programs, including federal health insurance marketplace participants	Justify the use of funds: This service category: - Is a HRSA-defined Core Medical Service - Is ranked as the #1 service need by PLWH; and use has increased - Adheres to a medical home model and is bundled with LPAP, Medical Case Management, and Service Linkage - Results in desirable health outcomes for clients who access the service - Referring and linking the status-unaware to Primary Care is the goal of the national and local EIIHA initiative	Can we make this service more efficient? No Can we bundle this service? Currently bundled with: LPAP, Medical Case Management, and Service Linkage Has a recent capacity issue been identified? No	**Motion 1:** Accept the service category definition as presented and keep financial eligibility the same: PriCare=300%, LPAP=300% + 500%, MCM/SLW=none; and ask the Office of Support to provide training on the Needs Assessment findings to case managers.

‡ Service Category for Part B/State Services only.

Service Category	**Is this a core service?** If no, how does the service support access to core services & support clients achieving improved outcomes?	**How does this service assist individuals *not in care** to access primary care?** **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	**Documentation of Need** (Sources of Data include: 2016 Needs Assessment, 2017-2021 Comp Plan, 2016 Outcome Measures, 2016 Chart Reviews, Special Studies and surveys, etc.)	**Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources** (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	**Justify the use of Ryan White Part A, Part B and State Services funds for this service.** **Is this a duplicative service or activity?**	**Service Efficiency** Can we make this service more efficient? For: a) Providers b) Clients Can we bundle this service? Has a recent capacity issue been identified?	**Recommendation(s)**
		support maintenance/retention in care and viral suppression for PLWH.	*(10% increase v. 2015) Medical Case Mgmt: 4,962 (2% decrease v. 2015) Non-Medical Case Mgmt, or Service Linkage: 6,582 (4% increase v. 2015)* Outcomes (FY2016): *Primary Care/LPAP:* 74% of Primary Care clients and 74% of LPAP clients were virally suppressed; *Medical Case Mgmt:* 76% of clients were in continuous HIV care following MCM; 71% of clients who received MCM were virally suppressed; *Non-Medical Case Mgmt, or Service Linkage:* 46% of clients were in continuous HIV care following Service Linkage	Medical Case Management: RW Part C and D Service Linkage: RW Part C and D, HOPWA, and a grant from a private foundation Covered under QHP? ✔ Yes ___No	- Referring and linking the out-of-care to Primary Care is the goal of reducing unmet need - Facilitates national, state, and local goals related to continuous HIV care, reducing unmet need, and viral load suppression - Addresses specific activities from Strategy #3 of the Comprehensive Plan and addresses certain Special Populations named in the Plan Is this a duplicative service or activity? - This service is funded locally by other public and private sources for (1) specific Special Populations (e.g., WICY), (2) those meeting income, disability, and/or age-		

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					related eligibility criteria, and (3) those with private sector health insurance.		
Public Clinic, Adult – Part A, Including LPAP, MCM & Svc Linkage (Includes OB/GYN) *See below for Rural, Pediatric, Vision* ***Workgroup 1*** ***Motion #1:*** *(Kelly/Bellard)* *Votes: Y=6; N=2;* *Abstentions = Kelly, Miertschin, Russey*	✔ Yes ___No	☒ EIIHA ☒ Unmet Need ☒ Continuum of Care EIIHA: The purpose of the HRSA EIIHA initiative is to identify the status-*unaware* and facilitate their entry into Primary Care Unmet Need: Facilitating entry/reentry into Primary Care reduces unmet need. Additionally, a criterion for met need is evidence of an ART prescription, and clients cannot access LPAP until they are enrolled in Primary Care. Continuum of Care: Primary Care, MCM, and LPAP	Epi: An estimated 5,448 people in the EMA are HIV+ and unaware of their status (2015). The current estimate of unmet need in the EMA is 6,333, or 24% of all PLWH (2015). Need (2016): Current # of living HIV cases in EMA: 26,041 Rank w/in 10 Core Services: *Primary Care: #1* *LPAP: #3* *Case Management: #2* Service Utilization (2015): # clients served: *Primary Care: 8,224* *(5% increase v. 2015)* *LPAP: 4*,392	Primary Care: Medicaid, Medicare, RW Part D, and private providers, including federal health insurance marketplace participants LPAP: ADAP, State Pharmacy Assistance Program, Medicaid, Medicare Part D, RW Health Insurance Assistance, the public clinic's pharmacy program, private sector Patient Assistance Programs, and private pharmacy benefit programs, including federal health insurance marketplace participants	Justify the use of funds: This service category: - Is a HRSA-defined Core Medical Service - Is ranked as the #1 service need by PLWH; and use has increased - Adheres to a medical home model and is bundled with LPAP, Medical Case Management, and Service Linkage - Results in desirable health outcomes for clients who access the service - Referring and linking the status-unaware to Primary Care is the goal of the national and local EIIHA initiative	Can we make this service more efficient? No Can we bundle this service? Currently bundled with: LPAP, Medical Case Management, and Service Linkage Has a recent capacity issue been identified? No	**Motion 1:** Accept the service category definition as presented and keep financial eligibility the same: PriCare=300%, LPAP=300% + 500%, MCM/SLW=none; and ask the Office of Support to provide training on the Needs Assessment findings to case managers.

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Service Category	**Is this a core service?** If no, how does the service support access to core services & support clients achieving improved outcomes?	**How does this service assist individuals *not in care** to access primary care?** **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	**Documentation of Need** (Sources of Data include: 2016 Needs Assessment, 2017-2021 Comp Plan, 2016 Outcome Measures, 2016 Chart Reviews, Special Studies and surveys, etc.)	**Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources** (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	**Justify the use of Ryan White Part A, Part B and State Services funds for this service.** **Is this a duplicative service or activity?**	**Service Efficiency** Can we make this service more efficient? For: a) Providers b) Clients Can we bundle this service? Has a recent capacity issue been identified?	**Recommendation(s)**
		support maintenance/retention in care and viral suppression for PLWH.	*(10% increase v. 2015) Medical Case Mgmt: 4,962 (2% decrease v. 2015) Non-Medical Case Mgmt, or Service Linkage: 6,582 (4% increase v. 2015)* Outcomes (FY2016): *Primary Care/LPAP:* 74% of Primary Care clients and 74% of LPAP clients were virally suppressed; *Medical Case Mgmt:* 76% of clients were in continuous HIV care following MCM; 71% of clients who received MCM were virally suppressed; *Non-Medical Case Mgmt, or Service Linkage:* 46% of clients were in continuous HIV care following Service Linkage	Medical Case Management: RW Part C and D Service Linkage: RW Part C and D, HOPWA, and a grant from a private foundation Covered under QHP? ✔ Yes ___No	- Referring and linking the out-of-care to Primary Care is the goal of reducing unmet need - Facilitates national, state, and local goals related to continuous HIV care, reducing unmet need, and viral load suppression - Addresses specific activities from Strategy #3 of the Comprehensive Plan and addresses certain Special Populations named in the Plan Is this a duplicative service or activity? - This service is funded locally by other public and private sources for (1) specific Special Populations (e.g., WICY), (2) those meeting income, disability, and/or age-		

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					related eligibility criteria, and (3) those with private sector health insurance.		
Rural, Adult – Part A, Including LPAP, MCM & Svc Linkage (Includes OB/GYN) *See below for Pediatric, Vision* ***Workgroup 1*** ***Motion #1:*** *(Kelly/Bellard)* *Votes: Y=6; N=2;* *Abstentions = Kelly, Miertschin, Russey*	✔ Yes ___No	☒ EIIHA ☒ Unmet Need ☒ Continuum of Care EIIHA: The purpose of the HRSA EIIHA initiative is to identify the status-*unaware* and facilitate their entry into Primary Care Unmet Need: Facilitating entry/reentry into Primary Care reduces unmet need. Additionally, a criterion for met need is evidence of an ART prescription, and clients cannot access LPAP until they are enrolled in Primary Care. Continuum of Care*:* Primary Care, MCM, and LPAP	Epi: An estimated 5,448 people in the EMA are HIV+ and unaware of their status (2015). The current estimate of unmet need in the EMA is 6,333, or 24% of all PLWH (2015). Need (2016): Current # of living HIV cases in EMA: 26,041 Rank w/in 10 Core Services: *Primary Care: #1* *LPAP: #3* *Case Management: #2* Service Utilization (2015): # clients served: *Primary Care: 8,224 (5% increase v. 2015)* *LPAP: 4*,392	Primary Care: Medicaid, Medicare, RW Part D, and private providers, including federal health insurance marketplace participants LPAP: ADAP, State Pharmacy Assistance Program, Medicaid, Medicare Part D, RW Health Insurance Assistance, the public clinic's pharmacy program, private sector Patient Assistance Programs, and private pharmacy benefit programs, including federal health insurance marketplace participants	Justify the use of funds: This service category: - Is a HRSA-defined Core Medical Service - Is ranked as the #1 service need by PLWH; and use has increased - Adheres to a medical home model and is bundled with LPAP, Medical Case Management, and Service Linkage - Results in desirable health outcomes for clients who access the service - Referring and linking the status-unaware to Primary Care is the goal of the national and local EIIHA initiative	Can we make this service more efficient? No Can we bundle this service? Currently bundled with: LPAP, Medical Case Management, and Service Linkage Has a recent capacity issue been identified? No	**Motion 1:** Accept the service category definition as presented and keep financial eligibility the same: PriCare=300%, LPAP=300% + 500%, MCM/SLW=none; and ask the Office of Support to provide training on the Needs Assessment findings to case managers.

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Service Category	**Is this a core service?** If no, how does the service support access to core services & support clients achieving improved outcomes?	**How does this service assist individuals *not in care** to access primary care?** **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	**Documentation of Need** (Sources of Data include: 2016 Needs Assessment, 2017-2021 Comp Plan, 2016 Outcome Measures, 2016 Chart Reviews, Special Studies and surveys, etc.)	**Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources** (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	**Justify the use of Ryan White Part A, Part B and State Services funds for this service.** **Is this a duplicative service or activity?**	**Service Efficiency** Can we make this service more efficient? For: a) Providers b) Clients Can we bundle this service? Has a recent capacity issue been identified?	**Recommendation(s)**
		support maintenance/retention in care and viral suppression for PLWH.	*(10% increase v. 2015) Medical Case Mgmt: 4,962 (2% decrease v. 2015) Non-Medical Case Mgmt, or Service Linkage: 6,582 (4% increase v. 2015)* Outcomes (FY2016): *Primary Care/LPAP:* 74% of Primary Care clients and 74% of LPAP clients were virally suppressed; *Medical Case Mgmt:* 76% of clients were in continuous HIV care following MCM; 71% of clients who received MCM were virally suppressed; *Non-Medical Case Mgmt, or Service Linkage:* 46% of clients were in continuous HIV care following Service Linkage	Medical Case Management: RW Part C and D Service Linkage: RW Part C and D, HOPWA, and a grant from a private foundation Covered under QHP? ✔ Yes ___No	- Referring and linking the out-of-care to Primary Care is the goal of reducing unmet need - Facilitates national, state, and local goals related to continuous HIV care, reducing unmet need, and viral load suppression - Addresses specific activities from Strategy #3 of the Comprehensive Plan and addresses certain Special Populations named in the Plan Is this a duplicative service or activity? - This service is funded locally by other public and private sources for (1) specific Special Populations (e.g., WICY), (2) those meeting income, disability, and/or age-		

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Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	Documentation of Need (Sources of Data include: 2016 Needs Assessment, 2017-2021 Comp Plan, 2016 Outcome Measures, 2016 Chart Reviews, Special Studies and surveys, etc.)	Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Providers b) Clients Can we bundle this service? Has a recent capacity issue been identified?	Recommendation(s)
					related eligibility criteria, and (3) those with private sector health insurance.		
Pediatric – Part A ***Workgroup 1*** ***Motion #1:*** *(Kelly/Bellard)* *Votes: Y=6; N=2;* *Abstentions = Kelly, Miertschin, Russey*	✔ Yes ___No	☒ EIIHA ☒ Unmet Need ☒ Continuum of Care EIIHA: The purpose of the HRSA EIIHA initiative is to identify the status-*unaware* and facilitate their entry into Primary Care Unmet Need: Facilitating entry/reentry into Primary Care reduces unmet need. Additionally, a criterion for met need is evidence of an ART prescription, and clients cannot access LPAP until they are enrolled in Primary Care. Continuum of Care*:* Primary Care, MCM, and LPAP	Epi: An estimated 5,448 people in the EMA are HIV+ and unaware of their status (2015). The current estimate of unmet need in the EMA is 6,333, or 24% of all PLWH (2015). Need (2016): Current # of living HIV cases in EMA: 26,041 Rank w/in 10 Core Services: *Primary Care: #1* *LPAP: #3* *Case Management: #2* Service Utilization (2015): # clients served: *Primary Care: 8,224 (5% increase v. 2015)* *LPAP: 4*,392	Primary Care: Medicaid, Medicare, RW Part D, and private providers, including federal health insurance marketplace participants LPAP: ADAP, State Pharmacy Assistance Program, Medicaid, Medicare Part D, RW Health Insurance Assistance, the public clinic's pharmacy program, private sector Patient Assistance Programs, and private pharmacy benefit programs, including federal health insurance marketplace participants	Justify the use of funds: This service category: - Is a HRSA-defined Core Medical Service - Is ranked as the #1 service need by PLWH; and use has increased - Adheres to a medical home model and is bundled with LPAP, Medical Case Management, and Service Linkage - Results in desirable health outcomes for clients who access the service - Referring and linking the status-unaware to Primary Care is the goal of the national and local EIIHA initiative	Can we make this service more efficient? No Can we bundle this service? Currently bundled with: LPAP, Medical Case Management, and Service Linkage Has a recent capacity issue been identified? No	**Motion 1:** Accept the service category definition as presented and keep financial eligibility the same: PriCare=300%, LPAP=300% + 500%, MCM/SLW=none; and ask the Office of Support to provide training on the Needs Assessment findings to case managers.

‡ Service Category for Part B/State Services only.

Service Category	**Is this a core service?** If no, how does the service support access to core services & support clients achieving improved outcomes?	**How does this service assist individuals *not in care** to access primary care?** **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	**Documentation of Need** (Sources of Data include: 2016 Needs Assessment, 2017-2021 Comp Plan, 2016 Outcome Measures, 2016 Chart Reviews, Special Studies and surveys, etc.)	**Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources** (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	**Justify the use of Ryan White Part A, Part B and State Services funds for this service.** **Is this a duplicative service or activity?**	**Service Efficiency** Can we make this service more efficient? For: a) Providers b) Clients Can we bundle this service? Has a recent capacity issue been identified?	**Recommendation(s)**
		support maintenance/retention in care and viral suppression for PLWH.	*(10% increase v. 2015) Medical Case Mgmt: 4,962 (2% decrease v. 2015) Non-Medical Case Mgmt, or Service Linkage: 6,582 (4% increase v. 2015)* Outcomes (FY2016): *Primary Care/LPAP:* 74% of Primary Care clients and 74% of LPAP clients were virally suppressed; *Medical Case Mgmt:* 76% of clients were in continuous HIV care following MCM; 71% of clients who received MCM were virally suppressed; *Non-Medical Case Mgmt, or Service Linkage:* 46% of clients were in continuous HIV care following Service Linkage	Medical Case Management: RW Part C and D Service Linkage: RW Part C and D, HOPWA, and a grant from a private foundation Covered under QHP? ✔ Yes ___No	- Referring and linking the out-of-care to Primary Care is the goal of reducing unmet need - Facilitates national, state, and local goals related to continuous HIV care, reducing unmet need, and viral load suppression - Addresses specific activities from Strategy #3 of the Comprehensive Plan and addresses certain Special Populations named in the Plan Is this a duplicative service or activity? - This service is funded locally by other public and private sources for (1) specific Special Populations (e.g., WICY), (2) those meeting income, disability, and/or age-		

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Service Category	**Is this a core service?** If no, how does the service support access to core services & support clients achieving improved outcomes?	**How does this service assist individuals *not in care** to access primary care?** **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	**Documentation of Need** (Sources of Data include: 2016 Needs Assessment, 2017-2021 Comp Plan, 2016 Outcome Measures, 2016 Chart Reviews, Special Studies and surveys, etc.)	**Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources** (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	**Justify the use of Ryan White Part A, Part B and State Services funds for this service.** **Is this a duplicative service or activity?**	**Service Efficiency** Can we make this service more efficient? For: a) Providers b) Clients Can we bundle this service? Has a recent capacity issue been identified?	**Recommendation(s)**
					related eligibility criteria, and (3) those with private sector health insurance.		
Vision – Part A ***Workgroup 1*** ***Motion #1:*** *(Torrente/Moses)* *Votes: Y=14; N=0;* *Abstentions = Russey*	☑ Yes ☐ No	☐ EIIHA ☐ Unmet Need ☒ Continuum of Care Continuum of Care: Vision services support maintenance/ retention in HIV care by increasing access to care and treatment for HIV-related and general ocular diagnoses. Untreated ocular diagnoses may act as logistical or financial barriers to HIV care.	Need (2016): Current # of living HIV cases in EMA: 26,041 Service Utilization (2016): # clients served: 2,186 *(<1% increase v. 2015)* Outcomes (FY2016): 11 diagnoses were reported for HIV-related ocular disorders in chart reviews	No known alternative funding sources exist for this service Covered under QHP?* ☐ Yes ☑ No *QHPs cover pediatric vision	No known alternative funding sources exist for this service	Can we make this service more efficient? No Can we bundle this service? Currently bundled with Primary Care Has a recent capacity issue been identified? No	**Motion 1:** Accept the service category definition as presented and keep financial eligibility the same at 300%.

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Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? *EIIHA: Early Identification of Individuals with HIV/AIDS seeks to identify the status-unaware and link them into care *Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months *Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	Documentation of Need (Sources of Data include: 2016 Needs Assessment, 2017-2021 Comp Plan, 2016 Outcome Measures, 2016 Chart Reviews, Special Studies and surveys, etc.)	Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Providers b) Clients Can we bundle this service? Has a recent capacity issue been identified?	Recommendation(s)
Clinical Case Management - Part A ***Workgroup 1*** ***Motion #1:*** *(Ross/Bellard) Votes: Y=13; N=0; Abstentions = Kelly, Russey*	✔ Yes ___No	☐ EIIHA ☒ Unmet Need ☒ Continuum of Care Unmet Need: Among PLWH with a history of unmet need, substance use is the #2 reason cited for falling out-of-care, making CCM is a strategy for preventing unmet need. CCM also addresses local priorities related to mental health and substance abuse co-morbidities Continuum of Care: CCM supports maintenance/ retention in care and viral suppression for PLWH.	Need (2016): Current # of living HIV cases in EMA: 26,041 Rank w/in 10 Core Services: #2 (Case Management - general) Service Utilization (2016): # clients served: 1,308 *(31% increase v. 2015)* Outcomes (FY2016): 40% of clients were in continuous care following receipt of CCM	RW Part C Covered under QHP? ___Yes ✔ No	Justify the use of funds: This service category: - Is a HRSA-defined Core Medical Service - Is ranked as the #2 service need by PLWH - Results in desirable health outcomes for clients who access the service - Prevents unmet need by addressing co-morbidities related to substance abuse and mental health - Facilitates national, state, and local goals related to continuous HIV care and reducing unmet need - Addresses a system-level objective (#8) from the Comprehensive Plan and addresses certain Special Populations named in the Plan Is this a duplicative service	Can we make this service more efficient? No Can we bundle this service? No Has a recent capacity issue been identified? No	**Motion 1:** Accept the service category definition as presented and keep financial eligibility the same at none.

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Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	Documentation of Need (Sources of Data include: 2016 Needs Assessment, 2017-2021 Comp Plan, 2016 Outcome Measures, 2016 Chart Reviews, Special Studies and surveys, etc.)	Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Providers b) Clients Can we bundle this service? Has a recent capacity issue been identified?	Recommendation(s)
					or activity? - This service is funded locally by other RW Parts for specific Special Populations and for clients served by specific funded agencies/programs only		
Case Management – Non-Medical - Part A (Service Linkage at testing sites) ***Workgroup 1*** ***Motion #1:*** *(Kelly/Bellard)* *Votes: Y=6; N=2;* *Abstentions = Kelly, Miertschin, Russey, Wright*	___Yes ✔ No Service Linkage at HIV testing sites provides active system navigation for newly diagnosed PLWH with an emphasis on hard-to-reach populations such as youth. Locating Service Linkage at public HIV testing sites ensures that linkage to primary care (and to other Core Medical Services) occurs immediately upon diagnosis, consistent with Test and Treat best practice.	☒ EIIHA ☒ Unmet Need ☒ Continuum of Care EIIHA: The EMA's EIIHA Strategy identifies Service Linkage as a local strategy for attaining Goals #3-4 of the national EIIHA initiative. Additionally, linking the newly diagnosed into HIV care via strategies such as Service Linkage fulfills the national, state, and local goal of linkage to HIV medical care ≤ 3 months of diagnosis. In 2015, 19% of	Need (2016): Current # of living HIV cases in EMA: 26,041 Medical, Clinical and SLW case management were not surveyed explicitly in the 2016 Needs Assessment (Case Management – General: Rank w/in 5 Support Services: #2) Service Utilization (2016): # clients served: 214 *(62% decrease v. 2015)* Outcomes (FY2016):	RW Part C and D, HOPWA, and a grant from a private foundation Covered under QHP? ___Yes ✔ No	Justify the use of funds: This service category: - Is a HRSA-defined Support Service - Results in desirable health outcomes for clients who access the service - Is a strategy for attaining national EIIHA goals locally - Prevents the newly diagnosed from having unmet need - Facilitates national, state, and local goals related to linkage to care Is this a duplicative service	Can we make this service more efficient? No Can we bundle this service? No Has a recent capacity issue been identified? No	**Motion 1:** Accept the service category definition as presented and keep financial eligibility the same at none.

‡ Service Category for Part B/State Services only.

Service Category	**Is this a core service?** If no, how does the service support access to core services & support clients achieving improved outcomes?	**How does this service assist individuals *not in care** to access primary care?** **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	**Documentation of Need** (Sources of Data include: 2016 Needs Assessment, 2017-2021 Comp Plan, 2016 Outcome Measures, 2016 Chart Reviews, Special Studies and surveys, etc.)	**Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources** (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	**Justify the use of Ryan White Part A, Part B and State Services funds for this service.** **Is this a duplicative service or activity?**	**Service Efficiency** Can we make this service more efficient? For: a) Providers b) Clients Can we bundle this service? Has a recent capacity issue been identified?	**Recommendation(s)**
		the newly diagnosed in the EMA were *not* linked within this timeframe. Unmet Need: Service Linkage at HIV testing sites is specifically designed to prevent newly diagnosed PLWH from falling out-of-care by facilitating entry into HIV primary care immediately upon diagnosis. In 2015, 12% of the newly diagnosed PLWH were not linked to care by the end of the year. Continuum of Care: Service Linkage supports linkage to care, maintenance/retention in care and viral suppression for PLWH.	Following Service Linkage, 46% of clients were in continuous HIV care, and 5% accessed HIV primary care for the first time		or activity? - This service is funded locally by other RW Parts for specific Special Populations and for clients served by specific funded agencies/programs only		

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	Documentation of Need (Sources of Data include: 2016 Needs Assessment, 2017-2021 Comp Plan, 2016 Outcome Measures, 2016 Chart Reviews, Special Studies and surveys, etc.)	Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Providers b) Clients Can we bundle this service? Has a recent capacity issue been identified?	Recommendation(s)
Early Intervention Services (EIS)‡ (Incarcerated) (Harris County Jail) ***Workgroup 3*** ***Motion #1:*** *(Ross/Boyle)* *Votes: Y=13; N=0;* *Abstentions= Starr*	✔ Yes ___No	☒ EIIHA ☒ Unmet Need ☒ Continuum of Care EIIHA: Local jail policy mandates HIV testing within 14 days of incarceration, thereby identifying status-unaware members of this population. In 2015, an estimated 386 PLWH were released from TDCJ into Harris County. During incarceration, 100% are linked to HIV care. EIS ensures that the newly diagnosed identified in jail maintain their HIV care post-release by bridging HIV infected offenders into community-based primary care. This is accomplished through care coordination by EIS staff in partnership with community-based	Need (2016): # of estimated PLWH released from TDCJ into Harris County: 386 (*2015*) Rank w/in 10 Core Services: #10 Service Utilization (2016): # clients served: 926 *(<1% decrease v. 2015)* Outcomes (2016): Of the client records reviewed, 50% of newly diagnosed clients had a discharge plan present and 81% of all client records reviewed had a discharge plan present. 46% of recently released respondents in a 2012 Special Study reported receiving EIS; 31% received a referral to a community-based primary care provider.	RW Part C provides non-targeted EIS Covered under QHP? ___Yes ✔ No	Justify the use of funds: This service category: - Is a HRSA-defined Core Medical Service - Results in desirable outcomes for clients who access the service - Links those newly diagnosed in a local EMA jail to community-based HIV primary care upon release, thereby maintaining linkage to care for and preventing unmet need in this Special Population - Addresses specific activities from Strategy #3 of the Comprehensive Plan and addresses certain Special Populations named in the Plan Is this a duplicative service or activity?	Can we make this service more efficient? No Can we bundle this service? No Has a recent capacity issue been identified? No	**Motion 1:** Accept the service category definition as presented and keep financial eligibility the same at None.

‡ Service Category for Part B/State Services only.

Service Category	**Is this a core service?** If no, how does the service support access to core services & support clients achieving improved outcomes?	**How does this service assist individuals *not in care** to access primary care?** **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	**Documentation of Need** (Sources of Data include: 2016 Needs Assessment, 2017-2021 Comp Plan, 2016 Outcome Measures, 2016 Chart Reviews, Special Studies and surveys, etc.)	**Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources** (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	**Justify the use of Ryan White Part A, Part B and State Services funds for this service.** **Is this a duplicative service or activity?**	**Service Efficiency** Can we make this service more efficient? For: a) Providers b) Clients Can we bundle this service? Has a recent capacity issue been identified?	**Recommendation(s)**
		providers/MOUs. Unmet Need: HIV infected offenders are at risk of lapsing their HIV care upon release from incarceration. EIS helps to prevent unmet need among this population by bridging HIV infected offenders into community-based primary care post-release. This is accomplished through care coordination by EIS staff in partnership with community-based providers/MOUs. Continuum of Care: EIS supports linkage to care, maintenance/retention in care and viral suppression for PLWH.	Also, ≤3 months of release from incarceration: *87% reported seeing a community-based HIV care provider; 59% reported meeting with a case manager; and 53% reported completing RW and ADAP eligibility.*		- No, there is no known alternative funding for this service as designed		

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Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	Documentation of Need (Sources of Data include: 2016 Needs Assessment, 2017-2021 Comp Plan, 2016 Outcome Measures, 2016 Chart Reviews, Special Studies and surveys, etc.)	Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Providers b) Clients Can we bundle this service? Has a recent capacity issue been identified?	Recommendation(s)
Emergency Financial Assistance (EFA) ***Workgroup - EFA*** ***Motion #1:*** *(Hawkins/Ross)* *Votes: Y=7; N=0;* *Abstentions= Artiaga, Kelly, Miertschin* ***Motion #2:*** *(Torrente/Ross)* *Votes: Y=6; N=0;* *Abstentions= Artiaga, Benoit, Kelly, Miertschin*	___Yes ✔ No Emergency Financial Assistance – Pharmacy Assistance will provided limited one-time and/or short-term 14-day supply of pharmaceuticals to patients otherwise ineligible for medications other payers.	☒ EIIHA ☒ Unmet Need ☒ Continuum of Care EIIHA: Early access to HIV medications following diagnosis is a critical component to effective service linkage and improved long-term health outcomes. EFA-Pharmacy Assistance would cover HIV medications while other payers are sought. Unmet Need: Medication provided through EFA-Pharmacy Assistance would reduce unmet need by increasing the proportion of PLWH in the Houston EMA/HSDA with access to HIV medications, a measure of met need	As EFA-Pharmacy Assistance would be a new service category, it was not evaluated in the 2016 Needs Assessment. However, when participants reported not taking HIV medication at the time of survey, this was most often because they lacked prescription drug coverage (29% of medication barriers reported). Additionally, 27% of participants reported that they experience difficulty paying for HIV medications.	While multiple other HIV medication payers exist (e.g. ADAP, PAP programs, health insurance providers), prolonged application and approval processes delay initiation or continuation of HIV medication. This service would provide HIV medications for a limited term while other payment sources are sought. Covered under QHP? ✔ Yes ____No	Justify the use of funds: This service category: - Is a HRSA-defined Support Service - Per HRSA/HAB Policy Clarification Notice (PCN) #16-02, LPAP is operated as a supplemental means of providing medication assistance when an ADAP has a restricted formulary, waiting list and/or restricted financial eligibility criteria, not when ADAP applications are pending submission or approval. Furthermore, program guidance indicates, "LPAP funds are not to be used for Emergency Financial Assistance. Emergency Financial Assistance may assist with medications not	Can we make this service more efficient? No Can we bundle this service? Per the draft Service Definition, EFA-Pharmacy Assistance would be bundled with Primary Medical Care, Medical Case Management, Service Linkage, and LPAP. Has a recent capacity issue been identified? No	**Motion 1:** Accept the proposed local service category definition for ***Pharmacy Assistance*** with the following: change '7-day supply' to '14-day supply with the option for a one-time 14-day refill if needed, with RWGA approval'. **Motion 2:** Accept the proposed special idea for the ***Compassionate Care Program***.

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Service Category	**Is this a core service?** If no, how does the service support access to core services & support clients achieving improved outcomes?	**How does this service assist individuals *not in care** to access primary care?** **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	**Documentation of Need** (Sources of Data include: 2016 Needs Assessment, 2017-2021 Comp Plan, 2016 Outcome Measures, 2016 Chart Reviews, Special Studies and surveys, etc.)	**Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources** (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	**Justify the use of Ryan White Part A, Part B and State Services funds for this service.** **Is this a duplicative service or activity?**	**Service Efficiency** Can we make this service more efficient? For: a) Providers b) Clients Can we bundle this service? Has a recent capacity issue been identified?	**Recommendation(s)**
		Continuum of Care: Short-term access to HIV medication supports medication adherence and viral suppression. Additionally, initiation of HIV medications soon after diagnosis is linked to improved long-term health outcomes, including viral suppression.			covered by the LPAP." Is this a duplicative service or activity? No, there is no known alternative funding for this service as designed		
Health Insurance Premium & Co-Pay Assistance **Part A** **Part B** **State Services** ***Workgroup 2*** ***Motion #1:*** *(Kelly/Pruitt)* *Votes: Y=6; N=1;* *Abstentions = Longoria*	✔ Yes __No	☐ EIIHA ☒ Unmet Need ☒ Continuum of Care Unmet Need: Reductions in unmet need can be aided by *preventing* PLWH from lapsing their HIV care. This service category can directly prevent unmet need by removing financial barriers to HIV care for those who are eligible for public or private health insurance. Currently,	Need (2016): Current # of living HIV cases in EMA: 26,041 Rank w/in 10 Core Services: #5 *% of RW clients with health insurance: 34% (4,603)* *% of RW clients with Marketplace coverage: 7% (884)* Service Utilization (2016): # clients served: 2,102 *(<1% decrease v. 2015)*	No known alternative funding sources exist for this service, though consumers between 100% and 400% FPL may qualify for Advanced Premium Tax Credits (subsidies). COBRA plans seems to have fewer out-of-pocket costs. Covered under QHP?	Justify the use of funds: This service category: - Is a HRSA-defined Core Medical Service - Has limited or no alternative funding source - Removes potential barriers to entry/retention in HIV care, thereby contributing to EIIHA goals and preventing unmet need - Facilitates national, state, and local goals related to	Can we make this service more efficient? Yes, see attached service definitions for changes. Can we bundle this service? No Has a recent capacity issue been identified? No	**Motion 1:** Accept the service category definition as presented and keep financial eligibility the same at 0 - 400% and ACA plans must have a subsidy.

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Service Category	**Is this a core service?** If no, how does the service support access to core services & support clients achieving improved outcomes?	**How does this service assist individuals *not in care** to access primary care?** **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	**Documentation of Need** (Sources of Data include: 2016 Needs Assessment, 2017-2021 Comp Plan, 2016 Outcome Measures, 2016 Chart Reviews, Special Studies and surveys, etc.)	**Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources** (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	**Justify the use of Ryan White Part A, Part B and State Services funds for this service.** **Is this a duplicative service or activity?**	**Service Efficiency** Can we make this service more efficient? For: a) Providers b) Clients Can we bundle this service? Has a recent capacity issue been identified?	**Recommendation(s)**
		42% of RW clients have some form of health insurance, and 6% have Marketplace coverage. This service will assist those clients to remain in HIV care via all insurance resources; This will also be utilized to assist federal health insurance marketplace participants. Continuum of Care: Health Insurance Assistance facilitates maintenance/ retention in care and viral suppression by increasing access to non-RW private and public medical and pharmaceutical coverage. The savings yielded by securing non-RW healthcare coverage for PLWH increases the amount of funding available to provide		___Yes ✔ No	retention in care and reducing unmet need - Supports federal health insurance marketplace participants Is this a duplicative service or activity? - No, there is no known alternative funding for this service as designed		

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Service Category	**Is this a core service?** If no, how does the service support access to core services & support clients achieving improved outcomes?	**How does this service assist individuals *not in care** to access primary care?** **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	**Documentation of Need** (Sources of Data include: 2016 Needs Assessment, 2017-2021 Comp Plan, 2016 Outcome Measures, 2016 Chart Reviews, Special Studies and surveys, etc.)	**Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources** (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	**Justify the use of Ryan White Part A, Part B and State Services funds for this service.** **Is this a duplicative service or activity?**	**Service Efficiency** Can we make this service more efficient? For: a) Providers b) Clients Can we bundle this service? Has a recent capacity issue been identified?	**Recommendation(s)**
		other needed services throughout the Continuum of Care.					
Home and Community-Based Services‡ (Facility-based) (Adult Day Treatment) ***Workgroup 2*** ***Motion #1:*** *(Pruitt/Russey)* *Votes: Y=6; N=0;* *Abstentions = Kelly, Moses*	✔ Yes __No	☐ EIIHA ☒ Unmet Need ☒ Continuum of Care Unmet Need: Facilitating entry into/return of the out-of-care into primary care is the intent of reducing unmet need. Adult Day Treatment contributes to this goal by providing a community-based alternative to in-patient care facilities for those with	Need (2016): Current # of living HIV cases in EMA: 26,041 Rank w/in 10 Core Services: #8 Service Utilization (2016): # clients served: 38 *(17% decrease v. 2015)* Chart Review (2016): 79% of client charts reviewed showed decreased or undetectable viral load	Medicaid Covered under QHP? ___Yes ✔ No	Justify the use of funds: This service category: - Is a HRSA-defined Core Medical Service; and use has increased - Results in desirable health outcomes for clients who access the service - Helps prevent unmet need for those with advanced HIV-related health concerns - Facilitates national, state,	Can we make this service more efficient? No Can we bundle this service? No Has a recent capacity issue been identified? No	**Motion 1:** Accept the service category definition as presented and keep financial eligibility the same at 300%.

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Service Category	**Is this a core service?** If no, how does the service support access to core services & support clients achieving improved outcomes?	**How does this service assist individuals *not in care** to access primary care?** **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	**Documentation of Need** (Sources of Data include: 2016 Needs Assessment, 2017-2021 Comp Plan, 2016 Outcome Measures, 2016 Chart Reviews, Special Studies and surveys, etc.)	**Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources** (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	**Justify the use of Ryan White Part A, Part B and State Services funds for this service.** **Is this a duplicative service or activity?**	**Service Efficiency** Can we make this service more efficient? For: a) Providers b) Clients Can we bundle this service? Has a recent capacity issue been identified?	**Recommendation(s)**
		advanced HIV-related health concerns. This, in turn, may prevent those with advanced stage illness or complex HIV-related health concerns from becoming out-of-care. In 2015, 19% of people with a Stage 3 HIV diagnosis were out-of-care in the EMA. In addition, the goal of Adult Day Treatment is to return clients to self-sufficient daily functioning, which includes maintenance in HIV care. Continuum of Care: Adult Day Treatment facilitates re-linkage and retention in care for PLWH by providing a community-based alternative to in-patient care facilities for those with advanced HIV-related health concerns, and may prevent those with advanced HIV-related health			and local goals related to retention in care, reducing unmet need, and viral load suppression Is this a duplicative service or activity? - This service is funded locally by one other public source for those meeting income or disability-related eligibility criteria		

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	Documentation of Need (Sources of Data include: 2016 Needs Assessment, 2017-2021 Comp Plan, 2016 Outcome Measures, 2016 Chart Reviews, Special Studies and surveys, etc.)	Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Providers b) Clients Can we bundle this service? Has a recent capacity issue been identified?	Recommendation(s)
		concerns from falling out-of-care.					
Hospice ‡ ***Workgroup 2*** ***Motion #1:*** *(Pruitt/Russey)* *Votes: Y=5; N=0;* *Abstentions = Kelly, Moses*	✔ Yes __No	☐ EIIHA ☒ Unmet Need ☒ Continuum of Care Unmet Need: Facilitating entry into/return of the out-of-care into primary care is the intent of reducing unmet need. Hospice contributes to this goal by providing facility-based skilled nursing and palliative care for those with a terminal AIDS diagnosis. This, in turn, may prevent	Need (2016): Current # of living HIV cases in EMA: 26,041 Service Utilization (2016): # clients served: 40 *(60% increase v. 2015)* Chart Review (2016): Of 100% of client charts reviewed: • *30% had experienced homeless at the time of*	Medicaid, Medicare Covered under QHP? ✔ Yes ___No	Justify the use of funds: This service category: - Is a HRSA-defined Core Medical Service - Prevents unmet need among PWA and those with co-occurring conditions - Facilitates national, state, and local goals related to retention in care and reducing unmet need - Addresses a system-level	Can we make this service more efficient? No Can we bundle this service? No Has a recent capacity issue been identified? No	**Motion 1:** Accept the service category definition as presented and keep financial eligibility the same at 300%.

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Service Category	**Is this a core service?** If no, how does the service support access to core services & support clients achieving improved outcomes?	**How does this service assist individuals *not in care** to access primary care?** **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	**Documentation of Need** (Sources of Data include: 2016 Needs Assessment, 2017-2021 Comp Plan, 2016 Outcome Measures, 2016 Chart Reviews, Special Studies and surveys, etc.)	**Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources** (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	**Justify the use of Ryan White Part A, Part B and State Services funds for this service.** **Is this a duplicative service or activity?**	**Service Efficiency** Can we make this service more efficient? For: a) Providers b) Clients Can we bundle this service? Has a recent capacity issue been identified?	**Recommendation(s)**
		PWA from becoming out-of-care. In 2015, 19% of people with a Stage 3 HIV diagnosis were out-of-care in the EMA. Hospice ensures clients with co-morbidities remain in HIV care. As a result, this service also addresses local priorities related to mental health and substance abuse co-morbidities. Continuum of Care: Hospice services support re-linkage and maintenance/retention in care for PLWH by providing facility-based skilled nursing and palliative care for those with a terminal AIDS diagnosis, preventing individuals with a terminal AIDS diagnosis from falling out of care.	*admission* • *17% had active substance abuse* • *26% of clients with an active psychiatric health concerns*		objective (#8) from the Comprehensive Plan and addresses certain Special Populations named in the Plan Is this a duplicative service or activity? - This service is funded locally by other public sources for those meeting income, disability, and/or age-related eligibility criteria		

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Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	Documentation of Need (Sources of Data include: 2016 Needs Assessment, 2017-2021 Comp Plan, 2016 Outcome Measures, 2016 Chart Reviews, Special Studies and surveys, etc.)	Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Providers b) Clients Can we bundle this service? Has a recent capacity issue been identified?	Recommendation(s)
Linguistic Services‡ ***Workgroup 2*** ***Motion #1:*** *(Pruitt/Sierra)* *Votes: Y=4; N=2;* *Abstentions = Russey*	___Yes ✔ No	☐ EIIHA ☒ Unmet Need ☒ Continuum of Care Unmet Need: Facilitating entry into/return of the out-of-care into primary care is the intent of reducing unmet need. By eliminating language barriers in RW-funded HIV care, this service facilitates entry into care and helps prevent lapses in care for monolingual PLWH. Continuum of Care: Linguistic Services support linkage to care, maintenance/retention in care, and viral suppression by eliminating language barriers and facilitating effective communication for non-Spanish monolingual PLWH.	Need (2016): Current # of living HIV cases in EMA: 26,041 Service Utilization (2016): # clients served: 67 *(46% increase v. 2015)*	RW providers must have the capacity to serve monolingual Spanish-speakers; Medicaid may provide language translation for *non-Spanish* monolingual clients Covered under QHP? ___Yes ✔ No	Justify the use of funds: This service category: - Is a HRSA-defined Support Service - Has limited or no alternative funding source - Removes potential barriers to entry/retention in HIV care for monolingual PLWH, thereby contributing to EIIHA goals and preventing unmet need - Facilitates national, state, and local goals related to retention in care and reducing unmet need - Linguistic and cultural competence is a Guiding Principle of the Comprehensive HIV Plan Is this a duplicative service or activity? - No, there is no known alternative funding for this	Can we make this service more efficient? No Can we bundle this service? No Has a recent capacity issue been identified? There is no waiting list at this time; however, the need for this service has the potential to exceed capacity due to new cohorts of languages spoken in the EMA/HSDA	**Motion 1:** Accept the service category definition as presented and keep financial eligibility the same at 300%.

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Service Category	**Is this a core service?** If no, how does the service support access to core services & support clients achieving improved outcomes?	**How does this service assist individuals *not in care** to access primary care?** **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	**Documentation of Need** (Sources of Data include: 2016 Needs Assessment, 2017-2021 Comp Plan, 2016 Outcome Measures, 2016 Chart Reviews, Special Studies and surveys, etc.)	**Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources** (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	**Justify the use of Ryan White Part A, Part B and State Services funds for this service.** **Is this a duplicative service or activity?**	**Service Efficiency** Can we make this service more efficient? For: a) Providers b) Clients Can we bundle this service? Has a recent capacity issue been identified?	**Recommendation(s)**
					service as designed		
Medical Nutritional Supplements and Therapy - Part A ***Workgroup 2*** ***Motion #1:*** *(Pruitt/Kelly)* *Votes: Y=7; N=0;* *Abstentions = Longoria*	✔ Yes ___No	☐ EIIHA ☒ Unmet Need ☒ Continuum of Care Unmet Need: The most commonly cited reason for referral to this service by a RW clinician is to mitigate side effects from HIV medication. Currently, 8% of PLWH report that side effects prevent them from taking HIV medication. This service category eliminates potential	Need (2016): Current # of living HIV cases in EMA: 26,041 Rank w/in 10 Core Services: #9 Clinician Survey (2012): 95% of clinicians surveyed by RWGA stated the service is "very useful" or "useful" for clients; most common referrals to the service were for weight loss, wasting syndrome, and medication	No known alternative funding sources exist for this service Covered under QHP?* ___Yes ✔ No *Some QHPs may cover prescribed supplements	Justify the use of funds: This service category: - Is a HRSA-defined Core Medical Service - Is ranked as the #9 service need by PLWH - Has limited or no alternative funding source - Results in desirable health outcomes for clients who access the service - Removes barriers to HIV medication adherence,	Can we make this service more efficient? No Can we bundle this service? No Has a recent capacity issue been identified? No	**Motion 1:** Accept the service category definition as presented and keep financial eligibility the same at 300%.

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	Documentation of Need (Sources of Data include: 2016 Needs Assessment, 2017-2021 Comp Plan, 2016 Outcome Measures, 2016 Chart Reviews, Special Studies and surveys, etc.)	Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Providers b) Clients Can we bundle this service? Has a recent capacity issue been identified?	Recommendation(s)
		barriers to HIV medication adherence by helping to alleviate side effects. In addition, evidence of an ART prescription is a criterion for met need. Continuum of Care: Medical Nutrition Therapy facilitates viral suppression by allowing PLWH to mitigate HIV medication side effects with supplements, and increasing medication adherence.	side effects Service Utilization (2016): # clients served: 501 *(6% decrease v. 2015)* Outcomes (FY2016): 80% of Medical Nutritional Therapy clients were virally suppressed		thereby facilitating national, state, and local goals related to viral load suppression Is this a duplicative service or activity? - Alternative funding for this service may be available through Medicaid.		
Mental Health Services‡ (Professional Counseling) ***Workgroup 2*** ***Motion #1:*** *(Pruitt/Moses)* *Votes: Y=6; N=0;* *Abstentions = Russey,*	✔ Yes ___No	☐ EIIHA ☒ Unmet Need ☒ Continuum of Care Unmet Need: Of 29% of 2016 Needs Assessment participants who reported falling out of care for >12 months since first entering care, 9% reported mental health concerns caused the	Need (2016): Current # of living HIV cases in EMA: 26,041 Rank w/in 10 Core Services: #6 Service Utilization (2016): # clients served: 351 *(14% increase v. 2015)* Chart Reviews (2016):	RW Part D (targets WICY), Medicaid, Medicare, private providers, and self-pay Some services provided by MHMRA Covered under QHP? ✔ Yes ___No	Justify the use of funds: This service category: - Is a HRSA-defined Core Medical Service - Is ranked as the #7 service need by PLWH - Facilitates national, state, and local goals related to retention in care and preventing unmet need	Can we make this service more efficient? No Can we bundle this service? No Has a recent capacity issue been identified? No	**Motion 1:** Accept the service category definition as presented and keep financial eligibility the same at 300%.

‡ Service Category for Part B/State Services only.

Service Category	**Is this a core service?** If no, how does the service support access to core services & support clients achieving improved outcomes?	**How does this service assist individuals *not in care** to access primary care?** **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	**Documentation of Need** (Sources of Data include: 2016 Needs Assessment, 2017-2021 Comp Plan, 2016 Outcome Measures, 2016 Chart Reviews, Special Studies and surveys, etc.)	**Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources** (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	**Justify the use of Ryan White Part A, Part B and State Services funds for this service.** **Is this a duplicative service or activity?**	**Service Efficiency** Can we make this service more efficient? For: a) Providers b) Clients Can we bundle this service? Has a recent capacity issue been identified?	**Recommendation(s)**
Sierra		lapse. Over half (57%) of participants recorded having a current mental health condition diagnosis, and 65% reported experiencing at least one mental/emotional distress symptom in the past 12 months to such an extent that they desired professional help. Mental Health Services offers professional counseling for those with a mental health condition/concern, and, as a result, may help reduce lapses in HIV care. Mental Health Services also address local priorities related to mental health co-morbidities. <u>Continuum of Care</u>: Mental Health Services facilitate linkage, maintenance/ retention in care, and viral suppression by helping PLWH manage mental and	Of 20% of client charts reviewed, 100% had documentation of clients receiving mental health services receiving a comprehensive assessment, a psychosocial history, and a treatment plan.		- Addresses a system-level objective (#8) from the Comprehensive Plan and (as a result of the motion) addresses certain Special Populations named in the Plan Is this a duplicative service or activity? - This service is funded locally by other public and private sources for (1) specific Special Populations (e.g., WICY), (2) those meeting income, disability, and/or age-related eligibility criteria, and (3) those with private sector health insurance.		

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	Documentation of Need (Sources of Data include: 2016 Needs Assessment, 2017-2021 Comp Plan, 2016 Outcome Measures, 2016 Chart Reviews, Special Studies and surveys, etc.)	Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Providers b) Clients Can we bundle this service? Has a recent capacity issue been identified?	Recommendation(s)
		emotional health concerns that may act as barriers to HIV care.					
Oral Health Untargeted – Part B Rural (North) – Part A ***Workgroup 2*** ***Motion #1:*** *(Moses/Pruitt)* *Votes: Y=7; N=0;* *Abstentions = Kelly*	✔ Yes ___No	☐ EIIHA ☐ Unmet Need ☒ Continuum of Care Continuum of Care: Oral Health services support maintenance in HIV care by increasing access to care and treatment for HIV-related and general oral health diagnoses. Untreated oral health diagnoses can create poor health outcomes and may act as a financial barrier to HIV care.	Need (2016): Current # of living HIV cases in EMA: 26,041 Rank w/in 10 Core Services: #4 Service Utilization (2016): # clients served: 3,372 *(3% decrease v. 2015)* Outcomes (FY2016): Oral Health Care – Rural Target: 88% of clients received an intraoral and an extraoral exam, and 92% received periodontal screening	In FY12, Medicaid Managed Care expanded benefits to include oral health services Covered under QHP*? ___Yes ✔ No *Some QHPs cover pediatric dental; low-cost add-on dental coverage can be purchased in Marketplace	Justify the use of funds: This service category: - Is a HRSA-defined Core Medical Service - Is ranked as the #4 service need by PLWH. Is this a duplicative service or activity? - This service is funded locally by one other public sources for its Managed Care clients only	Can we make this service more efficient? No Can we bundle this service? No Has a recent capacity issue been identified? Yes, clients report waiting lists for this service	**Motion 1:** Accept both service category definitions as presented and keep financial eligibility the same at 300%.

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	Documentation of Need (Sources of Data include: 2016 Needs Assessment, 2017-2021 Comp Plan, 2016 Outcome Measures, 2016 Chart Reviews, Special Studies and surveys, etc.)	Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Providers b) Clients Can we bundle this service? Has a recent capacity issue been identified?	Recommendation(s)
			Oral Health Care – Untargeted: 95% of client records had documentation of a hard and soft tissue exam in the last 12 months, and 96% had received oral health education.				
Outreach Services: Primary Care Re-Engagement - Part A ***Workgroup 1*** ***Motion #1:*** *(Ross/Bellard) Votes: Y=9; N=2; Abstentions = Kelly, Miertschin, Russey*	___Yes ✔ No	☐ EIIHA ☒ Unmet Need ☒ Continuum of Care Unmet Need: Facilitating maintenance in Primary Care reduces unmet need. In 2016, the Needs Assessment found that 29% of participants had a lapse in care of greater than 12 months at any point since their diagnosis. Additionally, in the 2014	As Outreach Services is a newly funded service category, it was not evaluated in the 2016 Needs Assessment. However, 29% of participants reported falling out of care for a period of 12 months or longer since their diagnosis, most often due to substance abuse concerns.	Beyond retention efforts offered in the provision of case management care coordination, there is currently no funding to support Outreach Services staff. Covered under QHP? ___Yes ✔ No	Justify the use of funds: This service category: - Is a HRSA-defined Support Service - Only 68% of diagnosed PLWH in the Houston EMA were retained in care in 2015 (60% not counting viral suppression as a measure of retention), lower than any other EMA/TGA in Texas	Can we make this service more efficient? No Can we bundle this service? Bundling Outreach Services with Primary Care, LPAP, Service Linkage, and MCM will allow for effective re-engagement and retention in care through HIV medical	**Motion 1:** Accept the service category definition with the understanding that there will be changes for the Quality Improvement Committee to review, and keep financial eligibility the same at none.

‡ Service Category for Part B/State Services only.

Service Category	**Is this a core service?** If no, how does the service support access to core services & support clients achieving improved outcomes?	**How does this service assist individuals *not in care** to access primary care?** **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	**Documentation of Need** (Sources of Data include: 2016 Needs Assessment, 2017-2021 Comp Plan, 2016 Outcome Measures, 2016 Chart Reviews, Special Studies and surveys, etc.)	**Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources** (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	**Justify the use of Ryan White Part A, Part B and State Services funds for this service.** **Is this a duplicative service or activity?**	**Service Efficiency** Can we make this service more efficient? For: a) Providers b) Clients Can we bundle this service? Has a recent capacity issue been identified?	**Recommendation(s)**
		Needs Assessment, 50% of participants responded that support of a clinician helps keep them in HIV medical care. Continuum of Care: Outreach Services is designed to facilitate maintenance in care for consumers at risk for falling out of care, thereby increasing retention in care as well as viral suppression for PLWH.			- Maintenance in care supports better health outcomes and viral suppression Is this a duplicative service or activity? No	visits, medication assistance, and case management within a medical home. Has a recent capacity issue been identified? No	
Program Support: (WITHIN THE ADMINISTRATIVE BUDGET)							
Council Support	___Yes _✔_No						**See Emergency Financial Assistance, Recommendations, Motion 2**
Project LEAP	___Yes _✔_No						

‡ Service Category for Part B/State Services only.

Service Category	**Is this a core service?** If no, how does the service support access to core services & support clients achieving improved outcomes?	**How does this service assist individuals *not in care** to access primary care?** **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	**Documentation of Need** (Sources of Data include: 2016 Needs Assessment, 2017-2021 Comp Plan, 2016 Outcome Measures, 2016 Chart Reviews, Special Studies and surveys, etc.)	**Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources** (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	**Justify the use of Ryan White Part A, Part B and State Services funds for this service.** **Is this a duplicative service or activity?**	**Service Efficiency** Can we make this service more efficient? For: a) Providers b) Clients Can we bundle this service? Has a recent capacity issue been identified?	**Recommendation(s)**
Blue Book	___Yes ✔ No						
Referral for Health Care and Support Services ***Workgroup - EFA*** ***Motion #1:*** *(Hawkins/Ross)* *Votes: Y=4; N=0;* *Abstentions= Artiaga, Benoit, Kelly, Miertschin*	___Yes ✔ No Referral For Health Care/Support Services – AIDS Drug Assistance Program Enrollment Worker at Ryan White Care Sites will fund one FTE ADAP enrollment worker per Ryan White Part A primary care site. Each ADAP enrollment worker will meet with all potential new ADAP enrollees, explain ADAP program benefits and requirements, and assist clients with submission of complete, accurate ADAP applications, as well as appropriate re-certifications	☐ EIIHA ☒ Unmet Need ☒ Continuum of Care Unmet Need: Assistance submitting complete and accurate ADAP applications and re-certifications reduces unmet need by increasing the proportion of PLWH in the Houston EMA/HSDA with access to HIV medication coverage. Continuum of Care: Increased access to HIV medication coverage supports medication adherence and viral suppression.	As Referral For Health Care/Support Services – AIDS Drug Assistance Program Enrollment Worker at Ryan White Care Sites would be a new service category, it was not evaluated in the 2016 Needs Assessment. However, when participants reported not taking HIV medication at the time of survey, this was most often because they lacked prescription drug coverage (29% of medication barriers reported). Additionally, 27% of participants reported that they experience difficulty paying for HIV medications.	Beyond assistance offered in the provision of case management care coordination, there is currently no funding to support dedicated ADAP Enrollment Workers at Ryan White primary care sites. Covered under QHP? ___Yes ✔ No	Justify the use of funds: This service category: - Is a HRSA-defined Support Service - State Services-Rebate (SS-R) funding is intended to ensure service continuation or bridge service gaps. - ADAP medication coverage reduces use of LPAP funding. Is this a duplicative service or activity? No	Can we make this service more efficient? Placement of ADAP Enrollment Workers at each Ryan White primary care site will make this service more efficient and accessible than placement at a single site. Can we bundle this service? N/a – this would be the only use of SS-R funding in the Houston EMA/HSDA Has a recent capacity issue been identified? No	**Motion 1:** Accept the proposed local service category definition for ***ADAP Enrollment Workers*** with the understanding that it will be updated to address the different agency scenarios.

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	Documentation of Need (Sources of Data include: 2016 Needs Assessment, 2017-2021 Comp Plan, 2016 Outcome Measures, 2016 Chart Reviews, Special Studies and surveys, etc.)	Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Providers b) Clients Can we bundle this service? Has a recent capacity issue been identified?	Recommendation(s)
	and attestations.						
Substance Abuse Treatment – Part A ***Workgroup 2*** ***Motion #1:*** *(Pruitt/Murray)* *Votes: Y=6; N=0;* *Abstentions = Russey*	☑ Yes ☐ No	☐ EIIHA ☒ Unmet Need ☒ Continuum of Care Unmet Need: Among PLWH with a history of unmet need, substance use is the #2 reason cited for falling out-of-care. Therefore, Substance Abuse Treatment services can directly prevent or reduce unmet need. Substance Abuse Treatment also addresses local priorities	Need (2016): Current # of living HIV cases in EMA: 26,041 Rank w/in 10 Core Services: #9 Service Utilization (2016): # clients served: 30 *(30% increase v. 2015)* Outcomes (FY2016): 83% of clients accessed primary care at least once after receiving Substance	RW Part C, Medicaid, Medicare, private providers, and self-pay. Some services provided by SAMHSA Covered under QHP? ☑ Yes ☐ No	Justify the use of funds: This service category: - Is a HRSA-defined Core Medical Service - Removes potential barriers to early entry into HIV care, thereby contributing to EIIHA goals - Prevents unmet need by addressing the #2 cause cited by PLWH for lapses in HIV care - Facilitates national, state,	Can we make this service more efficient? No Can we bundle this service? No Has a recent capacity issue been identified? No	**Motion 1:** Accept the service category definition as presented and keep financial eligibility the same at 300%.

‡ Service Category for Part B/State Services only.

Service Category	**Is this a core service?** If no, how does the service support access to core services & support clients achieving improved outcomes?	**How does this service assist individuals *not in care** to access primary care?** **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	**Documentation of Need** (Sources of Data include: 2016 Needs Assessment, 2017-2021 Comp Plan, 2016 Outcome Measures, 2016 Chart Reviews, Special Studies and surveys, etc.)	**Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources** (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	**Justify the use of Ryan White Part A, Part B and State Services funds for this service.** **Is this a duplicative service or activity?**	**Service Efficiency** Can we make this service more efficient? For: a) Providers b) Clients Can we bundle this service? Has a recent capacity issue been identified?	**Recommendation(s)**
		related to substance abuse co-morbidities. Continuum of Care: Substance Abuse Treatment facilitates linkage, maintenance/retention in care, and viral suppression by helping PLWH manage substance abuse that may act as barriers to HIV care.	Abuse Treatment services and 58% were virally suppressed.		and local goals related to continuous HIV care and reducing unmet need - Addresses a system-level objective (#8) from the Comprehensive Plan and addresses certain Special Populations named in the Plan Is this a duplicative service or activity? - This service is funded locally by other public and private sources for (1) those meeting income, disability, and/or age-related eligibility criteria, and (2) those with private sector health insurance.		

‡ Service Category for Part B/State Services only.

Service Category	Is this a core service? If no, how does the service support access to core services & support clients achieving improved outcomes?	How does this service assist individuals *not in care** to access primary care? **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	Documentation of Need (Sources of Data include: 2016 Needs Assessment, 2017-2021 Comp Plan, 2016 Outcome Measures, 2016 Chart Reviews, Special Studies and surveys, etc.)	Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	Justify the use of Ryan White Part A, Part B and State Services funds for this service. Is this a duplicative service or activity?	Service Efficiency Can we make this service more efficient? For: a) Providers b) Clients Can we bundle this service? Has a recent capacity issue been identified?	Recommendation(s)
Transportation – Pt A (Van-based, bus passes & gas vouchers) ***Workgroup 3*** ***Motion #1:*** *(Ross/Pruitt)* *Votes: Y=12; N=1;* *Abstentions* = Koumam-Njoh	___Yes ✔ No With an expansive service area (EMA = 6,287 mi^2; HSDA = 9,812 mi^2), the Ryan White program's transportation services eliminate barriers to accessing HIV Core Medical Service providers in the EMA/HSDA. This service can only be used to travel to/from HIV medical services.	☐ EIIHA ☒ Unmet Need ☒ Continuum of Care Unmet Need: Lack of transportation is the *fourth* most commonly-cited barrier among PLWH to accessing HIV core medical services. Transportation services eliminate this barrier to care, thereby supporting PLWH in continuous HIV care. Continuum of Care: Transportation supports linkage, maintenance/retention in care, and viral suppression by helping PLWH attend HIV primary care visits, and other vital services.	Need (2016): Current # of living HIV cases in EMA: 26,041 Rank w/in 5 Support Services: #2 Service Utilization (2016): # clients served: *Van-based: 723* *(4% decrease v. 2015)* *Bus pass: 2,171* *(7% decrease v. 2015)* Outcomes (FY2016): 69% of clients accessed primary care at least once after using van transportation; and 34% of clients accessed primary care after using bus pass services.	Medicaid, RW Part D (small amount of funds for parking and other transportation needs), and by other public sources for (1) specific Special Populations (e.g., WICY), and (2) those meeting income, disability, and/or age-related eligibility criteria. Covered under QHP*? ___Yes ✔ No	Justify the use of funds: This service category: - Is a HRSA-defined Support Service - Is ranked as the #2 need among Support Services by PLWH - Results in clients accessing HIV primary care - Removes potential barriers to entry/retention in HIV care, thereby contributing to EIIHA goals and preventing unmet need - Facilitates national, state, and local goals related to continuous HIV care and reducing unmet need Is this a duplicative service or activity? - This service is funded locally by other public sources for (1) specific	Can we make this service more efficient? No Can we bundle this service? No Has a recent capacity issue been identified? No	**Motion 1:** Accept the service category definition as presented and keep financial eligibility the same at 400%.

‡ Service Category for Part B/State Services only.

Service Category	**Is this a core service?** If no, how does the service support access to core services & support clients achieving improved outcomes?	**How does this service assist individuals *not in care** to access primary care?** **EIIHA: Early Identification of Individuals with HIV/AIDS* seeks to identify the status-unaware and link them into care **Unmet Need:* Individuals diagnosed with HIV but with no evidence of care for 12 months **Continuum of Care:* The continuum of interventions that begins with outreach and testing and concludes with HIV viral load suppression is generally referred to as the Continuum of HIV Care or Care Treatment Cascade.	**Documentation of Need** (Sources of Data include: 2016 Needs Assessment, 2017-2021 Comp Plan, 2016 Outcome Measures, 2016 Chart Reviews, Special Studies and surveys, etc.)	**Identify non-Ryan White Part A or Part B/ non-State Services Funding Sources** (i.e., Alternative Funding Sources) Is this service typically covered under a Qualified Health Plan (QHP)?	**Justify the use of Ryan White Part A, Part B and State Services funds for this service.** **Is this a duplicative service or activity?**	**Service Efficiency** Can we make this service more efficient? For: a) Providers b) Clients Can we bundle this service? Has a recent capacity issue been identified?	**Recommendation(s)**
					Special Populations (e.g., WICY), and (2) those meeting income, disability, and/or age-related eligibility criteria.		

‡ Service Category for Part B/State Services only.

Service Category	Justification for Discontinuing the Service
Part 2: Services *allowed* by HRSA but not offered by Part A, Part B or State Services funding in the Houston EMA/HSDA as of 03-01-14 *(In order for any of the services listed below to be considered for funding, a New Idea Form must be submitted to the Office of Support for the Ryan White Planning Council no later than **5 p.m. on June 6, 2014**. This form is available by calling the Office of Support: 713 572-3724)*	
Buddy Companion/Volunteerism	Low use, need and gap according to the 2002 Needs Assessment (NA).
Childcare Services (In Home Reimbursement; at Primary Care sites)	Primary care sites have alternative funding to provide this service so clients will continue to receive the service through alternative sources.
Emergency Financial Assistance	According to the HOPWA representative, they provide significant funding for emergency rent and utility assistance. (See City Council approved allocations.)
Food Pantry (Urban)	Service available from alternative sources.
HE/RR	In order to eliminate duplication, eliminate this service but strengthen the patient education component of primary care.
Home and Community-based Health Services (In-home services)	Category unfunded due to difficulty securing vendor.
Housing Assistance (Emergency rental assistance) **Housing Related Services** (Housing Coordination)	According to the HOPWA representative, they provide significant funding for emergency rent and utility assistance. (See City Council approved allocations.) But, HOPWA does not give emergency shelter vouchers because they feel there are shelters for this purpose and because it is more prudent to use limited resources to provide long-term housing.
Minority Capacity Building Program	The Capacity Building program targeted to minority substance abuse providers was a one-year program in FY2004.
Outreach Services	Significant alternative funding.
Psychosocial Support Services (Counseling/Peer)	Duplicates patient education program in primary care and case management. The boundary between peer and client gets confusing and difficult to supervise. Not cost effective, costs almost as much per client as medical services.
Rehabilitation	Service available from alternative sources.

‡ Service Category for Part B/State Services only.

Quality Assurance Committee

2016 Criteria for Reviewing Ideas

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

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

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

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

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

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

DRAFT

2016 Proposed Idea

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

THIS BOX TO BE COMPLETED BY RWPC SUPPORT STAFF ONLY

_____ Control Number Date Received_____

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

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

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

(OPTIONAL) This will provide _____ clients with _____ units of service.

2. ADDRESS THE FOLLOWING:

A. DESCRIPTION OF SERVICE:

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

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

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

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

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

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

REASON FOR RECOMMENDATION:

(Continue on Page 2 of this application form)

DRAFT

Proposed Idea

THIS PAGE IS FOR THE PRIORITY AND ALLOCATIONS COMMITTEE
(See Criteria and Principles to Guide Decision Making)

THIS BOX TO BE COMPLETED BY RWPC SUPPORT STAFF ONLY AND INCLUDE A BRIEF HISTORY OF RELATED SERVICE CATEGORY, IF AVAILABLE.

CURRENTLY APPROVED RELATED SERVICE CATEGORY ALLOCATION/UTILIZATION:
Allocation: $_____
Expenditure: $_____ Year-to-Date

Utilization: _____ Unduplicated Clients Served Year-to-Date
_____ Units of Service Provided Year-to-Date

AMOUNT OF FUNDING REQUESTED:
$_____This will provide funding for the following purposes which will further the objectives in this service category: (describe how):

PLEASE STATE HOW THIS IDEA WILL MEET THE PRIORITY AND ALLOCATIONS CRITERIA AND PRINCIPLES TO GUIDE DECISION MAKING. SITE SPECIFIC STEPS AND ITEMS WITHIN THE STEPS:

RECOMMENDATION OF PRIORITY AND ALLOCATIONS COMMITTEE:

___ Recommended for Funding in the Amount of: $_____
___ Not Recommended for Funding
___ Other:

REASON FOR RECOMMENDATION:

Houston Area HIV Services Ryan White Planning Council
Assessment of the Local Ryan White HIV/AIDS Program Administrative Mechanism
Assessment Checklist

(Quality Improvement Committee approved 05/18/17)

Background

The Ryan White CARE Act requires local Planning Councils to "[a]ssess the efficiency of the administrative mechanism in rapidly allocating funds to the areas of greatest need within the eligible area" (Ryan White Part A [formerly Title I] *Manual*, Section V, Chapter 1, Page 4). To meet this mandate, a time-specific documented observation of the local procurement, expenditure, and reimbursement process for Ryan White funds is conducted by the local Planning Councils (*Manual*, Section VI, Chapter 1, Page 7). 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 (*Manual*, Section VI, Chapter 1, Page 8). Instead, it produces information about the procurement, expenditure, and reimbursement process for the local *system* of Ryan White funding that can be used for overall quality improvement purposes.

Process

In the Houston eligible area, an assessment of the local administrative mechanism is performed for each Fiscal Year of Ryan White funding using a written checklist of specific data points. Taken together, the information generated by the checklist is intended to measure the overall efficacy of the local procurement, reimbursement, and contract monitoring processes of the administrative agents for (1) Ryan White Part A and Minority AIDS Initiative (MAI) funds; and (2) Ryan White Part B and State Services (SS) funds. The checklist is reviewed and approved annually by the Quality Improvement Committee of the Houston Area HIV Services Ryan White Planning Council, and application of the checklist, including data collection, review, analysis and reporting, is performed by the Ryan White Planning Council Office of Support in collaboration with the administrative agents for the funds. All data and documents reviewed in the process are publicly available.

Checklist

The checklist for the assessment of the administrative mechanism for the Houston eligible area is attached below. The following acronyms are used in the checklist:

AA:	Administrative Agent
DSHS:	Texas Department of State Health Services
FY:	Fiscal Year (The FY to be assessed for Part A, B, and MAI will be the immediate prior FY, ending February 28 [Part A and MAI] and March 31 [Part B]; the FY to be assessed for SS will be the most recent completed FY.
MAI:	Minority AIDS Initiative
MOU:	Memorandum of Understanding (between the AAs and the Planning Council)
NGA:	Notice of Grant Award
PC:	Ryan White Planning Council
RFP:	Request for Proposals
SOC:	Standards of Care
SS:	State Services

Checklist for the Assessment of the Ryan White Administrative Mechanism in the Houston Area (Quality Improvement Committee approved 05-18-17)

Intent of the Measure	Data Point to Measure	Method of Measurement	Data Source
Section I: Procurement/Request for Proposals Process			
• To assess the timeliness of the AA in authorizing contracted agencies to provide services	Time between receipt of NGA or funding contract by the AA and when contracts are executed with funded service providers	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)?	Part A/MAI: (1) NGA; and (2) Commissioner's Court Agendas Part B/SS: (1) DSHS Contract Face Sheet; and (2) Contract Tracking Sheet
• To assess the timeliness of the AA in procuring funds to contracted agencies to provide services	Time between receipt of NGA or funding contract by the AA and when funds are procured to contracted service providers	b) What percentage of the grant award was procured by the: ☐ 1st quarter? ☐ 2nd quarter? ☐ 3rd quarter?	Year-to-date and year-end FY Procurement Reports provided by AA to PC
• To assess if the AA awarded funds to service categories as designed by the PC	Comparison of the list of service categories awarded funds by the AA to the list of allocations made by the PC	c) Did the awarding of funds in specific categories match the allocations established by the PC at the: ☐ 1st quarter? ☐ 2nd quarter? ☐ 3rd quarter?	Year-to-date and year-end FY Procurement Reports provided by AA to PC Final PC Allocations Worksheet
• To assess if the AAs make potential bidders aware of the grant award process	Confirmation of communication by the AAs to potential bidders specific to the grant award process	d) Does the AA have a grant award process which: ☐ Provides bidders with information on applying for grants? ☐ Offers a bidder's conference?	RFP Courtesy Notices for Pre-Bid Conferences
• To assess if the AAs are requesting bids for service category definitions approved by the PC	Confirmation of communication by the AAs to potential bidders specific to PC products	e) Does the RFP incorporate service category definitions that are consistent with those defined by the PC?	RFP
• To assess if the AAs are procuring funds in alignment with allocations	Comparison of final amounts procured and total amounts allocated in each service category	f) At the end of the award process, were there still unobligated funds?	Year-end FY Procurement Reports provided by AA to PC
• To assess if the AAs are dispersing all available funds for services and, if not, are unspent funds within the limits allowed by the funder	Review of final spending amounts for each service category	g) At the end of the year, were there unspent funds? If so, in which service categories?	Year-end FY Procurement Reports provided by AA to PC

Checklist for the Assessment of the Ryan White Administrative Mechanism in the Houston Area (Quality Improvement Committee approved 05-18-17)

Intent of the Measure	Data Point to Measure	Method of Measurement	Data Source
Section I: Procurement/Request for Proposals Process (con't)			
• To assess if the AAs are making the PC aware of the procurement process	Confirmation of communication by the AAs to the PC specific to procurement results	h) Does the AA have a method of communicating back to the PC the results of the procurement process?	MOU PC Agendas
Section II: Reimbursement Process			
• To assess the timeliness of the AA in reimbursing contracted agencies for services provided	Time elapsed between receipt of an accurate contractor reimbursement request or invoice and the issuance of payment by the AA	a) 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? b) 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?	Annual Contractor Reimbursement Report
Section III: Contract Monitoring Process			
• To assess if the AA is monitoring adherence by contracted agencies to PC quality standards	Confirmation of use of adopted SOC in contract monitoring activities	a) Does the AA use the SOC as part of the contract monitoring process?	RFP Policy and Procedure for Performing Site Visits Quality Management Plan

Mental Health Services
Service Standard

HRSA Definition: Mental Health Services are the provision of outpatient psychological and psychiatric screening, assessment, diagnosis, treatment, and counseling services offered to clients living with HIV. Services are based on a treatment plan, conducted in an outpatient group or individual session, and provided by a mental health professional licensed or authorized with the state to render such services. Such professionals typically include psychiatrists, psychologists, and licensed clinical social workers.

Limitations: Mental Health Services are allowable only for HIV-infected clients.

Services: Mental health counseling services include outpatient mental health therapy and counseling (individual and family) provided solely by Mental Health Practitioners licensed in the State of Texas.

Mental health services include:

- Mental Health Assessment
- Treatment Planning
- Treatment Provision
- Individual psychotherapy
- Family psychotherapy
- Conjoint psychotherapy
- Group psychotherapy
- Psychiatric medication assessment, prescription and monitoring
- Psychotropic medication management
- Drop-In Psychotherapy Groups
- Emergency/Crisis Intervention

All mental health interventions must be based on proven clinical methods and in accordance with legal and ethical standards. The importance of maintaining confidentiality is of critical importance and cannot be overstated unless otherwise indicated based on federal, state and local laws and guidelines (i.e. abuse, self or other harm). All programs must comply with the Health Insurance Portability and Accountability Act (HIPAA) standards for privacy practices of protected health information (PHI) information.

Mental health services can be delivered via telehealth subject to federal guidelines, Texas State law, and DSHS policy.

Service Standard and Performance Measure

The following Standards and Performance Measures are guides to improving health outcomes for PLWH throughout the State of Texas within the Ryan White Part B and State Services Program.

STANDARD	PERFORMANCE MEASURE
Client Orientation: Orientation is provided to all new clients to introduce them to program services, to ensure their understanding of the need of continuous care, and to empower them in accessing services. Orientation includes written or verbal information provided to the client on the following: • Services available • Clinic hours and procedures for after-hours emergency and non-life-threatening urgent situations • How to reach staff member(s) as appropriate • Scheduling appointments • Client responsibilities for receiving program services and the agency's responsibilities for delivering them • Patient rights including the grievance process	Percentage of new clients with documented evidence of orientation to services available in the client's primary record.
Mental Health Assessment: All clients referred to the program will receive a Mental Health Assessment by licensed mental health professionals. A mental health assessment should be completed no later than the third counseling session and should include, at a minimum, the following as guided by licensure requirements: • Presenting problems • Completed mental status evaluation (including appearance and behavior, self-attitude, speech, psychomotor activity, mood, insight, judgment, suicidal tendencies, perceptual disturbances, obsessions/compulsions, phobias, panic attacks) • Cognitive assessment (level of consciousness, orientation, memory, and language) • Current risk of danger to self and others • Social support and family relationships, including client strengths/weaknesses, coping mechanisms and self-help strategies • Medical history	Percentage of clients with documented mental health assessment completed by the 3rd counseling session, unless otherwise noted, in the client's primary record.

• Substance use history
• Psychosocial history to include:
  • Education and employment history, including military service
  • Sexual and relationship history and status
  • Physical, emotional, and/or sexual abuse history
  • Domestic violence assessment
  • Trauma assessment
  • Legal history
  • Leisure and recreational activities
 	
Clients are assessed for care coordination needs, and referrals are made to case management programs as appropriate. If pressing mental health needs emerge during the mental health assessment requiring immediate attention that results in the assessment not being finalized by the third session, this must be documented in the client's primary record.	

Treatment Plan: All eligible client files should have documented evidence of a detailed treatment plan and documentation of services provided within the client's primary record. A treatment plan shall be completed within 30 days specific to the individual client's needs. The treatment plan should include: • Description of the mental health issue • Goals and objectives • Treatment type (individual, group, family, couples) • Start date for mental health services • Recommended number of sessions • Date for reassessment • Projected treatment end date (estimated) • Any recommendations for follow up Treatment, as clinically appropriate, should include counseling regarding: • Risk reduction and health promotion • Substance misuse • Treatment adherence • Development of social support systems • Community resources • Maximizing social and adaptive functioning • The role of spirituality and religion in a client's life, disability, death and dying and exploration of future goals The treatment plan must be signed by the mental health professional rendering service and developed in conjunction with the client. Treatment plans are reviewed and modified at a minimum of every 90 days, or more frequently as clinically indicated.	Percentage of clients with documented detailed treatment plan and documentation of services provided within the client's primary record. Percentage of clients with treatment plans completed and signed by the licensed mental health professional rendering services in the client's primary record. Percentage of clients with documented evidence of treatment plans reviewed/modified at a minimum of every 90 days in the client's primary record.
Psychiatric Referral: Clients are evaluated for psychiatric intervention and appropriate referrals are initiated as documented in the client's primary record.	Percentage of clients with documented need for psychiatric intervention are referred to services as evidenced in the client's primary record.
Psychotropic Medication Management: Psychotropic medication management	Percentage of clients accessing medication

services are available for all clients either directly or through referral as appropriate. Pharm Ds can provide psychotropic medication management services. Mental health professional will discuss the client's concerns with the client about prescribed medications (side effects, dosage, interactions with HIV medications, etc.). Mental health professional will encourage the client to discuss concerns about prescribed medications with their HIV-prescribing clinician (if the mental health professional is not the prescribing clinician) so that medications can be managed effectively. *Prescribing providers will follow all regulations required for prescribing of psychoactive medications as outlined by the Texas Administrative Code, Title 25, Part 1, Chapter 415, Subchapter A, Rule 415.10*	management services with documented evidence in the client's primary record of education regarding medications. Percentage of clients with changes to psychotropic/psychoactive medications with documented evidence of this change shared with the HIV-prescribing provider in the client's primary record.
Provision of Services: Services will be provided according to the individual's treatment plan and documented in the client's primary record. Progress notes are completed according to the agency's standardized format for each session and will include: • Client name • Session date • Focus of session • Interventions • Progress on treatment goals • Newly identified issues/goals • Counselor signature and authentication (credentials). In urgent non-life-threatening circumstances, an appointment will be scheduled within twenty-four (24) hours. If service cannot be provided within this time frame, the agency will offer to refer the client to another organization that can provide the requested services.	Percentage of client's with documented evidence of progress notes completed and signed in accordance with the individual's treatment plan in the client's primary record.
Coordination of Care: Care will be coordinated across all medical care coordination team members. The client is involved in the decision to initiate or defer treatments. The mental health professional will involve the entire care team in educating the client, providing support, and monitoring mental health treatment	Percentage of agencies who have documented evidence in the client's primary record or care coordination, as permissible, of shared MH treatment

adherence. Problem solving strategies or referrals are in place for clients who need to improve adherence (e.g., behavioral contracts). There is evidence of consultation with medical care/psychiatric/pharmacist as appropriate regarding medication management, interactions, and treatment adherence	adherence with the client's primary medical care provider.
Referrals: As needed, mental health providers will refer clients to full range of medical/mental health services including: • Psychiatric evaluation • Pharmacist for psychotropic medication management • Neuropsychological testing • Day treatment programs • In-patient hospitalization	Percentage of clients with documented referrals, as applicable, for other medical/mental health services in the client's primary record.
Discharge Planning: Discharge planning will be done with each client after 30 days without client contact or when treatment goals are met. Documentation for discharge planning will include, as applicable: • Circumstances of discharge • Summary of needs at admission • Summary of services provided • Goals and objectives completed during counseling • Discharge plan • Counselor authentication, in accordance with current licensure requirements	Percentage of clients with documentation of discharge planning within 30 days of treatment goals being met as evidenced in the client's primary record. Percentage of clients with documentation of discharge planning within 30 days of no client contact as evidenced in the client's primary record.

References

American Psychiatric Association. *The Practice Guideline for Treatment of Patients with HIV/AIDS,* , Washington, DC, 2001.

HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A April 2013. p. 17-18

HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B April, 2013. p. 17-18.

New York State Mental Health Standards of Care. Located at:
http://www.health.ny.gov/diseases/aids/providers/standards/mental_health/delivery_of_care.htm

Psychosocial Support Services
Service Standard

HRSA Definition: Psychosocial Support Services provide group and/or individual support and counseling services to assist eligible people living with HIV to address behavioral and physical health concerns. These services may include:

- Bereavement counseling;
- Child abuse and neglect counseling;
- HIV support groups;
- Nutrition counseling provided by a non-registered dietitian; and/or
- Pastoral care/counseling services.

Limitations: Funds under this service category may not be used to provide nutritional supplements (nutritional supplements may be allowable under Food Bank/Home Delivered Meals and/or Medical Nutrition Therapy). RWHAP-funded pastoral counseling must be available to all eligible clients regardless of their religious denominational affiliation. Funds may not be used for social/recreational activities or to pay for a client's gym membership.

Services: Psychosocial services may include providing support, either individually or through group settings, for eligible client's to assist PLWH in addressing behaviors that will enhance a client's continuity in medical care and to address physical health concerns that a client needs support in addressing. Psychosocial Support Services can also include individual and group counseling for child abuse and neglect, bereavement counseling, and associated HIV problems.

Pastoral care/counseling services must be:

- Provided by an institutional pastoral care program (e.g. components of AIDS interfaith networks, separately incorporated pastoral care and counseling centers, components of services provided by a licensed provider such as a home care or hospice provider);
- Provided by a licensed or accredited provider wherever such licensure or accreditation is either required or available; and
- Available to all individuals eligible for Ryan White services, regardless of their religious denominational affiliation.

Nutrition Counseling provides nutritional education, assessment, and counseling by a non-registered dietitian to persons living with HIV to assist clients in:

- Maintaining treatment regimens;
- Remaining in primary medical care; and/or
- Improving overall client wellness and quality of life.

This service is meant to help clients use food products in the best way possible to maintain or improve health and to maximize health benefits.

Note: A nutritional plan cannot be developed by a registered dietitian under this service category.

Service Standard and Performance Measure

The following Standards and Performance Measures are guides to improving health outcomes for PLWH throughout the State of Texas within the Ryan White Part B and State Services Program.

Standard	Performance Measure
Assessment/Plan of Care for Counseling Services: Within thirty (30) business days of referral for counseling, clients are assessed for: • Support system and psychosocial support needs • History of accessing primary care and other services and barriers to access—noting psychosocial support barriers in particular Staff explains to the client during the first encounter what services are available at the agency based on the client's identified needs. Within thirty (30) business days after the assessment a service plan will be developed and agreed upon by the client and provider outlining service goals, objectives, and interventions. This should include client identified needs as well as plans for continuity of primary medical care and support services. Client needs and service plan are reviewed and revised a minimum of every six months.	Percentage of clients with documented evidence in the client's primary record of a completed assessment within 30 business days of referral for counseling. Percentage of clients with documented evidence in the client's primary record of a service plan developed within 30 business days of the completed assessment. Percentage of clients with documented evidence in the client's primary record of service plans reviewed and/or revised every 6 months, at a minimum.
Support Group Service Plans: Within thirty (30) business days of first attendance, a client primary record should be established for all clients attending support groups only. Attendance and topic discussed should be documented in the progress notes with goals for the client outlined.	Percentage of clients attending group sessions will have documented evidence in the client's primary record of attendance and topic discussed in progress notes with goals for the client outlined.

Provision of Services - Counseling: Staff may provide counseling related to: • Child abuse and neglect counseling • Bereavement counseling Topics that should be covered in individual counseling sessions by non-professional staff include: • Treatment adherence (non-clinical, supportive discussion to reiterate importance of retention in care) • Access and engagement in primary care • Assess and engagement in case management if appropriate Psychosocial support staff will make appropriate referrals.	Percentage of clients with documented evidence, as applicable, in the client's primary record of counseling provided for child abuse and neglect. Percentage of clients with documented evidence, as applicable, in the client's primary record of counseling provided for bereavement. Percentage of clients with documented evidence in the client's primary record of discussion regarding retention in care regardless of type of counseling provided.
Provision of Service - Support Groups: HIV support groups provide discussion of topics relevant to the PLWH needs in the community through group facilitation. Staff or volunteers providing psychosocial support through group facilitation will include discussions on: • Treatment adherence (non-clinical, supportive discussion to reiterate importance of retention in care) • Access and engagement in primary care • Assess and engagement in case management if appropriate Evidence of client progress toward meeting established goals through documentation of activity including sign-in sheets, progress notes, group curricula, etc.	Percentage of clients engaged in HIV support group services with documented evidence, as applicable, in the client's primary record of client progression in meeting established goals.

Provision of Service - Pastoral Counseling/Care: If pastoral counseling/care is needed, may be provided by the agency either: • Directly if by a licensed healthcare services provider such as a home care or hospice provider; • Through referral to AIDS interfaith networks, separately incorporated pastoral care and counseling center, and/or a home care or hospice licensed provider o If client referred to another agency, referral and follow-up regarding outcome must be documented Must be available either directly or through referral to all individuals eligible to receive Ryan White services regardless of their religious denominational affiliation.	Percentage of clients with documented evidence, in the client's primary record, of pastoral care provided through progress notes. Percentage of clients with documented referral, as applicable, in the client's primary record to an eligible pastoral care program (as outlined in standard). Percentage of clients accessing pastoral care/counseling through referral with documented outcomes in client's primary record.
Provision of Service – Nutrition Counseling: Nutritional education and counseling provided under Psychosocial Support Services are by a non-registered dietitian and must be based on a client-specific nutritional assessment and plan that has been developed by a registered dietitian or other licensed nutrition professional (see Medical Nutrition Therapy Service Standard). Progress notes will be kept in the client primary record system and will include progress toward meeting objectives outlined in the nutritional plan.	Percentage of clients with documented evidence in the client's primary record of nutritional education and counseling provided based on a client-specific nutritional assessment and plan developed by a RD or other licensed nutrition professional. Percentage of clients with documented evidence in the client's primary record of an individualized nutritional plan based on the assessment. Percentage of clients with documented evidence in the client's primary record of progress notes indicating client's progression toward meeting objectives outlined in the nutritional plan.

Closure: An individual is deemed no longer to be in need of psychosocial support services and can be deemed inactive/case closed if one or more of these criteria is met: • Client expires; • Client's medical condition improves and counseling/group attendance is no longer necessary; and/or • Client elects not to participate.	Percentage of clients with documented evidence in client's primary record of case closure documented as applicable.

References

HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A April 2013. p. 42-43.

HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B April, 2013. p. 41-42.

Other Professional Services
Service Standards

HRSA Definition: Other Professional Services allow for the provision of professional and consultant services rendered by members of particular professions licensed and/or qualified to offer such services by local governing authorities.

Limitations: Legal services excludes criminal defense and class-action suits unless related to access to services eligible for funding under the Ryan White HIV/AIDS Program (RWHAP)..

Services: Services may include:

- Legal services provided to and/or on behalf of the individual living with HIV and involving legal matters related to or arising from their HIV disease, including:
    - Assistance with public benefits such as Social Security Disability Insurance (SSDI);
    - Interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the RWHAP.
    - Preparation of:
        - Healthcare power of attorney;
        - Durable powers of attorney;
        - Living wills.

- Permanency planning to help clients/families make decisions about the placement and care of minor children after their parents/caregivers are deceased or are no longer able to care for them, including:
    - Social service counseling or legal counsel regarding the drafting of wills or deleting powers of attorney;
    - Preparation for custody options for legal dependents including standby guardianship, joint custody, or adoption.

- Income tax preparation services to assist clients in filing Federal tax returns that are required by the Affordable Care Act for all individuals receiving premium tax credits

Service Standard and Performance Measure

The following Standards and Performance Measures are guides to improving healthcare outcomes for PLWH throughout the state of Texas within the Ryan White Part B and State Services Program.

Standard	Performance Measure
Provision of Services – Legal Services: Legal services are provided to and/or on behalf of the individual living with HIV and involving legal matters related to or arising from their HIV disease. Service Agreements will be developed and signed by both the attorney and the client. Clients will be kept informed and work together with legal staff to determine the objective(s) of the representation. Agency may provide the following types of legal representation, assistance, and education: Assistance with public benefits such as SSDI; HIV discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the RWHAP; and/or Preparation of: Healthcare power of attorney; Durable powers of attorney; and/or Living wills. Attorneys will document the following in the client's record: A description of how the legal service is necessitated by the individual's HIV status; Types of services provided; and Hours spent in the provision of such services.	Percentage of clients accessing legal services for assistance with public benefits, as applicable, with documentation in the client's primary record of the public benefits assistance and outcomes. Percentage of clients accessing legal services for preparation of documents allowed, as applicable, in the client's primary record with completion of healthcare POA, Durable POA, and/or living wills.

Provision of Services – Permanency Planning: Permanency planning to help clients/families make decisions about the placement and care of minor children after their parents/caregivers are deceased or are no longer able to care for them. Services include: Social service counseling or legal counsel regarding the drafting of wills or delegating powers of attorney; and/or Preparation of custody options for legal dependents including standby guardianship, joint custody, or adoption.	Percentage of clients accessing permanency planning services have documented evidence in the client's primary record of services needed with outcomes.
Provision of Services – Income Tax Preparation: Income tax preparation services to assist clients in filing Federal tax returns that are required by the Affordable Care Act for individuals receiving premium tax credits. Agencies must be licensed and/or qualified to offer income tax preparation services.	Percentage of clients accessing income tax preparation services with documented evidence of assistance and outcomes in the client's primary record.
Case Closure: Cases may be closed when: Legal or benefit issue has been resolved; Client has not had direct program contact for three (3) to six (6) months over a three-month period; Client is deceased; Client voluntarily discontinues the service; Client improperly uses the service; Client has not complied with the client services agreement. If the case is closed for a reason other than objectives met, agency will notify clients about case closure in writing.	Percentage of clients with documented evidence of case closure, including reasons stated, in the client's primary record.

References

HRSA/HAB Division of Metropolitan HIV/AIDS Programs Program Monitoring Standards – Part A April 2013. p. 36-37.

HRSA/HAB Division of State HIV/AIDS Programs National Monitoring Standards – Program Part B April, 2013. p. 35-37.

DRAFT
2017 Quarterly Report
Quality Improvement Committee
(May 2017)

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

1. Conduct the "How to Best Meet the Needs" (HTBMN) process, with particular attention to the continuum of care with respect to HRSA identified core services.

   DONE

2. Develop a process for including consumer input that is proactive and consumer friendly for the Standards of Care and Performance Measures review process.

   ON-GOING

3. Continue to improve the information, processes and reporting (within the committee and also thru collaboration with other Planning Council committees) needed to:

   a. Identify "The Un-met Need"; DONE

   b. Determine "How to Best Meet the Needs"; DONE

   c. *Strengthen and improve the description and measurement of medical and health related outcomes. DONE

4. *Identify and review the required information, processes and reporting needed to assess the "Efficiency of the Administrative Mechanism". Focus on the status of specific actions and related time-framed based information concerning the efficiency of the administrative mechanism operation in the areas of:

   a. Planning fund use (meeting RWPC identified needs, services and priorities);

   b. Allocating funds (reporting the existence/use of contract solicitation, contract award and contract monitoring processes including any time-frame related activity);

   c. Distributing funds (reporting contract/service/re-imbursement expenditures and status, as well as, reporting contract/service utilization information).

5. Annually, review the status of committee activities identified in the current Comprehensive Plan. IN PROCESS

IN PROCESS

Status of Tasks on the Timeline:

G. Sierra
Committee Chairperson

5/18/17
Date

Affected Community Committee Report

2017 Road 2 Success/Camino hacia tu Salud

(as of 05/23/17)

Road 2 Success: Understanding the HIV Care System and the Spanish version, *Camino hacia tu Salud*, is a series of free, seminars with the goal of providing HIV+ individuals and caregivers living in the Greater Houston area with information that will help them understand the complex HIV care system and empower them to:

- access HIV-related services
- access a source of payment for their services
- voice their concerns regarding HIV-related services
- participate in the development of the HIV prevention and care system

GUIDING PRINCIPLES: No boring or highly technical presentations. At least 2 seminars each year taught in Spanish. Select class locations that are familiar and comfortable for the consumers. No combative behavior.

Day, date, times	Event & Location	Information to be Presented	Participants
Thursday, June 29 12 noon – 2 pm	Road 2 Success – 2-hour seminar Thomas Street Health Center 2015 Thomas Street, 77009	Eligibility Requirements – Ryan White and Harris Health System Case Management Services My Health App – Patient Reminder System	**Need 5 Volunteers:** Curtis, Cecilia, Teresa, Denis, Isis. Back up: Alex.
Monday, August 28 6 pm – 8 pm	Camino hacia tu Salud – 2-hour seminar Positive713 Support Group Leonel Castillo Community Ctr. 2101 South Street, 77009	To be determined	**Need 7 Volunteers (incl. Spanish speaking):** Isis, Tana, Skeet, Curtis, Teresa, Tracy, Alex **ASK:** Steven, Vel
Saturday, November Exact date and time TBD	Road 2 Success – 4-hour seminar Montrose Center 401 Branard Street, 2nd Floor, 77006	To be determined	**Need 12 volunteers**
Saturday, December Exact date and time TBD	Camino hacia tu Salud – 4-hour seminar Tentative Location: Leonel Castillo Community Ctr. 2101 South Street, 77009	To be determined	**Need 8 Spanish Speaking Volunteers:** DISTRIBUTE LEAP FLYERS
January 2018 Exact date and time TBD	Road 2 Success – 4-hour seminar Location: To be determined	To be determined	**Need 10 Volunteers (incl. Spanish speaking):**

Affected Community Committee
2017 Community Events (as of 05/23/17)

Point Person (PP): Committee member who picks up display materials and returns them to the Office of Support.

Day, date, times	Event	Location	Participants
Sunday, March 5 1pm-Walk	AIDS Foundation Houston (AFH) AIDS Walk	Houston Park Downtown 1100 Bagby Street, 77002	Allen Murray will distribute Project LEAP flyers.
Saturday, June 24 Noon – 7:00 pm	Pride Festival	Downtown near City Hall	Shift 1 (11:30 am-2 pm) : **PP Tracy G,** Tana Shift 2 (2-4:30 pm) Alex, Allen Shift 3 (4:30-7 pm): **PP** _____**,** Rodney **To be Assigned:**
Thursday, June 29 11:30 am – 2 pm	Road 2 Success	Thomas Street Health Center 2015 Thomas Street, 77009	**Need 5 Volunteers:** Curtis, Cecilia, Teresa, Denis, Isis. Back up: Alex.
Monday, August 28 5 pm – 8 pm	Camino hacia tu Salud	Positive713 Leonel Castillo Community Center 2101 South Street, 77009	**Need 7 Volunteers:** Isis, Tana, Skeet, Curtis, Teresa, Tracy, Alex **ASK:** Steven, Vel
Sunday, October 22	MISS UTOPIA	Crowne Plaza Northwest-Brookhollow 12801 Northwest Freeway Houston, TX 77040	**Volunteers: PP: _____,** Skeet, Curits, Alex, Isis, Cecilia, Tana DISTRIBUTE LEAP FLYERS
Saturday in November	Road 2 Success	Montrose Center 401 Branard Street, 2nd Floor, 77006	**Need 12 volunteers**
Tuesday, December 1	World AIDS Day Events		Most committee members attend events DISTRIBUTE LEAP FLYERS
Saturday in December	Camino hacia tu Salud	Tentative: Leonel Castillo Community Ctr. 2101 South Street, 77009	**Need 8 Spanish Speaking Volunteers:** DISTRIBUTE LEAP FLYERS
Saturday in January	Road 2 Success	Montrose Center 401 Branard Street, 2nd Floor, 77006	**Need 10 Volunteers (incl. Spanish speaking):** DISTRIBUTE LEAP FLYERS

Greeters for 2017 Council Meetings

(Revised: 05-23-17)

2017 Meeting Dates (**Please arrive at 11:45 a.m.** Unless otherwise noted, the meetings are held at 2223 W. Loop South)	**Greeter #1** External Member	**Greeter #2**	**Greeter #3**
Thurs. March 9		Curtis	John
Thurs. April 13		Isis	Allen
Thurs. May 11	Alex	Denis	John
Thurs. June 8 – OFF SITE: Montrose Ctr.	Alex	Curtis	John
Thurs. July 13	Veria	Skeet	Teresa
Thurs. August 10	Curtis	Skeet	Isis
Thurs. September 14	Alex	Teresa	Rodney
Thurs. October 12	Veria	Teresa	Skeet
Thurs. November 9 External Committee Member Appreciation			
Thurs. December 14			

2017 QUARTERLY REPORT
AFFECTED COMMUNITY COMMITTEE

(To be submitted May 2017)

Status of Committee Goals and Responsibilities (* indicates a HRSA mandate):

1. Educate consumers so they understand how to access HIV/AIDS treatment and medication. Provide information that can be understood by consumers of diverse educational backgrounds on client-centered issues.
   Status: ON GOING. Road to success.

2. In 2017, get a better understanding of the needs of transgender individuals through training, attending meetings of the transgender community and more.

   ON GOING TO Be Addressed: Training for Affected Committee

3. Assure participation by people living with HIV/AIDS in all Council work products.
   Status: DONE

4. *Work with other committees to coordinate Public Hearings regarding the FY 2018 How to Best Meet the Need Results & Priorities and Allocations for Ryan White Parts A and B and State Services.
   Status: Taking Place Today May 22 2017 and City Hall 901 Babay. and ~~on~~ IN June.

5. Recruit Council applicants throughout the year.
   Status: ONGOING. Recruited for Leap Class 2017.

6. Annually, review the status of committee activities identified in the current Comprehensive Plan.
   Status: To Be prepared for Later. Specific activate. Identified in Fall season ~~of~~ of 2017.

Committee Chairperson

Date May 22 2017

Operations Committee Report

DRAFT

Budget – Printed in Summer 2017

2018 - 2019 Blue Book

*The exact cost of reproducing the 2017 – 2018 Blue Book is not available at this time since the largest budget item, printing costs, fluctuates with the price of oil/ink.

Budget for the 2017 – 2018 Blue Book

Graphic Design	5,000
Updating the Book (in house)	
Advertising	3,000
Spanish Translation	2,000
App Support	1,000
Software	1,000
Postage	4,000
Printing 50,000 copies ($.88/book)	44,000*
TOTAL	**$60,000***

FY 2017 vs. FY 2018 Council Support Budget Comparison

(as of 05/15/17)

Budget Item	FY 2017 Amount	FY 2018 Amount	Difference	Notes
Equipment	$ 500	$ 2,000	$ + 1,500	
Travel	2,000	3,500	+ 1,500	HRSA Conference
Resource Guide	60,000	17,000	- 43,000	Reprints only
Needs Assessment	2,115	5,000	+ 2,885	
Council Education	3,500	4,000	+ 500	
Road 2 Success	0	16,220	+ 16,220	Added in FY 2017
Postage	5,000	10,000	+ 5,000	
TOTALS			$15,395	Return to RWGA

Houston Ryan White Planning Council
FY 2018 Council Support Budget
(Prepared 05-03-17)

		Subtotal	Total
PERSONNEL			
RWPC Manager (V. Williams) ($6621/mo. X 12 mos. X 100%) Responsible for overall functioning of planning council, supervises all support staff.	$79,446	**$258,002**	
RWPC Health Planner (A. Harbolt) ($6068/mo. X 12 mos. X 100%) Responsible for coordinating Comprehensive Planning and Needs Assessment activities. Analyzing and presenting data.	$72,820		
RWPC Coordinator (D. Beck) ($4,718/mo x 12 mos. X 100%) Coordinates support activities for the RW Planning Council and committees. Provides routine administrative duties (minutes, scheduling of meetings, mailouts, etc.).	$56,611		
Assistant Coordinator (R. Avila) ($4094/mo x 12 mos. X 100%) Coordinates support activities for assigned committees. Provides routine administrative duties (minutes, scheduling of meetings, mailouts, etc.)	$49,125		
FRINGE		**$115,386**	
Social Security @ 7.65%	$19,737		
Health Insurance (4 x $13,000/FTE)	$52,000		
Retirement @ 14%	$36,120		
Workers Compensation @ 0.83%	$2,141		
Supplemental Death Insurance @ 0.50	$1,290		
Unemployment Insurance @ 0.60%	$1,548		
Incentives/allowances	$2,550		

Houston Ryan White Planning Council
FY 2018 Council Support Budget
(Prepared 05-03-17)

		Subtotal	Total
EQUIPMENT Replacement computers to replace obsolete units	$2,000	**$2,000**	
TRAVEL		**$3,500**	
Local travel @ $0.535/mile for Planning Council Support Staff	$500		
Out of EMA travel: Two out of state trips for Office of Support staff for HIV planning meeting and five in State trips for staff and/or volunteer Council members for statewide HIV Planning meetings	$3,000		
SUPPLIES General consumable office supplies including materials for Council Members and Public Meetings	$5,000	**$5,000**	
CONTRACTUAL	$0	**$0**	
OTHER		**$113,156**	
Resource Guide	$17,000		
Needs Assessment Activities	$5,000		
Reimbursement for PC member expenses: Reimbursement for travel, childcare, meals and other eligible expenses resulting from participation in Council approved/ HRSA grant required activities.	$23,686		
Advertising for PC Activities: For publication of meeting announcements in community papers; invitations to participate in needs assessment activities and focus groups; advertisments for additional volunteers.	$6,000		
Communications (phone, pagers): For local and long distance phone expenses and internet charges.	$3,500		
Web Page Technical Assitance Costs: For additional training/consultation to staff in order to update/improve web site.	$500		

Houston Ryan White Planning Council
FY 2018 Council Support Budget
(Prepared 05-03-17)

		Subtotal	Total
Council Education: For speakers & training costs primarily for room rentals & the cost of speakers for ongoing training to insure that key decision-makers receive necessary & relevant information. This includes the January Orientation and one Council meeting to be held off-site in Harris County.	$4,000		
Project LEAP Student Reimbursement: 30 participants for 17 week course including travel, childcare and other eligible expenses resulting from participation in Council approved training activities related to the HRSA grant.	$5,500		
Project LEAP Education: Training costs for 17 weeks including speaker fees, room rental for off-site meetings & educational materials.	$9,500		
Consumer Education: Training costs for 5 seminars including speaker fees & room rental for off-site meetings & educational materials.	16,220		
Interpreter Services For Spanish-speaking and sign-language interpretation services during public meetings, focus groups, etc.	$1,500		
Fees and Dues Registration costs for attending meetings, trainings and conferences related to HIV/AIDS health planning.	$500		
English/Spanish Translation (written): For professional translation of Council materials into Spanish.	$1,000		
Postal Machine Rental & Postage: For mailouts of Committee and Council agendas, minutes and attachments; HIV/AIDS Resource Guides for those who are unable to pickup in person; other office of support communications.	$10,000		
Copier Rental: For rental, service agreement of high-use Xerox machine used for Council and Office of Support.	$9,250		
TOTAL			**$497,044**

Houston Ryan White Planning Council
FY 2017 Council Support Budget
(Prepared 01-27-17)

		Subtotal	Total
PERSONNEL			
RWPC Manager (V. Williams) ($6621/mo. X 12 mos. X 100%) Responsible for overall functioning of planning council, supervises all support staff.	$79,446	**$258,002**	
RWPC Health Planner (A. Harbolt) ($6068/mo. X 12 mos. X 100%) Responsible for coordinating Comprehensive Planning and Needs Assessment activities. Analyzing and presenting data.	$72,820		
RWPC Coordinator (D. Beck) ($4,718/mo x 12 mos. X 100%) Coordinates support activities for the RW Planning Council and committees. Provides routine administrative duties (minutes, scheduling of meetings, mailouts, etc.).	$56,611		
Assistant Coordinator (R. Avila) ($4094/mo x 12 mos. X 100%) Coordinates support activities for assigned committees. Provides routine administrative duties (minutes, scheduling of meetings, mailouts, etc.)	$49,125		
FRINGE		**$115,386**	
Social Security @ 7.65%	$19,737		
Health Insurance (4 x $13,000/FTE)	$52,000		
Retirement @ 14%	$36,120		
Workers Compensation @ 0.83%	$2,141		
Supplemental Death Insurance @ 0.50	$1,290		
Unemployment Insurance @ 0.60%	$1,548		
Incentives/allowances	$2,550		

Houston Ryan White Planning Council
FY 2017 Council Support Budget
(Prepared 01-27-17)

		Subtotal	Total
EQUIPMENT Replacement computers to replace obsolete units	$500	**$500**	
TRAVEL		**$2,000**	
Local travel @ $0.535/mile for Planning Council Support Staff	$500		
Out of EMA travel: One out of state trip for Office of Support staff for HIV planning meeting and five in State trips for staff and/or volunteer Council members for statewide HIV Planning meetings	$1,500		
SUPPLIES General consumable office supplies including materials for Council Members and Public Meetings	$5,000	**$5,000**	
CONTRACTUAL	$0	**$0**	
OTHER		**$131,551**	
Resource Guide	$60,000		
Needs Assessment Activities	$2,115		
Reimbursement for PC member expenses: Reimbursement for travel, childcare, meals and other eligible expenses resulting from participation in Council approved/ HRSA grant required activities.	$23,686		
Advertising for PC Activities: For publication of meeting announcements in community papers; invitations to participate in needs assessment activities and focus groups; advertisments for additional volunteers.	$6,000		
Communications (phone, pagers): For local and long distance phone expenses and internet charges.	$3,500		
Web Page Technical Assitance Costs: For additional training/consultation to staff in order to update/improve web site.	$500		

Houston Ryan White Planning Council
FY 2017 Council Support Budget
(Prepared 01-27-17)

		Subtotal	Total
Council Education: For speakers & training costs primarily for Council member orientation, room rentals & the cost of speakers for ongoing training to insure that key decision-makers receive necessary and relevant information. This includes the Sept. & Nov. 2015 Council meetings & the Jan. 2016 training/orientation meeting, all to be held off-site at locations within Harris County, Texas.	$3,500		
Project LEAP Student Reimbursement: 30 participants for 17 week course including travel, childcare and other eligible expenses resulting from participation in Council approved training activities related to the HRSA grant.	$5,500		
Project LEAP Education: Training costs for 17 weeks including speaker fees, room rental for off-site meetings & educational materials.	$9,500		
Interpreter Services For Spanish-speaking and sign-language interpretation services during public meetings, focus groups, etc.	$1,500		
Fees and Dues Registration costs for attending meetings, trainings and conferences related to HIV/AIDS health planning.	$500		
English/Spanish Translation (written): For professional translation of Council materials into Spanish.	$1,000		
Postal Machine Rental & Postage: For mailouts of Committee and Council agendas, minutes and attachments; HIV/AIDS Resource Guides for those who are unable to pickup in person; other office of support communications.	$5,000		
Copier Rental: For rental, service agreement of high-use Xerox machine used for Council and Office of Support.	$9,250		
TOTAL			**$512,439**

HOUSTON AREA HIV HEALTH SERVICES
RYAN WHITE PLANNING COUNCIL

EST. JUL. 15, 1997 **REV JUNE 12, 2014** **POLICY No. 900.01**

PETTY CASH

PURPOSE

This policy establishes the guidelines by which petty cash reimbursements of expenses to attend Houston Area HIV Health Services (Ryan White) Planning Council meetings are made. While all members of the RWPC are eligible for reimbursement this policy notes that members who are not Persons Living with HIV/AIDS (PWAs) are encouraged to pay for their own expenses out of their own funds. This policy includes both internal as well as external members.

AUTHORITY

"Guidelines for Reimbursement of People on a Ryan White Title I Planning" dated January 21, 1997, revised 05/29/98 of the Ryan White C.A.R.E. Act Title I manual, Guidelines for Reimbursement. The RWPC voted on February 10, 1996 to set as a priority the reimbursement of expenses to attend RWPC meetings (including subcommittee and related meetings). Those eligible to receive reimbursement of expenses to attend committee, subcommittee and related meetings include Council and external committee members.

DEFINITIONS

Meetings - are defined as outlined in the RWPC adoption of its Bylaws, Article IX. Rev. 12/07.

Meals - are those that are related to and occur as the result of attending any Houston area HIV/AIDS Health Services (Ryan White) Planning Council meeting.

PROCESS

Review – Annually, the Operations Committee will review RWPC petty cash policies and forms.

Transportation - Expenses will be reimbursed as a result of a Planning Council or external committee member attending a scheduled meeting. If travel is conveyed through the use of the members own vehicle the rate will be the same as the county rate per mile. Council and external committee members are reimbursed for mileage to and from a consistent, designated starting point (either home or work). The start point will be documented in the member's file and mileage will be determined by an Internet site selected annually by the Office of Support. If the member travels by cab, then an official cab company receipt must accompany the request for reimbursement. Bus expenses will be reimbursed at the prevailing METRO rate (round trip).

Traveling by cab should be the option of last resort, with the following exceptions. Council and external committee members who are accompanied by children are allowed to take a cab to and from work, home and/or the child care provider. Parents must provide the Office of Support with the location from where they will be coming at least 24 hours in advance of a meeting. Members are also allowed to use a cab if no other means of transportation is available or there

are barriers to existing transportation. Members are allowed to ask the Operations Committee for additional exemptions if necessary.

Meals - Snacks are provided at all Council related meetings to assist individuals with dietary needs. Individuals will not be reimbursed for purchasing a meal if staff notifies members that a meal is being provided at a particular meeting. Exceptions will be made for individuals with special dietary needs. If a meeting takes place near a meal time and the Office of Support has not announced that a meal will be provided, members are allowed to purchase a meal one hour before the scheduled start time of the meeting. Members will not be reimbursed if the receipt indicates that a meal was purchased after the scheduled start time for the meeting. Members will be reimbursed for food as well as transportation and childcare when representing the Council at off-site events such as health fairs, unless a meal is provided at the event.

Expenses for meals are to be reimbursed for "in-town" and "out-of-town" meetings. In-town meetings are those that occur as a result of a regularly scheduled meeting and a meal reimbursement is requested. The maximum amount allowed will be in accordance with current Harris County reimbursement rate for meals and receipts will be required.

Child Care - Expenses for childcare will be $35 per child per visit, not to exceed $100 per day (total). An exception to this would be an activity that takes place outside of normal business hours (6 am – 6 pm) in which case a volunteer could be reimbursed for an additional $35 per child per visit, not to exceed $100 (total). A Council approved Child Care Expense Receipt must be attached to the Claim for Reimbursement. Child Care reimbursements are based on RWPC meetings or committee related events.

Other - Council and External Committee members who choose to attend a non-assigned meeting or event will not be reimbursed from petty cash for their participation in that meeting. Also, members will not be reimbursed for transportation, childcare and/or food if they arrive 20 minutes after the scheduled start time for the meeting. Within the calendar year, members are allowed two exemptions if they arrive at a meeting 20 minutes late. If necessary, members are allowed to ask the Operations Committee for additional exemptions for reimbursement if they are more than 20 minutes late to a meeting.

MAXIMUM REIMBURSEMENT RATES

All Ryan White Council and external committee members can receive up to the following amount in petty cash reimbursement within a 12 month calendar year, unless the member receives a waiver for an increased amount from the Operations Committee based upon personal circumstances.

The allowable amount for all members is:

11 committee meetings
+ 2 trainings
+ 3 workgroups or Public Hearings
16 meetings/year x $100/meeting = $1,600

Council Chair: up to $5,000/year
($1,600 + 12 Council meetings + 12 Steering Committee meetings + 10 additional misc. meetings)

Officers & Committee Chairs: up to $4,000/year
($1,600 + 12 Council meetings + 12 Steering Committee meetings)

Council Members: up to $2,800/year
($1,600 + 12 Council meetings)

External Committee Members: up to $1,600/year

If an individual uses their work address as the point of origin for their travel reimbursement, then they are not eligible for childcare reimbursement. Requests for exceptions can be submitted to the Operations Committee for review and approval.

If it becomes clear that an individual is going to exceed the amount listed above within a calendar year, the following steps are to be taken:

Step 1: The Manager of the Office of Support will verbally bring the matter to the attention of the member and document the conversation in the member's folder.

Step 2: If the situation continues after two conversations with the member, the member will receive a letter signed by the Chair of the Planning Council and the Manager of the Office of Support. The letter will document the total amount the member has received in petty cash reimbursement and request a meeting to outline ways in which the individual can begin to limit reimbursement.

Step 3: If the member is unable or unwilling to limit reimbursement than the Council Chair will review and possibly reappoint the member to a committee that has fewer meetings and/or fewer outside activities.

Step 4: If the individual member reaches the cap outlined above, they can request a waiver from the policy from the Operations Committee. The Operations Committee will review the request and, after consulting with the Chair of the Ryan White Planning Council and the Manager of the Office of Support, the Committee will have final approval regarding the response to the request for a waiver and will notify the individual of their decision in writing. If the request for a waiver is denied, the member will not be reimbursed for mileage, childcare and/or meals for the remainder of the calendar year. The member will be eligible to receive petty cash reimbursement for activities that take place in the next calendar year, once the New Year begins.

Per Harris County policy, petty cash is not allowed to be taken off site. Therefore, members will be reimbursed for off-site meetings the next time they are at the Office of Support. Members will not be reimbursed for travel to the Office if the sole reason for coming to the Office is to be reimbursed for an off-site meting.

Reimbursement requests are to be submitted to the Office of Support for payment. Receipts can be submitted at anytime within 45 days of the date of the event, with the exception of end of year reimbursements which must be submitted within 30 days after the end of the Ryan White Part A fiscal year. Any request over and above the amounts and time frames as outlined above needs to be submitted in writing to the RWPC Manager for approval. Reimbursement requests presented 30 days after the end of the fiscal year will not be approved. All reimbursements are available from the RWPC Support Staff.

The RWPC will not reimburse members for loss of wages as a result of attending meetings.

SLATE OF NOMINEES

As of Wednesday, May 24, 2017, the following people have been nominated to run for the position of Vice Chair for the 2017 Ryan White Planning Council:

Vice Chair:

Skeet Boyle

Tracy Gorden

Teresa Pruitt

2017 QUARTERLY REPORT
OPERATIONS COMMITTEE
(submit May 2017)

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

1. Design and implement Orientation for Council members and new external committee members in January and February 2017.
   Status: done

2. When necessary, address member needs for additional orientation and training, including through the Committee Mentoring Program. (Example: create more training for mentors and a "Frequently Asked Questions" form. The information for this document can be gathered from Project LEAP and others.)
   Status: done + ongoing

3. *When necessary, review and revise the bylaws, policies, and procedures of the Ryan White Planning Council.
   Status: ongoing

4. When necessary, review and revise policies and procedures for the Council support staff.
   Status: ongoing

5. *Investigate and make recommendations regarding complaints and grievances brought before the committee in order to assure member/staff compliance with bylaws, policies, and procedures.
   Status: NA

6. *Resolve any grievances brought forward.
   Status: NA

7. *Make nominations to the CEO, which ensure the reflectiveness and representativeness of the Council.
   Status: not yet

8. Evaluate the performance of the Manager in conjunction with the Planning Council Chair and CEO.
   Status: not yet

9. Ensure that the Council is complying with HRSA, County and other open meeting requirements.
   Status: done - ongoing

10. Annually, review the status of Committee activities identified in the Comprehensive Plan.
    not yet

Status of Tasks on the Timeline:

OK

Nancy Mietschin
Committee Chairperson

May 17, 2017
Date

Priority and Allocations 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 Reconciliation (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
1	**Outpatient/Ambulatory Primary Care**	**9,746,354**	**516,252**	**399,947**	**0**	**0**	**10,662,553**	**49.70%**	**10,662,553**	**0**		**10,064,136**	**94%**
1.a	Primary Care - Public Clinic (a)	3,570,049	73,790	0	0		3,643,839	16.99%	3,643,839	0	3/1/2016	$4,318,811	119%
1.b	Primary Care - CBO Targeted to AA (a) (e) (f)	1,066,552	148,743	108,329	0		1,323,624	6.17%	1,323,624	0	3/1/2016	$1,250,761	94%
1.c	Primary Care - CBO Targeted to Hispanic (a) (e) (f)	929,215	128,225	108,329	0		1,165,769	5.43%	1,165,769	0	3/1/2016	$931,698	80%
1.d	Primary Care - CBO Targeted to White/MSM (a) (e)	926,294	78,076	108,329	0		1,112,699	5.19%	1,112,699	0	3/1/2016	$629,119	57%
1.e	Primary Care - CBO Targeted to Rural (a) (e)	1,143,032	23,626	0	0		1,166,658	5.44%	1,166,658	0	3/1/2016	$1,003,518	86%
1.f	Primary Care - Women at Public Clinic (a)	1,863,570	38,519	0			1,902,089	8.87%	1,902,089	0	3/1/2016	$1,611,222	85%
1.g	Primary Care - Pediatric (a.1)	15,124	313				15,437	0.07%	15,437	0	3/1/2016	$14,622	95%
1.h	Vision	232,518	24,960	74,960	0		332,438	1.55%	332,438	0	3/1/2016	$329,790	99%
2	**Medical Case Management**	**2,215,702**	**0**	**174,999**	**0**	**0**	**2,390,701**	**11.14%**	**2,390,701**	**0**		**2,155,774**	**90%**
2.a	Clinical Case Management	488,656	0		0		488,656	2.28%	488,656	0	3/1/2016	$485,750	99%
2.b	Med CM - Public Clinic (a)	162,622	0	0	0		162,622	0.76%	162,622	0	3/1/2016	$350,566	216%
2.c	Med CM - Targeted to AA (a) (e)	321,070	0	58,333	0		379,403	1.77%	379,403	0	3/1/2016	$421,490	111%
2.d	Med CM - Targeted to H/L (a) (e)	321,072	0	58,333	0		379,405	1.77%	379,405	0	3/1/2016	$176,655	47%
2.e	Med CM - Targeted to W/MSM (a) (e)	107,247	0	58,333	0		165,580	0.77%	165,580	0	3/1/2016	$116,243	70%
2.f	Med CM - Targeted to Rural (a)	348,760	0	0			348,760	1.63%	348,760	0	3/1/2016	$283,207	81%
2.g	Med CM - Women at Public Clinic (a)	180,311	0	0			180,311	0.84%	180,311	0	3/1/2016	$138,441	77%
2.h	Med CM - Targeted to Pedi (a.1)	160,051	0	0	0		160,051	0.75%	160,051	0	3/1/2016	$112,006	70%
2.i	Med CM - Targeted to Veterans	80,025	0	0	0		80,025	0.37%	80,025	0	3/1/2016	$68,773	86%
2.j	Med CM - Targeted to Youth	45,888	0	0			45,888	0.21%	45,888	0	3/1/2016	$2,645	6%
3	**Local Pharmacy Assistance Program (a) (e)**	**2,581,440**	**53,356**		**0**	**0**	**2,634,796**	**12.28%**	**2,634,796**	**0**	3/1/2016	**$2,393,204**	**91%**
4	**Oral Health**	**166,404**	**0**	**30,000**	**0**	**0**	**196,404**	**0.92%**	**196,404**	**0**	3/1/2016	**196,400**	**100%**
4.a	Oral Health - Untargeted (c)	0					0	0.00%	0	0	N/A	$0	0%
4.b	Oral Health - Targeted to Rural	166,404	0	30,000			196,404	0.92%	196,404	0	3/1/2016	$196,400	100%
5	**Mental Health Services (c)**	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**	**NA**	**$0**	**0%**
6	**Health Insurance (c)**	**1,029,422**	**0**	**0**	**0**	**0**	**1,029,422**	**4.80%**	**1,029,422**	**0**	3/1/2016	**$1,029,176**	**100%**
7	**Home and Community-Based Services (c)**	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**	**NA**	**$0**	**0%**
8	**Substance Abuse Services - Outpatient**	**45,677**	**0**	**0**	**0**	**0**	**45,677**	**0.21%**	**45,677**	**0**	3/1/2016	**$35,669**	**78%**
9	**Early Intervention Services (c)**	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**	**NA**	**$0**	**0%**
10	**Medical Nutritional Therapy (supplements)**	**341,395**	**0**	**0**	**0**	**0**	**341,395**	**1.59%**	**341,395**	**0**	3/1/2016	**$339,118**	**99%**
11	**Hospice Services**	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**	**NA**	**$0**	**0%**
12	**Non-Medical Case Management**	**1,440,385**	**0**	**35,378**	**0**	**0**	**1,475,763**	**6.88%**	**1,475,763**	**0**		**1,100,518**	**75%**
12.a	Service Linkage targeted to Youth	110,793		0			110,793	0.52%	110,793	0	3/1/2016	$79,668	72%
12.b	Service Linkage targeted to Newly-Diagnosed/Not-in-Care	245,497			0		245,497	1.14%	245,497	0	3/1/2016	$68,695	28%
12.c	Service Linkage at Public Clinic (a)	490,886		0	0		490,886	2.29%	490,886	0	3/1/2016	$79,668	16%
12.d	Service Linkage embedded in CBO Pcare (a) (e)	593,209		35,378	0		628,587	2.93%	628,587	0	3/1/2016	$568,360	90%
13	**Medical Transportation**	**527,362**	**0**	**40,000**	**0**	**0**	**567,362**	**2.64%**	**567,362**	**0**		**389,864**	**69%**
13.a	Medical Transportation services targeted to Urban	252,680	0	20,000	0		272,680	1.27%	272,680	0	3/1/2016	$299,796	110%
13.b	Medical Transportation services targeted to Rural	97,185	0	20,000	0		117,185	0.55%	117,185	0	3/1/2016	$90,068	77%
13.c	Transportation vouchering (bus passes & gas cards)	177,497	0	0	0		177,497	0.83%	177,497	0	3/1/2016	$0	0%
14	**Linguistic Services (c)**	**0**	**0**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**	**NA**	**$0**	**0%**
15	**Legal Assistance**	**293,406**	**-293,406**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0**	NA	**$0**	**0%**
BE027518	**Total Service Dollars**	**18,387,547**	**276,202**	**680,324**	**0**	**0**	**19,344,073**	**90.17%**	**19,344,073**	**0**		**17,703,859**	**92%**
	Grant Administration	**1,612,704**	**0**	**0**	**0**	**0**	**1,612,704**	**7.52%**	**1,612,704**	**0**	**N/A**	**1,463,413**	**91%**
BE027517	HCPHES/RWGA Section	1,146,388	0	0		0	1,146,388	5.34%	1,146,388	0	N/A	$1,080,632	94%
PC	County Judge & RWPC Support*	466,316	0			0	466,316	2.17%	466,316	0	N/A	382,781	82%
BE027521	Quality Management	**495,000**	**0**	**0**	**0**	**0**	**495,000**	**2.31%**	**495,000**	**0**	**N/A**	**$478**	**0%**
		20,495,251	**276,202**	**680,324**	**0**	**0**	**21,451,777**	**100.00%**	**21,451,777**	**0**		**19,167,750**	**89%**
								Unallocated	Unobligated				
	Part A Grant Award:	20,771,451	*Carry Over:*	680,325		*Total Part A:*	21,451,776	-1	-1				

Prepared by: Ryan White Grant Administration

FY 2016 Ryan White Part A and MAI Service Utilization Report

SUR - 4th Quarter Cumulative (3/1-2/28)																	
Priority	Service Category	Goal	Unduplicated Clients Served YTD	Male	Female	AA (non-Hispanic)	White (non-Hispanic)	Other (non-Hispanic)	Hispanic	0-12	13-19	20-24	25-34	35-44	45-49	50-64	65 plus
1	**Outpatient/Ambulatory Primary Care (excluding Vision)**	**6,467**	**7,579**	**74%**	**26%**	**50%**	**15%**	**2%**	**33%**	**0%**	**1%**	**6%**	**26%**	**27%**	**13%**	**25%**	**2%**
1.a	Primary Care - Public Clinic (a)	2,350	3,477	69%	31%	53%	11%	2%	35%	0%	0%	3%	19%	26%	13%	35%	3%
1.b	Primary Care - CBO Targeted to AA (a) (g)	1,060	1,814	69%	31%	99%	0%	1%	0%	0%	1%	11%	35%	26%	11%	15%	1%
1.c	Primary Care - CBO Targeted to Hispanic (a) (g)	960	1,227	84%	16%	0%	0%	0%	100%	0%	0%	7%	30%	32%	14%	16%	1%
1.d	Primary Care - CBO Targeted to White and/or MSM (a)	690	755	88%	12%	0%	88%	11%	0%	0%	0%	5%	26%	24%	16%	27%	2%
1.e	Primary Care - CBO Targeted to Rural (a)	400	740	73%	27%	46%	19%	2%	32%	0%	1%	7%	32%	27%	12%	19%	2%
1.f	Primary Care - Women at Public Clinic (a)	1,000	1,065	0%	100%	65%	8%	2%	26%	0%	0%	2%	16%	31%	15%	33%	3%
1.g	Primary Care - Pediatric (a)	7	18	61%	39%	50%	6%	0%	44%	28%	50%	22%	0%	0%	0%	0%	0%
1.h	Vision	1,600	2,149	74%	26%	47%	16%	2%	34%	0%	0%	4%	21%	22%	16%	32%	3%
2	**Local Drug Reimbursement Program (a)**	**2,845**	**4,387**	**78%**	**22%**	**49%**	**16%**	**2%**	**33%**	**0%**	**0%**	**6%**	**30%**	**28%**	**14%**	**20%**	**1%**
3	**Medical Case Management (f)**	**3,075**	**5,385**														
3.a	Clinical Case Management	600	1,406	74%	26%	59%	22%	2%	17%	0%	0%	6%	25%	23%	13%	30%	3%
3.b	Med CM - Targeted to Public Clinic (a)	280	585	98%	2%	56%	10%	2%	31%	0%	2%	17%	21%	19%	9%	30%	2%
3.c	Med CM - Targeted to AA (a)	550	1,885	69%	31%	99%	0%	1%	0%	0%	1%	9%	32%	25%	11%	20%	1%
3.d	Med CM - Targeted to H/L(a)	550	883	85%	15%	0%	0%	0%	100%	0%	0%	7%	32%	28%	14%	16%	1%
3.e	Med CM - Targeted to White and/or MSM (a)	260	568	87%	13%	0%	89%	11%	0%	0%	1%	3%	24%	22%	16%	32%	3%
3.f	Med CM - Targeted to Rural (a)	150	793	72%	28%	46%	24%	3%	27%	0%	1%	6%	27%	24%	13%	26%	3%
3.g	Med CM - Targeted to Women at Public Clinic (a)	240	281	0%	100%	68%	7%	1%	23%	0%	2%	11%	13%	29%	15%	27%	3%
3.h	Med CM - Targeted to Pedi (a)	125	102	51%	49%	75%	5%	0%	21%	59%	30%	11%	0%	0%	0%	0%	0%
3.i	Med CM - Targeted to Veterans	200	175	95%	5%	75%	16%	1%	8%	0%	0%	0%	2%	3%	5%	69%	21%
3.j	Med CM - Targeted to Youth	120	113	99%	1%	64%	6%	2%	28%	0%	10%	90%	0%	0%	0%	0%	0%
4	**Oral Health**	**200**	**290**	**68%**	**32%**	**42%**	**32%**	**1%**	**24%**	**0%**	**0%**	**5%**	**22%**	**27%**	**12%**	**29%**	**3%**
4.a	Oral Health - Untargeted (d)	NA	NA	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
4.b	Oral Health - Rural Target	200	290	68%	32%	42%	32%	1%	24%	0%	0%	5%	22%	27%	12%	29%	3%
5	**Medical Nutritional Therapy/Nutritional Supplements**	**650**	**503**	**77%**	**23%**	**41%**	**23%**	**4%**	**33%**	**0%**	**0%**	**2%**	**11%**	**20%**	**19%**	**42%**	**7%**
6	**Mental Health Services (d)**	**NA**	**NA**														
7	**Health Insurance**	**1,700**	**1,220**	**83%**	**17%**	**41%**	**30%**	**2%**	**27%**	**0%**	**0%**	**3%**	**15%**	**23%**	**16%**	**39%**	**4%**
8	**Substance Abuse Treatment - Outpatient**	**40**	**29**	**93%**	**7%**	**28%**	**55%**	**0%**	**17%**	**0%**	**0%**	**3%**	**28%**	**31%**	**14%**	**24%**	**0%**
9	**Hospice Services (d)**	**NA**	**NA**														
10	**Home and Community Based Services (d)**	**NA**	**NA**														
11	**Early Medical Intervention Services (d)**	**NA**	**NA**														
12	**Non-Medical Case Management**	**7,045**	**7,289**														
12.a	Service Linkage Targeted to Youth	320	243	78%	22%	59%	8%	2%	31%	0%	14%	86%	0%	0%	0%	0%	0%
12.b	Service Linkage at Testing Sites	260	197	68%	32%	68%	9%	1%	23%	0%	0%	0%	35%	22%	12%	27%	5%
12.c	Service Linkage at Public Clinic Primary Care Program (a)	3,700	3,049	68%	32%	61%	11%	2%	27%	0%	0%	0%	20%	24%	13%	39%	4%
12.d	Service Linkage at CBO Primary Care Programs (a)	2,765	3,800	76%	24%	54%	15%	2%	29%	2%	1%	8%	29%	25%	12%	22%	2%
13	**Food Pantry ~~(funded by State Services)~~**	**NA**	**NA**														
14	**Transportation**	**2,850**	**3,215**														
14.a	Transportation Services - Urban	170	545	69%	31%	58%	12%	2%	28%	0%	0%	8%	28%	26%	11%	24%	4%
14.b	Transportation Services - Rural	130	156	77%	23%	35%	38%	1%	26%	0%	0%	8%	22%	18%	15%	33%	4%
14.c.1	Transportation vouchering (bus passes)	2,500	2,446														
14.c.2	Transportation vouchering (gas vouchers)	50	68														
15	**Legal Assistance**	**390**	**0**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
16	**Linguistic Services (d)**	**NA**	**NA**														
Net unduplicated clients served - all categories*		**10,200**	**12,527**	**74%**	**26%**	**53%**	**16%**	**2%**	**29%**	**1%**	**1%**	**6%**	**23%**	**24%**	**13%**	**29%**	**3%**
Living AIDS cases + estimated Living HIV non-AIDS (from FY 14 App) (b)		**NA**	**22,830**	**74%**	**26%**	**49%**	**23%**	**3%**	**25%**	**0%**	**6%**		**18%**	**27%**	**30%**	**18%**	

***10,200** clients to be served is based on the number of unduplicated clients served in FY 2013 (update per CPCDMS)

Printed: 5/3/2017

DRAFT

Worksheet for Determining FY 2017 Service Priorities – includes Committee changes made on 05/25/17

Core Services	HL Scores	HL Rank	Approved FY 2015 & FY 2016 Priorities	Proposed FY 2017 Priorities	Justification
Ambulatory/Outpatient Medical Care	HHH	2	1	1	Service Priorities are the same in FY 2015, FY 2016 and FY 2017 because there is no new needs assessment data or significant additional data.
Medical Case Management	HHH	2	2	2	
Local Pharmacy Assistance Program	HHH	2	3	3	
Oral Health Services	HHH	2	4	4	
Mental Health Services	HLH	4	5	5	
Health Insurance	LHH	6	6	6	
Day Treatment	LLH	7	7	7	
Substance Abuse Treatment	LLH	7	8	8	
Early Intervention Services (jail)	LLL	8	9	9	
Medical Nutritional Therapy	LLL	8	10	10	
Hospice*	-	-	11	11	
Support Services	**HL Scores**	**HL Rank**	**Approved FY 2015 & FY 2016 Priorities**	**Proposed FY 2017 Priorities**	**Justification**
Outreach*				12	Due to 64% retention rates and a Comprehensive Plan goal of 85%, make this service the first priority among support services.
Non-medical case management	HHH	2	12	13	
Medical Transportation	LHH	6	13	14	
Linguistics Services	LLH	7	14	15	
Other Professional Services	LLL	8	15	16	
Emergency Financial Assistance*				17	Added per QI Committee recommendation.
Referral for Health Care & Support Services*				18	Added per QI Committee recommendation.

*Hospice, Outreach, Emergency Financial Assistance, and Referral for Health Care & Support Services do not have HL Score or HL Rank as they were not included in the 2014 Needs Assessment service category need and accessibility rankings.

Criteria for Determining FY 2015 Service Priorities

(DRAFT May 18, 2017)

Type	Definition	Data Source	Example
1. Need*	**Proportion of PLWHA reporting a need for the service in the past 12 months.** Calculation: Total number of needs assessment participants reporting a need for the service in the past 12 months, including both ease (a) and difficulty (b) to access, divided by the total number of respondents (N) to the service category: (a+b)/N=% (rounded)	Needs Assessment	*Primary care*: 491 needs assessment participants reported they needed primary care and it was easy to access; 87 reported they needed primary care and it was difficult to access, for a total of 578 participants who needed primary care. A total of 664 participants responded to the primary care survey question. Therefore, the percent needing primary care is 87% (or 578/664).
2. Use	**Number of PLWHA who received the service in the past 12 months.** Calculation: Total number of unduplicated clients served in each service category for the designated calendar year (January 1 to December 31)	CPCDMS	*Primary care*: 7,000 persons were served in primary care in calendar year 2013. Therefore, the value for use is 7,000.
3. Accessibility*	**Proportion of PLWHA reporting a need for the service in the past 12 months who also reported the service was easy to access.** Calculation: Total number of needs assessment participants reporting they needed the service and it was easy to access (a) divided by the total number of participants reporting a need for the service in the past 12 months regardless of ease (a) or difficulty (b): a/(a+b)=% (rounded)	Needs Assessment	*Primary care*: A total of 578 participants reported a need for primary care (regardless of ease or difficulty to access). Of this total, 491 reported that primary care was easy to access. Therefore, the accessibility rating for primary care is 85% (or 491/578).

*This methodology will be used for all Service Categories measured explicitly in the 2014 Houston Area HIV/AIDS Needs Assessment. This excludes Non-Medical Case Management, which was not surveyed explicitly. For Non-Medical Case Management, an alternate methodology based on data availability will be used as follows:

- Need: Proportion of needs assessment participants diagnosed in the past 12 months (newly-diagnosed) who reported receipt of service linkage
- Accessibility: Proportion of participants diagnosed in the past 12 months (newly-diagnosed) who reported being linked to HIV medical care within 90 days

Setting Priorities

Table 1 below serves as an initial guide for the prioritization process. Services have been ranked based upon needs assessment survey information collected in 2014

Table 1: Prioritizing Needs

Possible Scenarios	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**
Need	High	High	High	High	Low	Low	Low	Low
Use	High	High	Low	Low	High	High	Low	Low
Ease in Accessing	Low	High	Low	High	Low	High	High	Low

1. HHL – Clients indicate this as a high need and that it is readily used in the area. However, clients indicate that the service is difficult to access.

2. HHH - Clients indicate this as a highly needed service in the area. Clients also indicate that the service is readily used in their area and high access to service. Thus, ranking it second highest to ensure that this service continues to be accessible.

3. HLL – Clients indicate this as a high need, but the service is not readily used in the area. In addition, clients indicate that the service is not very accessible.

4. HLH – Clients indicate this as a high need and that the service is not readily used. However, clients indicate a high access to this service.

5. LHL – Clients indicate this as a low service need, but that it is readily used. However, clients indicate the service is difficult to access.

6. LHH – Clients indicate this as a low need, and that it is readily used in the area. In addition, clients indicate a high access to this service.

7. LLH – Clients indicate this as a low need and that the service is not readily used. In addition, clients indicate a high access to this service. It is there if needed.

8. LLL – Clients indicate this as a low need and the service is not readily used in the area. In addition, clients indicate difficulty to accessing this service. Not readily needed nor used thus low priority of having it accessible.

Request for Service Category Increase
Ryan White Part A and MAI

Control #3

A.	Name of Agency **(not provided to RWPC)**						
B.	Contract Number **(not provided to RWPC)**						
C.	Service Category Title (per RFP)	**VISION**				Control No.	3
D.	Request for Increase under (check one):	Part A: **X**	or	MAI:			
	Request Period (check one):	April: **X**	August:	Oct:	Final Qtr:		
E.	Amount of additional funding Requested:	**$50,000.00**					
F.	Unit of Service: (list only those units and disbursements where an increase is requested)	a. Number of units in current contract:	b. Cost/unit	c. Number of additional units requested:	d. Total: (b x c)		
	1. VISION	**755**	**$100.00**	**500**	**$50,000.00**		
	2.				$0.00		
	3.				$0.00		
	4.				$0.00		
	5.				$0.00		
	6.				$0.00		
	7.				$0.00		
	8. Disbursements (list current **amount** in column a. and **requested**amount in column c.)	$0.00	N/A		$0.00		
	9.Total additional funding (must match E. above):				**$50,000.00**		
G.	Number of new/additional clients to be served with requested increase.	**250**					
H.	Number of clients served under current contract - Agencies must use the CPCDMS to document numbers served. **De-identified CPCDMS-generated reports will be provided to the RWPC by RWGA.**	a. Number of clients served per CPCDMS	b. Percent AA (non-Hispanic)	c. Percent White (non-Hispanic)	d. Percent Hispanic (all races)	e. Percent Male	f. Percent Female
	1. Number of clients that received this service under Part A (or MAI) in FY 2016.* (March 1, 2016 - February 28, 2017) *If agency was funded for service under Part A (or MAI) in FY 2016 - if not, mark these cells as "NA"	**918**	**57% (raw# = 520)**	**11% (raw# = 102)**	**30% (raw# = 273)**	**69% (raw# = 637)**	**31% (raw# = 281)**
	2. Number of clients that have received this service under Part A (or MAI) in FY 2017. a. April Request Period = Not Applicable b. August Request Period = 03/01/17 - 06/30/17 c. October Request Period = 03/01/17 - 09/30/17 d. 4th Qtr. Request Period = 03/01/17- 11/30/17	**Not Applicable**	**Not Applicable**	**Not Applicable**	**Not Applicable**	**Not Applicable**	**Not Applicable**

Request for Service Category Increase
Ryan White Part A and MAI

I.	Additional Information Provided by Requesting Agency (subject to audit by RWGA). Answer all questions that are applicable to agency's current situation.	a. Enter Number of Weeks in this column	b. How many Weeks will this be if full amount of request is received?	c. Comments (do **not** include agency name or identifying information):
	1. Length of waiting time (in weeks) for an appointment for a **new** client:	**3-4 weeks**	**1-2 weeks**	**We would like to be able to provide new patients services within 1 week of scheduling an appointment. With the steady increase in new patient appointments the appointment times could easily be expanded to a 4-5 week appointment time without increased funding.**
	2. Length of waiting time (in weeks) for an appointment for a **current** client:	**2 weeks**	**0 weeks**	**We would be able to see existing patients within the same week with funding increase.**
	3. Number of clients on a "waiting list" for services (per Part A SOC):	**0**	**0**	**No waiting list at this time as we have been able to continue scheduling all patients for appointments.**
	3. Number of clients unable to access services monthly (number unable to make an appointment) (per Part A SOC):	**0**	**0**	

J.	List all other sources and amounts of funding for **similar** services currently in place with agency:	a. Funding Source:	b. End Date of Contract:	c. Amount	d. Comment (50 words or less):
	1.				
	2.				
	3.				
	4.				

K.	Submit the following documentation at the same time as the request (budget narrative and fee-for-service budgets may be hard copy or fax):
	Revised Budget Narrative (Table I.A.) corresponding to the revised contract total (amount in Item F.9.d. plus current contract amount).
	This form must be submitted electronically via email by published deadline to Carin Martin: cmartin@hcphes.org

HARRIS COUNTY PUBLIC HEALTH AND ENVIRONMENTAL SERVICES - RWGA

SERVICE UTILIZATION REPORT

[Agency]: [Grant]: all [Service]: ALL [Service Performer]: 0
Services performed between 3/1/16 and 2/28/17 [1]
[Age Group]: AgeGrp2 (condensed) [Include/Exclude SubCats]: INCLUDE
[Contract 1]: [Sub Cats 1]: All [Contract 2]: n/a [Sub Cats 2]: All
[Contract 3]: n/a [Sub Cats 3]: All
[Contract 4]: n/a [Sub Cats 4]: All [Contract 5]: n/a [Sub Cats 5]: All
[MAI]: ALL [ShowDetail]: False [Registration Type]: ALL [NewClientsOnly]: No [3]

		BIRTH GENDER								
		MALE			FEMALE			BOTH GENDERS		
RACE	AGE[2]		Hispanic	Non-Hisp		Hispanic	Non-Hisp		Hispanic	Non-Hisp
AFRICAN AMERICAN	0-12	**0**	0	0	**0**	0	0	**0**	0	0
	13-24	**34**	0	34	**7**	0	7	**41**	0	41
	25-49	**240**	9	231	**121**	2	119	**361**	11	350
	50-64	**69**	2	67	**57**	1	56	**126**	3	123
	65+	1	0	1	**5**	0	5	**6**	0	6
	SubTotals:	*344*	*11*	*333*	*190*	*3*	*187*	*534*	*14*	*520*
ASIAN	0-12	**0**	0	0	**0**	0	0	**0**	0	0
	13-24	**0**	0	0	**0**	0	0	**0**	0	0
	25-49	**4**	1	3	**1**	0	1	**5**	1	4
	50-64	**3**	1	2	**1**	0	1	**4**	1	3
	65+	**0**	0	0	**0**	0	0	**0**	0	0
	SubTotals:	*7*	*2*	*5*	*2*	*0*	*2*	*9*	*2*	*7*
MULTI-RACE	0-12	**0**	0	0	**0**	0	0	**0**	0	0
	13-24	**1**	0	1	**0**	0	0	**1**	0	1
	25-49	**5**	1	4	**5**	1	4	**10**	2	8
	50-64	**1**	1	0	**0**	0	0	**1**	1	0
	65+	**0**	0	0	**0**	0	0	**0**	0	0
	SubTotals:	*7*	*2*	*5*	*5*	*1*	*4*	*12*	*3*	*9*
NATIVE AMERICAN	0-12	**0**	0	0	**0**	0	0	**0**	0	0
	13-24	**0**	0	0	**0**	0	0	**0**	0	0
	25-49	**3**	0	3	**1**	0	1	**4**	0	4
	50-64	**0**	0	0	**0**	0	0	**0**	0	0
	65+	**0**	0	0	**0**	0	0	**0**	0	0
	SubTotals:	*3*	*0*	*3*	*1*	*0*	*1*	*4*	*0*	*4*
PAC.ISLND/HAWAII	0-12	**0**	0	0	**0**	0	0	**0**	0	0
	13-24	**0**	0	0	**0**	0	0	**0**	0	0
	25-49	**1**	0	1	**0**	0	0	**1**	0	1
	50-64	**1**	0	1	**1**	0	1	**2**	0	2
	65+	**0**	0	0	**0**	0	0	**0**	0	0
	SubTotals:	*2*	*0*	*2*	*1*	*0*	*1*	*3*	*0*	*3*
WHITE	0-12	**0**	0	0	**0**	0	0	**0**	0	0
	13-24	**19**	18	1	**4**	2	2	**23**	20	3
	25-49	**183**	142	41	**52**	34	18	**235**	176	59
	50-64	**66**	40	26	**24**	14	10	**90**	54	36
	65+	**7**	4	3	**2**	1	1	**9**	5	4
	SubTotals:	*275*	*204*	*71*	*82*	*51*	*31*	*357*	*255*	*102*
ALL RACES	0-12	**0**	0	0	**0**	0	0	**0**	0	0
	13-24	**54**	18	36	**11**	2	9	**65**	20	45

		BIRTH GENDER								
		MALE			FEMALE			BOTH GENDERS		
RACE	AGE[2]		Hispanic	Non-Hisp		Hispanic	Non-Hisp		Hispanic	Non-Hisp
ALL RACES	25-49	**436**	153	283	**180**	37	143	**616**	190	426
	50-64	**140**	44	96	**83**	15	68	**223**	59	164
	65+	**8**	4	4	7	1	6	**15**	5	10
	SubTotals:	***638***	***219***	***419***	***281***	***55***	***226***	***919***	***274***	***645***

Clients Served This Period

Unduplicated clients:	919
Client visits: [3]	1670
Spanish speaking (primary language at home) clients served:	175
Deaf/hard of hearing clients served:	5
Blind/sight impaired clients served:	7
Homeless clients served:	207
Transgender M to F clients served:	11
Transgender F to M clients served:	0
Clients served this period who live w/in Harris County:	791
Clients served this period who live outside Harris County:	128
Active substance abuse clients served:	27
Active psychiatric illness clients served:	115

Methods of Exposure (not mutually exclusive)

PerinatalTransmission	7
Hemophilia Coagulation	1
Transfusion	9
Heterosexual Contact	404
MSM (not IDU)	370
IV Drug Use (not MSM)	10
MSM/IDU	0
Multiple Exposure Categories	31
Other risk	137

Multi-Race Breakdown

BLK,ASN	1
BLK,NTV	4
BLK,WHT	5
NTV,WHT	2

FOOTNOTES

[1] Visit = time spent per client per agency per service per day

[2] Age as of 2/28/17

[3] If New Client = Yes is selected then clients were only included if they had no encounters (for the service, agency, and grant selected) in the twelve months prior to 3/1/2016; encounters (for the service, agency, and grant selected) may or may not have occurred prior to 03/01/15.

CONTROL # B Workgroup Recommended

THE RESOURCE GROUP

April 6, 2017

To:
Houston Ryan White Planning Council
Houston Ryan White Grant Administration
Houston EMA/HSDA HIV Care Providers

Subject: AA recommendation per DSHS for Clinical-Based ADAP Enrollment Service Linkage Worker

Greetings,
This is the official notice from The Resource Group, Inc. (TRG), Ryan White Part B and State Services Grant Administration Agency, to recommend use of the additional DSHS State Services funding. DSHS is distributing its rebate funds to its AAs to expend under the label "State Services-Rebate(SS-R)". Each AA has the flexibility of distribution of the funding to ensure the continuous services and/or to fill any gaps in services. TRG is recommending use of these funds to support the ADAP/RW Eligibility Enrollment Network (RWAN) by co-locating a Clinical-Based ADAP Enrollment Service Linkage position at each Part A funded clinical site. TRG would like to recommend that $375,000 be allocated to implement Clinical-Based ADAP Enrollment Service Linkage Workers for Ryan White primary care funded agencies in Houston EMA/HSDA.

HOUSTON REGIONAL HIV/AIDS RESOURCE GROUP, INC.

Currently, the Ryan White Regional ADAP Liaison, Marcus Benoit, has created the RWAN through signed MOU's with all Ryan White Care sites and supportive service agencies in the 6 HSDAs including Houston throughout East Texas. Over the past 6 months TRG has collected data through informal ADAP site visits to assess the need for ADAP Enrollment Service Linkage workers at Ryan White Care sites in Houston EMA/HSDA. Results indicated that having a designated position to focus on ADAP applications would be beneficial to the clients, providers and the Texas HIV Medication Program. Through DSHS funding, this same process has been implemented in Texarkana HSDA, Tyler HSDA, Lufkin HSDA, Beaumont HSDA and Galveston HSDA where each DSHS funded clinic has hired an ADAP Enrollment Linkage position. This has resulted in much success and improvements in submitting completed THMP applications with accurate supportive documentation.

Please take this recommendation into consideration for the Houston HSDA, as many of the applications submitted to the Texas HIV Medication Program office comes from the Houston area.

Kind regards,

Yvette Garvin, Executive Director

500 Lovett Blvd.
Suite 100
Houston
Texas
77006

713 526-1016
FAX 713 526-2369
www.hivtrg.org

CONTROL # A Workgroup Recommended

2017 Special Idea

To be considered, this form must be received by Tori Williams: victoria.williams@cjo.hctx.net or Fax 713 572-3740 before the deadline of 8:00 a.m. on Monday, April 17, 2017. Thank you.

THIS BOX TO BE COMPLETED BY RWPC SUPPORT STAFF ONLY

Service Category: TBD

DESCRIPTION OF THE IDEA (this form cannot be more than one page):

Compassionate Care Rx Program

This plan would take effect approximately 7 days after that the patient's physician visit and would provide medications until ADAP (or other) coverage begins.

As DSHS has informed the HIV community, they are continuing to receive a substantial amount of funds from pharmaceutical companies in the form of rebates for medications purchased by ADAP -- approximately $20 million annually.

[redacted] a non-profit organization which represents a large number of pharmaceutical companies who have joined together to offer a single, common application and prescription processing for patient assistance programs offered by all the separate companies. Initially, [redacted] provided this service at no cost to patients or pharmacies, however more recently they have begun requiring that an administration fee for each prescription be paid, which presents a barrier to both patients and Ryan White pharmacies.

By utilizing some of the rebate funds being paid to DSHS to pay the administrative fees to [redacted] for all Ryan White pharmacies, access to the [redacted] patient assistance program could be made available to a greater number of patients and could be administered much more easily than if each pharmacy were required to enter into a separate contract.

The Resource Group and DSHS would work together to determine the best way to administer the contract. Both organizations have indicated their willingness to pursue this idea if it receives community support.

See attached document which shows how the three funding streams involved would work together to provide seamless provision of medications to patients

LIST AND ATTACH DOCUMENTS THAT SUPPORT THIS IDEA:

Summary of Integrated Plans to PRovide Continuous HIV Medications

ESTIMATED COST FOR 12 MONTHS: $ 720,000

(over)

Summary of Integrated Plans to Provide Continuous HIV Medication

Stage of Med Coverage	Description of Plans	Amount Needed	Funding Source
Initial supply of drugs	• At preliminary screening/eligibility visit, patient begins completing applications for and ADAP • Patient receives a prescription for 7 days of ARV drugs at first visit with physician, provided results of lab tests are available, and picks up drugs on-site. • After patient receives initial prescription, applications are submitted to ADAP and HP.	Est. cost of drugs for 7-day supply: $500 per patient x 500 patients = $250,000 annually	***Part A*** funds for Emergency Financial Assistance would pay cost of initial 7-day supply of drugs.
Intermediate supply of drugs while ADAP application is being processed	• sends 30-day supply of drugs to patient within 7 days of physician visit. • Patients would be allowed to utilize for up to 90 days	For Houston HSDA: Est. 2,000 patients needing intermediate supply of drugs (newly diagnosed, changing meds, reapplying to ADAP) 2,000 x 3 Rx each x $12 per Rx (est.) = $720,000	***DSHS (SS-R)*** State drug rebate funds (SS-R) would be used to cover administrative fee charged by DSHS and TRG will contract with to pay administrative fees for all Ryan White primary care providers in HSDA to have access to patient assistance program.
Ongoing supply of drugs	• Patient picks up ADAP medications at designated pharmacy. • Patient submits renewal information (attestations and reapplications) as required by DSHS.		ADAP

April 14, 2017

(over)

DRAFT

2017 QUARTERLY REPORT
PRIORITY AND ALLOCATIONS COMMITTEE

(submitted April 2017)

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

1. Conduct training to familiarize committee members with decision-making tools.
   Status: Feb Committee and orientation for new members on 05/25/17.

2. Review the final quarter allocations made by the administrative agents.
   Status: To be done in June 2017

3. *Improve the processes for and strengthen accountability in the FY 2018 priority-setting, allocations and subcategory allocations processes for Ryan White Parts A and B and State Services funding.
   Status: Ongoing

4. When applicable, plan for specialty dollars like Minority AIDS Initiative (MAI) and special populations such as Women, Infants, Children and Youth (WICY) throughout the priority setting and allocation processes.
   Status: To be discussed at June meetings.

5. *Determine the FY 2018 priorities, allocations and subcategory allocations for Ryan White Parts A and B and State Services funding.
   Status: In process

6. *Review the FY 2017 priorities as needed.
   Status: Done

7. *Review the FY 2017 allocations as needed.
   Status: In process

8. Evaluate the processes used.
   Status: To be done later.

9. Annually, review the status of Committee activities identified in the current Comprehensive Plan.
   Status: To be done later.

Status of Tasks on the Timeline:

Committee Chairperson

05/25/17
Date

FYI

TEXAS Health and Human Services | Texas Department of State Health Services

Good Afternoon!

The Texas HIV Medication Program is changing the way we recertify clients who use our program. Currently, the program mails recertification packets by the 15th of each month for those clients who need to recertify by the end of the following month.

Starting June, 2017, the program will switch to birth month recertification. **This means that everybody with a July birthday will receive a recertification packet in June, even if they have just recently completed eligibility for the program or have just recently been recertified. Self-attestation will be completed six months later.**

You can view the letters clients will be receiving about this change in English and Spanish (PDF).

Below are some common questions we have received about this change. Please feel free to share this with others and let us know what other questions you may have:

1. **What is recertification?** Recertification allows the THMP program to show that you continue to be eligible for the program. When you complete recertification (or recertify), you will need to submit a complete application with all required documents.

2. **Why do I need to recertify?** The THMP program is funded by a grant. This grant requires that THMP makes sure that the funding is used by eligible persons. Recertification is how THMP does this.

3. **What is a "self-attestation"?** Self-attestation is six months after recertification (your "half-birthday month"). At the self-attestation, we will only ask for documents about what has changed (for example, if you have a new job we will ask for your new pay stubs).

4. **What does my birth month have to do with my eligibility?** A lot of things can change in your life. You may move, you may go to a different clinic, or you may forget the day you were last approved for THMP. By recertifying on your birthday, we are helping you to make sure the one thing that doesn't change is your THMP enrollment. This also helps your enrollment or eligibility worker know when you need to recertify for the program, even if they didn't work with you when you were last approved for THMP.

5. **What do you mean by "birth month."** When do I recertify if my birthday is April 15th? If your birthday is in April, you will recertify on April 30th. This is true if your birthday is on April 1st, April 30th, or any day in between. You will always recertify the last day of the month you were born. See the Birth Month Recertification Schedule (PDF) to learn more.

6. **Why is this happening now?** This is part of a plan DSHS has to help you stay on THMP. We also have brought on more enrollment workers and made the application shorter. Our goal is to better serve you.

7. **What if I have more questions?** Contact the agency where you receive medical care or support services. They can answer your questions, or help you find somebody who can.

Please take some time to discuss this with your clients, and let us know if you have any questions.

TEXAS
Health and Human Services

Texas Department of State Health Services

John Hellerstedt, M.D.
Commissioner

Estimado(a) cliente del THMP:

Agradecemos su participación en el programa THMP. A partir del **1 de Junio de 2017** la renovación de su elegibilidad se determinará de acuerdo a su fecha de nacimiento.

Por favor considere lo siguiente sobre este cambio:

- Será necesario que presente la solicitud de renovación para THMP antes del último día del mes en que nació, aunque haya presentado una aplicación de elegibilidad recientemente.
    - Por ejemplo: Si usted nació el 1 de Julio, la solicitud deberá ser presentada en nuestras oficinas antes del último día de Julio (el 31 de Julio).
    - Otro ejemplo: Si usted nació el 31 de Julio, deberá presentar su solicitud antes del 31 de Julio, porque ese es el último día de Julio, el mes en que usted nació.
- Seis meses después, deberá presentar una atestación informando a THMP si ha habido cambios en sus ingresos o residencia.
- Asegúrese de que tenemos su domicilio actualizado. Si usted no recibe una solicitud, llame a su agencia local o al THMP para obtener una copia. Deberá presentar su solicitud antes del último día del mes en que nació, aunque no haya recibido el formulario.
- Si no recibimos su solicitud antes de la fecha límite, no podrá hacer sus pedidos de medicamentos a través del THMP hasta que hayamos recibido su información.

Por favor reúna los siguientes documentos antes de la fecha de su renovación:

1. Comprobante de ingresos
2. Comprobante de residencia en Texas
3. Si tiene seguro médico o lo ha tenido, comprobante del seguro.

Si tiene alguna pregunta, por favor llame al THMP al 1-800-255-1090 y pida hablar con un especialista en elegibilidad.

Atentamente,

Rachel Sanor, LMSW, MBA

Rachel Sanor, LMSW, MBA
Gerente, THMP

The Resource Group is hosting a Focus Group

If you are a Caregiver or a Youth 12-24

YOUR EXPERIENCE MATTERS TO US

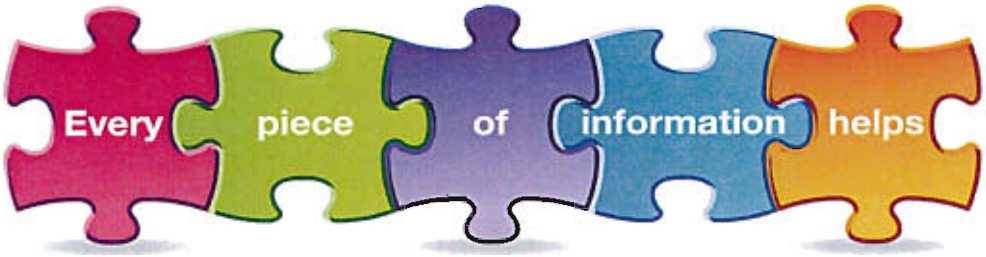
Lunch will be provided

June 14th 11:30 am to 1pm
at the University of Houston Main Campus

Three separate groups: caregivers of a person living with a medical/ health condition, youth 12-17 and young adults 18-24.

Topics which will be discussed in these sessions may include but are not limited to are;

- Parenting skills and methods when caring for a child with a chronic illness.
- Managing relationships and the discussion of disclosure.
- Career planning for caregivers and youth
- Self-care for caregivers and youth



Please contact 832-533-0743 by text or voice mail to RSVP and with any request for transportation assistance, child care onsite while you participate, Spanish interviewer.

LGBTQ SENIOR HEALTHCARE SEMINAR

Free Seminar + Complimentary Breakfast & Lunch

the Montrose Center | 401 Branard St.

FRIDAY, JUNE 16 | 8AM - 5PM

6.0 clock/contact hours available for Social Workers (1.0 Hour Ethics)
CEU's are FREE and offered by UH GCSW Alumni Association

PRESENTATION TOPICS:

- Historical & Political Perspective on LGBTQ Community
- Ethical Considerations when working with LGBTQ patients
- Aging Issues in the Gay Male community
- SPRY Program Information
- Aging Issues in the Lesbian Community
- Aging Issues in the Transgender Community
- LGBTQ Senior Panel Discussion

SEATING IS LIMITED

- RSVP by 6/14/2017 to tonyf@bridgesolutionshealth.com

the Montrose Center

SENIORS PREPARING FOR RAINBOW YEARS spry

HOUSTON UH ALUMNI ASSOCIATION
GRADUATE COLLEGE OF SOCIAL WORK ALUMNI